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LIVED EXPERIENCES OF NURSES WITH COVID-19 CARE IN INDIA: A PHENOMENOLOGICAL STUDY

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ABSTRACT **Background:** In India in March 2020, the Covid-19 started spreading rapidly, bringing pressure and challenges to nursing staff as frontline health care workers. **Objective:** To explore the lived experiences of nurses with Covid-19 patient care. **Methods:** Using a phenomenological approach, 25 nurses were selected as samples. **Results:** The lived experience of nurses caring for Covid-19 patients is summarized into 4 themes; the second theme was the negative emotions experienced by them with five subthemes in the third theme, we found them gaining control with subthemes and in the final fourth theme of growing under pressure, we found three subthemes. Though initially, they struggled with this experience with their perseverance and dedication they slowly gained control of the situation and emerged with the meaning of this experience and insight. **Conclusion:** Coping styles, new team, and psychological growth played an important role in providing meaning to their new role of warrior.

KEYWORDS : Covid-19, Nurses, Experience, And Phenomenology

INTRODUCTION:

Though COVID was ragging its war in China we at India were far removed from the reality that it could also extend its hand against us. We had our issues to tackle in terms of physical, psychological, social, and political aspects of daily life. So when it came, though we were aware of it peripherally yet we were not prepared to tackle it.

Our nursing workforce was caught unaware of its impact. Though as nurses we heard far away stories of its devastating effect, we were not prepared with knowledge, information's on its containment and treatment. It caught us a like tsunami and we got marooned by it for some time.

Generally, Indian nurses, even on normal days are so caught up with the day-to-day workload. Even in good times Indian nurses generally suffered from a lack of the necessary equipment and infrastructure.

So when the disease hit us in mid of March 2020, we were equally unprepared like the Chinese nurses who faced it for the first time with limited data on the disease progress and the risk of contracting the disease, without any definite drugs and treatment to contain and cure the virus. Nurses in India were pushed into it on the forefront with limited protective equipment. Similarly, Indian nurses were given a day notice to a week of preparation before taking care of Covid-19 patients. Indians nurses' experiences were echoed by the Chinese counterparts - states that "Due to the ragging pandemic, nurses without any experience with infectious diseases had to start their duties for Covid-19 patients."[1]

Initially, the diagnosis and treatment were given at Government health facilities; private hospitals offered to extend their help by keeping their expert nursing workforce on critical care as the substitute for the Government nurses workforce if the situation escalates. So earlier parts of April and May 2020, patients were handled only through Government facilities.

As the disease started increasing rapidly in later parts of May and June, the government facilities were insufficient to handle the crisis; therefore few select private setups with intensive care facilities signed a MoU with Government for extending the care facilities for Covid-19 patients in their hospitals.

In the earlier part, the nurses handling Covid-19 cases were asked to come and stay on the hospital premises so that they will not spread illness to their family and community. The nurses were made to work for one week and then were given a week of rest. This pattern continued for sometimes but with the increasing influx of Covid cases, the nurses were made to work for 2 weeks straight and then given 2 weeks of rest, slowly the rest period was shortened to 3 days.

While few volunteered to work in the area, many were asked to report due to the intensity of the spread of disease. So the nurses and their families had to face lots of fear and anxiety and change in their routine personal lives. When the nearby families in society came to know that the nurse is working in the Covid area, the families were ostracized in few places. This kind of behavior was seen in other countries too. ICN chief executive Howard Cotton stated "Completely unacceptable and reprehensible attacks on health care workers battling Covid – 19 largely due to ignorance about their work, combined with countries not doing enough to protect them."[2]

In the initial period, there was an acute shortage of PPES in India and due to short supply, only doctors were given fresh PPEs, and nurses were asked to reuse their PPEs.[3] Not all nurses had to wear the PPE, as it was not conducive to the weather of India, in May and June the nurses in some places wore cotton operations theatre gowns, masks, and gloves for giving care to suspected COVID positive patients. Only nurses working in the intensive care units, where invasive procedures were performed were wearing disposable plastic PPEs.

After peaking from April to October 2020, Covid -19 started a steady decline in all the states of India. Covid-19 has so far claimed the lives of 162 doctors, 107 nurses, and 44 ASHA workers in the country, Rajya Sabha was told on 2nd February 2021, Tuesday. The figures are based on the intimations received from the states till January 22. This was stated by Minister of State for Health Ashwini Kumar Choubey in the House in response to a question on how many healthcare staff, including

doctors, nurses, and ASHA workers who have been affected died due to Covid-19.[4] As of 2nd March 2021 active cases are 168358, Discharged (97.07%) 10798921 and Deaths (1.41%) 157248.[5]

Though we knew that nurses as frontline warriors had lots of challenges with the care of Covid-19, however, these were hearsay stories without evidence and documentation. Previous studies show that when faced with caring for Infectious diseases nurses suffer from loneliness, fear, fatigue, anxiety and, sleep disorder, and other health problems.[6] Studies have shown that the incidence of depression insomnia and post-traumatic stress in nurses caring for SARS ranged from 33 to 39%.[7] Health workers providing care for patients with SARS and MERS outbreaks were under extraordinary stress related to high risk of infection, stigmatization, understaffing, and uncertainty.[8] To our knowledge, there were no qualitative studies were published in India about nurses' lived experience with Covid-19. While being quarantined at home during the initial four lockdowns and continuing our work from home through educating nursing students online, from April to June 2020, we were curious to know whether our nurses also experienced similar distress as other health workers who faced SARS, MERS, and also wanted to make sure the experiences our alumni and fellow nurses who volunteered and took up the challenge as a call of professional responsibility is not lost to history due to lack of recording and evidence. Since nurses lived the experience of working with Covid–19, talking to them and exploring their experiences would be the only way to understand it. There were a few Indian studies and review studies that addressed mental health problems faced by health workers due to the Covid -19; no study was done on the lived experience of nurses with Covid-19 care in India. Therefore this study was undertaken.

The objective of the study is to explore the lived experiences of nurses with Covid-19 patient care.

MATERIAL AND METHODS:

Research Approach And Design:

This study employed a qualitative phenomenological Inquiry approach.

Subjects:

Nurses who are working in state government and private hospitals in the state of Maharashtra and who worked in the Covid -19 areas were invited to participate in this study.

Sampling:

Purposive snowball sampling.

Sampling Criteria:

Nurses, who had a minimum of one month of working experience with covid-19 patient care.

Inclusion Criteria:

1. Nurses who worked in covid-19 areas
2. Nurses who volunteered to participate in this study.

Exclusion Criteria:

Nurses who were not able to participate in the interviews.

Interview Outline:

Conducting one-to-one interview on mobile using an audio recording.

The Semi-structured Interview Guideline Questions Were:

1. How did you come to accept the Covid-19 patient care assignment?
2. What were your feelings while accepting this assignment?
3. What were your family and neighbors' reactions to your acceptance of this assignment?
4. What are the main challenges you experienced while working for Covid -19?
5. What were your coping strategies for these challenges?
6. What are your insights?
7. What message do you wish to share?

Study Permission:

Ethics approval for this research was received from the institutional review board of the Institute. The study objectives were explained through a Google Sheet and willing participants who filled the sheets were explained regarding the voluntary nature of the study, and oral informed consent was obtained before each telephone interview.

Piloting:

We piloted the study on 5 nurses and then modified our semi-structured questions to 7 instead of 8.

Study Procedure:

The Google sheet that was circulated to all possible participants required them to fill in their details if they are willing to participate in the study. For those who volunteered semi-structured, in-depth telephone interviews were done at a time convenient for participants from November 20th to December 31st, 2020.

With participant permission, all interviews were audio-recorded. At the start, the interviewer introduced self and thanked them for their willingness to participate in the study, and explained about confidential nature of the interview and data and after obtaining their verbal consent, they were asked to introduce themselves and the interview started loosely following the semi-structured questions and open-ended follow up questions were used in needed places to obtain detailed descriptions when needed. At times probing questions, such as "Please elaborate more on this" was used to enhance the depth of discussion. At the end of the interview, the researcher summarized her understanding and clarified with the participant on the consistency of it and then thanked them and concluded the interview. Our sample size was determined by data saturation that is to the point where no new experiences were shared and the same experiences were repeated.

Data collection occurred concurrently with data transcription. The audio recordings were transcribed verbatim by the Principal Researcher and the interviews were typed by the interviewers and reviewed by both for accuracy. The interviews, original transcriptions, and data analysis were done in English.

Data Analysis

Colaizzi's 7 steps method was used to analyze transcripts. The First step of the analysis included reading the transcript several times to gain an understanding of the meanings conveyed, then identifying significant phrases about phenomena, which was the second step. Then in the Third and Fourth steps were formulating meanings and validating meanings through research team discussions to reach a consensus on codes, and categories. Continuous comparisons of codes and categories and re-categorization were done by the team. Then, identifying and organizing themes into subthemes were done. In the Fifth, an exhaustive description was made. Then in the sixth step, the descriptions were concised to identify the fundamental structure of the phenomena then finally the seventh step of credibility check was done through checking with similar studies on the phenomena for similarities. To ensure trustworthiness and credibility, findings were then compared and discussed by the team until consensus on themes, sub-themes were achieved. The final results were presented to five participants to check the credibility of the themes and subthemes. The audio recordings were maintained to ensure all analysis steps could be traced back to original interviews.

Table 1. Sample Characteristics

Sr. No.	Characteristics		N (%) or Mean ± SD	Median(Range)
1	Age in years		30.8 ± 5.72	32 (22-45)
2	Gender	Female	22 (88)	
		Male	03 (12)	
3	Marital status	Single	10 (40)	
		Married without children	02 (8)	
		Married with children	13 (52)	
4	Educational qualification	GNM	08 (32)	
		B.B.Sc.(N)	05 (20)	
		P.B.B.Sc.(N)	09 (36)	
		M.Sc.(N)	03 (12)	
5	Type of Hospital/ organization	Government	17 (68)	
		Corporation	03 (12)	
		Private	05 (20)	
6	Total years of experience		7.73 ± 5.11	7 (1.5–19)

7	Work experience in Covid area (in months)		6.68 ± 2.47	7 (1-9)
8	Work experience in the communicable area	Yes	17 (68)	
		No	08 (32)	
9	Years of experience in the communicable area	< 1	06 (35.29)	
		1-2	06 (35.29)	
		>2	05 (29.41)	
10	Tested for Covid	Yes	16 (64)	
		No	09 (36)	
11	Report of Covid	Positive	02 (12.5)	
		Negative	14 (87.5)	
12	Received prophylaxis	Yes	12 (48)	
		No	13 (52)	
13	Name of prophylaxis	Tab. Arsenic Album, home remedies	01 (8.33)	
		Tab. HCQ & Arsenic album	01(8.33)	
		Tab. Chlorhexidine	01 (8.33)	
		Tab. HCQ	03 (25)	
		Tab, HCQ, and Vit -D	01 (8.33)	
		Tab. Arsenic album	01 (8.33)	
		Tab HCQ, Vit C, zinc & MVBC	01 (8.33)	
		Tab. Vitamin D	01 (8.33)	
		Tab. Vitamin C	02 (16.66)	
14	Stay during Covid postings	Hostel in hospital campus	09 (36)	
		Rented with friends	02 (8)	
		Hostel outside	06 (24)	
		Home with family	08 (32)	
15	History of chronic illness	Yes	01 (4)	
		No	24 (96)	

The participants' mean age was 30.8. It ranged from 22 -45 years. Ten participants were unmarried and one was married without children the rest were married with children. Twenty participants worked in Government setups and five in private. Three participants were males and the rest were females. Their work experience ranged from eighteen months to nineteen years.

Thirty-two percent of them were diploma holders and fifty-six percent were degree holders and twelve percent were post-graduate in nursing. Their work experience in Covid-19 ranged from 1-9 months with a mean of 6.68 ± 2.47months. Sixteen participants (64 percent) were tested for Covid-19 among which two had become positive to Covid-19 and both continued in Covid 19 care on completion of treatment. Eight of the participants continued living with the family during the Covid-19 care. One participant suffered from hypertension.

We explored the lived experience of nurses with COVID-19 using phenomenological methods. We found four themes and their subthemes. They are summarized below. Appropriate quotes for each theme are displayed in Table 2.

Table 2. Themes And Subthemes

Theme	Subtheme	Quotations
1. Initiation as a Covid warrior	Volunteering	"I joined voluntarily on my own. I applied to the advertisement given by local corporation and I was selected".
		"I accepted it voluntarily, It is a challenge for us nurses working in non - Covid area, I went, as it was like a war"
		"I accepted this voluntarily. My family members and my child were in the village and due to lockdown, they couldn't come back home. I was alone at home
		"When COVID come in March, it was an anxious time; staffs were not ready to work in this area. We had lectures and then online forms were circulated for volunteers in the hospital (private) I applied for it and got accepted".
	Accepting it as part of the duty	"Initially there was only one ward assigned for COVID in my hospital but as cases increased our hospital was converted to COVID care "
		"I got the letter from the local municipal corporation on 11th March for COVID duty, I joined immediately"
		"I am ICU in charge for the last 4 years and COVID serious patients were admitted in my ICU, initially no staffs of mine were willing to work. I had many meetings, counseling and, conferences and my staff joined I had to be the role model to them".
		"Initially in March only seniors were with 8-10 years were called for COVID care. Then as patients increased I was asked to join for COVID duty".
		"I was told one day in March around 11 am, that tomorrow 7 am onwards, I have to report in a COVID center 10 Kms away from my present workplace and home.
	Families fear and resistance	"My family was scared; they said you don't have to work now. Let Covid end, then you join work back My parents were worried as I have allergic asthma"
		"My aunt was against me working in the Covid area. She called my mother and asked her to tell me to leave my job".
		"My mother was supportive; my father was totally against it. He was angry that why I was taking this responsibility and bringing infection home".
		"There was initial fear in my family. Parents had why invite trouble attitude. I was engaged to be married in May 2020, my future mother in law was not happy with my decision of joining for Covid duty".
		"My mother said don't go for duty. She said do any other work, but not this duty. I told her if I get sick with this disease and all have the same attitude, who will help me? So likewise I am a nurse. I have to be there, so I volunteered".
		"My family was not allowing me to join Covid duty; I had insisted to my family that I will work in this area, so my family did not talk to me for one month".

	Societal discrimination	"I went with a friend for her ANC check-up when knowing we are working in COVID area, the clinic people discriminated us and kept her separately
		“Initially my colony people were non-cooperative they were saying you left your in-laws house and staying here in your parents' house, you will infect us so go away "gradually and slowly they started accepting me".
		“Initially when we used to go down to buy vegetables; my neighbors would close their doors, as they were afraid of getting corona from me”.
		"Our maid refused to work for us since we worked in the COVID area, I managed to get another maid and promised her if anything happens to her I will take care"
		“We and our neighbors always shared our cooked vegetables. When they came to know that I am working for Covid, they refused to accept our vegetables I felt isolated by this”.
		Our hospital had arranged our stay in an apartment of a society. So when society people come to know that we are working for COVID, they were not allowing us to enter society. Our hospital told us to tell society people that we can give police complaints on this. So I did that. Then they stopped harassing us. They used to make us wash our vehicle each time we returned from the hospital”.
	Work pressure	"There was a lot of pressure from administration lots of deadline pressure. There was a lack of oxygen, no central oxygen. We had to be on our toes to maintain the O2 levels of patients.
		"My first rotation was for 65 patients, and two of us were there. Initially, once patients come to know that they are Covid positive), they used to get breathless, that time corona meant death, and O2 beds were very limited"
		"Initially we were assigned at 1:4 ratios, later patients started increasing, and many permanent staff became Covid positive. Then the ratio increased to 1:8 then to 1:10. Each ward had 50-60 patients with 3 staff on the floor per shift".
		"Medications, injections, admissions, discharges, X-ray within an hour of admission. Ensuring staff meal, basic care, O2 inhalations, and any unexpected emergencies. Overall very busy"
		“In ICU duty routine, donning PPE took 30 mts, then take over, check inventory, read patient's condition, assist for procedures, CPRs, intubations, we did not know where things like stilets were kept, so you have to find out, take it and run. You cannot drink, urinate, you have to feed, give basic care, change diapers… it was hectic”.
		"Three wards were connected. Each ward had 30-40 patients and one staff for one ward and one as stand-by for all three wards. Even if you faint or feel sick only one standby for relief. We had to adjust with less staff".
		"Nurses were held responsible for everything, like collecting data to report to the collector, basic care as no relatives and class IV employees were less. So much continuous work, it was tiring"
		"In normal times patients' relatives stayed with them and also assisted in basic care. Covid times no such help we have to do everything. And it is very tiring"
	PPE shortage	“Initially very anxious, as we had no PPE kits. We used HIV/Red kits
		“There was a shortage of PPE. We did not feel like wasting it. So no drinking water, washroom for 7-8 hours at a stretch"
		Our hospital provided a PPE kit only in ICU. We wore OT Gowns and a plastic apron and N-95 masks for the care of Covid patients in the ward"
		“We couldn't take a break in between due to shortage of PPE”.
		"In ICU we had a 6hrs shift. Once you go in with PPE till you get out, we had no water, no washroom breaks. Unless very urgent we did not go out. We did not feel like wasting PPE as they were in short supply"
	Difficulty and discomfort with using PPE	“Had sweating, dehydration, skin irritations, acidity, sleeplessness due to PPE”.
		“Once you were PPE, your ears get twisted with a mask; you cannot touch your face. You have to stay like that I got wounds around my nose and ears”.
		“Physically we had no habit of wearing PPE kits, no toilet, sweating, and no drinking, so dehydrated and physically tired. But we couldn't remove the kit as they were in short supply. Slowly we got used to it”.
		"PPE kit was initially uncomfortable, had a backache, headache, full bladder, sweating, dry skin, dry hand, as PPE material was different each time".
		"Initially PPE kits were made of jute material, we were suffocated in it, I do not know, God only knows how we managed in it, we just used to look at the clock and feel better as the time kept moving … only one move hour to go…"
		"Every time after each procedure, we had to change the outside gloves. It was time-consuming 5 mts work took 30 mts
		“April-May months were hot, and PPE kits were horrible, N95 mask was tight”.
		"PPE suits would be jumpsuit or raincoat type, within one hour of PPE, we would become so wet as if we got wet from the rain. I fainted twice. It was a difficulty we had to wear four masks. So I had injuries on my nose and ears. Then slowly the quality of PPE kits improved. Now just like clothes, we are comfortable".
		“Had sweating, dehydration, skin irritations, acidity, sleeplessness due to PPE”.
		“You couldn't see near who is in front of you whether Doctor or servant. So later we wrote on their back of PPE for identification”.

	Sense of commitment to the cause	"More than our fears, patients were scared. We tried counseling them, by controlling our fears. They needed counseling more than medicine. No relatives with them, so they needed our support"
		“I talked to patients. Nobody talked to patients even Doctors had limited contact with the patients. But I talked to them as they were isolated and disturbed”.
		"We gave the same care to our patients, just like general times, gave psychological support, counseled them and gave comprehensive care".
		“My decision to work for Covid was right. No relatives were allowed with the patient. We were like mother & father to them. Till date I stayed in Covid area and I am happy for that”.
		“When you care for Covid patients, they bless us. This is 'Nurses Year' and we have to fight against Covid”.
		“How many people were affected and lost their families. It is our duty and we should take care of them”
		“This is our job, we have to it, and we cannot run away. Society's opinion towards nurses has changed. They appreciate our work now”
		“I thought I have chosen this profession and they have called me to work here that means they have seen something in me to choose for this assignment”.
2. Experiencing negative emotions	Fear of getting infected	“Initially I had lots of fear, my first patient was healthy and I talked to this patient without a mask and then he tested positive"
		"Initially I did not know much about the disease. A patient I cared for was shifted to a communicable disease hospital and became positive, I was scared, but I didn't want to spread the fear, so managed it on my own”.
		"It was scary, a lot of stigma was attached to it. If anybody got infected, everyone became aware. So I did not go out everywhere for the first 3 months”.
		"I was afraid, anxious, and scared that I may get the disease. Patients were afraid. My family was afraid. Now we are all fine with it”.
		"Initially people were scared, not for death, but infection to self and family".
	Fear of infecting others	“Initially I was scared, though I was happy in a way that this kind of opportunity will not come. I was scared for my family. I took utmost precautions. I thought if I followed all the protocols, I can prevent the infection, so then, I become relaxed”
		"We saw in the news how people died in Italy, USA and China. We were very scared. I and my husband decided not to mix with other people, only talk to people on the phone if needed, as both of us are nurses and working in Covid areas”.
	The anxiety of leaving the family	"Initially we were so panicky and scared and worried because of our children. Who will take care of them? Who will feed them? As there were no crèche facilities." I was scared for my family. Because of me, they should not get Covid, but I was confident that I will be able to take care".
		“Overnight I was asked to shift and report to Covid center away from our home and workplace. My husband was also on Covid duty outstation. I was asked to shift to this new center for one month leaving my teenage daughter alone at home. I was so scared for my daughter. How will she manage alone? Nobody should face difficulty like this leaving a kid alone without anybody at home".
		"I have one son. We left him with relatives. Slowly he started becoming withdrawn and homesick. He wouldn't talk on the phone with me. I brought him back home ”
		“I was away from my family and no visiting then, so I felt sad. So on holidays I spent maximum time with my daughter. She was not troubling me like she used to do before”.
		“Initially, when I informed my family they were scared. I decided that I will stay in the hotel arranged by my hospital so the family will be safe”.
		"My father was angry with me and he asked why I am taking this responsibility and bringing infection home. So I decided to stay in the hostel so that I won't spread the infection to family and neighbors".
	Helplessness	"People especially old were scared; people with comorbidities were scared too. They had lots of fears. Seeing their fears and pain I wish the vaccine should come fast"
		"At times I felt why I am doing this. Why am I putting myself at risk, no food, and no water and it was difficult".
		"It was disturbing, depressing seeing patients die every day. Sometimes 8-10 death per day and at times 6-7 deaths in 6-hour shift. Relatives were not able to see the patient's face. No good thing was happening around, relatives and even children were becoming positive for COVID. It was a depressing atmosphere”.
		“ Felt helpless seeing a mother getting transferred to another hospital because she tested positive for Covid-19, leaving the new-born staying with us “
		“It was difficult to comprehend as all of a sudden minor complaints progressed to severe breathlessness, lungs collapse. Some came in dying situation”.
		“Psychologically I was suffering from uncertainty and frustration. Normally we had relations of patients to help with patient care. But in Covid, we had to do everything and there was a shortage of class-IV employees. Socially no life, no going out, no birthdays how many days we have to live like this”.
		“Since six months I couldn't concentrate on my family and especially my youngest child grew without me”.
		“Till the swab report after Covid rotation, I used to not eat, but pray continuously that I shouldn't be positive for COVID”.
		“During the lockdown, there was no Bazar, so after Covid duty, no vegetables, how to cook food was an issue for me".

		"What was painful for me that when a fourth class worker became Covid positive, all of us who worked with him were quarantined, in a center where there were no facilities for food and washroom. All slum dwellers were admitted with us. Our hospital took no responsibility they did not even check on us even once. I was so stressed, that I decided to leave my job".
	Anxiety about managing family routines and the inability to afford quarantine at home	"We had to manage everything at home so after duty, after a thorough wash, I mixed with my children; I did not wear a mask at home so that my children will not be afraid".
		"We took permission and wore OT dress after doffing to go home. I kept Savlon and water outside for hand washing and clothes. I washed my clothes and dried them out, had a bath, then cooked food for my children. At home, I wore a mask while cooking and serving".
		"I have a 22 months old baby and I am still breastfeeding him. Ours is a nuclear family, so I had to stay with my family. I kept breastfeeding my child".
3. Gaining hold on the situation	Developing coping strategies	"Self-motivation by reading Bible was all I did. One week of duty and one week of rest were good. During one week of rest, I did exercise, walking, cycling and felt rejuvenated"
		"I started doing yoga for 30 minutes. It made me feel good, created positive thoughts and vibes and I am continuing it".
		"Socially couldn't meet my friends. Sometimes, I was not motivated and was feeling low; my new teammates counseled and encouraged me. We understood each other. All of us were going through the same thing. We even prayed together".
		"Spiritually became close to God. God has brought this Covid, and He would take this out".
		"All friends, we prayed together, as all temples were closed"
		"When I came back from work to the hotel, I used to chant mantras, and, listen to music. That is how I managed".
		"I took care of myself following protocols, took Vitamin C, Vitamin D3, and drank lots of hot water that is how I managed".
		"I made up my mind, I set it, whatever may be the difficulty I can handle it, and this is a unique opportunity. This pandemic has come after 100 years, I have to face it".
		"All negative experiences can be made positive; I learnt all art forms like mehendi, drawing, and craft."
		"Mentally this disease is frustrating. Waiting for it to stop".
	Forming new relationships with team members	"We helped each other, our team became our family. Our relationship with each other improved".
		"We supported each other as a team and our seniors were not getting used to PPE and were getting irritated, so we told them to record and do other work".
		"The main thing was Doctors supported us and our team was good, so I adjusted well".
		"My team was good, Doctors were with us".
		"I could not meet my friends so I made new friends with my teammates. They motivated me when I was feeling low; we counseled and encouraged each other. We understood each other and we shared everything. All of us were going through the same thing".
	Gaining confidence and control	"We did all activities, complete basic care, medication relatives were not allowed. So call them on a video call and connect them with patients, even for unconscious patients we communicated relatives on their progress"
		"Patients used to shout, not accepts as not all were symptomatic. So they shout at us to take out their frustration". We kept cool and continued to counsel them as we could relate to their fears and frustrations".
		"The pain of being Covid positive is very psychological. So we kept talking and motivating our patients".
		"The initial fear subsided. I realized if I took all the precautions and followed the protocols I can prevent the infection. So I became relaxed".
		"Some patients were mentally disturbed, we got corona, we are going to die, and we had to counsel them".
		All the care for patients was same, except the change was the PPE kit".
		"I read all about COVID, attended online courses. Made myself knowledgeable, when people ask me, I have to be aware of the subject. I washed my hands frequently, ate healthy meals regularly, and chatted with friends on phone".
		"I learnt to travel to home at night after duty. I was not scared anymore to travel alone"
4. Growth under pressure	Finding meaning	"Earlier everyone in my family depended on me, now they are managing the household work and supporting me in all chores".
		"Due to this Covid protocol of mask, sanitization & social distance, even other illness-which is seasonal like cold & cough also reduced. Peoples hygiene has improved".
		"I think I am very positive because I am not affected, if I had become corona positive, what would have been my attitude, I am not sure".
		"I am so lucky to have this experience".
	Gaining insight	"You cannot say what will happen tomorrow, you can't have all advantage in technology, and earth came to standstill with COVID".
		"I feel more confident, I like giving bedside care. Ten years of working as a staff nurse, that satisfaction is lesser than 6 months of COVID care. More satisfied with COVID care".

		"Self-discipline- is all you need. Prepare yourself for an emergency, keep everything ready. Sanitize yourself frequently, finish all the work when you get time, don't procrastinate".
		“Only people can come to help people, not money”.
		“I can face any situation and my confidence has increased”.
		“Vaccine is the solution to prevent this illness in future”.
		"One old patient, on discharge said, people in my vasti, did not come near me, but you came near me and touched me, talked to me and cleared my fear. I will not forget you please tell me your name, I said I am a nurse"
	Sharing insight	“Support Covid patients don't discriminate them. It is a short illness accept and support them”.
		“Stay positive, no matter what don't get dragged into negative energy. Don't be scared, face it. Life is very important”.
		“There is a solution for all; you have to learn to handle it”.
		“Nursing is the best profession in the world, yet you don't get acceptance. Doctors are given the incentives, as Covid warriors, but nobody appreciates us, no incentive and no recognition”.
		“We are all together in this, we have to face it. We have less understanding on it, so take a slow step, experience it and you will realize that there is nothing to be afraid of".
		“All medical and nursing syllabuses should include a unit on pandemic and how to handle it. We are only learning about communicable diseases”.
		“This disease was already in china, so anticipating this, in India we should have kept ready PPE material according to our scenario, whereas, we copied china”.
		"People are thinking Covid is over, but it is still going on, so people should still follow respiratory etiquettes, social distancing, and sanitization".
		“You may take all the precautions, but maybe the other person not, so all pregnant women, people with small children shouldn't go out, ought to take care”.
		“This disease is an outside syllabus for all of us. I wish to say, please make cotton PPEs, Please realize though nurses were kept behind they faced this disease in front and fought for all positively, society needs to realize this”.

Theme1: Initiation As A Covid Warrior

Sub-theme – volunteering and accepting it as part of the duty:

Forty - four percent of nurses volunteered and the rest accepted this challenge as part of the duty with little knowledge and preparation. In the initial period the Government setup jumbo facilities temporarily for Covid -19 care. Through private agencies authorized by the government, nurses were recruited on a 6months contract. Five participants joined on a contract basis. The rest joined duty as their setups were converted to Covid Treatment centers through the collector's order.

Working in this trying situation was considered by nurses in this study as the calling of their duty.

Sub-theme – Families fear and resistance:

Fifteen participants' families had told them not to accept this responsibility. Four participants' families were positive regarding this responsibility and the rest were neutral to it. One participant stated, "I stayed and traveled from home to work I stay with my father. He said this is your job; you have to do and cannot run away”. A Life Insurance Policy of 50 lakhs on the demise of a Health Care Worker was announced, and some participants working in Government setups were asked to fill it before joining Covid duty and this also added to the anxiety of families. They did not want their loved ones to volunteer for this.

Sub-theme –Societal discrimination:

Since the mode of transmission was unclear the general public was in a panic mode. They felt nurses working in the Covid area will spread the disease to them and their families. Thirty-six percent experienced some form of social discrimination by neighbors and housing society members and strangers.

Two participants were felicitated by the neighbors for working with Covid -19. "My neighbors appreciated that I am working for Covid-19 and they were waiting with bouquets wearing their face masks. They stayed awake till 10 pm to welcome me”.

Sub-theme – Work pressure:

As the Covid patients started increasing the nurse-patient ratio increased to 1:5 in ICUs and 1:20 to 30 in wards. In normal times the patients had their relatives who would assist them with basic care, for Covid patients no relatives were allowed, therefore nurses had to all the work including reporting census, giving basic care, assisting with diagnosis, and implementing treatment, connecting patients to their relatives, communicating with relatives, recording, and reporting.

Sub-theme – PPE shortage:

In the initial month, most of the participants (n = 23) faced a shortage of protective equipment, so most of them wore HIV kits. Due to a shortage of PPEs they did not take a break in-between the shift to avoid wasting one more PPE. Three participants were treated for UTI caused by dehydration.

Sub-theme – Difficulty, and discomfort with using PPEs:

All the participants had difficulties and discomfort with PPEs. Sweating, fogging, skin irritation, sores on ears and nose were the main complaints of all. The months of April and May being hottest and almost all facilities were without air conditioning all participants experienced profuse sweating, dehydration. The PPE materials were not suited for Indian summer. The participants wore four masks including an N-95 which caused difficulty with breathing and three pairs of gloves which caused difficulty using adhesive tapes for securing IV infusions and endotracheal tubes. Three participants had 12 hours of nightshifts, with donning, doffing, and reporting it got extended to 13 hours. During this time they could not use washroom facilities.

Sub-theme – Sense of commitment to the cause:

More than their fears patients fear and anxiety had moved them to overlook their discomforts and counsel and comfort the patients. The nurses persisted in the challenge with a sense of responsibility and professional commitment. Eighty-eight percent of them continued working in the Covid unit for more than 6 months.

Theme 2: Experiencing Negative Emotions

Sub-theme – Fear of getting infected:

Sixty-eight percent faced a tremendous amount of fear regarding getting infected and spreading the infection to others. Initial ambiguity and lots of information and misinformation given by mass media increased their fears. Most of the Covid patients denied having symptoms due to fear of discrimination and stigma, and they hid their symptoms and stayed home until it became severe. Some patients were asymptomatic but were positive for Covid. All these confounding factors increased nurses' fear of getting infected.

Sub-theme – Fear of getting others infected:

More than their fear of getting infected, nurses were afraid of infecting others. Willingly they self-quarantined themselves to prevent the spread of disease by joining the hostel or hotel facilities offered by their management for quarantining aftercare.

Sub-theme – Anxiety of leaving family:

Ten participants had anxiety regarding leaving the family and their

routine family role of being a primary caregiver. They also experienced anxiety, fear, depression, and a sense of helplessness related to losing control with routines, seeing people die, and not getting adequate food items in the hostels due to lockdown.

Sub-theme – Helplessness:
Fifty percent felt powerless and experienced anxiety, sadness to depression due to changes in the patient's condition as mild symptoms progressed to breathlessness to severe respiratory problems resulting in death. In some cases, the separation of the newborn from their mothers due to their mother's Covid status caused anxiety and sadness in them. They were feeling helpless when tested for Covid after each rotation. They were afraid of becoming Covid positive and being quarantined.

Sub-theme- Anxiety about managing family routines and the inability to afford quarantine at home:
Three participants had small children and nuclear families and due to lockdown, there was no facility for extended families to help them with this crisis these three participants had added the burden of managing their family routines along with fear of infecting children.

Theme 3: Gaining control
Sub-theme - Developing Coping Strategies:
Gradually they gained more control in their working situation and developed better stamina to stand the difficulties with PPEs, work pressure, and fear. They also employed self-copying strategies such as forming emotional bonding with their new team members and employed some relaxation strategies like yoga, art therapy. Few became close to God and prayed together with new teammates. Some started taking a high protein diet and vitamin supplements. A few were frustrated with the new routines as stated by one participant 'mentally this disease is frustrating waiting for it to stop.'

Sub-theme- Forming new relationships with team members:
Most of the participants became close to their new team members. The Doctor- Nurse Communication gap on normal times reduced and became good teamwork.

Sub-theme- Gaining confidence and control:
Gradually they settled and adjusted with their new routines. They performed all the basic care, treatment schedules, and counseled their patients, understood and tolerated their patients' frustrations, and kept motivating the patients. Some read more on the disease condition to explain to others. One participant learnt to travel home at night on a two-wheeler alone.

Theme 4: Growing under pressure
Sub-theme- Finding meaning:
Most of the participants and their families have learnt to adjust to the new routines and participants are able to find meaning in this experience. They are more positive, more in control, and are in a position to value their team relationships and profession.

Sub-theme- Gaining insight:
Participants expressed confidence and appreciation for this experience. While some were cautious about the unpredictability of the future, wanted people to have more self-discipline, and understand the transience of material wealth and the need for relationships with each other, some were more confident regarding their ability to face a crisis such as this. Some felt the only vaccine would put an end to this crisis.

Sub-theme- Sharing insight:
When asked to share their learning from this experience one participant wanted others not to discriminate against Covid -19 patients and some want others not to be afraid, but take the slow step to normalcy. Some wanted the general public not to take this disease for granted and become relaxed with preventive measures towards this illness.

DISCUSSION:
The result of this study showed the participants took up this challenge of being a frontline carer with very little preparation, they faced lots of fears and anxiety, but their perseverance and commitment to the cause of being a Covid warrior got them through this experience unscathed. A similar study also found that "Working in this trying situation was considered by nurses as the calling of their duty and chosen profession. Although serving society as nurses was not a new thing for them, this crisis has made them appreciate the value and purpose of their chosen profession of nursing."[9]

Though there were efforts on spreading awareness to the public through mass media, the constant barrage of information on the severity and infectivity of this illness increased the public fear to maximum height through the constant of information and misinformation given by the mass media. A study by Cawcutt, K. A., Starlin, R., & Rupp, M. E. found that amid the pandemic and shortages, anxiety and fear were rampant, fuelled by real risk and amplified by the 24-hour news feed and social media.[10]

Participants used coping strategies such as turning to the support of God and becoming closer to their team members, helping each other, and counseling each other. However, some of them expressed grief regarding losing patients, becoming powerless when new-borns were separated from their Covid positive mothers, and felt depressed when patient's bodies were packed without allowing their relatives to see their faces for cremation. A similar study on coping strategies by Japanese health workers showed that to minimize social isolation and loneliness, participants incorporated new activities, such as online communication, and health management activities such as physical exercises and arts and crafts[11]. Although in this study the participants managed their emotional ordeal without professional support, they found their innovative ways of coping with it by taking up prayer, yoga, meditation, and art.

Finally, the participants have grown under the pressure and become positive, more in control, and are in a position to value this experience. A study on the posttraumatic experience in holocaust survivors found that survivors have found meaning in painful experiences, and discovered a positive change in self[12]. Similarly, our participants also found meaning in this difficult situation.

As this is a novel experience, many hospitals set up that were forced to take up Covid patients were ill-prepared with infection prevention and control, personal protection skills, a safe environment, and sufficient PPE supplies. They also lacked continuous training and psychological support of their Health Care Workers. However, in the future, there should be a better mechanism of preparedness to handle pandemics, through on-going training, monitoring, and creating a support system for smooth supply of equipment, articles, and manpower. The administrators and support system should be given training on keeping supplies ready for an emergency. A team of psychiatrists, psychotherapists, and psychiatric nurses to be made as part of the disaster management team, to handle and treat the psychological impact of the pandemic on Health Care Workers.

Nurses are the collaborators of patient care in any health setup. They have a leading role in facilitating communication and collaboration among health-care team members; this crisis of Covid improved the mutual trust and respectful environments with positive communication between doctors and nurses. A conscious effort to be made by the Governments and managements to maintain this by clarifying the roles and by establishing standardized procedures related to HR.

Implications of the study:
For continuing to fight this illness and face future challenges similar to this nurses need comprehensive support from administrators by involving nurses in policy-making and appreciating their experiences and difficulties with Covid-19. Nurses need better suited protective devices, reasonable work schedules, smooth communication, better monitoring and supervision in controlling the infection, and psychological support. They need intensive training with mock drills to prepare them for the future pandemic in any.

CONCLUSION:
In the face of emergency with Covid-19 nurses showed strong dedication and professional commitment to volunteer or accept this challenge of caring for the patients with limited knowledge and resources, by putting their health and families' health at risk. They performed a heavy workload and difficult task of rendering care with less manpower and smooth communication. Despite these severe limitations each of the participants tried to provide the best possible care for the recovery of each of their patients. This intensive work has drained them physically, psychologically, and spiritually. They need comprehensive support to safeguard their wellbeing and better preparedness and facilities for a future emergency if any as soon as possible.

REFERENCES

1. Guo, Y. R., Cao, Q. D., Hong, Z. S., Tan, Y. Y., Chen, S. D., Jin, H. J., ... & Yan, Y. (2020). The origin, transmission and clinical therapies on coronavirus disease 2019 (COVID-19) outbreak–an update on the status. Military Medical Research, *7*(1), 1-10.
2. Health Economic Times. (2020, May 06). Latest updates on Covid 19 https://economictimes.indiatimes.comhttps://economictimes.indiatimes.com/news/international/world-news/over-90000-health-workers-infected-with-covid-19-worldwide/articleshow/75578439.cm.
3. Somya L. (2020, May 26). Nurse's death: Colleagues say had to wear used PPEs. https://indianexpress.com/article/cities/delhi.
4. Mint e Paper. (2021, February 02). Covid-19: 162 doctors, 107 nurses, 44 ASHA workers killed due to virus. https://www.livemint.com/news/india.
5. Ministry of Health and Family Welfare. (2021, March 02). Covid 19 India. https://www.mohfw.gov.in.
6. Honey, M., & Wang, W. Y. (2013). New Zealand nurses perceptions of caring for patients with influenza A (H1N1). *Nursing in critical care*, *18*(2), 63-69.
7. Su, T. P., Lien, T. C., Yang, C. Y., Su, Y. L., Wang, J. H., Tsai, S. L., & Yin, J. C. (2007). Prevalence of psychiatric morbidity and psychological adaptation of the nurses in a structured SARS caring unit during outbreak: a prospective and periodic assessment study in Taiwan. *Journal of psychiatric research*, *41*(1-2), 119-130.
8. Lee, S. M., Kang, W. S., Cho, A. R., Kim, T., & Park, J. K. (2018). Psychological impact of the 2015 MERS outbreak on hospital workers and quarantined hemodialysis patients. *Comprehensive Psychiatry*, *87*, 123-127.
9. Sadang, J. M. (2021). The lived experience of Filipino nurses' work in COVID-19 quarantine facilities: a descriptive phenomenological study. *Pacific Rim International Journal of Nursing Research*, *25*(1), 154-164. https://www.researchgate.net/publication/346791330
10. Cawcutt, K. A., Starlin, R., & Rupp, M. E. (2020). Fighting fear in healthcare workers during the COVID-19 pandemic. *Infection Control & Hospital Epidemiology*, *41*(10), 1192-1193.
11. Tahara, M., Mashizume, Y., & Takahashi, K. (2021). Coping Mechanisms: Exploring Strategies Utilized by Japanese Healthcare Workers to Reduce Stress and Improve Mental Health during the COVID-19 Pandemic. *International journal of environmental research and public health*, *18*(1), 131.
12. Wulandari, S., Poerwandari, E. K., & Basri, A. A. (2019, August). The journey of finding meaning in life: Posttraumatic growth experience in notable holocaust survivors. In *2nd International Conference on Intervention and Applied Psychology (ICIAP 2018)* (pp. 444-457). Atlantis Press.