

## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected **need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.**

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. **Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.**

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). [GRI]The perceived lack of

defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018,[A2]). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009[A3], Corley et al., 2010[A4]). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007[A5]).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). [GR6]Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009[A7]). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020[A8]). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010[A9])

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018[A10]). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005[A11], Kim, 2018[A12]). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012[A13]). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007[A14]). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013[A15], Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008)[A16]. The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013,[A17] Chung et al., 2005[A18]). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who

have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## **Study rigor**

To establish this study's rigour, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## **Ethical considerations**

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## **RESULTS**

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

### **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

#### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

### **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

## *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

## *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

## *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was



excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

## *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, “My roommate, she’s elderly, was suffocated, so I helped take care of her.” Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, “The PCR results were too long... I have to wait a few days [after the swab] until I can go home.” Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

## **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, “Now I disciplined myself to wear a

mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

## **Theme1. Experience at diagnoses (Pre Isolation)**

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). [GR19]Pasien terkonfirmasi COVID-19 cenderung mengalami tekanan terkait dengan kondisi dialami yang dapat mempengaruhi kondisi fisik, emosional, mental, sosial, dan spiritual (Roman et al., 2020). [A20]Penelitian (Clerkin et al., 2020)[A21] yang menyatakan bahwa laporan awal menunjukkan gejala yang paling umum terinfeksi COVID-19 adalah demam (88%). Berdasarkan penelitian (Biscardi et al., 2020)[A22] menyatakan bahwa Sekitar 80% orang yang terkonfirmasi COVID-19 mengalami gejala ringan hingga sedang yaitu mengalami batuk kering atau sakit tenggorokan. Berdasarkan (Kumar et al., 2020)[A23] menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf perifer, akan menyebabkan gejala seperti gangguan pengecap dan gangguan penciuman. Sedangkan penelitian (Jesmi et al., 2021)[A24] menyatakan bahwa keluhan yang sering pasien yang terkonfirmasi COVID-19 mengungkapkan masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah.

Fear is an adaptive response to a potentially threatening situation (Ornell et al., 2020). The most important mental strain of COVID-19 patients is the fear of death and worsening of symptoms (Jesmi et al., 2021). Severe psychological stress experienced by these patients can increase the risk of psychological tension, including post-traumatic stress. Therefore, psychological support for these patients is essential to reduce the negative consequences of psychological tension. Also Mertens et al. (2020) stated that in an online survey of 439 patients with COVID-19, they showed fear in social aspects, including intolerance of uncertainty, their health anxiety, and those of their loved ones (Mertens et al., 2020).

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression finding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization.

Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The

negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease. Saat pandemi COVID-19 saat

ini, beberapa pasien terkonfirmasi COVID-19 masih mendapat perlakuan

didiskriminasi, diperlakukan secara terpisah karena terdiagnosa terinfeksi

COVID-19. Hal ini berdampak negatif kepada mereka yang terkonfirmasi

COVID-19 dan keluarga. Stigma dapat merusak hubungan sosial dan mendorong

kemungkinan isolasi sosial kelompok yang mengakibatkan lebih banyak masalah

kehatan yang parah dan kesulitan mengendalikan wabah penyakit karena

mendorong seseorang yang terinfeksi COVID-19 menyembuyikan penyakitnya

untuk menghindari diskriminasi (WHO, IFRC, 2020). [A25]

## **Theme 2. Experience in the isolation room**

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Participants' experiences where the body conditions in the isolation room are the same as reported in the study of Jesmi et al. (2021) as always have nervous, respiratory, gastrointestinal, and systemic manifestations (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020). Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries

(Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

Berpisah dengan keluarga dan diisolasi dalam jangka waktu lama pasien cenderung khawatir atas pemenuhan tanggung jawab keluarga mereka sehingga menimbulkan kesedihan selama berpisah dengan orang-orang yang dicintai (Wang et al., 2020)[A26] Pernyataan stres yang dialami partisipan disebabkan karena sendirian diruang isolasi atau dirawat bersama pasien yang kondisinya berat serta stres memikirkan kondisi kesehatan akan memburuknya gejala yang dialami. Stres yang dialami pasien terkonfirmasi COVID-19 merupakan respon normal terhadap penyakit. Stres dapat menyebabkan penurunan sistem kekebalan tubuh dan menyebabkan disregulasi imun yang dapat memperburuk kondisi kesehatan pasien yang terkonfirmasi COVID-19 (Kaligis et al., 2020)[A27] Beberapa faktor yang berpengaruh terhadap kesehatan psikologis pasien yang terkonfirmasi COVID-19 adalah angka kasus COVID-19 tidak terkendali dalam penyebaran virus, pasien yang diisolasi mengalami masalah pernapasan akut dan penyakit COVID-19 dapat menyebabkan kematian. Sehingga hal tersebut dapat menyebabkan kecemasan pada pasien terkonfirmasi COVID-19 (Jesmi et al., 2021)[A28].

Ketidakpuasan intervensi klinis yang diterima dan kualitas perawatan diruang isolasi COVID-19 yang disebabkan karena pembatasan jam masuk tim medis COVID-19 ke dalam ruangan isolasi COVID-19. Berdasarkan (Tim Mitigasi Dokter PB IDI, 2020)[A29] shift kerja harus memperhatikan durasi kerja yang sesuai dengan peraturan yaitu Permenkes No.52 Tahun 2018. Waktu kerja lebih pendek diijinkan pada kondisi tekanan pekerjaan tidak normal atau resiko tinggi seperti tim medis COVID-19 harus memakai hazmat terus menerus sepanjang shift. Shift pendek lebih disarankan dibandingkan shift panjang sehingga dapat membantu melindungi dari risiko kelelahan mental dari beban kerja yang berat. Kelelahan tersebut dapat meningkatkan resiko cedera dan memperburuk kondisi kesehatan yang rentan terhadap infeksi penyakit, peningkatan tekanan psikologis yang mempengaruhi kesehatan tim medis, dan kualitas serta keamanan perawatan yang diberikan. Maka perlunya edukasi tim medis COVID-19 kepada pasien terkonfirmasi COVID-19 yang menjalani perawatan diruang isolasi COVID-19 terkait adanya perubahan rotasi dan durasi kerja tim medis diruang isolasi COVID-19. Hal ini dilakukan untuk mengurangi pajanan tenaga kesehatan terhadap virus yang ditujukan untuk menjaga kesehatan fisik dan mental dan mempertahankan kualitas pelayanan para tim medis

### **Theme 3. Post-isolation experiences**

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants'

statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

Emosi positif yang terkait dengan dukungan yang diterima pasien terkonfirmasi COVID-19 berasal dari berbagai sumber salah satunya adalah dukungan keluarga. Berdasarkan (Aunguroch et al., 2020) [A30] menyatakan bahwa dukungan sosial dari anggota keluarga menunjukkan bahwa manusia adalah makhluk sosial yang tidak dapat hidup tanpa dukungan sosial termasuk dalam penanganan penyakit COVID-19. Dan emosi positif berperan penting dalam pemulihan dan penyesuaian psikologis (Sun et al., 2020) [A31] Suasana hati pasien terkonfirmasi COVID-19 yang baik akan meningkatkan dopamin yang tinggi didalam darah sehingga akan mengoptimalkan dan meningkatkan sistem kekebalan tubuh. Dukungan dari teman dapat memberikan respon yang positif terhadap pemuliharaan kesehatan (T. Habib, 2021) [A32] Perawatan dan tindakan intervensi yang diberikan tim medis secara profesional setiap hari akan menghasilkan rasa terimakasih dari pasien (Wang et al., 2020) [A33]

Spiritualitas dapat memberikan harapan dan makna dalam situasi sulit termasuk dimasa pandemi COVID-19 (Teresa et al., 2021) [A34] Spiritual menciptakan emosi positif dalam diri seseorang. Spiritualitas dan agama dapat membantu manusia dalam kesedihansaat-saat krisis dan dapat menjadi obat penenang yang berguna pada manusia (Chronic et al., 2020) [A35]

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

PostCOVID-19 syndromeyang dialami partisipan bervariasi beberapa partisipan menyatakan post COVID-19 syndrome masih dirasakan walaupun sudah dinyatakan negatif COVID-19. Hal ini sejalan dengan

(Care & Resource, 2020) [A36] menyatakan bahwa Oktober 2020, NICE (*the national institute for health and care excellence*) mengakui ketidakpastian efek jangka

panjang dari virus SARS-CoV-2 dan mendefinisikan post COVID-19 syndromesebagai gejala yang berlangsung lebih dari 12 minggu. Keluhan kondisi fisik jangka panjang pada pasien terkonfirmasi COVID-19 bervariasi dengan waktu yang lama dan berfluktuasi, tergantung pada tingkat keparahan penyakit dan status kesehatan pasien dengan mempertimbangkan komorbiditas dan kelemahan secara keseluruhan. Kondisi ini muncul dengan gejala yang dapat berubah seiring waktu dan dapat mempengaruhi sistem didalam tubuh. Gejala umum post COVID-19 syndrom yaitu kelelahan dan kelemahan ekstrem, sesak napas saat aktivitas ringan, nyeri sendi, demam ringan yang terus-menerus, sakit kepala, vertigo, pilek, sakit tenggorokan, perubahan suara dan kesulitan menelan, kehilangan atau perubahan penciuman dan perasa yang berkepanjangan, rambut rontok, gangguan gastrointestinal termasuk kehilangan nafsu makan, sakit perut, diare, muntah, ketidakmampuan untuk berkonsentrasi dan susah tidur (Care & Resource, 2020).

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

## ACKNOWLEDGMENTS



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### LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

### AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

### CONFLICT OF INTEREST

There is no conflict of interest in this research

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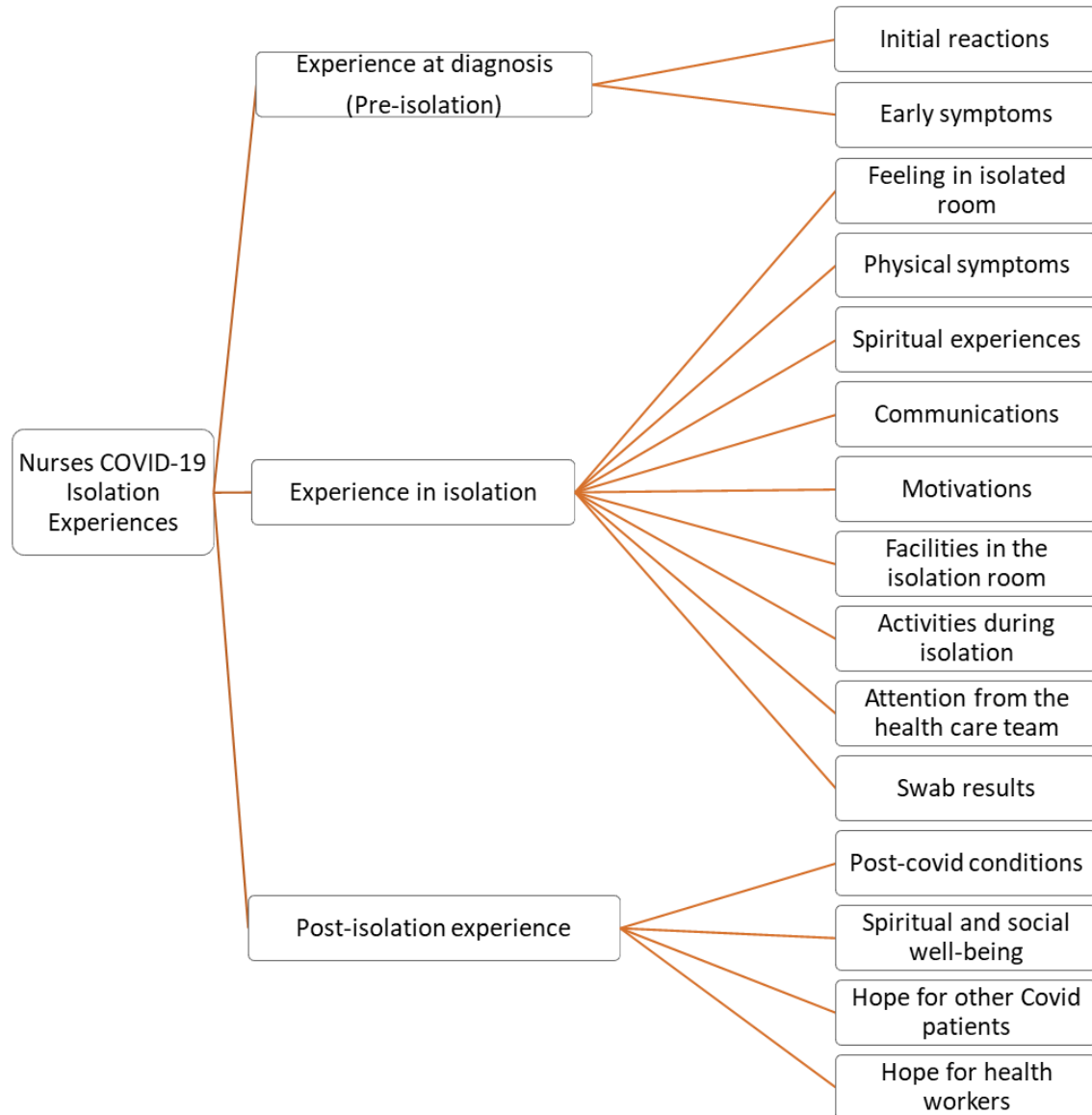
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## TABLE

**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** Themes and Subthemes

## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience



## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

**Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). The perceived lack of**

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defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009, Corley et al., 2010). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010).

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005, Kim, 2018). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013, Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008). The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

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often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013, Chung et al., 2005). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who

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have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

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description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

### Study rigor

To establish this study's rigor, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

### Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

### RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

#### Theme 1: Experience at diagnoses (Pre-isolation)

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants' initial reactions and early symptoms.

##### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

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Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, “... I had mixed feelings, how could I get covid? I always wear full PPE!”. Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, “...I didn’t believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying.”

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

### **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

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### *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

### *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

### *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

### *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was

excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

### *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

### *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

### *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

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As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

### **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of 'post-covid conditions', 'spiritual and social well-being', 'hope for other covid patients' and 'hope for health workers.'

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, "Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be" (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, "Now I disciplined myself to wear a

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mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements."

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. "My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance" (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, "If I hear a friend has Covid, I'll be happy to send them food. I'll support them." Another participant echoed this, "Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation" (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, "My message is, I've been through it and recovered, so you do too," and another commented "don't stress it too much, keep eating, have lots of rest and make yourself happy" (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, "My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to." Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. "Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care" (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

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## Theme1. Experience at diagnoses (Pre Isolation)

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members.

Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). Pasien terkonfirmasi COVID-

19 cenderung mengalami tekanan terkait dengan kondisi dialami yang dapat mempengaruhi kondisi fisik, emosional, mental, sosial, dan spiritual (Roman et al., 2020). Penelitian (Clerkin et al., 2020) yang menyatakan bahwa laporan awal menunjukkan gejala yang paling umum terinfeksi COVID-19 adalah demam (88%). Gejala paling umum pada awal penyakit COVID-19 adalah demam, batuk dan kelelahan. Sementara gejala lainnya termasuk produksi sputum, sakit kepala, hemoptisis, diare, dyspnoe, dan limfopenia. COVID-19 menunjukkan gejala klinis pada saluran pernapasan atas seperti rinorea, bersin dan sakit tenggorokan. Selain itu berdasarkan hasil radiografi dada beberapa kasus menunjukkan infiltrat dilobus atas paru-paru yang

berhubungan dengan peningkatan dispnea dengan hipoksemia (Rothan &

Byrareddy, 2020). Berdasarkan penelitian (Biscardi et al., 2020) menyatakan

bahwa Sekitar 80% orang yang terkonfirmasi COVID-19 mengalami gejala ringan hingga sedang yaitu mengalami batuk kering atau sakit tenggorokan.

Patients confirmed with COVID-19 tend to experience stress related to the conditions they experienced which can affect their physical, emotional, mental, social, and spiritual state (Roman et al., 2020). Research (Clerkin et al., 2020) states that initial reports show that fever (88%) is the most common symptom of being infected with COVID-19. Other symptoms include sputum production, headache, hemoptysis, diarrhea, dyspnoea, and lymphopenia. COVID-19 shows clinical symptoms in the upper respiratory tract such as rhinorrhea, sneezing and sore throat. In addition, based on the results of chest radiographs, several cases showed upper lobe infiltration of the lungs is associated with increased dyspnea with hypoxemia (Rothan & Byrareddy, 2020). Based

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on a research (Biscardi et al., 2020) it is stated that around 80% of people with positive COVID-19 experience mild to moderate symptoms, namely having a dry cough or sore throat.

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression. The overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease.

Saat pandemi COVID-19 saat ini, beberapa pasien terkonfirmasi COVID-19 masih mendapat perlakuan didiskriminasi, dipisahkan secara terpisah karena terdiagnosa terinfeksi COVID-19. Hal ini berdampak negatif kepada mereka yang terkonfirmasi COVID-19 dan keluarga. Stigma dapat merusak hubungan sosial dan mendorong kemungkinan isolasi sosial kelompok yang mengakibatkan lebih banyak masalah kesehatan yang parah dan kesulitan mengendalikan wabah penyakit karena mendorong seseorang yang terinfeksi COVID-19 menyembuyikan penyakitnya untuk menghindari diskriminasi (WHO, IFRC, 2020).

During the current COVID-19 pandemic, some patients positive with COVID-19 are still being discriminated, treated separately because they were diagnosed with COVID-19. This has a negative impact on those who are confirmed to be COVID-19 positive and their families. Stigma can undermine social relationships and encourage the possibility of social group isolation resulting in more severe health problems and difficulty controlling disease outbreaks because it encourages someone infected with COVID-19 to hide their illness to avoid discrimination.

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### Theme 2. Experience in the isolation room

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Berpisah dengan keluarga dan diisolasi dalam jangka waktu lama pasien cenderung khawatir atas pemenuhan tanggung jawab keluarga mereka sehingga menimbulkan kesedihan selama berpisah dengan orang-orang yang dicintai (Wang et al., 2020). Pernyataan stres yang dialami partisipan disebabkan karena sendirian diruang isolasi atau dirawat bersama pasien yang kondisinya berat serta stres memikirkan kondisi kesehatan akan memburuknya gejala yang dialami. Stres yang dialami pasien terkonfirmasi COVID-19 merupakan respon normal terhadap penyakit. Stres dapat menyebabkan penurunan sistem kekebalan tubuh dan menyebabkan disregulasi imun yang dapat memperburuk kondisi kesehatan pasien yang terkonfirmasi COVID-19 (Kaligis et al., 2020). Beberapa faktor yang berpengaruh terhadap kesehatan psikologis pasien yang terkonfirmasi COVID-19 adalah angka kasus COVID-19 tidak terkendali dalam penyebaran virus, pasien yang diisolasi mengalami masalah pernapasan akut dan penyakit COVID-19 dapat menyebabkan kematian. Sehingga hal tersebut dapat menyebabkan kecemasan pada pasien terkonfirmasi COVID-19 (Jesmi et al., 2021).

Berdasarkan (Kumar et al., 2020) menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf perifer, akan menyebabkan gejala seperti gangguan pengecap dan gangguan penciuman. Menurut (Munhoz et al., 2020) menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf pusat akan menyebabkan gejala seperti pusing, sakit kepala, gangguan kesadaran, ataksia, dan kejang. Sedangkan penelitian (Jesmi et al., 2021) menyatakan bahwa keluhan yang sering pasien yang terkonfirmasi COVID-19 mengungkapkan masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah. Berdasarkan penelitian (Syam, 2021) menyatakan bahwa pasien terkonfirmasi COVID-19 dengan gejala awal diare, virus cenderung bertahan didalam tubuh lebih lama daripada mereka yang tidak mengalami gejala gastrointestinal. Gejala gastrointestinal pada pasien terkonfirmasi COVID-19 memiliki tingkat insiden 64 yang bervariasi. Secara umum kasus terkonfirmasi COVID-19 dengan gejala diare sekitar 2-10% kasus, mual sekitar 2-15% kasus, muntah sekitar 1-5% kasus, nyeri abdomen sekitar 2-6% kasus dan kehilangan nafsu makan sekitar 80% kasus. Hal ini sejalan dengan penelitian (Jesmi et al., 2021) menyatakan bahwa keluhan yang sering pasien ungkapkan adalah masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah.

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Separated away from family and isolated for a long time, patients tend to worry about fulfilling their family responsibilities, causing sadness when they are separated from loved ones (Wang et al., 2020). The statement of stress experienced by participants was caused by being alone in an isolation room or being treated with a patient whose condition was also severe and the stress of thinking about their health condition that would worsen their symptoms. The stress experienced by patients positive with COVID-19 is a normal response to illness. Stress can cause a decrease in the immune system and cause immune dysregulation which can worsen the health condition of patients with COVID-19 (Kaligis et al., 2020). Several factors that affect the psychological health of patients with COVID-19 are the number of uncontrolled COVID-19 cases. Isolated patients experience acute respiratory problems and COVID-19 disease can cause death. This can cause anxiety in patients with confirmed COVID-19 (Jesmi et al., 2021).

It was (Kumar et al., 2020) stated that SARS-CoV-2 which attacks the peripheral nervous system, will cause symptoms such as impaired taste and smell disorders. According to Munhoz et al. (2020), SARS-CoV-2 which attacks the central nervous system will cause symptoms such as dizziness, headache, impaired consciousness, ataxia, and seizures. Meanwhile, a research stated that the frequent complaints of patients who were confirmed by COVID-19 revealed digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting (Jesmi et al., 2021). Based on research by Syam (2021), patients with confirmed COVID-19 with early symptoms of diarrhea, the virus tended to stay in the body longer than those who did not experience gastrointestinal symptoms. Gastrointestinal symptoms in patients with confirmed COVID-19 have varying incidence rates. In general, confirmed cases of COVID-19 with symptoms of diarrhea in about 2-10% of cases, nausea in about 2-15% of cases, vomiting in about 1-5% of cases, abdominal pain in about 2-6% of cases and loss of appetite in about 80% of cases. This is in line with research (Jesmi et al., 2021) which states that the complaints that patients often express are digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting.

Participants' experiences where the body conditions in the isolation room are the same as reported in the study of Jesmi et al. (2021) as always have nervous, respiratory, gastrointestinal, and systemic manifestations (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020). Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this

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disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries (Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

Suasana hati pasien terkonfirmasi COVID-19 yang baik akan meningkatkan dopamin yang tinggi didalam darah sehingga akan mengoptimalkan dan meningkatkan sistem kekebalan tubuh. Maka strategi untuk mendukung kekebalan tubuh adalah dengan menjaga suasana hati dalam keadaan baik seperti dengan video call dengan keluarga dan orang-orang yang dicintai, bermain handphone dan mendengarkan musik. Diketahui bahwa pasien terkonfirmasi COVID-19 yang menjalani isolasi diruang COVID-19 mendengarkan musik efektif dalam mengurangi kecemasan, mengurangi halusinasi yang menyebabkan rasa takut dan membantu memiliki pengalaman yang lebih positif (T. Habib, 2021). Sedangkan mendengarkan musik dapat mengurangi masalah psikologi berdasarkan reaksi subjektif terhadap situasi. Mendengarkan musik dijadikan suatu komponen yang berinteraksi dalam pencegahan gangguan cemas, bosan, stress dan pasca trauma (Panteleeva et al., 2018). Berdasarkan (Umarella et al., 2020) menyatakan bahwa ibadah, doa dan membaca al-quran adalah alternatif yang baik untuk mengobati penyakit psikologis dan meningkatkan kualitas hidup.

The positive mood of COVID-19 confirmed patients will increase high dopamine in the blood and will optimize and boost the immune system. So, the strategy to support immunity is to maintain a good mood such as by video calling family and loved ones, playing with handphons and listening to music. It is known that COVID-19 confirmed patients undergoing isolation in the COVID-19 ward that listen to music is an effective way in reducing anxiety, hallucinations that cause fear and helps to have a more positive experience (T. Habib, 2021). Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is used as an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeva et al., 2018). It is (Umarella et al., 2020) stated that

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worship, prayer and al-quran reading are good alternatives to treat illness psychological well-being and improve quality of life.

Berdasarkan(Aungsueroch et al., 2020) menyatakan bahwa dukungan sosial dari anggota keluarga menunjukkan bahwa manusia adalah makhluk sosial yang tidak dapat hidup tanpa dukungan sosial termasuk dalam penanganan penyakit COVID-19. Dan emosi positif berperan penting dalam pemulihan dan penyesuaian psikologis (Sun et al., 2020). Dukungan dari teman dapat memberikan respon yang positif terhadap pemuliharaan kesehatan (T. Habib, 2021).

Based on research by (Aungsueroch et al. (2020) support from family members shows that humans are social beings who cannot live without social support including in handling COVID-19 disease. And positive emotions play an important role in recovery and psychological adjustment (Sun et al. al., 2020). Support from friends can give a positive response to health promotion ((T. Habib, 2021). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and treatment in the COVID-19 isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020).

### Theme 3. Post-isolation experiences

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants' statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

PostCOVID-19 syndromeyang dialami partisipan bervariasi beberapa partisipan menyatakan post COVID-19 syndrome masih dirasakan walaupun sudah dinyatakan negatif COVID-19. Hal ini sejalan dengan (Care & Resource, 2020) menyatakan bahwa Oktober 2020, NICE(the national institute for health and care excellence) mengakui ketidakpastian efek jangka panjang dari virus SARS-CoV-2 dan mendefinisikan post COVID-19 syndromesebagai gejala yang berlangsung lebih dari 12 minggu. Keluhan kondisi fisik jangka panjang pada pasien terkonfirmasi COVID-19 bervariasi dengan waktu yang lama dan berfluktuasi, tergantung pada tingkat keparahan penyakit dan status kesehatan pasien dengan mempertimbangkan komorbiditas dan kelemahan secara keseluruhan. Kondisi ini muncul dengan gejala yang dapat berubah seiring waktu dan dapat mempengaruhi sistem didalam tubuh. Gejala umum post COVID-19 syndrom

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yaitu kelelahan dan kelemahan ekstrem, sesak napas saat aktivitas ringan, nyeri sendi, demam ringan yang terus-menerus, sakit kepala, vertigo, pilek, sakit tenggorokan, perubahan suara dan kesulitan menelan, kehilangan atau perubahan penciuman dan perasa yang berkepanjangan, rambut rontok, gangguan gastrointestinal termasuk kehilangan nafsu makan, sakit perut, diare, muntah, ketidakmampuan untuk berkonsentrasi dan susah tidur (Care & Resource, 2020).

The post-COVID-19 syndrome experienced by the participants varied, some participants stated that the post-COVID-19 syndrome could still be felt even though it had been declared negative for COVID-19. This is in line with (Care & Resource, 2020) stating that in October 2020, NICE (the national institute for health and care excellence) recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer up to 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over a long period of time and fluctuate, depending on the severity of the disease and the patient's health status taking into account comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste. prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia (Care & Resource, 2020).

Pengalaman pasca-covid, mereka lebih sadar spiritual dan menemukan kedamaian melalui kegiatan spiritual. Spiritualitas dapat memberikan harapan dan makna dalam situasi sulit termasuk dimasa pandemi COVID-19 (Teresa et al., 2021). Spiritual menciptakan emosi positif dalam diri seseorang. Spiritualitas dan agama dapat membantu manusia dalam kesedihannya saat krisis dan dapat menjadi obat penenang yang berguna pada manusia (Chronic et al., 2020).

During post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations including during the COVID-19 pandemic (Teresa et al., 2021). Spiritual creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be a useful "sedative" for humans (Chronic et al., 2020)

Dukungan dari tim medis sangat dibutuhkan pasien terkonfirmasi COVID-19 dalam menjalani perawatan dan pengobatan di ruang isolasi COVID-19. Perawatan dan tindakan intervensi yang diberikan tim medis secara profesional setiap hari akan menghasilkan rasa terimakasih dari pasien (Wang et al., 2020). Pemberian perawatan dan pengobatan dari tim medis dapat meningkatkan pendekatan manajemen diri yang membantu pasien untuk semangat melawan penyakit yang mereka alami. Kepuasan intervensi klinis yang diterima dan kualitas perawatan selama menjalani perawatan

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diruang isolasi COVID-19 serta rasa hormat yang diterima dari profesional tim medis(Olufadewa et al., 2020).

Support from the medical team is urgently needed for patients with confirmed COVID-19 undergoing treatment in the isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). The provision of care and treatment from the medical team can improve self-management approaches that help patients to be more enthusiastic in order to fight the disease they are suffering from. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room as well as the respect received from medical team professionals (Olufadewa et al., 2020).

Ketidakpuasan intervensi klinis yang diterima dan kualitas perawatan diruang isolasi COVID-19 yang disebabkan karena pembatasan jam masuk tim medis COVID-19 ke dalam ruangan isolasi COVID-19. Berdasarkan(Tim Mitigasi Dokter PB IDI, 2020)shift kerja harus memperhatikan durasi kerja yang sesuai dengan peraturan yaitu Permenkes No.52 Tahun 2018. Waktu kerja lebih pendek diijinkan pada kondisi tekanan pekerjaan tidak normal atau resiko tinggi seperti tim medis COVID-19 harus memakai hazmat terus menerus sepanjangshift. Shift pendek lebih disarankan dibandingkan shift panjang sehingga dapat membantu melindungi dari risiko kelelahan mental dari beban kerja yang berat. Kelelahan tersebut dapat meningkatkan resiko cedera dan memperburuk kondisi kesehatan yang rentan terhadap infeksi penyakit, peningkatan tekanan psikologis yang mempengaruhi kesehatan tim medis, dan kualitas serta keamanan perawatan yang diberikan. Maka perlunya edukasi tim medis COVID-19 kepada pasien terkonfirmasi COVID-19 yang menjalani perawatan diruang isolasi COVID-9 terkait adanya perubahan rotasi dan durasi kerja tim medis diruang isolasi COVID-19. Hal ini dilakukan untuk mengurangi pajanan tenaga kesehatan terhadap virus yang ditujukan untuk menjaga kesehatan fisik dan mental dan mempertahankan kualitas pelayanan para tim medis

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on a study (PB IDI Doctor Mitigation Team, 2020) the work shift must pay attention to the duration of work in accordance with the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short

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shifts are recommended over long shifts so they can help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increased psychological stress that affects the health of the medical team, and the quality and safety of the care provided. It is necessary to educate the COVID-19 medical team to confirmed COVID-19 patients undergoing treatment in the COVID-9 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This was done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team.

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

## ACKNOWLEDGMENTS

The authors would like to thank the participants in this study for their cooperation and support during data collection.

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## LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

## AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

## CONFLICT OF INTEREST

There is no conflict of interest in this research

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## TABLE

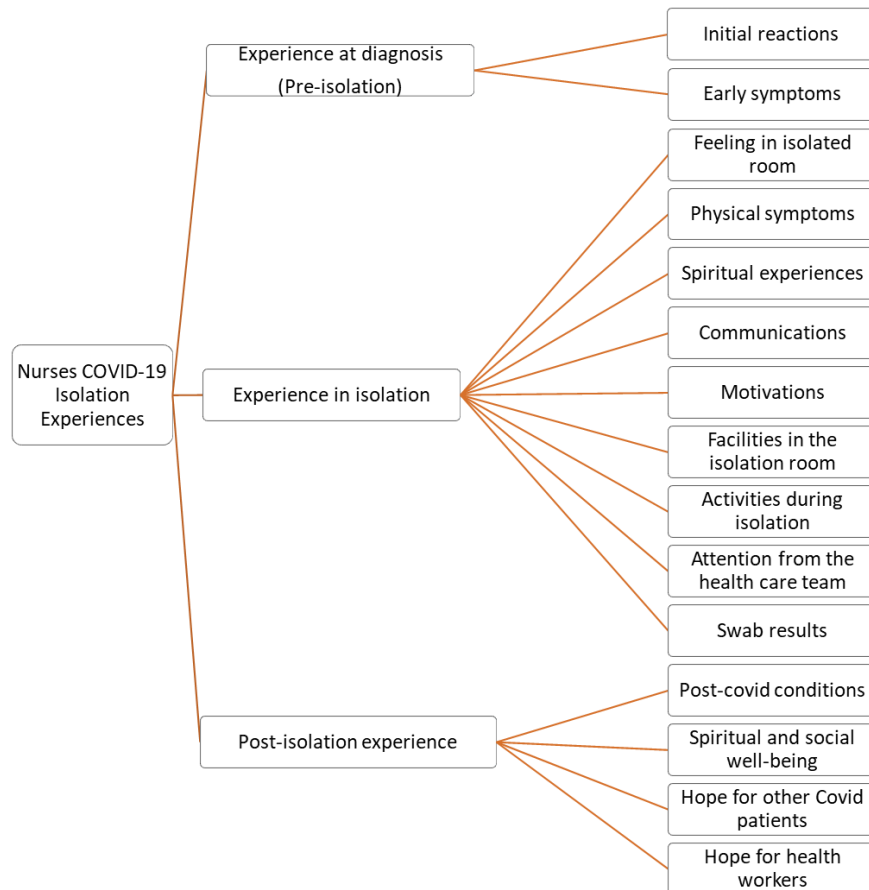
**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

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## FIGURE



**Figure 1.** Themes and Subthemes

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## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, treatments to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

The perceived lack of defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang, Son, Chae, & Corte, 2018). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives, et al., 2009) (Corley, Hamond, & Fraser, 2009). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih, et al., 2007).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after

discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives, et al., 2009). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam, Kwong, Hung, & Chien, 2020). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley, Hamond, & Fraser, 2009).

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang, Son, Chae, & Corte, 2018). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung, Wong, Suen, & Y., 2005; Kim, 2018). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh, Hegney, & Drury, 2012). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih, et al., 2007). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives, et al., 2009; Lam & Hung, 2013; Koh, Hegney, & Drury, 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih, et al., 2007; Holroyd & McNaught, 2008). The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam & Hung, 2013; Chung, Wong, Suen, & Y., 2005). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd & McNaught, 2008; Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang, Son, Chae, & Corte, 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd & McNaught, 2008; Koh, Hegney, & Drury, 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## **OBJECTIVE**

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## **METHODS**

### **Design**

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### **Settings and Participants**

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## Study rigor

To establish this study's rigour, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data

collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## **Ethical considerations**

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## **RESULTS**

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

### **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

#### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, "When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this" (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, "I always think of my children. I'm worried they may also get exposed [by corona virus]." Likewise, P7 explained how she tried not



to pass the disease on to her husband: "... I refused to be held by my husband. I'm afraid of transmitting it [COVID-19] to him" (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, "It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I'm terrified to be outcasted and ostracized." This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: "... I was afraid to inform the neighborhood leader, people may know and ostracized me" (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

"I was wondered, why I'm not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable." (P7)

"The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste." (P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants' experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: 'Feelings of being in isolation room', 'Physical symptoms', 'Spiritual experiences', 'Communications', 'Motivations', 'Facilities in the isolation room', 'Activities during isolation', 'Attention from the health care team', and 'Swab results'.

### *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, “I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried.”

### *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. “My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell” (R4). Likewise, R5 commented, “...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy”. Several participants also stated that enduring these symptoms was very tiring. As R7 said, “It’s tough to endure. That condition made me exhausted.”

### *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, “I prayed more often and drew closer to God.” R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, “Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy” (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, “I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength.”

### *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, “It’s nice to have roommates to share with finally. We talked and got to know each other” (R6). Another participant commented: “ By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated” (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, “While being treated in the isolation room, my sisters always contacted me. They strengthened me.”

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

## *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

## *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

## *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

## **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of 'post-covid conditions', 'spiritual and social well-being', 'hope for other covid patients' and 'hope for health workers.'

## *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, "Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be" (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, "Now I disciplined myself to wear a mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements."

## *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. "My spiritual life has changed. I have a

special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I’ll be happy to send them food. I’ll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses’ daily life and their work. In this study, we aim to explore the experience of nurses who were COVID-19 infected. The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

### **Theme1. Experience at diagnoses (Pre Isolation)**

Participants’ initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear

of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members.

Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). Patients confirmed with COVID-19 tend to experience stress related to the conditions they experienced which can affect their physical, emotional, mental, social, and spiritual state (Roman, Mthembu, & Hoosen, 2020). Research (Clerkin, et al., 2020) states that initial reports show that fever (88%) is the most common symptom of being infected with COVID-19. Other symptoms include sputum production, headache, hemoptysis, diarrhea, dyspnoea, and lymphopenia. COVID-19 shows clinical symptoms in the upper respiratory tract such as rhinorrhea, sneezing and sore throat. In addition, based on the results of chest radiographs, several cases showed upper lobe infiltration of the lungs is associated with increased dyspnea with hypoxemia (Rothan & Byrareddy, 2020). Based on a research (Biscardi, Unit, & Maggiore, 2020) it is stated that around 80% of people with positive COVID-19 experience mild to moderate symptoms, namely having a dry cough or sore throat.

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depressifinding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021). Fearful of being ostracized, participants experienced the frustration of stigmatization. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease.

During the current COVID-19 pandemic, some patients positive with COVID-19 are still being discriminated, treated separately because they were diagnosed with COVID-19. This has a negative impact on those who are confirmed to be COVID-19 positive and their families. Stigma can undermine social relationships and encourage the

possibility of social group isolation resulting in more severe health problems and difficulty controlling disease outbreaks because it encourages someone infected with COVID-19 to hide their illness to avoid discrimination (World Health Organization, 2020).

## **Theme 2. Experience in the isolation room**

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Separated away from family and isolated for a long time, patients tend to worry about fulfilling their family responsibilities, causing sadness when they are separated from loved ones (Wang, et al., 2020). The statement of stress experienced by participants was caused by being alone in an isolation room or being treated with a patient whose condition was also severe and the stress of thinking about their health condition that would worsen their symptoms. The stress experienced by patients positive with COVID-19 is a normal response to illness. Stress can cause a decrease in the immune system and cause immune dysregulation which can worsen the health condition of patients with COVID-19 (Kaligis, Indraswari, & Ismail, 2020). Several factors that affect the psychological health of patients with COVID-19 are the number of uncontrolled COVID-19 cases. Isolated patients experience acute respiratory problems and COVID-19 disease can cause death. This can cause anxiety in patients with confirmed COVID-19 (Jesmi, Mohammadzade-tabrizi, Rad, & Hosseinzadeh-younesi, 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020).

The changes in physical conditions experienced by each individual are different when infected with COVID-19. It was (Kumar, Kulieet, Anand, & Kumar, 2020) stated that SARS-CoV-2 which attacks the peripheral nervous system, will cause symptoms such as impaired taste and smell disorders. According to (Munhoz, et al., 2020), SARS-CoV-2 which attacks the central nervous system will cause symptoms such as dizziness, headache, impaired consciousness, ataxia, and seizures. Meanwhile, a research stated that the frequent complaints of patients who were confirmed by COVID-19 revealed digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting (Jesmi, Mohammadzade-tabrizi, Rad, & Hosseinzadeh-younesi, 2021). Based on research by (Syam, 2021), patients with confirmed COVID-19 with early symptoms of diarrhea, the virus tended to stay in the body longer than those who did not experience gastrointestinal symptoms. Gastrointestinal symptoms in patients with confirmed

COVID-19 have varying incidence rates. In general, confirmed cases of COVID-19 with symptoms of diarrhea in about 2-10% of cases, nausea in about 2-15% of cases, vomiting in about 1-5% of cases, abdominal pain in about 2-6% of cases and loss of appetite in about 80% of cases. This is in line with research (Jesmi, Mohammadzade-tabrizi, Rad, & Hosseinzadeh-younesi, 2021) which states that the complaints that patients often express are digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting.

Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries (Jesmi, Mohammadzade-tabrizi, Rad, & Hosseinzadeh-younesi, 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

The positive mood of COVID-19 confirmed patients will increase high dopamine in the blood and will optimize and boost the immune system. So, the strategy to support immunity is to maintain a good mood such as by video calling family and loved ones, playing with handphones and listening to music. It is known that COVID-19 confirmed patients undergoing isolation in the COVID-19 ward that listen to music is an effective way in reducing anxiety, hallucinations that cause fear and helps to have a more positive experience (Habib, 2021). Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is used as an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeya, Ceschi, Glowinski, Courvoisier, & Grandiean, 2018). It is (Umarella, Farid, & Ab Rahman, 2020) stated that worship, prayer and al-quran reading are good alternatives to treat illness psychological well-being and improve quality of life.

Based on research by (Aungsuroch, Juanamasta, & Gunawan, 2020) support from family members shows that humans are social beings who cannot live without



social support including in handling COVID-19 disease. And positive emotions play an important role in recovery and psychological adjustment (Sun, et al., 2020) Support from friends can give a positive response to health promotion (Habib, 2021). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and treatment in the COVID-19 isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang, et al., 2020). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

### **Theme 3. Post-isolation experiences**

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants' statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

The post-COVID-19 syndrome experienced by the participants varied, some participants stated that the post-COVID-19 syndrome could still be felt even though it had been declared negative for COVID-19. This is in line with (Care & Resource, 2020) stating that in October 2020, NICE (the national institute for health and care excellence) recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer up to 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over a long period of time and fluctuate, depending on the severity of the disease and the patient's health status taking into account comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste. prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia (Care & Resource, 2020).

During post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations including during the COVID-19 pandemic (Teresa, Guss, & Boyd, 2021). Spiritual creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be a useful "sedative" for humans (Chronic, Care, & Fardin, 2020).

Support from the medical team is urgently needed for patients with confirmed COVID-19 undergoing treatment in the isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang, et al., 2020). The provision of care and treatment from the medical team can improve self-management approaches that help patients to be more enthusiastic in order to fight the disease they are suffering from. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room as well as the respect received from medical team professionals (Olufadewa, et al., 2020).

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on a study (Tim Mitigasi PB IDI, 2020) the work shift must pay attention to the duration of work in accordance with the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short shifts are recommended over long shifts so they can help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increased psychological stress that affects the health of the medical team, and the quality and safety of the care provided. It is necessary to educate the COVID-19 medical team to confirmed COVID-19 patients undergoing treatment in the COVID-9 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This was done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team.

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017).

## Implications of Research Result

The results of this study explore the experiences of nurses that were confirmed positive of COVID-19 while undergoing treatment in the COVID-19 isolation room.

The results of this study can be used by the hospital as an input to improve the quality of care and services for patients confirmed with COVID-19 comprehensively. Particularly, it implicates for the medical team that handles COVID-19 cases by managing the care and treatment of the patients to provide holistic care (bio-psycho-socio-spiritual). It is hoped to improve the quality of nursing care for patients with confirmed COVID-19 while undergoing treatment in the COVID-19 isolation room. Implicates for policy makers, nursing and health care groups or organizations to be actively involved in supporting nurses both during and after a pandemic or epidemic. It is imperative that nurses receive clear, concise and up-to-date information on the best practice of nursing care and infection control, as well as adequate access to appropriate PPE to optimize their safety. Adequate staffing is essential to ensure that nurses can take breaks during shifts, take time off when they are sick and provide an appropriate mix of skills. Without this support, nurses are likely to experience significant stress, anxiety, and physical side effects which can lead to burnout and the absence of nurses from the workforce.

## Limitations

The limitations of this study are that some nurse participants who were infected with COVID-19 refused to join as respondents due to the physical and psychological experiences they had experienced and there were still many participants who refused to be included in this study because they thought that confirmed COVID-19 was an embarrassing disease that should be hidden.

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

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## LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

## **AUTHOR CONTRIBUTION**

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

## **CONFLICT OF INTEREST**

There is no conflict of interest in this research

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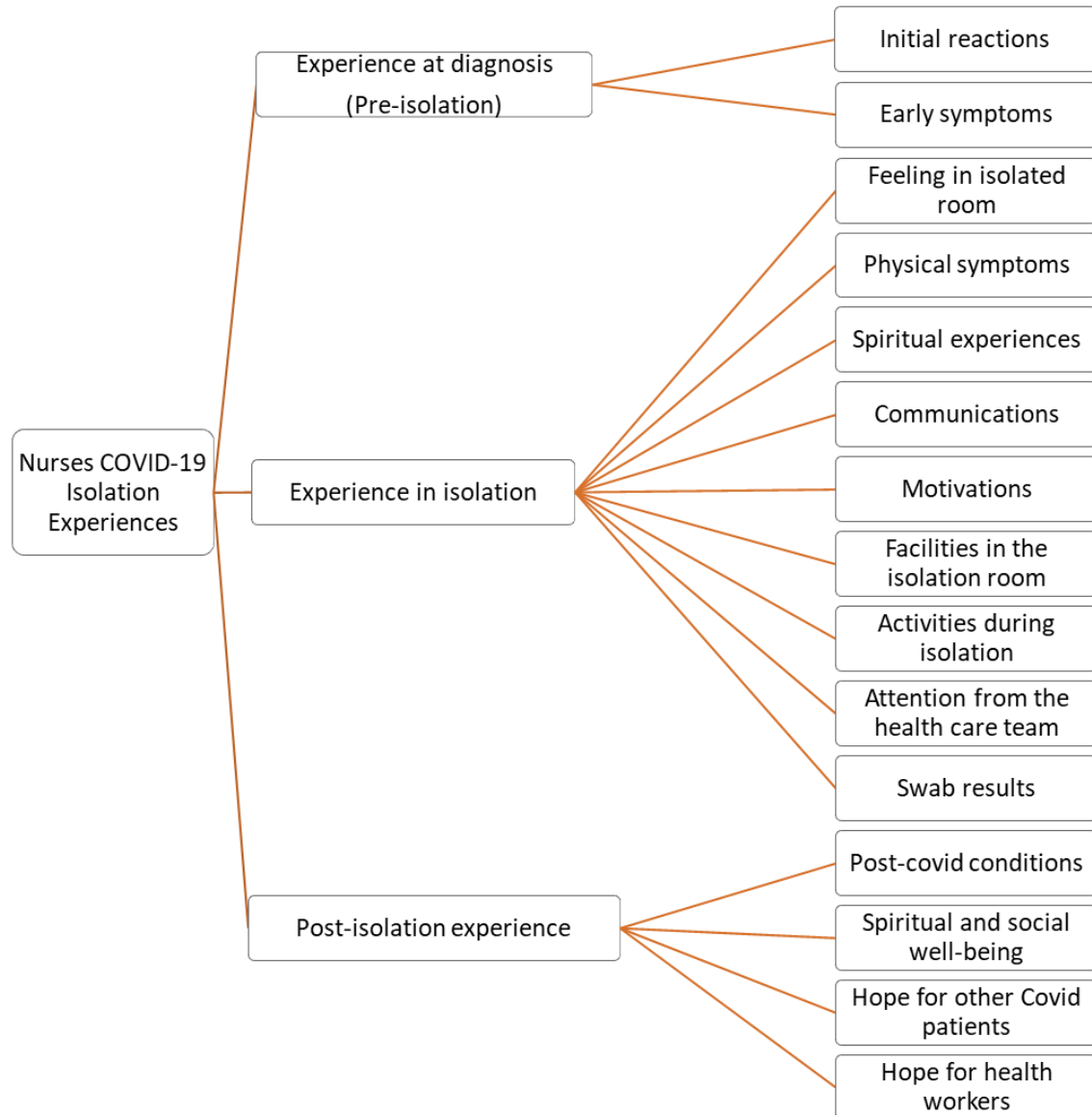
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## TABLE

**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** Themes and Subthemes

## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: ernawatisiagian@unai.edu

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected **need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.**

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. **Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.**

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). [GRI]The perceived lack of

defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018,<sup>[A2]</sup>). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009<sup>[A3]</sup>, Corley et al., 2010<sup>[A4]</sup>). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007<sup>[A5]</sup>).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021).<sup>[GR6]</sup> Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009<sup>[A7]</sup>). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020<sup>[A8]</sup>). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010<sup>[A9]</sup>).

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018<sup>[A10]</sup>). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005<sup>[A11]</sup>, Kim, 2018<sup>[A12]</sup>). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012<sup>[A13]</sup>). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007<sup>[A14]</sup>). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013<sup>[A15]</sup>, Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008)<sup>[A16]</sup>. The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013,[A17] Chung et al., 2005[A18]). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who



have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## **Study rigor**

To establish this study's rigour, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## **Ethical considerations**

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## **RESULTS**

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

### **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

#### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

## *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

## *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

## *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

## *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was

excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

## *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, “My roommate, she’s elderly, was suffocated, so I helped take care of her.” Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, “The PCR results were too long... I have to wait a few days [after the swab] until I can go home.” Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

## **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, “Now I disciplined myself to wear a

mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

## **Theme1. Experience at diagnoses (Pre Isolation)**

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members.

Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). [GR19]Patients confirmed with COVID-19 tend to experience stress related to the conditions they experienced which can affect their physical, emotional, mental, social, and spiritual state (Roman et al., 2020[A20]). Research (Clerkin et al., 2020[A21]) states that initial reports show that fever (88%) is the most common symptom of being infected with COVID-19. Other symptoms include sputum production, headache, hemoptysis, diarrhea, dyspnoea, and lymphopenia. COVID-19 shows clinical symptoms in the upper respiratory tract such as rhinorrhea, sneezing and sore throat. In addition, based on the results of chest radiographs, several cases showed upper lobe infiltration of the lungs is associated with increased dyspnea with hypoxemia (Rothan & Byrareddy, 2020[A22]). Based on a research (Biscardi et al., 2020[A23]) it is stated that around 80% of people with positive COVID-19 experience mild to moderate symptoms, namely having a dry cough or sore throat.

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depressifinding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative



consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease.

During the current COVID-19 pandemic, some patients positive with COVID-19 are still being discriminated, treated separately because they were diagnosed with COVID-19. This has a negative impact on those who are confirmed to be COVID-19 positive and their families. Stigma can undermine social relationships and encourage the possibility of social group isolation resulting in more severe health problems and difficulty controlling disease outbreaks because it encourages someone infected with COVID-19 to hide their illness to avoid discrimination (WHO, IFRC, 2020) [A24]

## **Theme 2. Experience in the isolation room**

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Separated away from family and isolated for a long time, patients tend to worry about fulfilling their family responsibilities, causing sadness when they are separated from loved ones (Wang et al., 2020) [A25]. The statement of stress experienced by participants was caused by being alone in an isolation room or being treated with a patient whose condition was also severe and the stress of thinking about their health condition that would worsen their symptoms. The stress experienced by patients positive with COVID-19 is a normal response to illness. Stress can cause a decrease in the immune system and cause immune dysregulation which can worsen the health condition of patients with COVID-19 (Kaligis et al., 2020) [A26]. Several factors that affect the psychological health of patients with COVID-19 are the number of uncontrolled COVID-19 cases. Isolated patients experience acute respiratory problems and COVID-19 disease can cause death. This can cause anxiety in patients with confirmed COVID-19 (Jesmi et al., 2021) [A27]. Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020).

The changes in physical conditions experienced by each individual are different when infected with COVID-19. It was (Kumar et al., 2020) [A28] stated that SARS-CoV-2 which attacks the peripheral nervous system, will cause symptoms such as impaired taste and smell disorders. According to (Munhoz et al. (2020) [A29]), SARS-CoV-2 which attacks the central nervous system will cause symptoms such as dizziness, headache, impaired consciousness, ataxia, and seizures. Meanwhile, a research stated that the frequent complaints of patients who were confirmed by COVID-19 revealed digestive

problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting (Jesmi et al., 2021)[A30]). Based on research by Syam (2021)[A31], patients with confirmed COVID-19 with early symptoms of diarrhea, the virus tended to stay in the body longer than those who did not experience gastrointestinal symptoms. Gastrointestinal symptoms in patients with confirmed COVID-19 have varying incidence rates. In general, confirmed cases of COVID-19 with symptoms of diarrhea in about 2-10% of cases, nausea in about 2-15% of cases, vomiting in about 1-5% of cases, abdominal pain in about 2-6% of cases and loss of appetite in about 80% of cases. This is in line with research (Jesmi et al., 2021) [A32] which states that the complaints that patients often express are digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting.

Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries (Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

The positive mood of COVID-19 confirmed patients will increase high dopamine in the blood and will optimize and boost the immune system. So, the strategy to support immunity is to maintain a good mood such as by video calling family and loved ones, playing with handphones and listening to music. It is known that COVID-19 confirmed patients undergoing isolation in the COVID-19 ward that listen to music is an effective way in reducing anxiety, hallucinations that cause fear and helps to have a more positive experience (T. Habib, 2021)[A33]. Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is used as an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeva et al., 2018)[A34]. It is (Umarella et al., 2020)[A35] stated that worship, prayer and al-quran reading are good alternatives to treat illness psychological well-being and improve quality of life.

Based on research by (Aunguroch et al. (2020)[A36]) support from family members shows that humans are social beings who cannot live without social support including in handling COVID-19 disease. And positive emotions play an important role in recovery and psychological adjustment ((Sun et al. al., 2020)[A37]). Support from friends can give a positive response to health promotion ((T. Habib, 2021)[A38][A39]). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and treatment in the COVID-19 isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient ((Wang et al., 2020)[A40]). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

### **Theme 3. Post-isolation experiences**

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants' statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

The post-COVID-19 syndrome experienced by the participants varied, some participants stated that the post-COVID-19 syndrome could still be felt even though it had been declared negative for COVID-19. This is in line with ((Care & Resource, 2020)[A41]) stating that in October 2020, NICE (the national institute for health and care excellence) recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer up to 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over a long period of time and fluctuate, depending on the severity of the disease and the patient's health status taking into account comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste. prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia ((Care & Resource, 2020).[A42])

During post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations including during the COVID-19 pandemic ((Teresa et al., 2021)[A43]). Spiritual creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be a useful “sedative” for humans ((Chronic et al., 2020)[A44])

Support from the medical team is urgently needed for patients with confirmed COVID-19 undergoing treatment in the isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020)[A45]. The provision of care and treatment from the medical team can improve self-management approaches that help patients to be more enthusiastic in order to fight the disease they are suffering from. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room as well as the respect received from medical team professionals (Olufadewa et al., 2020).[A46]

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on a study (PB IDI Doctor Mitigation Team, 2020[A47]) the work shift must pay attention to the duration of work in accordance with the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short shifts are recommended over long shifts so they can help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increased psychological stress that affects the health of the medical team, and the quality and safety of the care provided. It is necessary to educate the COVID-19 medical team to confirmed COVID-19 patients undergoing treatment in the COVID-9 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This was done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team.

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017).

## Implications of Research Result

The results of this study explore the experiences of nurses that were confirmed positive of COVID-19 while undergoing treatment in the COVID-19 isolation room.

The results of this study can be used by the hospital as an input to improve the quality of care and services for patients confirmed with COVID-19 comprehensively. Particularly, it implicates for the medical team that handles COVID-19 cases by managing the care and treatment of the patients to provide holistic care (bio-psycho-socio-spiritual). It is hoped to improve the quality of nursing care for patients with confirmed COVID-19 while undergoing treatment in the COVID-19 isolation room. Implicates for policy makers, nursing and health care groups or organizations to be actively involved in supporting nurses both during and after a pandemic or epidemic. It is imperative that nurses receive clear, concise and up-to-date information on the best practice of nursing care and infection control, as well as adequate access to appropriate PPE to optimize their safety. Adequate staffing is essential to ensure that nurses can take breaks during shifts, take time off when they are sick and provide an appropriate mix of skills. Without this support, nurses are likely to experience significant stress, anxiety, and physical side effects which can lead to burnout and the absence of nurses from the workforce.

## Limitations

The limitations of this study are that some nurse participants who were infected with COVID-19 refused to join as respondents due to the physical and psychological experiences they had experienced and there were still many participants who refused to be included in this study because they thought that confirmed COVID-19 was an embarrassing disease that should be hidden.

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

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## LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

## AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

## CONFLICT OF INTEREST

There is no conflict of interest in this research

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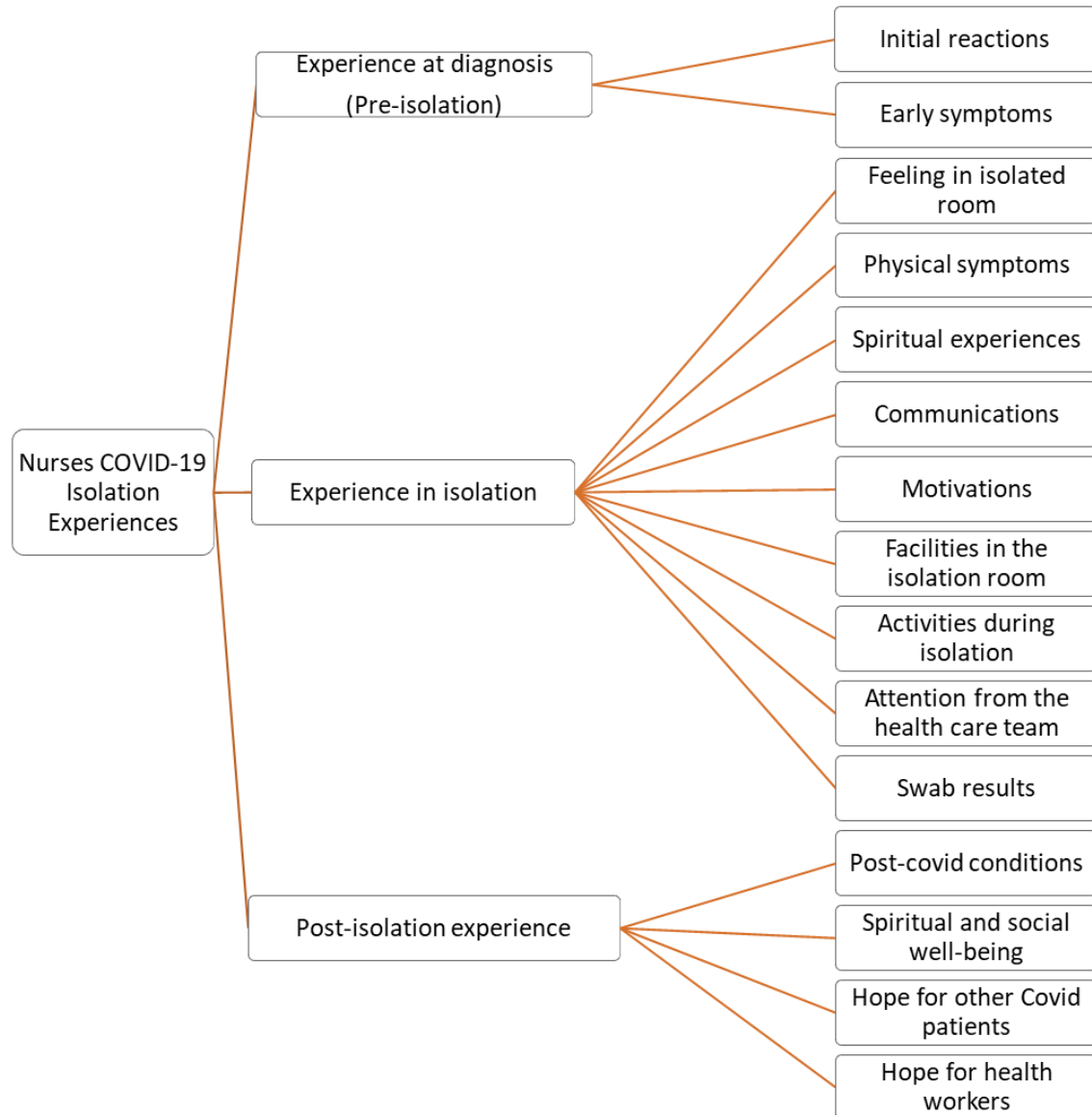
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## TABLE

**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** Themes and Subthemes

## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

**Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). The perceived lack of**

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defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009, Corley et al., 2010). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010).

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005, Kim, 2018). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013, Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008). The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

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often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013, Chung et al., 2005). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who

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have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

### Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

### Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

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description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

### Study rigor

To establish this study's rigor, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

### Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

### RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

#### Theme 1: Experience at diagnoses (Pre-isolation)

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants' initial reactions and early symptoms.

##### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

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Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, “... I had mixed feelings, how could I get covid? I always wear full PPE!”. Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, “...I didn’t believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying.”

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

### **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

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## *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

## *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

## *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was

excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: " By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

### *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

### *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

### *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

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As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

### **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of 'post-covid conditions', 'spiritual and social well-being', 'hope for other covid patients' and 'hope for health workers.'

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, "Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be" (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, "Now I disciplined myself to wear a

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mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

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## Theme1. Experience at diagnoses (Pre Isolation)

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members.

Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). Patients confirmed with COVID-19 tend to experience stress related to the conditions they experienced which can affect their physical, emotional, mental, social, and spiritual state (Roman et al., 2020). Research (Clerkin et al., 2020) states that initial reports show that fever (88%) is the most common symptom of being infected with COVID-19. Other symptoms include sputum production, headache, hemoptysis, diarrhea, dyspnoea, and lymphopenia. COVID-19 shows clinical symptoms in the upper respiratory tract such as rhinorrhea, sneezing and sore throat. In addition, based on the results of chest radiographs, several cases showed upper lobe infiltration of the lungs is associated with increased dyspnea with hypoxemia (Rothan & Byrareddy, 2020). Based on a research (Biscardi et al., 2020) it is stated that around 80% of people with positive COVID-19 experience mild to moderate symptoms, namely having a dry cough or sore throat.

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression finding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative

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consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease.

During the current COVID-19 pandemic, some patients positive with COVID-19 are still being discriminated, treated separately because they were diagnosed with COVID-19. This has a negative impact on those who are confirmed to be COVID-19 positive and their families. Stigma can undermine social relationships and encourage the possibility of social group isolation resulting in more severe health problems and difficulty controlling disease outbreaks because it encourages someone infected with COVID-19 to hide their illness to avoid discrimination (WHO, IFRC, 2020)

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## Theme 2. Experience in the isolation room

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Separated away from family and isolated for a long time, patients tend to worry about fulfilling their family responsibilities, causing sadness when they are separated from loved ones (Wang et al., 2020). The statement of stress experienced by participants was caused by being alone in an isolation room or being treated with a patient whose condition was also severe and the stress of thinking about their health condition that would worsen their symptoms. The stress experienced by patients positive with COVID-19 is a normal response to illness. Stress can cause a decrease in the immune system and cause immune dysregulation which can worsen the health condition of patients with COVID-19 (Kaligis et al., 2020). Several factors that affect the psychological health of patients with COVID-19 are the number of uncontrolled COVID-19 cases. Isolated patients experience acute respiratory problems and COVID-19 disease can cause death. This can cause anxiety in patients with confirmed COVID-19 (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020).

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**Commented [A27]:** Jesmi, A., Mohammadzade-tabrizi, Z., Rad, M., & Hosseinzadeh-younesi, E. (2021). Lived experiences of patients with COVID-19 infection : a phenomenology study. 18(September 2020), 18–26.

**Commented [A28]:** Kumar, S., Kuljeet, S., Anand, S., Juneja, A., & Kumar, R. (2020). Neurological Problems in COVID-19 Pandemic.

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The changes in physical conditions experienced by each individual are different when infected with COVID-19. It was (Kumar et al., 2020) stated that SARS-CoV-2 which attacks the peripheral nervous system, will cause symptoms such as impaired taste and smell disorders. According to (Munhoz et al. (2020)), SARS-CoV-2 which attacks the central nervous system will cause symptoms such as dizziness, headache, impaired consciousness, ataxia, and seizures. Meanwhile, a research stated that the frequent complaints of patients who were confirmed by COVID-19 revealed digestive

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problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting (Jesmi et al., 2021). Based on research by Syam (2021), patients with confirmed COVID-19 with early symptoms of diarrhea, the virus tended to stay in the body longer than those who did not experience gastrointestinal symptoms. Gastrointestinal symptoms in patients with confirmed COVID-19 have varying incidence rates. In general, confirmed cases of COVID-19 with symptoms of diarrhea in about 2-10% of cases, nausea in about 2-15% of cases, vomiting in about 1-5% of cases, abdominal pain in about 2-6% of cases and loss of appetite in about 80% of cases. This is in line with research (Jesmi et al., 2021) which states that the complaints that patients often express are digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting.

Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries (Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

The positive mood of COVID-19 confirmed patients will increase high dopamine in the blood and will optimize and boost the immune system. So, the strategy to support immunity is to maintain a good mood such as by video calling family and loved ones, playing with handphones and listening to music. It is known that COVID-19 confirmed patients undergoing isolation in the COVID-19 ward that listen to music is an effective way in reducing anxiety, hallucinations that cause fear and helps to have a more positive experience (T. Habib, 2021). Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is used as an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeva et al., 2018). It is (Umarella et al., 2020) stated that worship, prayer and al-quran reading are good alternatives to treat illness psychological well-being and improve quality of life.

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Based on research by (Aunguroch et al., 2020) support from family members shows that humans are social beings who cannot live without social support including in handling COVID-19 disease. And positive emotions play an important role in recovery and psychological adjustment (Sun et al., 2020). Support from friends can give a positive response to health promotion (T. Habib, 2021). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and treatment in the COVID-19 isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

## Theme 3. Post-isolation experiences

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants' statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

The post-COVID-19 syndrome experienced by the participants varied, some participants stated that the post-COVID-19 syndrome could still be felt even though it had been declared negative for COVID-19. This is in line with (Care & Resource, 2020) stating that in October 2020, NICE (the national institute for health and care excellence) recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer up to 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over a long period of time and fluctuate, depending on the severity of the disease and the patient's health status taking into account comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste, prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia (Care & Resource, 2020).

During post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations including during the COVID-19 pandemic (Teresa et al., 2021). Spirituality creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be a useful "sedative" for humans (Chronic et al., 2020)

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**Commented [A43]:** Teresa, M. T., Guss, C. D., & Boyd, L. (2021). Thriving during COVID-19: Predictors of psychological well-being and ways of coping. *PLoS ONE*, 16(3 March), 1–19.

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Support from the medical team is urgently needed for patients with confirmed COVID-19 undergoing treatment in the isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). The provision of care and treatment from the medical team can improve self-management approaches that help patients to be more enthusiastic in order to fight the disease they are suffering from. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room as well as the respect received from medical team professionals (Olufadewa et al., 2020).

**Commented [A45]:** Wang, S., Liu, Y., She, H., Wang, T., Feng, X., & Hsiao, C. (2020). *Psychological Experiences of Patients with COVID-19 : A Phenomenological Study*. 3(1), 193–201.

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on a study (PB IDI Doctor Mitigation Team, 2020) the work shift must pay attention to the duration of work in accordance with the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short shifts are recommended over long shifts so they can help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increased psychological stress that affects the health of the medical team, and the quality and safety of the care provided. It is necessary to educate the COVID-19 medical team to confirmed COVID-19 patients undergoing treatment in the COVID-9 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This was done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team.

**Commented [A46]:** Olufadewa, I. I., Adesina, M. A., Oladokun, B., Baru, A., Oladele, R. I., Iyanda, T. O., Ajibade, O. J., & Abudu, F. (2020). "I Was Scared I Might Die Alone": A Qualitative Study on the Physiological and Psychological Experience of COVID-19 Survivors and the Quality of Care Received at Health Facilities. *International Journal of Travel Medicine and Global Health*, 8(2), 51–57.

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Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017).

## Implications of Research Result

The results of this study explore the experiences of nurses that were confirmed positive of COVID-19 while undergoing treatment in the COVID-19 isolation room.

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The results of this study can be used by the hospital as an input to improve the quality of care and services for patients confirmed with COVID-19 comprehensively. Particularly, it implicates for the medical team that handles COVID-19 cases by managing the care and treatment of the patients to provide holistic care (bio-psycho-socio-spiritual). It is hoped to improve the quality of nursing care for patients with confirmed COVID-19 while undergoing treatment in the COVID-19 isolation room. Implicates for policy makers, nursing and health care groups or organizations to be actively involved in supporting nurses both during and after a pandemic or epidemic. It is imperative that nurses receive clear, concise and up-to-date information on the best practice of nursing care and infection control, as well as adequate access to appropriate PPE to optimize their safety. Adequate staffing is essential to ensure that nurses can take breaks during shifts, take time off when they are sick and provide an appropriate mix of skills. Without this support, nurses are likely to experience significant stress, anxiety, and physical side effects which can lead to burnout and the absence of nurses from the workforce.

### Limitations

The limitations of this study are that some nurse participants who were infected with COVID-19 refused to join as respondents due to the physical and psychological experiences they had experienced and there were still many participants who refused to be included in this study because they thought that confirmed COVID-19 was an embarrassing disease that should be hidden.

### CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

### ACKNOWLEDGMENTS

The authors would like to thank the participants in this study for their cooperation and support during data collection.

### LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

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**AUTHOR CONTRIBUTION**

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

**CONFLICT OF INTEREST**

There is no conflict of interest in this research

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## TABLE

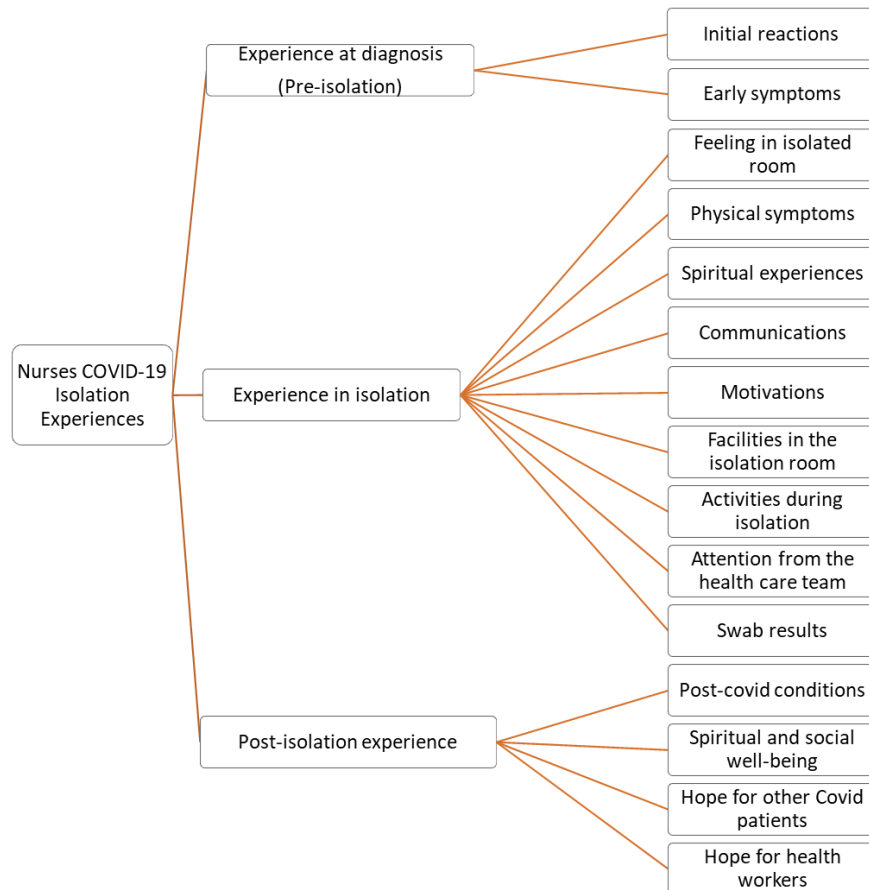
**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

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## FIGURE



**Figure 1.** Themes and Subthemes

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## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: ernawatisiagian@unai.edu

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected **need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.**

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. **Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.**

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). [GRI]The perceived lack of

defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018,<sup>[A2]</sup>). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009<sup>[A3]</sup>, Corley et al., 2010<sup>[A4]</sup>). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007<sup>[A5]</sup>).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021).<sup>[GR6]</sup> Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009<sup>[A7]</sup>). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020<sup>[A8]</sup>). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010<sup>[A9]</sup>).

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018<sup>[A10]</sup>). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005<sup>[A11]</sup>, Kim, 2018<sup>[A12]</sup>). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012<sup>[A13]</sup>). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007<sup>[A14]</sup>). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013<sup>[A15]</sup>, Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008)<sup>[A16]</sup>. The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013,[A17] Chung et al., 2005[A18]). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who



have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## **Study rigor**

To establish this study's rigour, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## **Ethical considerations**

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## **RESULTS**

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

### **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

#### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

## *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

## *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

## *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

## *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was

excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

## *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, “My roommate, she’s elderly, was suffocated, so I helped take care of her.” Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, “The PCR results were too long... I have to wait a few days [after the swab] until I can go home.” Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

## **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, “Now I disciplined myself to wear a

mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

## **Theme1. Experience at diagnoses (Pre Isolation)**

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members.

Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). [GRI19]Pasien terkonfirmasi COVID-19 cenderung mengalami tekanan terkait dengan kondisi dialami yang dapat mempengaruhi kondisi fisik, emosional, mental, sosial, dan spiritual (Roman et al., 2020). [A20]Penelitian (Clerkin et al., 2020)[A21] yang menyatakan bahwa laporan awal menunjukkan gejala yang paling umum terinfeksi COVID-19 adalah demam (88%). Gejala paling umum pada awal penyakit COVID-19 adalah demam, batuk dan kelelahan. Sementara gejala lainnya termasuk produksi sputum, sakit kepala, hemoptisis, diare, dyspnoe, dan limfopenia. COVID-19 menunjukkan gejala klinis pada saluran pernapasan atas seperti rinorea, bersin dan sakit tenggorokan. Selain itu berdasarkan hasil radiografi dada beberapa kasus menunjukkan infiltrat dilobus atas paru-paru yang berhubungan dengan peningkatan dispnea dengan hipoksemia (Rothan & Byrareddy, 2020)[A22]. Berdasarkan penelitian (Biscardi et al., 2020)[A23] menyatakan bahwa Sekitar 80% orang yang terkonfirmasi COVID-19 mengalami gejala ringan hingga sedang yaitu mengalami batuk kering atau sakit tenggorokan.

Patients with confirmed COVID-19 tend to experience stress related to the conditions experienced which can affect their physical, emotional, mental, social, and spiritual conditions (Roman et al., 2020). Research (Clerkin et al., 2020) which states that initial reports show the most common symptom of being infected with COVID-19 is fever (88%). While other symptoms include sputum production, headache, hemoptysis, diarrhea, dyspnoea, and lymphopenia. COVID-19 shows clinical symptoms in the upper respiratory tract such as rhinorrhea, sneezing and sore throat. In addition, based on the results of chest radiographs, several cases showed upper lobe infiltration of the lungs associated with increased dyspnea with hypoxemia (Rothan & Byrareddy,



2020). Based on research (Biscardi et al., 2020) it is stated that around 80% of people with confirmed COVID-19 experience mild to moderate symptoms, namely having a dry cough or sore throat.

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression. The overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease.

Saat pandemi COVID-19 saat ini, beberapa pasien terkonfirmasi COVID-19 masih mendapat perlakuan didiskriminasi, diperlakukan secara terpisah karena terdiagnosa terinfeksi COVID-19. Hal ini berdampak negatif kepada mereka yang terkonfirmasi COVID-19 dan keluarga. Stigma dapat merusak hubungan sosial dan mendorong kemungkinan isolasi sosial kelompok yang mengakibatkan lebih banyak masalah kesehatan yang parah dan kesulitan mengendalikan wabah penyakit karena mendorong seseorang yang terinfeksi COVID-19 menyembuyikan penyakitnya untuk menghindari diskriminasi (WHO, IFRC, 2020). [A24]

During the current COVID-19 pandemic, some patients with confirmed COVID-19 are still being discriminated against, treated separately because they were diagnosed with COVID-19. This has a negative impact on those who are confirmed to be COVID-19 and their families. Stigma can undermine social relationships and encourage the possibility of group social isolation resulting in more severe health problems and difficulty controlling disease outbreaks because it encourages someone infected with COVID-19 to hide their illness to avoid discrimination.

## Theme 2. Experience in the isolation room

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Berpisah dengan keluarga dan diisolasi dalam jangka waktu lama pasien cenderung khawatir atas pemenuhan tanggung jawab keluarga mereka sehingga menimbulkan kesedihan selama berpisah dengan orang-orang yang dicintai (Wang et al., 2020)[A25] Pernyataan stres yang dialami partisipan disebabkan karena sendirian diruang isolasi atau dirawat bersama pasien yang kondisinya berat serta stres memikirkan kondisi kesehatan akan memburuknya gejala yang dialami. Stres yang dialami pasien terkonfirmasi COVID-19 merupakan respon normal terhadap penyakit. Stres dapat menyebabkan penurunan sistem kekebalan tubuh dan menyebabkan disregulasi imun yang dapat memperburuk kondisi kesehatan pasien yang terkonfirmasi COVID-19 (Kaligis et al., 2020)[A26] Beberapa faktor yang berpengaruh terhadap kesehatan psikologis pasien yang terkonfirmasi COVID-19 adalah angka kasus COVID-19 tidak terkendali dalam penyebaran virus, pasien yang diisolasi mengalami masalah pernapasan akut dan penyakit COVID-19 dapat menyebabkan kematian. Sehingga hal tersebut dapat menyebabkan kecemasan pada pasien terkonfirmasi COVID-19 (Jesmi et al., 2021)[A27].

Berdasarkan (Kumar et al., 2020)[A28] menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf perifer, akan menyebabkan gejala seperti gangguan pengecap dan gangguan penciuman. Menurut (Munhoz et al., 2020)[A29] menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf pusat akan menyebabkan gejala seperti pusing, sakit kepala, gangguan kesadaran, ataksia, dan kejang. Sedangkan penelitian (Jesmi et al., 2021)[A30] menyatakan bahwa keluhan yang sering pasien yang terkonfirmasi COVID-19 mengungkapkan masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah. Berdasarkan penelitian (Syam, 2021)[A31] menyatakan bahwa pasien terkonfirmasi COVID-19 dengan gejala awal diare, virus cenderung bertahan didalam tubuh lebih lama daripada mereka yang tidak mengalami gejala gastrointestinal. Gejala gastrointestinal pada pasien terkonfirmasi COVID-19 memiliki tingkat insiden 64 yang bervariasi. Secara umum kasus terkonfirmasi COVID-19 dengan gejala diare sekitar 2-10% kasus, mual sekitar 2-15% kasus, muntah sekitar 1-5% kasus, nyeri abdomen sekitar 2-6% kasus dan kehilangan nafsu makan sekitar 80% kasus. Hal ini sejalan dengan penelitian (Jesmi et al., 2021) menyatakan bahwa keluhan yang sering pasien ungkapkan adalah masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah.

Separated from family and isolated for a long time, patients tend to worry about fulfilling their family responsibilities, causing sadness during separation from loved ones (Wang et al., 2020). The statement of stress experienced by participants was caused by being alone in an isolation room or being treated with a patient whose condition was severe and the stress of thinking about their health condition would worsen their symptoms. The stress experienced by patients with confirmed COVID-19 is a normal response to illness. Stress can cause a decrease in the immune system and cause immune dysregulation which can worsen the health condition of patients with confirmed COVID-19 (Kaligis et al., 2020). Several factors that affect the psychological health of patients with confirmed COVID-19 are the number of COVID-19 cases not controlled in the spread of the virus, isolated patients experience acute respiratory problems and COVID-19 disease can cause death. So that this can cause anxiety in patients with confirmed COVID-19 (Jesmi et al., 2021).

Based on (Kumar et al., 2020) stated that SARS-CoV-2 which attacks the peripheral nervous system, will cause symptoms such as impaired taste and smell disorders. According to (Munhoz et al., 2020) stated that SARS-CoV-2 which attacks the central nervous system will cause symptoms such as dizziness, headache, impaired consciousness, ataxia, and seizures. Meanwhile, research (Jesmi et al., 2021) stated that the frequent complaints of patients who were confirmed by COVID-19 revealed digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting. Based on research (Syam, 2021) stated that patients with confirmed COVID-19 with early symptoms of diarrhea, the virus tended to stay in the body longer than those who did not experience gastrointestinal symptoms. Gastrointestinal symptoms in patients with confirmed COVID-19 have varying incidence rates. In general, confirmed cases of COVID-19 with symptoms of diarrhea in about 2-10% of cases, nausea in about 2-15% of cases, vomiting in about 1-5% of cases, abdominal pain in about 2-6% of cases and loss of appetite in about 80% of cases. This is in line with research (Jesmi et al., 2021) which states that the complaints that patients often express are digestive problems, namely diarrhea, constipation, loss of appetite, nausea and vomiting.

Participants' experiences where the body conditions in the isolation room are the same as reported in the study of Jesmi et al. (2021) as always have nervous, respiratory, gastrointestinal, and systemic manifestations (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020). Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this

disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries (Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

Suasana hati pasien terkonfirmasi COVID-19 yang baik akan meningkatkan dopamin yang tinggi didalam darah sehingga akan mengoptimalkan dan meningkatkan sistem kekebalan tubuh. Maka strategi untuk mendukung kekebalan tubuh adalah dengan menjaga suasana hati dalam keadaan baik seperti dengan video call dengan keluarga dan orang-orang yang dicintai, bermain handphone dan mendengarkan musik. Diketahui bahwa pasien terkonfirmasi COVID-19 yang menjalani isolasi diruang COVID-19 mendengarkan musik efektif dalam mengurangi kecemasan, mengurangi halusinasi yang menyebabkan rasa takut dan membantu memiliki pengalaman yang lebih positif (T. Habib, 2021)[A32]. Sedangkan mendengarkan musik dapat mengurangi masalah psikologi berdasarkan reaksi subjektif terhadap situasi. Mendengarkan musik dijadikan suatu komponen yang berinteraksi dalam pencegahan gangguan cemas, bosan, stress dan pasca trauma (Panteleeva et al., 2018)[A33] Berdasarkan (Umarella et al., 2020)[A34] menyatakan bahwa ibadah, doa dan membaca al-quran adalah alternatif yang baik untuk mengobati penyakit psikologis dan meningkatkan kualitas hidup.

The positive mood of COVID-19 confirmed patients will increase high dopamine in the blood so that it will optimize and boost the immune system. So the strategy to support immunity is to maintain a good mood such as by video calling with family and loved ones, playing cellphones and listening to music. It is known that COVID-19 confirmed patients undergoing isolation in the COVID-19 ward listening to music are effective in reducing anxiety, reducing hallucinations that cause fear and helping to have a more positive experience (T. Habib, 2021). Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is used as an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeva et al., 2018) Based on (Umarella et al.,

2020) stating that worship, prayer and al-quran reading are good alternatives to treat illness psychological well-being and improve quality of life.

Berdasarkan(Aungsueroch et al., 2020) menyatakan bahwa dukungan sosial dari anggota keluarga menunjukkan bahwa manusia adalah makhluk sosial yang tidak dapat hidup tanpa dukungan sosial termasuk dalam penanganan penyakit COVID-

19. Dan emosi positif berperan penting dalam pemulihan dan penyesuaian

psikologis (Sun et al., 2020). Dukungan dari teman dapat memberikan respon yang positif terhadap pemuliharaan kesehatan (T. Habib, 2021).

Based on (Aungsueroch et al., 2020[A35]) states that social support from family members shows that humans are social beings who cannot live without social support including in handling COVID-19 disease. And positive emotions play an important role in recovery and psychological adjustment (Sun et al. al., 2020[A36]). Support from friends can give a positive response to health promotion (T. Habib, 2021[A37][A38]). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and treatment in the COVID-19 isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020)[A39].

### Theme 3. Post-isolation experiences

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants' statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

PostCOVID-19 syndromeyang dialami partisipan bervariasi beberapa partisipan menyatakan post COVID-19 syndrome masih dirasakan walaupun sudah dinyatakan negatif COVID-19. Hal ini sejalan dengan (Care & Resource, 2020)[A40] menyatakan bahwa Oktober 2020, NICE(*the national institute for health and care excellence*) mengakui ketidakpastian efek jangka panjang dari virus SARS-CoV-2 dan mendefinisikan post COVID-19 syndromesebagai gejala yang berlangsung lebih dari 12 minggu. Keluhan kondisi fisik jangka panjang pada pasien terkonfirmasi COVID-19 bervariasi dengan waktu yang lama dan berfluktuasi, tergantung pada tingkat keparahan penyakit dan status kesehatan pasien dengan mempertimbangkan komorbiditas dan kelemahan secara keseluruhan. Kondisi ini muncul dengan gejala yang dapat berubah seiring waktu dan dapat mempengaruhi sistem didalam tubuh. Gejala umum post COVID-19 syndrom

yaitu kelelahan dan kelemahan ekstrem, sesak napas saat aktivitas ringan, nyeri sendi, demam ringan yang terus-menerus, sakit kepala, vertigo, pilek, sakit tenggorokan, perubahan suara dan kesulitan menelan, kehilangan atau perubahan penciuman dan perasa yang berkepanjangan, rambut rontok, gangguan gastrointestinal termasuk kehilangan nafsu makan, sakit perut, diare, muntah, ketidakmampuan untuk berkonsentrasi dan susah tidur (Care & Resource, 2020).

The post-COVID-19 syndrome experienced by the participants varied, some participants stated that the post-COVID-19 syndrome was still felt even though it had been declared negative for COVID-19. This is in line with (Care & Resource, 2020) stating that in October 2020, NICE (the national institute for health and care excellence) recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer. of 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over a long period of time and fluctuate, depending on the severity of the disease and the patient's health status taking into account comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste. prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia (Care & Resource, 2020).

Pengalaman pasca-covid, mereka lebih sadar spiritual dan menemukan kedamaian melalui kegiatan spiritual. Spiritualitas dapat memberikan harapan dan makna dalam situasi sulit termasuk dimasa pandemi COVID-19 (Teresa et al., 2021). [A41] Spiritual menciptakan emosi positif dalam diri seseorang. Spiritualitas dan agama dapat membantu manusia dalam kesedihansaat-saat krisis dan dapat menjadi obat penenang yang berguna pada manusia (Chronic et al., 2020) [A42]

Post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations including during the COVID-19 pandemic (Teresa et al., 2021). Spiritual creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be useful sedatives for humans (Chronic et al., 2020)

Dukungan dari tim medis sangat dibutuhkan pasien terkonfirmasi COVID-19 dalam menjalani perawatan dan pengobatan diruang isolasi COVID-19. Perawatan dan tindakan intervensi yang diberikan tim medis secara profesional setiap hari akan menghasilkan rasa terimakasih dari pasien (Wang et al., 2020). [A43] Pemberian perawatan dan pengobatan dari tim medis dapat meningkatkan pendekatan manajemen diri yang membantu pasien untuk semangat melawan penyakit yang mereka alami. Kepuasan intervensi klinis yang diterima dan kualitas perawatan selama menjalani perawatan

diruang isolasi COVID-19 serta rasa hormat yang diterima dari profesional tim medis(Olufadewa et al., 2020).

Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and treatment in the COVID-19 isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). The provision of care and treatment from the medical team can improve self-management approaches that help patients to be enthusiastic about fighting the disease they are experiencing. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room as well as the respect received from medical team professionals (Olufadewa et al., 2020).

Ketidakpuasan intervensi klinis yang diterima dan kualitas perawatan diruang isolasi COVID-19 yang disebabkan karena pembatasan jam masuk tim medis COVID-19 ke dalam ruangan isolasi COVID-19. Berdasarkan(Tim Mitigasi Dokter PB IDI, 2020[A44])shift kerja harus memperhatikan durasi kerja yang sesuai dengan peraturan yaitu Permenkes No.52 Tahun 2018. Waktu kerja lebih pendek diijinkan pada kondisi tekanan pekerjaan tidak normal atau resiko tinggi seperti tim medis COVID-19 harus memakai hazmat terus menerus sepanjangshift. Shift pendek lebih disarankan dibandingkan shift panjang sehingga dapat membantu melindungi dari risiko kelelahan mental dari beban kerja yang berat. Kelelahan tersebut dapat meningkatkan resiko cedera dan memperburuk kondisi kesehatan yang rentan terhadap infeksi penyakit, peningkatan tekanan psikologis yang mempengaruhi kesehatan tim medis, dan kualitas serta keamanan perawatan yang diberikan. Maka perlunya edukasi tim medis COVID-19 kepada pasien terkonfirmasi COVID-19 yang menjalani perawatan diruang isolasi COVID-9 terkait adanya perubahan rotasi dan durasi kerja tim medis diruang isolasi COVID-19. Hal ini dilakukan untuk mengurangi pajanan tenaga kesehatan terhadap virus yang ditujukan untuk menjaga kesehatan fisik dan mental dan mempertahankan kualitas pelayanan para tim medis

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on (PB IDI Doctor Mitigation Team, 2020) the work shift must pay attention to the duration of work in accordance with the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short

shifts are recommended over long shifts so they can help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increased psychological stress that affects the health of the medical team, and the quality and safety of the care provided. So it is necessary to educate the COVID-19 medical team to confirmed COVID-19 patients undergoing treatment in the COVID-9 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This is done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

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## LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

## AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

## CONFLICT OF INTEREST

There is no conflict of interest in this research

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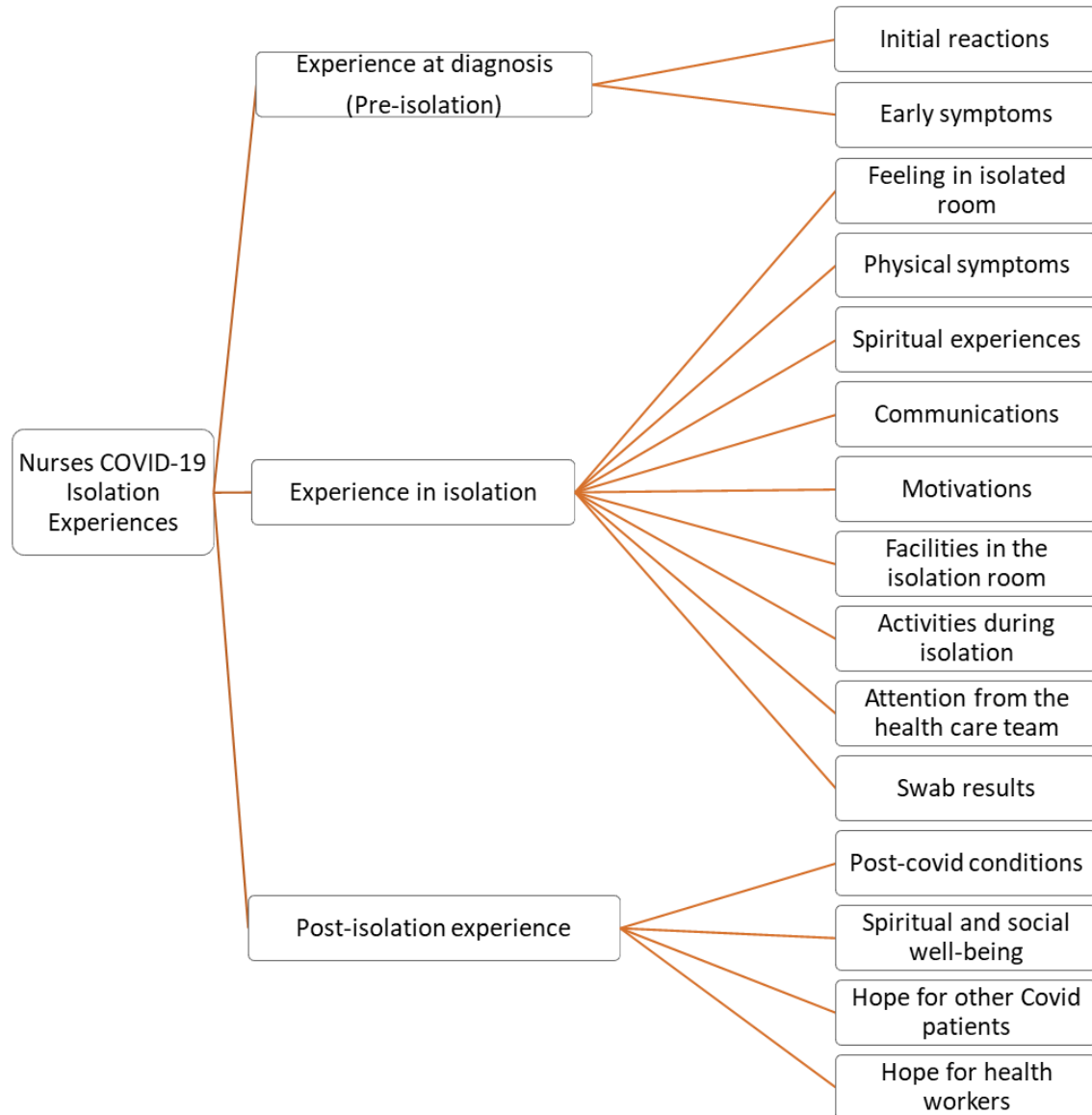
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## TABLE

**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** Themes and Subthemes

## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience



## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

**Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study,**

further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR

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test. **Purposive sampling was used to recruit participants.** Data saturation were reached from 7 nurse participants.

**Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who have completed isolation from the hospital's nurse manager.** Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

### Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. **The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience.** The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. **The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.**

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

### Data analysis

**Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was**

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re-read, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

### Study rigor

To establish this study's rigor, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

### Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

### RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

#### Theme 1: Experience at diagnoses (Pre-isolation)

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

##### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the

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disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, "When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this" (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, "I always think of my children. I'm worried they may also get exposed [by corona virus]." Likewise, P7 explained how she tried not to pass the disease on to her husband: "... I refused to be held by my husband. I'm afraid of transmitting it [COVID-19] to him" (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, "It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I'm terrified to be outcasted and ostracized." This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: "... I was afraid to inform the neighborhood leader, people may know and ostracized me" (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

"I was wondered, why I'm not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable." (P7)

"The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste." (P3)

### **Theme 2: Experience in the isolation room**

This theme was about participants' experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: 'Feelings of being in

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isolation room', 'Physical symptoms', 'Spiritual experiences', 'Communications', 'Motivations', 'Facilities in the isolation room', 'Activities during isolation', 'Attention from the health care team', and 'Swab results'.

### *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

### *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

### *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

### *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

### *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

### *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

## *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

## *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

## **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of 'post-covid conditions', 'spiritual and social well-being', 'hope for other covid patients' and 'hope for health workers.'

## *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, "Although my test was negative, there's a thing called post-covid reaction.

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My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be" (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, "Now I disciplined myself to wear a mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements."

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. "My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance" (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, "If I hear a friend has Covid, I'll be happy to send them food. I'll support them." Another participant echoed this, "Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation" (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, "My message is, I've been through it and recovered, so you do too," and another commented "don't stress it too much, keep eating, have lots of rest and make yourself happy" (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, "My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to." Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. "Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care" (R5).

## **DISCUSSION**

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# Submissions Template for Authors

**Nurse Media**

JOURNAL OF NURSING

Instructions/Template for Preparing Manuscript for Nurse Media Journal of Nursing

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

## **Theme1. Experience at diagnoses (Pre Isolation)**

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. **Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020).**

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Fear is an adaptive response to a potentially threatening situation (Ornell et al., 2020). The most important mental strain of COVID-19 patients is the fear of death and worsening of symptoms (Jesmi et al., 2021). Severe psychological stress experienced by these patients can increase the risk of psychological tension, including post-traumatic stress. Therefore, psychological support for these patients is essential to reduce the negative consequences of psychological tension. Also Mertens et al. (2020) stated that in an online survey of 439 patients with COVID-19, they showed fear in social aspects, including intolerance of uncertainty, their health anxiety, and those of their loved ones (Mertens et al., 2020).

**Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression finding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).**

Fearful of being ostracized, participants experienced the frustration of stigmatization. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the

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negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease.

### Theme 2. Experience in the isolation room

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Participants' experiences where the body conditions in the isolation room are the same as reported in the study of Jesmi et al. (2021) as always have nervous, respiratory, gastrointestinal, and systemic manifestations (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020). Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries (Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

### Theme 3. Post-isolation experiences

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants' statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated.

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Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

### CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

### ACKNOWLEDGMENTS

The authors would like to thank the participants in this study for their cooperation and support during data collection.

### LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

### AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

### CONFLICT OF INTEREST

There is no conflict of interest in this research

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## TABLE

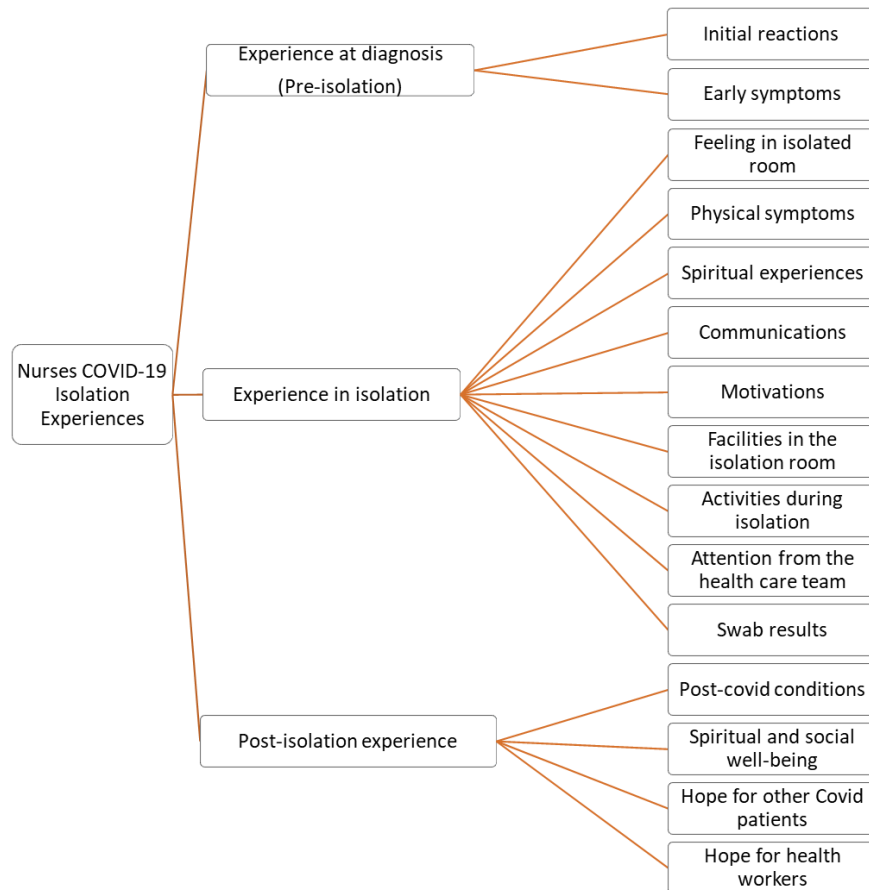
**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

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## FIGURE



**Figure 1.** Themes and Subthemes

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## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

### BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

**Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). The perceived lack of**

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defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009, Corley et al., 2010). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010).

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005, Kim, 2018). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013, Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008). The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

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often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013, Chung et al., 2005). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who

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have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

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description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

### Study rigor

To establish this study's rigor, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

### Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

### RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

#### Theme 1: Experience at diagnoses (Pre-isolation)

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants' 'initial reactions and early symptoms.

##### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

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Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, “... I had mixed feelings, how could I get covid? I always wear full PPE!”. Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, “...I didn’t believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying.”

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

### **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

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### *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

### *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

### *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

### *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was

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excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

### *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

### *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

### *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

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As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

### **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of 'post-covid conditions', 'spiritual and social well-being', 'hope for other covid patients' and 'hope for health workers.'

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, "Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be" (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, "Now I disciplined myself to wear a

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mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

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## Theme1. Experience at diagnoses (Pre Isolation)

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). Pasien terkonfirmasi COVID-19 cenderung mengalami tekanan terkait dengan kondisi dialami yang dapat mempengaruhi kondisi fisik, emosional, mental, sosial, dan spiritual (Roman et al., 2020). Penelitian (Clerkin et al., 2020) yang menyatakan bahwa laporan awal menunjukkan gejala yang paling umum terinfeksi COVID-19 adalah demam (88%). Berdasarkan penelitian (Biscardi et al., 2020) menyatakan bahwa Sekitar 80% orang yang terkonfirmasi COVID-19 mengalami gejala ringan hingga sedang yaitu mengalami batuk kering atau sakit tenggorokan. Berdasarkan (Kumar et al., 2020) menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf perifer, akan menyebabkan gejala seperti gangguan pengecap dan gangguan penciuman. Sedangkan penelitian (Jesmi et al., 2021) menyatakan bahwa keluhan yang sering pasien yang terkonfirmasi COVID-19 mengungkapkan masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah.

Fear is an adaptive response to a potentially threatening situation (Ornell et al., 2020). The most important mental strain of COVID-19 patients is the fear of death and worsening of symptoms (Jesmi et al., 2021). Severe psychological stress experienced by these patients can increase the risk of psychological tension, including post-traumatic stress. Therefore, psychological support for these patients is essential to reduce the negative consequences of psychological tension. Also Mertens et al. (2020) stated that in an online survey of 439 patients with COVID-19, they showed fear in social aspects, including intolerance of uncertainty, their health anxiety, and those of their loved ones (Mertens et al., 2020).

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression finding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization.

Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The

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negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease. Saat pandemi COVID-19 saat

ini, beberapa pasien terkonfirmasi COVID-19 masih mendapat perlakuan didiskriminasi, diperlakukan secara terpisah karena terdiagnosa terinfeksi COVID-19. Hal ini berdampak negatif kepada mereka yang terkonfirmasi COVID-19 dan keluarga. Stigma dapat merusak hubungan sosial dan mendorong kemungkinan isolasi sosial kelompok yang mengakibatkan lebih banyak masalah kesehatan yang parah dan kesulitan mengendalikan wabah penyakit karena mendorong seseorang yang terinfeksi COVID-19 menyembuyikan penyakitnya untuk menghindari diskriminasi (WHO, IFRC, 2020).

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## Theme 2. Experience in the isolation room

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Participants' experiences where the body conditions in the isolation room are the same as reported in the study of Jesmi et al. (2021) as always have nervous, respiratory, gastrointestinal, and systemic manifestations (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020). Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries

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(Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

Berpisah dengan keluarga dan diisolasi dalam jangka waktu lama pasien cenderung khawatir atas pemenuhan tanggung jawab keluarga mereka sehingga menimbulkan kesedihan selama berpisah dengan orang-orang yang dicintai (Wang et al., 2020). Pernyataan stres yang dialami partisipan disebabkan karena sendirian diruang isolasi atau dirawat bersama pasien yang kondisinya berat serta stres memikirkan kondisi kesehatan akan memburuknya gejala yang dialami. Stres yang dialami pasien terkonfirmasi COVID-19 merupakan respon normal terhadap penyakit. Stres dapat menyebabkan penurunan sistem kekebalan tubuh dan menyebabkan disregulasi imun yang dapat memperburuk kondisi kesehatan pasien yang terkonfirmasi COVID-19 (Kaligis et al., 2020). Beberapa faktor yang berpengaruh terhadap kesehatan psikologis pasien yang terkonfirmasi COVID-19 adalah angka kasus COVID-19 tidak terkendali dalam penyebaran virus, pasien yang diisolasi mengalami masalah pernapasan akut dan penyakit COVID-19 dapat menyebabkan kematian. Sehingga hal tersebut dapat menyebabkan kecemasan pada pasien terkonfirmasi COVID-19 (Jesmi et al., 2021).

Ketidakpuasan intervensi klinis yang diterima dan kualitas perawatan diruang isolasi COVID-19 yang disebabkan karena pembatasan jam masuk tim medis COVID-19 ke dalam ruangan isolasi COVID-19. Berdasarkan (Tim Mitigasi Dokter PB IDI, 2020) shift kerja harus memperhatikan durasi kerja yang sesuai dengan peraturan yaitu Permenkes No.52 Tahun 2018. Waktu kerja lebih pendek diijinkan pada kondisi tekanan pekerjaan tidak normal atau resiko tinggi seperti tim medis COVID-19 harus memakai hazmat terus menerus sepanjang shift. Shift pendek lebih disarankan dibandingkan shift panjang sehingga dapat membantu melindungi dari risiko kelelahan mental dari beban kerja yang berat. Kelelahan tersebut dapat meningkatkan resiko cedera dan memperburuk kondisi kesehatan yang rentan terhadap infeksi penyakit, peningkatan tekanan psikologis yang mempengaruhi kesehatan tim medis, dan kualitas serta keamanan perawatan yang diberikan. Maka perlunya edukasi tim medis COVID-19 kepada pasien terkonfirmasi COVID-19 yang menjalani perawatan diruang isolasi COVID-19 terkait adanya perubahan rotasi dan durasi kerja tim medis diruang isolasi COVID-19. Hal ini dilakukan untuk mengurangi pajanan tenaga kesehatan terhadap virus yang ditujukan untuk menjaga kesehatan fisik dan mental dan mempertahankan kualitas pelayanan para tim medis

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## Theme 3. Post-isolation experiences

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants'

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statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

Emosi positif yang terkait dengan dukungan yang diterima pasien terkonfirmasi COVID-19 berasal dari berbagai sumber salah satunya adalah dukungan keluarga. Berdasarkan (Aunguroch et al., 2020) menyatakan bahwa dukungan sosial dari anggota keluarga menunjukkan bahwa manusia adalah makhluk sosial yang tidak dapat hidup tanpa dukungan sosial termasuk dalam penanganan penyakit COVID-19. Dan emosi positif berperan penting dalam pemulihan dan penyesuaian psikologis (Sun et al., 2020). Suasana hati pasien terkonfirmasi COVID-19 yang baik akan meningkatkan dopamin yang tinggi didalam darah sehingga akan mengoptimalkan dan meningkatkan sistem kekebalan tubuh. Dukungan dari teman dapat memberikan respon yang positif terhadap pemuliharaan kesehatan (T. Habib, 2021). Perawatan dan tindakan intervensi yang diberikan tim medis secara profesional setiap hari akan menghasilkan rasa terimakasih dari pasien (Wang et al., 2020).

Spiritualitas dapat memberikan harapan dan makna dalam situasi sulit termasuk dimasa pandemi COVID-19 (Teresa et al., 2021). Spiritual menciptakan emosi positif dalam diri seseorang. Spiritualitas dan agama dapat membantu manusia dalam kesedihansaat-saat krisis dan dapat menjadi obat penenang yang berguna pada manusia (Chronic et al., 2020).

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

PostCOVID-19 syndrome yang dialami partisipan bervariasi beberapa partisipan menyatakan post COVID-19 syndrome masih dirasakan walaupun sudah dinyatakan negatif COVID-19. Hal ini sejalan dengan

(Care & Resource, 2020) menyatakan bahwa Oktober 2020, NICE (the national institute for health and care excellence) mengakui ketidakpastian efek jangka

**Commented [A30]:** Aunguroch, Y., Juanamasta, I. G., & Gunawan, J. (2020). Experiences of patients with coronavirus in the covid-19 pandemic era in Indonesia. *Asian Journal for Public Opinion Research*, 8(3), 377-392.

**Commented [A31]:** Sun, T., Wei, L., Shi, S., Jiao, D., Song, R., & Ma, L. (2020). Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information. January

**Commented [A32]:** T. Habib, P. (2021). COVID-19 symphony: A review of possible music therapy effect in supporting the immune system of COVID-19 patient. *Highlights in BioScience*, May, bs202105

**Commented [A33]:** Wang, S., Liu, Y., She, H., Wang, T., Feng, X., & Hsiao, C. (2020). Psychological Experiences of Patients with COVID-19: A Phenomenological Study. 3(1), 193-201

**Commented [A34]:** Teresa, M. T., Guss, C. D., & Boyd, L. (2021). Thriving during COVID-19: Predictors of psychological well-being and ways of coping. *PLoS ONE*, 16(3 March), 1-19.

**Commented [A35]:** Chronic, J. J., Care, D., & Fardin, M. A. (2020). COVID-19 Epidemic and Spirituality: A Review of the Benefits of Religion in Times of Crisis COVID-19 Epidemic and Spirituality: A Review of the Benefits of Religion in Times of Crisis. May

**Commented [A36]:** Care, P., & Resource, N. (2020). *Living with Covid-19 (Long Covid) and Beyond Community and Primary Care Nursing Resource*. 19, 1-19.

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panjang dari virus SARS-CoV-2 dan mendefinisikan post COVID-19 syndromesebagai gejala yang berlangsung lebih dari 12 minggu. Keluhan kondisi fisik jangka panjang pada pasien terkonfirmasi COVID-19 bervariasi dengan waktu yang lama dan berfluktuasi, tergantung pada tingkat keparahan penyakit dan status kesehatan pasien dengan mempertimbangkan komorbiditas dan kelemahan secara keseluruhan. Kondisi ini muncul dengan gejala yang dapat berubah seiring waktu dan dapat mempengaruhi sistem didalam tubuh. Gejala umum post COVID-19 syndrom yaitu kelelahan dan kelemahan ekstrem, sesak napas saat aktivitas ringan, nyeri sendi, demam ringan yang terus-menerus, sakit kepala, vertigo, pilek, sakit tenggorokan, perubahan suara dan kesulitan menelan, kehilangan atau perubahan penciuman dan perasa yang berkepanjangan, rambut rontok, gangguan gastrointestinal termasuk kehilangan nafsu makan, sakit perut, diare, muntah, ketidakmampuan untuk berkonsentrasi dan susah tidur (Care & Resource, 2020).

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

## ACKNOWLEDGMENTS

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The authors would like to thank the participants in this study for their cooperation and support during data collection.

## LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

## AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

## CONFLICT OF INTEREST

There is no conflict of interest in this research

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## TABLE

**Table 1.** Participants characteristics

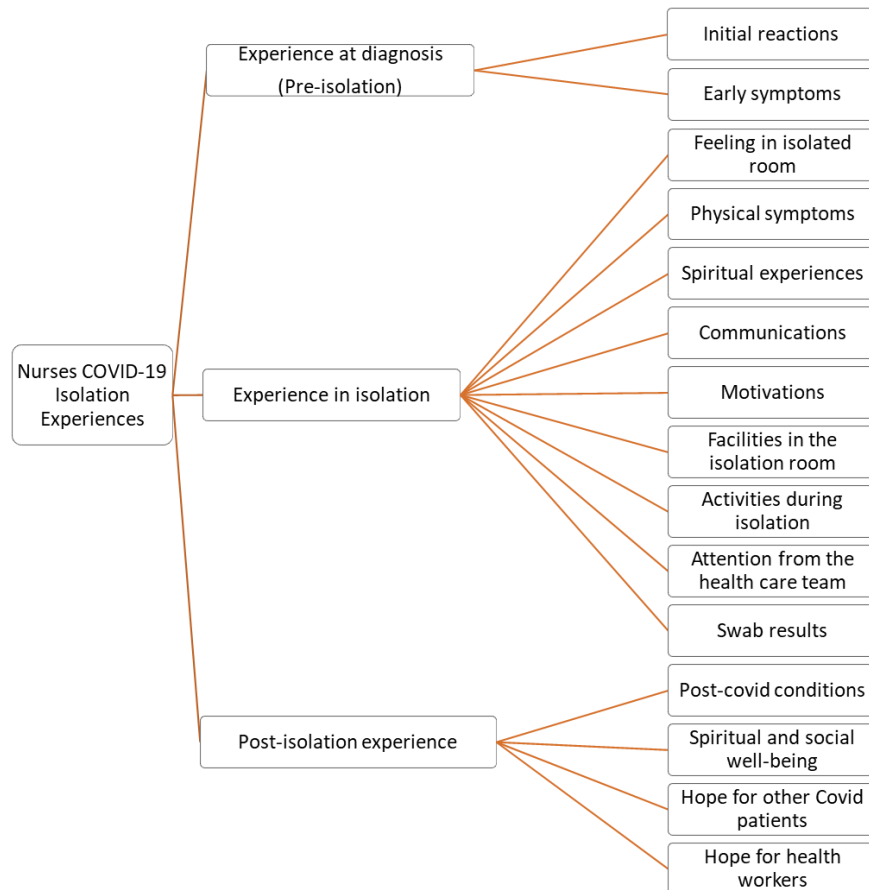
Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

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## FIGURE



**Figure 1.** Themes and Subthemes

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## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected **need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.**

**Purpose:** **This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.**

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. **Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.**

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). [GRI]The perceived lack of

defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018,[A2]). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009[A3], Corley et al., 2010[A4]). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007[A5]).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). [GR6]Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009[A7]). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020[A8]). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010[A9])

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018[A10]). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005[A11], Kim, 2018[A12]). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012[A13]). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007[A14]). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013[A15], Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008)[A16]. The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013,[A17] Chung et al., 2005[A18]). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who

have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## Study rigor

To establish this study's rigour, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

### Theme 1: Experience at diagnoses (Pre-isolation)

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

#### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

## *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.



## *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

## *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

## *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was

excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

## *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, “My roommate, she’s elderly, was suffocated, so I helped take care of her.” Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, “The PCR results were too long... I have to wait a few days [after the swab] until I can go home.” Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

## **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, “Now I disciplined myself to wear a

mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

## **Theme1. Experience at diagnoses (Pre Isolation)**

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). [GR19]Pasien terkonfirmasi COVID-19 cenderung mengalami tekanan terkait dengan kondisi dialami yang dapat mempengaruhi kondisi fisik, emosional, mental, sosial, dan spiritual (Roman et al., 2020). [A20]Penelitian (Clerkin et al., 2020)[A21] yang menyatakan bahwa laporan awal menunjukkan gejala yang paling umum terinfeksi COVID-19 adalah demam (88%). Berdasarkan penelitian (Biscardi et al., 2020)[A22] menyatakan bahwa Sekitar 80% orang yang terkonfirmasi COVID-19 mengalami gejala ringan hingga sedang yaitu mengalami batuk kering atau sakit tenggorokan. Berdasarkan (Kumar et al., 2020)[A23] menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf perifer, akan menyebabkan gejala seperti gangguan pengecapan dan gangguan penciuman. Sedangkan penelitian (Jesmi et al., 2021)[A24] menyatakan bahwa keluhan yang sering pasien yang terkonfirmasi COVID-19 mengungkapkan masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah.

Fear is an adaptive response to a potentially threatening situation (Ornell et al., 2020). The most important mental strain of COVID-19 patients is the fear of death and worsening of symptoms (Jesmi et al., 2021). Severe psychological stress experienced by these patients can increase the risk of psychological tension, including post-traumatic stress. Therefore, psychological support for these patients is essential to reduce the negative consequences of psychological tension. Also Mertens et al. (2020) stated that in an online survey of 439 patients with COVID-19, they showed fear in social aspects, including intolerance of uncertainty, their health anxiety, and those of their loved ones (Mertens et al., 2020).

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression finding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization.

Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The

negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease. Saat pandemi COVID-19 saat

ini, beberapa pasien terkonfirmasi COVID-19 masih mendapat perlakuan

didiskriminasi, diperlakukan secara terpisah karena terdiagnosa terinfeksi

COVID-19. Hal ini berdampak negatif kepada mereka yang terkonfirmasi

COVID-19 dan keluarga. Stigma dapat merusak hubungan sosial dan mendorong

kemungkinan isolasi sosial kelompok yang mengakibatkan lebih banyak masalah

kehatan yang parah dan kesulitan mengendalikan wabah penyakit karena

mendorong seseorang yang terinfeksi COVID-19 menyembuyikan penyakitnya

untuk menghindari diskriminasi (WHO, IFRC, 2020). [A25]

## **Theme 2. Experience in the isolation room**

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Participants' experiences where the body conditions in the isolation room are the same as reported in the study of Jesmi et al. (2021) as always have nervous, respiratory, gastrointestinal, and systemic manifestations (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020). Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries

(Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

Berpisah dengan keluarga dan diisolasi dalam jangka waktu lama pasien cenderung khawatir atas pemenuhan tanggung jawab keluarga mereka sehingga menimbulkan kesedihan selama berpisah dengan orang-orang yang dicintai (Wang et al., 2020)[A26] Pernyataan stres yang dialami partisipan disebabkan karena sendirian diruang isolasi atau dirawat bersama pasien yang kondisinya berat serta stres memikirkan kondisi kesehatan akan memburuknya gejala yang dialami. Stres yang dialami pasien terkonfirmasi COVID-19 merupakan respon normal terhadap penyakit. Stres dapat menyebabkan penurunan sistem kekebalan tubuh dan menyebabkan disregulasi imun yang dapat memperburuk kondisi kesehatan pasien yang terkonfirmasi COVID-19 (Kaligis et al., 2020)[A27] Beberapa faktor yang berpengaruh terhadap kesehatan psikologis pasien yang terkonfirmasi COVID-19 adalah angka kasus COVID-19 tidak terkendali dalam penyebaran virus, pasien yang diisolasi mengalami masalah pernapasan akut dan penyakit COVID-19 dapat menyebabkan kematian. Sehingga hal tersebut dapat menyebabkan kecemasan pada pasien terkonfirmasi COVID-19 (Jesmi et al., 2021)[A28].

Ketidakpuasan intervensi klinis yang diterima dan kualitas perawatan diruang isolasi COVID-19 yang disebabkan karena pembatasan jam masuk tim medis COVID-19 ke dalam ruangan isolasi COVID-19. Berdasarkan (Tim Mitigasi Dokter PB IDI, 2020)[A29] shift kerja harus memperhatikan durasi kerja yang sesuai dengan peraturan yaitu Permenkes No.52 Tahun 2018. Waktu kerja lebih pendek diijinkan pada kondisi tekanan pekerjaan tidak normal atau resiko tinggi seperti tim medis COVID-19 harus memakai hazmat terus menerus sepanjang shift. Shift pendek lebih disarankan dibandingkan shift panjang sehingga dapat membantu melindungi dari risiko kelelahan mental dari beban kerja yang berat. Kelelahan tersebut dapat meningkatkan resiko cedera dan memperburuk kondisi kesehatan yang rentan terhadap infeksi penyakit, peningkatan tekanan psikologis yang mempengaruhi kesehatan tim medis, dan kualitas serta keamanan perawatan yang diberikan. Maka perlunya edukasi tim medis COVID-19 kepada pasien terkonfirmasi COVID-19 yang menjalani perawatan diruang isolasi COVID-19 terkait adanya perubahan rotasi dan durasi kerja tim medis diruang isolasi COVID-19. Hal ini dilakukan untuk mengurangi pajanan tenaga kesehatan terhadap virus yang ditujukan untuk menjaga kesehatan fisik dan mental dan mempertahankan kualitas pelayanan para tim medis

### **Theme 3. Post-isolation experiences**

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants'

statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

Emosi positif yang terkait dengan dukungan yang diterima pasien terkonfirmasi COVID-19 berasal dari berbagai sumber salah satunya adalah dukungan keluarga. Berdasarkan (Aunguroch et al., 2020) [A30] menyatakan bahwa dukungan sosial dari anggota keluarga menunjukkan bahwa manusia adalah makhluk sosial yang tidak dapat hidup tanpa dukungan sosial termasuk dalam penanganan penyakit COVID-19. Dan emosi positif berperan penting dalam pemulihan dan penyesuaian psikologis (Sun et al., 2020) [A31] Suasana hati pasien terkonfirmasi COVID-19 yang baik akan meningkatkan dopamin yang tinggi didalam darah sehingga akan mengoptimalkan dan meningkatkan sistem kekebalan tubuh. Dukungan dari teman dapat memberikan respon yang positif terhadap pemuliharaan kesehatan (T. Habib, 2021) [A32] Perawatan dan tindakan intervensi yang diberikan tim medis secara profesional setiap hari akan menghasilkan rasa terimakasih dari pasien (Wang et al., 2020) [A33]

Spiritualitas dapat memberikan harapan dan makna dalam situasi sulit termasuk dimasa pandemi COVID-19 (Teresa et al., 2021) [A34] Spiritual menciptakan emosi positif dalam diri seseorang. Spiritualitas dan agama dapat membantu manusia dalam kesedihansaat-saat krisis dan dapat menjadi obat penenang yang berguna pada manusia (Chronic et al., 2020) [A35]

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

PostCOVID-19 syndromeyang dialami partisipan bervariasi beberapa partisipan menyatakan post COVID-19 syndrome masih dirasakan walaupun sudah dinyatakan negatif COVID-19. Hal ini sejalan dengan

(Care & Resource, 2020) [A36] menyatakan bahwa Oktober 2020, NICE (*the national institute for health and care excellence*) mengakui ketidakpastian efek jangka



panjang dari virus SARS-CoV-2 dan mendefinisikan post COVID-19 syndromesebagai gejala yang berlangsung lebih dari 12 minggu. Keluhan kondisi fisik jangka panjang pada pasien terkonfirmasi COVID-19 bervariasi dengan waktu yang lama dan berfluktuasi, tergantung pada tingkat keparahan penyakit dan status kesehatan pasien dengan mempertimbangkan komorbiditas dan kelemahan secara keseluruhan. Kondisi ini muncul dengan gejala yang dapat berubah seiring waktu dan dapat mempengaruhi sistem didalam tubuh. Gejala umum post COVID-19 syndrom yaitu kelelahan dan kelemahan ekstrem, sesak napas saat aktivitas ringan, nyeri sendi, demam ringan yang terus-menerus, sakit kepala, vertigo, pilek, sakit tenggorokan, perubahan suara dan kesulitan menelan, kehilangan atau perubahan penciuman dan perasa yang berkepanjangan, rambut rontok, gangguan gastrointestinal termasuk kehilangan nafsu makan, sakit perut, diare, muntah, ketidakmampuan untuk berkonsentrasi dan susah tidur (Care & Resource, 2020).

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

## ACKNOWLEDGMENTS

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### LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

### AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

### CONFLICT OF INTEREST

There is no conflict of interest in this research

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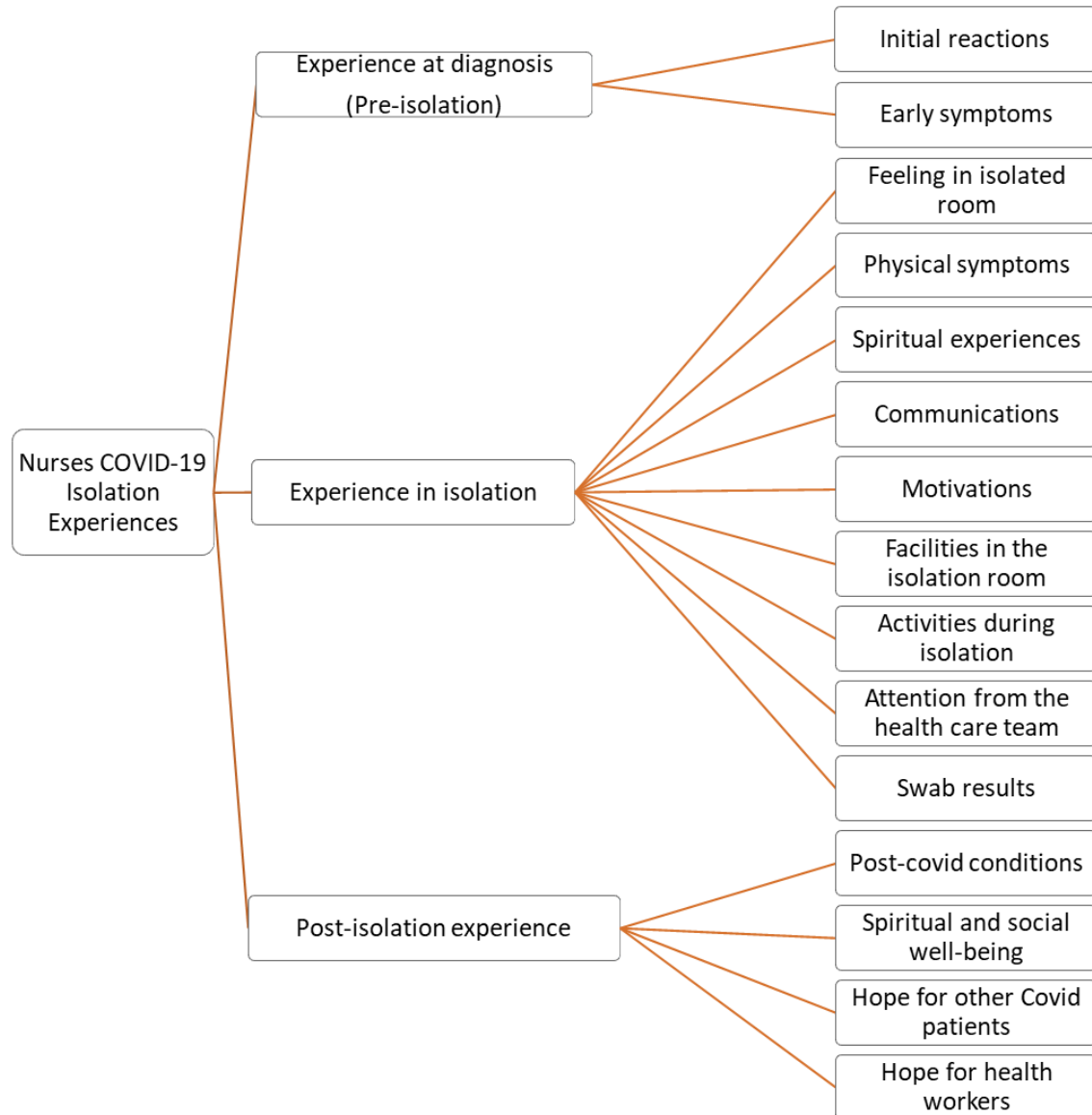
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## TABLE

**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** Themes and Subthemes



## The Experience of Nurses Who were Isolated due to Covid-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: ernawatisiagian@unai.edu

### ABSTRACT

**Background:** Along with the increase in COVID-19 cases in Indonesia, health services and hospital care have an important role in handling and controlling cases. In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses experience during their isolation period as this may change how they treat COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore nurses' experiences of being infected by COVID-19 and being isolated in the hospital isolation unit.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach, and participants were selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process.

### Keywords:

COVID-19; descriptive phenomenology; nurse experience

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, **treatments** to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Healthcare workers who treat Covid-19 patients are a group with a very high risk of exposure. Studies have shown that the probability of medical workers being infected with Covid-19 is 3.8%, mainly due to unprotected initial contact with infected patients (Liu et al., 2020; Wu & McGoogan, 2020). Health workers in the frontline include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In addition, nurses provide nursing care to patients at risk of exposure (COVID-19). During nursing care, nurses are involved in diagnosis, prevention, control and direct patient care, and therefore they have a high risk of getting infected (Sun et al., 2020). Moreover, facing a critical situation, health workers on the front lines who are directly involved in the diagnosis, treatment and care of Covid-19 patients are at risk of experiencing psychological disorders in the form of depression and other mental health symptoms. Various factors have been investigated and reported including heavy workloads, depleted personal protective equipment, excessive and widespread media coverage, lack of certain medications, and feelings of not being adequately supported also contribute to the mental burden of health workers (Lai et al., 2020).

Doctors, nurses and other healthcare workers who participate in the care of COVID-19 patients must face the risk of being infected by SARS-CoV-2 itself and the risk of suffering from mental health problems such as feelings of fear or anxiety (Rana et al., 2020). Research has found that 37.5% of 557 critical care and emergency nurses, representing 26 public hospitals in the Madrid area, work with the fear of infection from treating COVID-19 patients (González et al., 2021). According to a Spanish study involving 92 nurses representing two hospitals, emotional work and workload during a pandemic is a risk to nurses' psychosocial health, whereas available resources, actions and information are protective factors for their psychosocial health. In the same study, further research is proposed to expand knowledge on how to protect and care for nurses while working during a pandemic (Giménez et al., 2020). [GRI]The perceived lack of

defensive resources, (PPE), were contributing factors to nurses concerns and fears working during pandemics (Kang et al., 2018,<sup>[A2]</sup>). The uncertainty that the level of protection provided to nursing staff was effective and efficient to minimise infection risk affected many nurses' ability to cope (Ives et al., 2009<sup>[A3]</sup>, Corley et al., 2010<sup>[A4]</sup>). Despite low PPE supplies in some hospitals, nurses demonstrated their resilience by collaborating with colleagues to develop alternative protection, with some using disposable raincoats as PPE (Shih et al., 2007<sup>[A5]</sup>).

Many research studies have focused on the clinical aspects of the disease, experience, and psychological status of Covid-19 patients (Jin et al., 2020; Wang et al., 2020; Zu et al., 2020). These patients experience more health problems during an outbreak than other patients so they may have long-term health problems even after discharge from the hospital. For example, Sahoo et al. (2020) conducted a narrative study on 3 COVID-19 patients and showed that these patients experienced anger, guilt, and shame. Likewise, Rahmatinejad et al. (2020) demonstrated that COVID-19 patients experience anxiety, stigma, and ambiguity throughout their illness. Those issues were also shared by nurses whom COVID-19 infected. For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021).<sup>[GR6]</sup> Rapidly changing advice and knowledge about the contagion increased the stress levels among nursing staff (Ives et al., 2009<sup>[A7]</sup>). Many nurses wanted to ensure that they were equipped with the appropriate information to provide quality patient care. Yet nurses expressed inadequate training in caring for patients affected by an emerging infectious disease (Lam et al., 2020<sup>[A8]</sup>). This confusion also exacerbated nurses' anxiety and perception of risk. The communication of information was often felt to be difficult and not succinct thus creating additional confusion and distress for the already busy nurses (Corley et al., 2010<sup>[A9]</sup>).

The nurses experienced heightened anxiety for their own health while caring for infected patients during a pandemic (Kang et al., 2018<sup>[A10]</sup>). Concerns over their own susceptibility to infection was largely associated with fear of the new phenomenon, and with the possibility of death (Chung et al., 2005<sup>[A11]</sup>, Kim, 2018<sup>[A12]</sup>). Nurses feared not only being exposed to infected patients, but were scared that infection could be spread through nursing colleagues sharing resources (Koh et al., 2012<sup>[A13]</sup>). Beside their own personal health, nurses feared that with the uncertainty of the working environment and new disease threat that they were placing their family and friends at greater risk of infection (Shih et al., 2007<sup>[A14]</sup>). Nurses were particularly concerned with spreading the infection to vulnerable family members, such as the elderly, immunocompromised and young children (Ives et al., 2009, Lam and Hung, 2013<sup>[A15]</sup>, Koh et al., 2012).

The perception of personal, social and economic consequences from the uncertainty of a pandemic led to psychological distress and fear among nurses working during a pandemic (Shih et al., 2007, Holroyd and McNaught, 2008)<sup>[A16]</sup>. The sense of powerlessness was overwhelming for nurses as they were under extreme pressure and

often feared that their practice was being affected by work demands and community fear generated by the pandemic (Lam and Hung, 2013,[A17] Chung et al., 2005[A18]). Despite the professional camaraderie, the unfamiliarity of the pandemic environment created a sense of loneliness (Kim, 2018) and frustration among nurses. Additionally, relatives of patients were seen to be projecting their emotions towards the nurses (Holroyd and McNaught, 2008, Kim, 2018). Not having control over patient flow also generated both physical and psychological exhaustion (Kang et al., 2018). Deaths amongst some of their nursing colleagues as a result of the pandemic created uncertainty and heightened anxiety and stress (Holroyd and McNaught, 2008, Koh et al., 2012).

However, studies exploring nurses experience in Indonesia are barely found. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Through this research, it is expected that we can obtain patterns that produce labels and things that can be used as a basis for developing a design approach that can be used to improve the quality of service and the quality of life of patients in related conditions.

## OBJECTIVE

This study aimed to explore and describe the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## METHODS

### Design

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi (1978) and applied the EQUATOR guidelines for publication in qualitative research (COREQ) (Tong et al., 2007).

### Settings and Participants

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who

have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

## Data Collection

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic. The nine questions are as follows: (1) "Please tell me how you felt when you first found out you tested positive for Covid-19?" (2) "Can you share your experience while being treated in the Covid-19 room?" (3) "Describe your experience undergoing Covid-19 therapy?" (4) "Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?" (5) "Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?" (6) "Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?" (7) "If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?" (8) "How do you describe your current quality of life?" (9) "Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?". Interview times were varied, and each may last for 40 to 60 minutes. The interview guide questions were developed by counselling with nursing experts in a qualitative study. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed

description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## **Study rigor**

To establish this study's rigour, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln and Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## **Ethical considerations**

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## **RESULTS**

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 1).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

### **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

#### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. R3 said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (R6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, P7 explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (R7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. R2 explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (R7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, R3 reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. R2 said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

## *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.” (P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

## *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, "... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate" (R6). The expression of disappointment was seen from R6. The loneliness made her feel stressed; R6 added, "I can go crazy if I stay here for a long time. I don't know whom I can interact with."

For participants who were isolated in the emergency room, the situation became much worse because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. R5 explained, "I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried."

## *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. "My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell" (R4). Likewise, R5 commented, "...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy". Several participants also stated that enduring these symptoms was very tiring. As R7 said, "It's tough to endure. That condition made me exhausted."

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, R7 said, "I prayed more often and drew closer to God." R2 also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, "Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy" (R2).

In addition, many participants reported that they found peace and power simply by remembering God. As R4 said, "I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength."

## *Communications*

Communication was an important thing that participants often reported. Particularly, communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was



excellent and supportive. P6, for example, was glad to be able to communicate and create a friendship with other patients. She said, "It's nice to have roommates to share with finally. We talked and got to know each other" (R6). Another participant commented: "By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated" (R4). To some participants, maintaining communication with their loved one were significant to help them survive as R6 said, "While being treated in the isolation room, my sisters always contacted me. They strengthened me."

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, "Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process." (R7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As R1 said, "I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions." Likewise, R3 conveyed his concerns about his family during the isolation period, "I have two children. They needed me. I need to recover soon."

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. R2, for example, said, "I have to be able to motivate myself... So I thought positively and tried to be happy." Similarly, P1 revealed, "If I think negatively, I will stay in the isolation room longer" (R1).

## *Facilities in the isolation room*

Majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. R6 was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (R6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (R1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, R2 was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (R2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, R7 shared, “My roommate, she’s elderly, was suffocated, so I helped take care of her.” Likewise, R6 reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

### *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As R3 said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

### *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, R2 reported, “The PCR results were too long... I have to wait a few days [after the swab] until I can go home.” Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (R6).

## **Theme 3: Post-isolation experiences**

Participants experiences after the isolation were completed, and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (R6).

Participants COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, R3 described, “Now I disciplined myself to wear a

mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (R3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, P6 said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (R4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, R2 said, “My message is, I've been through it and recovered, so you do too,” and another commented “don't stress it too much, keep eating, have lots of rest and make yourself happy” (R7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some of the participants suggested that nurses need to improve communication with their patients and support patients who are in hospital isolation, as R3 argued, “My hope is that the nurses can motivate the patient more, have a conversation with them. Try to comfort them. Most of the time, nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (R5).

## **DISCUSSION**

COVID-19 has affected nurses as frontline workers in many ways, including how to provide care to infected patients. Unfortunately, many nurses end up being exposed and then becoming infected. This situation affects many factors in nurses' daily life and their work. **In this study, we aim to explore the experience of nurses who were COVID-19 infected.** The findings of this study support the body of literature on nurses attitudes and perceptions before, during and after infection.

## **Theme1. Experience at diagnoses (Pre Isolation)**

Participants' initial responses to the fact that they were COVID-19 positive included feared and worried. The results of this study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. Studies show that in the acute phase of the disease, every patient fears death due to the worsening of the clinical condition (Banzett et al., 2020). [GR19]Pasien terkonfirmasi COVID-19 cenderung mengalami tekanan terkait dengan kondisi dialami yang dapat mempengaruhi kondisi fisik, emosional, mental, sosial, dan spiritual (Roman et al., 2020). [A20]Penelitian (Clerkin et al., 2020)[A21] yang menyatakan bahwa laporan awal menunjukkan gejala yang paling umum terinfeksi COVID-19 adalah demam (88%). Berdasarkan penelitian (Biscardi et al., 2020)[A22] menyatakan bahwa Sekitar 80% orang yang terkonfirmasi COVID-19 mengalami gejala ringan hingga sedang yaitu mengalami batuk kering atau sakit tenggorokan. Berdasarkan (Kumar et al., 2020)[A23] menyatakan bahwa SARS-CoV-2 yang menyerang sistem saraf perifer, akan menyebabkan gejala seperti gangguan pengecap dan gangguan penciuman. Sedangkan penelitian (Jesmi et al., 2021)[A24] menyatakan bahwa keluhan yang sering pasien yang terkonfirmasi COVID-19 mengungkapkan masalah pencernaan yaitu diare, sembelit, hilangnya nafsu makan, mual dan muntah.

Fear is an adaptive response to a potentially threatening situation (Ornell et al., 2020). The most important mental strain of COVID-19 patients is the fear of death and worsening of symptoms (Jesmi et al., 2021). Severe psychological stress experienced by these patients can increase the risk of psychological tension, including post-traumatic stress. Therefore, psychological support for these patients is essential to reduce the negative consequences of psychological tension. Also Mertens et al. (2020) stated that in an online survey of 439 patients with COVID-19, they showed fear in social aspects, including intolerance of uncertainty, their health anxiety, and those of their loved ones (Mertens et al., 2020).

Safrika et al. (2021) stated that in an online survey of a total of 1,622 participants from 34 provinces in Indonesia were involved in this study and completed the online questionnaires on demographics, social media exposure, self-rated health, and depression finding found on levels the overall prevalence of depression levels was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) were significantly influencing depression ( $p < 0.05$ ) (Safrika et al., 2021).

Fearful of being ostracized, participants experienced the frustration of stigmatization.

Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The

negative consequences of the stigma of controlling COVID-19 disease include hiding the disease, avoiding treatment and immediately implementing healthy lifestyle behaviors, as well as interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020). Therefore, to reduce the negative consequences of stigma, the health team must provide social support for these patients and increase public awareness of this disease. Saat pandemi COVID-19 saat

ini, beberapa pasien terkonfirmasi COVID-19 masih mendapat perlakuan

didiskriminasi, diperlakukan secara terpisah karena terdiagnosa terinfeksi

COVID-19. Hal ini berdampak negatif kepada mereka yang terkonfirmasi

COVID-19 dan keluarga. Stigma dapat merusak hubungan sosial dan mendorong

kemungkinan isolasi sosial kelompok yang mengakibatkan lebih banyak masalah

kehatan yang parah dan kesulitan mengendalikan wabah penyakit karena

mendorong seseorang yang terinfeksi COVID-19 menyembuyikan penyakitnya

untuk menghindari diskriminasi (WHO, IFRC, 2020). [A25]

## **Theme 2. Experience in the isolation room**

In this theme describes The feeling of being in an isolation room, Physical symptoms, Spiritual Experiences, Communications, Motivations, The facility in the isolation room, Activities during isolation, attention from the health care team, Swab results.

Participants' experiences where the body conditions in the isolation room are the same as reported in the study of Jesmi et al. (2021) as always have nervous, respiratory, gastrointestinal, and systemic manifestations (Jesmi et al., 2021). Kar et al. (2020) found that quarantined COVID-19 people experienced various mental disorders such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Reducing anxiety and improving sleep quality in COVID-19 patients by progressive muscle relaxation and deep breathing (Liu et al., 2020). Spiritual experiences, positive thoughts and perceptions of social support, influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation and increased the level of adjustment to the disease condition. Shaban et al. (2020) showed that COVID-19 patients after recovering from their illness made new behaviors, including healthy behaviors and lifestyle changes (Shaban et al., 2020). The participants' spiritual awakening is a God-centered spirituality which means finding the meaning of God as a source of strength in their difficult situation. Jesmi et al. (2021) stated that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries

(Jesmi et al., 2021). Improving and training coping mechanisms according to the patient's culture can have a positive effect on these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as strong sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

Berpisah dengan keluarga dan diisolasi dalam jangka waktu lama pasien cenderung khawatir atas pemenuhan tanggung jawab keluarga mereka sehingga menimbulkan kesedihan selama berpisah dengan orang-orang yang dicintai (Wang et al., 2020)[A26] Pernyataan stres yang dialami partisipan disebabkan karena sendirian diruang isolasi atau dirawat bersama pasien yang kondisinya berat serta stres memikirkan kondisi kesehatan akan memburuknya gejala yang dialami. Stres yang dialami pasien terkonfirmasi COVID-19 merupakan respon normal terhadap penyakit. Stres dapat menyebabkan penurunan sistem kekebalan tubuh dan menyebabkan disregulasi imun yang dapat memperburuk kondisi kesehatan pasien yang terkonfirmasi COVID-19 (Kaligis et al., 2020)[A27] Beberapa faktor yang berpengaruh terhadap kesehatan psikologis pasien yang terkonfirmasi COVID-19 adalah angka kasus COVID-19 tidak terkendali dalam penyebaran virus, pasien yang diisolasi mengalami masalah pernapasan akut dan penyakit COVID-19 dapat menyebabkan kematian. Sehingga hal tersebut dapat menyebabkan kecemasan pada pasien terkonfirmasi COVID-19 (Jesmi et al., 2021)[A28].

Ketidakpuasan intervensi klinis yang diterima dan kualitas perawatan diruang isolasi COVID-19 yang disebabkan karena pembatasan jam masuk tim medis COVID-19 ke dalam ruangan isolasi COVID-19. Berdasarkan (Tim Mitigasi Dokter PB IDI, 2020)[A29] shift kerja harus memperhatikan durasi kerja yang sesuai dengan peraturan yaitu Permenkes No.52 Tahun 2018. Waktu kerja lebih pendek diijinkan pada kondisi tekanan pekerjaan tidak normal atau resiko tinggi seperti tim medis COVID-19 harus memakai hazmat terus menerus sepanjang shift. Shift pendek lebih disarankan dibandingkan shift panjang sehingga dapat membantu melindungi dari risiko kelelahan mental dari beban kerja yang berat. Kelelahan tersebut dapat meningkatkan resiko cedera dan memperburuk kondisi kesehatan yang rentan terhadap infeksi penyakit, peningkatan tekanan psikologis yang mempengaruhi kesehatan tim medis, dan kualitas serta keamanan perawatan yang diberikan. Maka perlunya edukasi tim medis COVID-19 kepada pasien terkonfirmasi COVID-19 yang menjalani perawatan diruang isolasi COVID-19 terkait adanya perubahan rotasi dan durasi kerja tim medis diruang isolasi COVID-19. Hal ini dilakukan untuk mengurangi pajanan tenaga kesehatan terhadap virus yang ditujukan untuk menjaga kesehatan fisik dan mental dan mempertahankan kualitas pelayanan para tim medis

### **Theme 3. Post-isolation experiences**

In this theme describes Post-covid conditions, Spiritual and social well-being, Hope for other covid patients, Hope for health workers. In this study, participants'

statements showed that emotional support and care provided by family, friends, or close people significantly impacted their recovery.

Emosi positif yang terkait dengan dukungan yang diterima pasien terkonfirmasi COVID-19 berasal dari berbagai sumber salah satunya adalah dukungan keluarga. Berdasarkan (Aunguroch et al., 2020) [A30] menyatakan bahwa dukungan sosial dari anggota keluarga menunjukkan bahwa manusia adalah makhluk sosial yang tidak dapat hidup tanpa dukungan sosial termasuk dalam penanganan penyakit COVID-19. Dan emosi positif berperan penting dalam pemulihan dan penyesuaian psikologis (Sun et al., 2020) [A31] Suasana hati pasien terkonfirmasi COVID-19 yang baik akan meningkatkan dopamin yang tinggi didalam darah sehingga akan mengoptimalkan dan meningkatkan sistem kekebalan tubuh. Dukungan dari teman dapat memberikan respon yang positif terhadap pemuliharaan kesehatan (T. Habib, 2021) [A32] Perawatan dan tindakan intervensi yang diberikan tim medis secara profesional setiap hari akan menghasilkan rasa terimakasih dari pasien (Wang et al., 2020) [A33]

Spiritualitas dapat memberikan harapan dan makna dalam situasi sulit termasuk dimasa pandemi COVID-19 (Teresa et al., 2021) [A34] Spiritual menciptakan emosi positif dalam diri seseorang. Spiritualitas dan agama dapat membantu manusia dalam kesedihansaat-saat krisis dan dapat menjadi obat penenang yang berguna pada manusia (Chronic et al., 2020) [A35]

Cabrini et al. (2020) also stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes (Cabrini et al., 2020). Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients, along with a deep feeling of empathy because of the patient's condition and being away from family members, affects patient satisfaction when being treated. Research conducted by Nusantara nurses' empathy feelings had a significant relationship in the moderate category with the level of patient satisfaction in the inpatient room (Nusantara et al., 2017). Improving facilities, especially swab results, which are currently still taking a long time. According to the Ministry of Health (KEMENKES) (2020) in cases of investigators who are self-isolating, monitoring is carried out by health workers and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

PostCOVID-19 syndromeyang dialami partisipan bervariasi beberapa partisipan menyatakan post COVID-19 syndrome masih dirasakan walaupun sudah dinyatakan negatif COVID-19. Hal ini sejalan dengan

(Care & Resource, 2020) [A36] menyatakan bahwa Oktober 2020, NICE (*the national institute for health and care excellence*) mengakui ketidakpastian efek jangka

panjang dari virus SARS-CoV-2 dan mendefinisikan post COVID-19 syndromesebagai gejala yang berlangsung lebih dari 12 minggu. Keluhan kondisi fisik jangka panjang pada pasien terkonfirmasi COVID-19 bervariasi dengan waktu yang lama dan berfluktuasi, tergantung pada tingkat keparahan penyakit dan status kesehatan pasien dengan mempertimbangkan komorbiditas dan kelemahan secara keseluruhan. Kondisi ini muncul dengan gejala yang dapat berubah seiring waktu dan dapat mempengaruhi sistem didalam tubuh. Gejala umum post COVID-19 syndrom yaitu kelelahan dan kelemahan ekstrem, sesak napas saat aktivitas ringan, nyeri sendi, demam ringan yang terus-menerus, sakit kepala, vertigo, pilek, sakit tenggorokan, perubahan suara dan kesulitan menelan, kehilangan atau perubahan penciuman dan perasa yang berkepanjangan, rambut rontok, gangguan gastrointestinal termasuk kehilangan nafsu makan, sakit perut, diare, muntah, ketidakmampuan untuk berkonsentrasi dan susah tidur (Care & Resource, 2020).

## CONCLUSION

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. The results of this study can help nursing managers and health care providers, including nursing staff, understand nurses' perceptions and experiences when they are infected with COVID-19. It was highlighted from the findings that psychological, social, and spiritual support from family and fellow nurses were significant for nurses recovery. By understanding pre, during and post covid-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, hospital and nursing managers can protect the nurses during their duty through infection control education and providence of protective equipment.

## ACKNOWLEDGMENTS



The authors would like to thank the participants in this study for their cooperation and support during data collection.

### LIMITATIONS

This study was not conducted on a large scale and is still within the scope of one hospital setting. Further research is needed.

### AUTHOR CONTRIBUTION

All authors participated sufficiently in the concept, design, analysis, writing, or revision of the manuscript.

### CONFLICT OF INTEREST

There is no conflict of interest in this research

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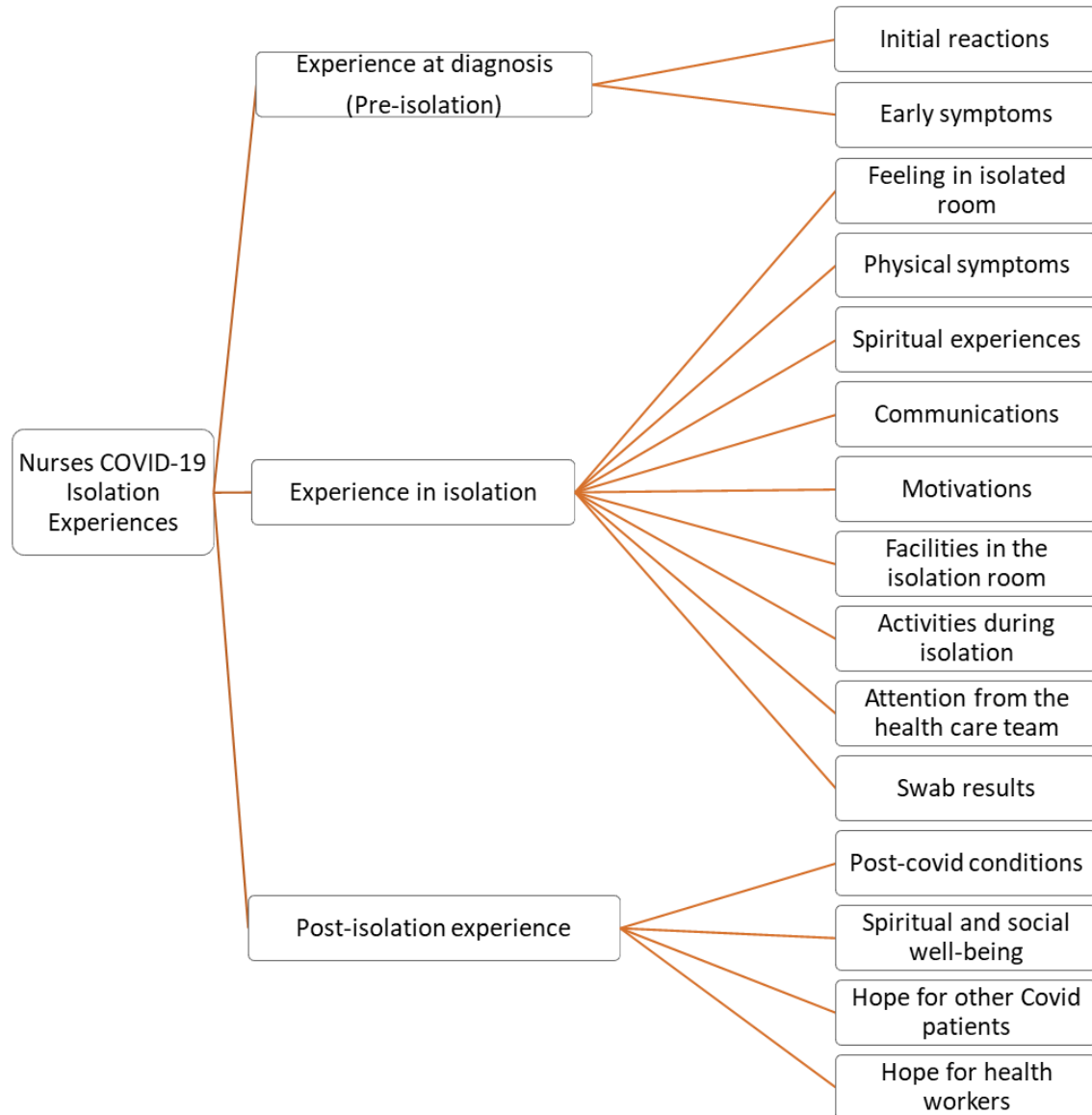
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## TABLE

**Table 1.** Participants characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** Themes and Subthemes

## The Experience of Nurses Who were Isolated due to COVID-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses' experiences during isolation as this could change the way they provide nursing care for COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore the experience of nurses who were isolated in the hospital due to Covid-19 infection.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach. The participants were nurses who had been hospitalized in an isolation room, selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process. Appropriate care planning and approaches are expected to support nurses infected with COVID-19. Further research in the larger scope of area and wider range of healthcare professionals is needed.

### Keywords:

COVID-19; descriptive phenomenology; nurse experiences



## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, treatments to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Frontline healthcare workers in COVID-19 include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In particular, nurses and doctors play a critical role in the treatment of patients with COVID-19. During nursing care, nurses are involved in diagnosis, prevention, control, and direct patient care, making themselves more vulnerable to getting infected (Sun et al., 2020). Moreover, many nurses and doctors are unsure about their safety while caring for infected patients, which creates stress (Aggar et al., 2022; Hendy et al., 2021; Lorente et al., 2021). The fast-changing information related to treatment and disease progression, lack of training, depleted personal protective equipment (PPE), lack of certain medications, workload, lack of staff support, conflict with physician or other nurses were also found as predictive factors that may affect stress and mental distress among nurses caring for COVID-19 patients (Hendy et al., 2021; Lai et al., 2020; Lorente et al., 2021).

Those involved in the treatment of COVID-19 patients have a high risk of exposure. Many healthcare workers worldwide have been infected and died from COVID-19 (Bandyopadhyay et al., 2020; Burdorf et al., 2020; Xiang et al., 2020). This phenomenon has also been reported in Indonesia (Soebandrio et al., 2021). When nurses contracted the virus, their mental burden gets heavier (Moghimian et al., 2022). For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). They felt lost, frightened, and blamed themselves that they may risk other people's lives and also their own (He et al., 2021). A study in Iran reported that COVID-19 infected nurses and physicians experienced fear, anxiety, feeling abandoned, and denial (Moghimian et al., 2022). Frustration and helplessness seem unavoidable to some nurses (Turale et al., 2020).

However, little is known about the experience of Indonesian nurses when they were diagnosed with COVID-19. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Thus, this study aimed to gain insight into the experiences of nurses who were infected by COVID-19 and had undergone isolation.

## **OBJECTIVE**

This study aimed to explore the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## **METHODS**

### **Design**

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi et al. (1978).

### **Settings and Participants**

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

### **Data Collection**

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic (Table 1). Questions are based on qualitative interview guidelines in the form of a research matrix containing information in making interview guides developed by the author and nursing experts in qualitative studies. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## Study rigor

To establish this study's rigor, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln & Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, the dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 2).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged

from the data (Figure 1). The themes are ‘Pre-isolation’, ‘During isolation’, and ‘Post-isolation’.

## **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants’ descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants ‘initial reactions and early symptoms.

### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. (P3) said, “...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It’s terrifying. I’m afraid that I will end up like that.”

Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (P6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, (P7) explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (P7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. (P2) explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (P7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, (P3) reported, “... I had mixed feelings, how could I get covid? I always wear full PPE!”. Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. (P2) said, “...I didn’t believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying.”

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general

weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.”(P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

### *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, “... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate” (P6). The expression of disappointment was seen from P6. The loneliness made her feel stressed; (P6) added, “I can go crazy if I stay here for a long time. I don't know whom I can interact with.”

For participants who were isolated in the emergency room, the situation became much worst because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. (P5) explained, “I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried.”

### *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. “My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell” (P4). Likewise, (P5) commented, “...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy”. Several participants also stated that enduring these symptoms was very tiring. As (P7) said, “It's tough to endure. That condition made me exhausted.”

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, (P7) said, “I prayed more often and drew closer to God.” (P2) also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, “Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy” (P2).

In addition, many participants reported that they found peace and power simply by remembering God. As (P4) said, “I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength.”

## *Communications*

Communication was an important point that participants often reported—particularly communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was excellent and supportive. (P6), for example, was glad to be able to communicate and create a friendship with other patients. She said, “It's nice to have roommates to share with finally. We talked and got to know each other” (P6). Another participant commented: “ By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated” (P4). To some participants, maintaining communication with their loved one were significant to help them survive as (P6) said, “While being treated in the isolation room, my sisters always contacted me. They strengthened me.”

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, “Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process.” (P7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As (P1) said, “I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions.” Likewise, R3 conveyed his concerns about his family during the isolation period, “I have two children. They needed me. I need to recover soon.”

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. (P2), for example, said, “I have to be able to motivate myself... So I thought positively and tried to be happy.” Similarly, (P1) revealed, “If I think negatively, I will stay in the isolation room longer” (P1).

## *Facilities in the isolation room*

The majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. (P6) was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (P6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (P1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, (P2) was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (P2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, (P7) shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, (P6) reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

## *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As (P3) said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

## *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, (P2) reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (P6).

## **Theme 3: Post-isolation experiences**

Participants' experiences after the isolation were completed and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health

workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

## *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (P6).

Participants' COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, (P3) described, “Now I disciplined myself to wear a mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

## *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (P3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, (P6) said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (P4).

## *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, (P2) said, “My message is, I've been through it and recovered, so you do too,” and another commented, “don't stress it too much, keep eating, have lots of rest and make yourself happy” (P7).

## *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some participants suggested that nurses need to improve communication with their patients and support patients in hospital isolation; as (P3) argued, “I hope that the nurses can motivate the patient more and have a conversation with them. Try to comfort them. Most of the time,



nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (P5).

## DISCUSSION

This study explored the experience of nurses who were isolated in the hospital due to Covid-19 infection. Three themes were generated from the interviews, those are pre-isolation experiences, experience in the isolation room, and post-isolation experiences.

### **Theme1. Experience at diagnoses (Pre-Isolation)**

Nurses’ initial responses to the fact that they were COVID-19 positive included feared and worried. This study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. Banzett et al. (2020) reported that patients in the acute phase of the disease might often fear death due to worsening clinical conditions. Patients confirmed with COVID-19 tend to experience stress related to the conditions they experience, which can affect their physical, emotional, mental, social, and spiritual state (Roman et al., 2020). The finding related to COVID-19 patients is also accords with that of Sarfika et al. (2021) involved 1,622 participants from 34 provinces in Indonesia and reported that the prevalence of depression in Indonesia was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) was significantly influencing depression ( $p < 0.05$ ) (Sarfika et al., 2021).

Nurses in this study were frustrated by stigmatization and afraid of being ostracized. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the condition, avoiding treatment and immediately implementing healthy lifestyle behaviours, and interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020).

## **Theme 2. Experience in the isolation room**

As a result of their isolation, the nurses in this study frequently feel frustrated and alone. According to Kar et al. (2020), quarantined COVID-19 people experienced various mental disorders, such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Nurses in this study were worried about fulfilling their family responsibilities while they were away from family and isolated. This situation also caused sadness, especially when separated from loved ones. The statement of stress experienced by nurses was generated thinking about their health condition that would worsen. This finding is consistent with who reported that patients in isolation might have been affected psychologically due to the number of uncontrolled COVID-19 cases and the death rate.

Spiritual experiences, positive thoughts and perceptions of social support influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation. They increased the level of adjustment to the disease condition. Shaban et al. (2020) also found that people diagnosed with COVID-19 modified their behaviors, including healthy eating, positive thinking, lifestyle changes, and becoming more spiritual. The participants' spiritual awakening is a God-centered spirituality that means finding God's meaning as a source of strength in their difficult situation (Shaban et al., 2020). Jesmi et al. (2021) also reported that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries. Improving and training coping mechanisms according to the patient's culture can positively affect these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as solid sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

The positive mood of COVID-19 confirmed patients would increase high dopamine in the blood and will optimize and boost the immune system. So, the strategy to support immunity is to maintain a good mood, such as by video calling family and loved ones, playing with handphones and listening to music. It is known that COVID-19 confirmed for patients undergoing isolation in the COVID-19 ward that listening to music is an effective way to reduce anxiety and hallucinations that cause fear and helps to have a more positive experience (Habib, 2021). Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeva et al., 2018). It is stated that worship, prayer and al-Quran reading are good alternatives to treat illness psychological well-being and improve quality of life (Umarella et al., 2020)

Based on research by Aunguroch et al. (2020), support from family members shows that humans are social beings who cannot live without social support. Positive emotions play an important role in recovery and psychological adjustment (Sun, et al., 2020). Support from friends can positively respond to health promotion (Habib, 2021). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and isolation. The care and intervention that the medical

team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). Improving facilities, especially swab results, are currently still taking a long time. According to the Ministry of Health of the Republic of Indonesia (2020), in cases of investigators who are self-isolating, monitoring is carried out by health workers, and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

### **Theme 3. Post-isolation experiences**

The post-COVID-19 syndrome experienced by nurses are varied. Some stated that the post-COVID-19 syndrome could still be felt even though it had been declared negative for COVID-19. This is in line with Shah et al. (2021) report that stated that in October 2020, NICE (the national institute for health and care excellence) has recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer up to 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over time and fluctuate, depending on the severity of the disease and the patient's health status, considering comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of the post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste. Prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia (Higgins et al., 2021; Shah et al., 2021).

During post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations, including during the COVID-19 pandemic (Teresa et al., 2021). Spiritual creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be a useful “sedative” for humans (Fardin, 2020). Support from the medical team is urgently needed for patients with confirmed COVID-19 undergoing treatment in the isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). The provision of care and treatment from the medical team can improve self-management approaches that help patients be more enthusiastic to fight the disease they are suffering from. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room, as well as the respect received from medical team professionals (Olufadewa et al., 2020).

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room was caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on a study by Mitigation team PB IDI (2020), the work shift must pay attention to the duration of work by the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk, such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short shifts are

recommended over long shifts to help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increase psychological stress that affects the health of the medical team and the quality and safety of the care provided. It is necessary to educate the COVID-19 medical team to confirm COVID-19 patients undergoing treatment in the COVID-19 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This was done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team.

Cabrini et al. (2020) stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes. Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients and a deep feeling of empathy because of the patient's condition and being away from family members affect patient satisfaction when being treated.

## **Implications and limitations**

This study provides insight into the experiences of nurses who were infected with COVID-19 and undergoing isolation in the hospital. Their feelings and needs while diagnosed with COVID-19 and isolated in COVID-19 units are identified in this study. The finding highlights the necessity of family and caregivers' support throughout their isolation period. Useful guidance and training on preventing COVID-19 transmission to nurses are also required, along with regulations related to PPE and how nurses may return to work after recovering from COVID infection. In addition, the study also has implications for nurses. Nurses diagnosed with COVID-19 may use their experience as a lesson when dealing with COVID-19 patients. From their experiences, the nurse can be more empathetic to patients and families and become more sensitive to patients' physical, social, and spiritual needs in isolation.

We acknowledge that this study has limitations. To get information about nurses' experience, we collected qualitative data from one hospital sample. Therefore, the findings may not be generalized as Indonesian nurses' experiences. Additionally, the study is limited by the lack of information on how nurses cope with isolation. Although some information provided may reflect how nurses deal with their situation, the focus of this study was on their experiences only, and results may not reflect actual nurses coping mechanisms towards their isolation treatments. We encouraged further research to be conducted in larger scope of area and wider range of healthcare professionals.

## **CONCLUSION**

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. It was highlighted from the findings that psychological, social,

and spiritual support from family, fellow nurses and nurse managers were significant for nurses' recovery. By understanding pre, during and post COVID-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, nursing managers can protect the nurses during their duty through infection control education and training, as well as regulations that help nurses work during COVID-19 pandemic.

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## AUTHOR CONTRIBUTION

Both authors participated sufficiently in the concept, design, analysis, writing, and critical revision of the manuscript. The first author conducted the interviews and data collection.

## CONFLICT OF INTEREST

There is no conflict of interest in this research.

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## TABLE

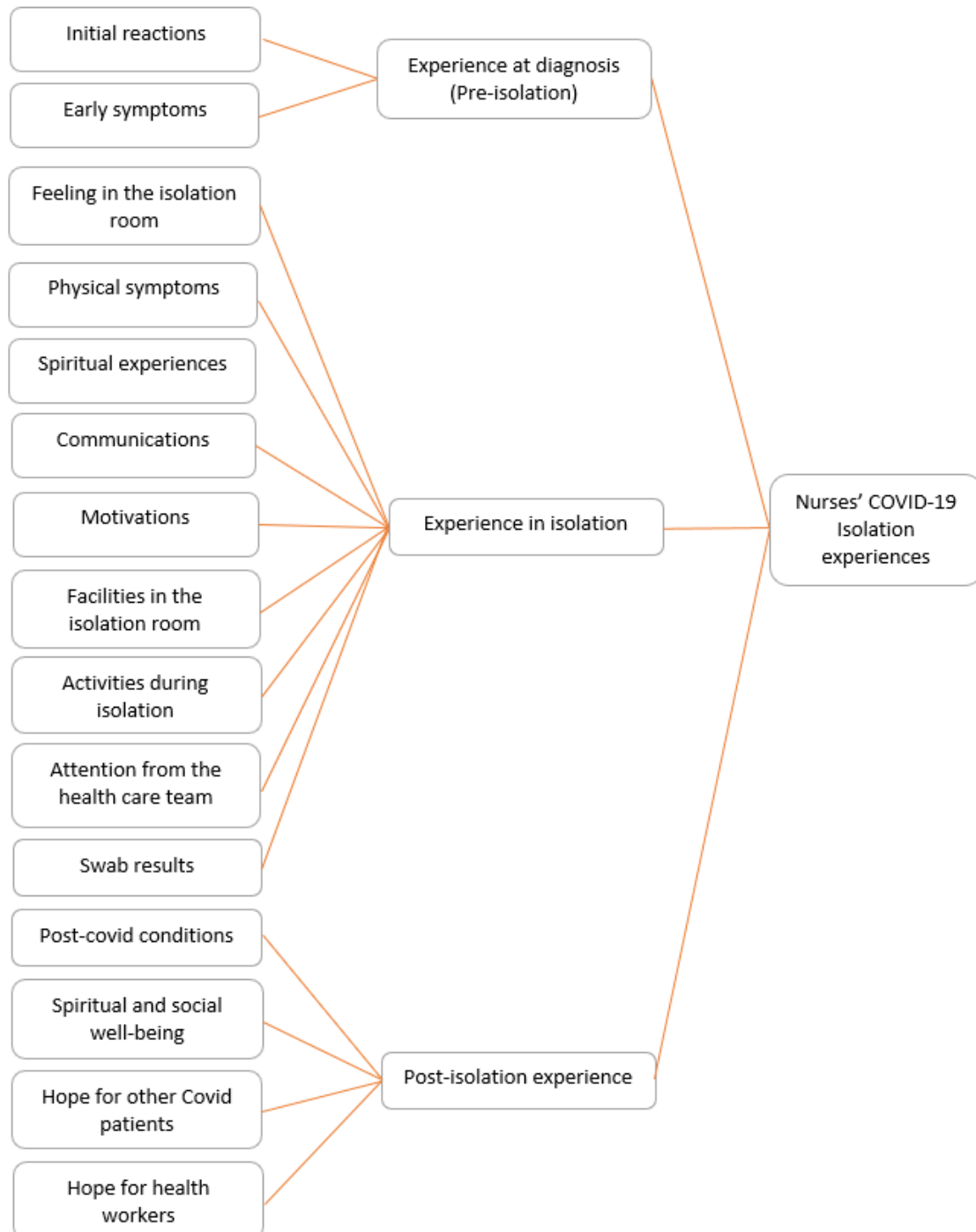
**Table 1.** Interview Questions

No.	The Questions
1	“Please tell me how you felt when you first found out you tested positive for Covid-19?”
2	“Can you share your experience while being treated in the Covid-19 room?”
3	“Describe your experience undergoing Covid-19 therapy?”
4	"Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?"
5	"Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?"
6	“Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?"
7	“If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?”
8	“How do you describe your current quality of life?”
9	"Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?".

**Table 2.** Participants’ characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** The subthemes and Themes

## The Experience of Nurses Who were Isolated due to COVID-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses' experiences during isolation as this could change the way they provide nursing care for COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore the experience of nurses who were isolated in the hospital due to Covid-19 infection.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach. The participants were nurses who had been hospitalized in an isolation room, selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process. Appropriate care planning and approaches are expected to support nurses infected with COVID-19. Further research in the larger scope of area and wider range of healthcare professionals is needed.

### Keywords:

COVID-19; descriptive phenomenology; nurse experiences

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, treatments to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Frontline healthcare workers in COVID-19 include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In particular, nurses and doctors play a critical role in the treatment of patients with COVID-19. During nursing care, nurses are involved in diagnosis, prevention, control, and direct patient care, making themselves more vulnerable to getting infected (Sun et al., 2020). Moreover, many nurses and doctors are unsure about their safety while caring for infected patients, which creates stress (Aggar et al., 2022; Hendy et al., 2021; Lorente et al., 2021). The fast-changing information related to treatment and disease progression, lack of training, depleted personal protective equipment (PPE), lack of certain medications, workload, lack of staff support, conflict with physician or other nurses were also found as predictive factors that may affect stress and mental distress among nurses caring for COVID-19 patients (Hendy et al., 2021; Lai et al., 2020; Lorente et al., 2021).

Those involved in the treatment of COVID-19 patients have a high risk of exposure. Many healthcare workers worldwide have been infected and died from COVID-19 (Bandyopadhyay et al., 2020; Burdorf et al., 2020; Xiang et al., 2020). This phenomenon has also been reported in Indonesia (Soebandrio et al., 2021). When nurses contracted the virus, their mental burden gets heavier (Moghimian et al., 2022). For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). They felt lost, frightened, and blamed themselves that they may risk other people's lives and also their own (He et al., 2021). A study in Iran reported that COVID-19 infected nurses and physicians experienced fear, anxiety, feeling abandoned, and denial (Moghimian et al., 2022). Frustration and helplessness seem unavoidable to some nurses (Turale et al., 2020).

However, little is known about the experience of Indonesian nurses when they were diagnosed with COVID-19. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Thus, this study aimed to gain insight into the experiences of nurses who were infected by COVID-19 and had undergone isolation.

## **OBJECTIVE**

This study aimed to explore the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## **METHODS**

### **Design**

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi et al. (1978).

### **Settings and Participants**

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

### **Data Collection**

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic (Table 1). Questions are based on qualitative interview guidelines in the form of a research matrix containing information in making interview guides developed by the author and nursing experts in qualitative studies. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## Study rigor

To establish this study's rigor, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln & Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, the dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 2).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged



from the data (Figure 1). The themes are ‘Pre-isolation’, ‘During isolation’, and ‘Post-isolation’.

## **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants’ descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants ‘initial reactions and early symptoms.

### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. (P3) said, “...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It’s terrifying. I’m afraid that I will end up like that.”

Most of the participants were also worried that they would die without their families being present. For example, one participant said, “When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this” (P6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, “I always think of my children. I’m worried they may also get exposed [by corona virus].” Likewise, (P7) explained how she tried not to pass the disease on to her husband: “... I refused to be held by my husband. I’m afraid of transmitting it [COVID-19] to him” (P7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. (P2) explained, “It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I’m terrified to be outcasted and ostracized.” This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: “... I was afraid to inform the neighborhood leader, people may know and ostracized me” (P7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, (P3) reported, “... I had mixed feelings, how could I get covid? I always wear full PPE!”. Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. (P2) said, “...I didn’t believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying.”

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general

weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.”(P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

### *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, “... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate” (P6). The expression of disappointment was seen from P6. The loneliness made her feel stressed; (P6) added, “I can go crazy if I stay here for a long time. I don't know whom I can interact with.”

For participants who were isolated in the emergency room, the situation became much worst because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. (P5) explained, “I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried.”

### *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. “My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell” (P4). Likewise, (P5) commented, “...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy”. Several participants also stated that enduring these symptoms was very tiring. As (P7) said, “It's tough to endure. That condition made me exhausted.”

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, (P7) said, “I prayed more often and drew closer to God.” (P2) also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, “Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy” (P2).

In addition, many participants reported that they found peace and power simply by remembering God. As (P4) said, “I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength.”

## *Communications*

Communication was an important point that participants often reported—particularly communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was excellent and supportive. (P6), for example, was glad to be able to communicate and create a friendship with other patients. She said, “It's nice to have roommates to share with finally. We talked and got to know each other” (P6). Another participant commented: “ By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated” (P4). To some participants, maintaining communication with their loved one were significant to help them survive as (P6) said, “While being treated in the isolation room, my sisters always contacted me. They strengthened me.”

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, “Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process.” (P7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As (P1) said, “I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions.” Likewise, R3 conveyed his concerns about his family during the isolation period, “I have two children. They needed me. I need to recover soon.”

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. (P2), for example, said, “I have to be able to motivate myself... So I thought positively and tried to be happy.” Similarly, (P1) revealed, “If I think negatively, I will stay in the isolation room longer” (P1).

## *Facilities in the isolation room*

The majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. (P6) was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (P6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (P1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, (P2) was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (P2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, (P7) shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, (P6) reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

## *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As (P3) said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

## *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, (P2) reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (P6).

## **Theme 3: Post-isolation experiences**

Participants' experiences after the isolation were completed and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health

workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

### *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (P6).

Participants' COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, (P3) described, “Now I disciplined myself to wear a mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

### *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (P3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, (P6) said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (P4).

### *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, (P2) said, “My message is, I've been through it and recovered, so you do too,” and another commented, “don't stress it too much, keep eating, have lots of rest and make yourself happy” (P7).

### *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some participants suggested that nurses need to improve communication with their patients and support patients in hospital isolation; as (P3) argued, “I hope that the nurses can motivate the patient more and have a conversation with them. Try to comfort them. Most of the time,

nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (P5).

## DISCUSSION

This study explored the experience of nurses who were isolated in the hospital due to Covid-19 infection. Three themes were generated from the interviews, those are pre-isolation experiences, experience in the isolation room, and post-isolation experiences.

### **Theme1. Experience at diagnoses (Pre-Isolation)**

Nurses’ initial responses to the fact that they were COVID-19 positive included feared and worried. This study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. Banzett et al. (2020) reported that patients in the acute phase of the disease might often fear death due to worsening clinical conditions. Patients confirmed with COVID-19 tend to experience stress related to the conditions they experience, which can affect their physical, emotional, mental, social, and spiritual state (Roman et al., 2020). The finding related to COVID-19 patients is also accords with that of Sarfika et al. (2021) involved 1,622 participants from 34 provinces in Indonesia and reported that the prevalence of depression in Indonesia was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) was significantly influencing depression ( $p < 0.05$ ) (Sarfika et al., 2021).

Nurses in this study were frustrated by stigmatization and afraid of being ostracized. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the condition, avoiding treatment and immediately implementing healthy lifestyle behaviours, and interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020).

## **Theme 2. Experience in the isolation room**

As a result of their isolation, the nurses in this study frequently feel frustrated and alone. According to Kar et al. (2020), quarantined COVID-19 people experienced various mental disorders, such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Nurses in this study were worried about fulfilling their family responsibilities while they were away from family and isolated. This situation also caused sadness, especially when separated from loved ones. The statement of stress experienced by nurses was generated thinking about their health condition that would worsen. This finding is consistent with who reported that patients in isolation might have been affected psychologically due to the number of uncontrolled COVID-19 cases and the death rate.

Spiritual experiences, positive thoughts and perceptions of social support influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation. They increased the level of adjustment to the disease condition. Shaban et al. (2020) also found that people diagnosed with COVID-19 modified their behaviors, including healthy eating, positive thinking, lifestyle changes, and becoming more spiritual. The participants' spiritual awakening is a God-centered spirituality that means finding God's meaning as a source of strength in their difficult situation (Shaban et al., 2020). Jesmi et al. (2021) also reported that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries. Improving and training coping mechanisms according to the patient's culture can positively affect these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as solid sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

The positive mood of COVID-19 confirmed patients would increase high dopamine in the blood and will optimize and boost the immune system. So, the strategy to support immunity is to maintain a good mood, such as by video calling family and loved ones, playing with handphones and listening to music. It is known that COVID-19 confirmed for patients undergoing isolation in the COVID-19 ward that listening to music is an effective way to reduce anxiety and hallucinations that cause fear and helps to have a more positive experience (Habib, 2021). Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeva et al., 2018). It is stated that worship, prayer and al-Quran reading are good alternatives to treat illness psychological well-being and improve quality of life (Umarella et al., 2020)

Based on research by Aunguroch et al. (2020), support from family members shows that humans are social beings who cannot live without social support. Positive emotions play an important role in recovery and psychological adjustment (Sun, et al., 2020). Support from friends can positively respond to health promotion (Habib, 2021). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and isolation. The care and intervention that the medical

team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). Improving facilities, especially swab results, are currently still taking a long time. According to the Ministry of Health of the Republic of Indonesia (2020), in cases of investigators who are self-isolating, monitoring is carried out by health workers, and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

### **Theme 3. Post-isolation experiences**

The post-COVID-19 syndrome experienced by nurses are varied. Some stated that the post-COVID-19 syndrome could still be felt even though it had been declared negative for COVID-19. This is in line with Shah et al. (2021) report that stated that in October 2020, NICE (the national institute for health and care excellence) has recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer up to 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over time and fluctuate, depending on the severity of the disease and the patient's health status, considering comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of the post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste. Prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia (Higgins et al., 2021; Shah et al., 2021).

During post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations, including during the COVID-19 pandemic (Teresa et al., 2021). Spiritual creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be a useful “sedative” for humans (Fardin, 2020). Support from the medical team is urgently needed for patients with confirmed COVID-19 undergoing treatment in the isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). The provision of care and treatment from the medical team can improve self-management approaches that help patients be more enthusiastic to fight the disease they are suffering from. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room, as well as the respect received from medical team professionals (Olufadewa et al., 2020).

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room was caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on a study by Mitigation team PB IDI (2020), the work shift must pay attention to the duration of work by the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk, such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short shifts are



recommended over long shifts to help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increase psychological stress that affects the health of the medical team and the quality and safety of the care provided. It is necessary to educate the COVID-19 medical team to confirm COVID-19 patients undergoing treatment in the COVID-19 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This was done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team.

Cabrini et al. (2020) stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes. Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients and a deep feeling of empathy because of the patient's condition and being away from family members affect patient satisfaction when being treated.

## **Implications and limitations**

This study provides insight into the experiences of nurses who were infected with COVID-19 and undergoing isolation in the hospital. Their feelings and needs while diagnosed with COVID-19 and isolated in COVID-19 units are identified in this study. The finding highlights the necessity of family and caregivers' support throughout their isolation period. Useful guidance and training on preventing COVID-19 transmission to nurses are also required, along with regulations related to PPE and how nurses may return to work after recovering from COVID infection. In addition, the study also has implications for nurses. Nurses diagnosed with COVID-19 may use their experience as a lesson when dealing with COVID-19 patients. From their experiences, the nurse can be more empathetic to patients and families and become more sensitive to patients' physical, social, and spiritual needs in isolation.

We acknowledge that this study has limitations. To get information about nurses' experience, we collected qualitative data from one hospital sample. Therefore, the findings may not be generalized as Indonesian nurses' experiences. Additionally, the study is limited by the lack of information on how nurses cope with isolation. Although some information provided may reflect how nurses deal with their situation, the focus of this study was on their experiences only, and results may not reflect actual nurses coping mechanisms towards their isolation treatments. We encouraged further research to be conducted in larger scope of area and wider range of healthcare professionals.

## **CONCLUSION**

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. It was highlighted from the findings that psychological, social,

and spiritual support from family, fellow nurses and nurse managers were significant for nurses' recovery. By understanding pre, during and post COVID-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, nursing managers can protect the nurses during their duty through infection control education and training, as well as regulations that help nurses work during COVID-19 pandemic.

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## AUTHOR CONTRIBUTION

Both authors participated sufficiently in the concept, design, analysis, writing, and critical revision of the manuscript. The first author conducted the interviews and data collection.

## CONFLICT OF INTEREST

There is no conflict of interest in this research.

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## TABLE

**Table 1.** Interview Questions

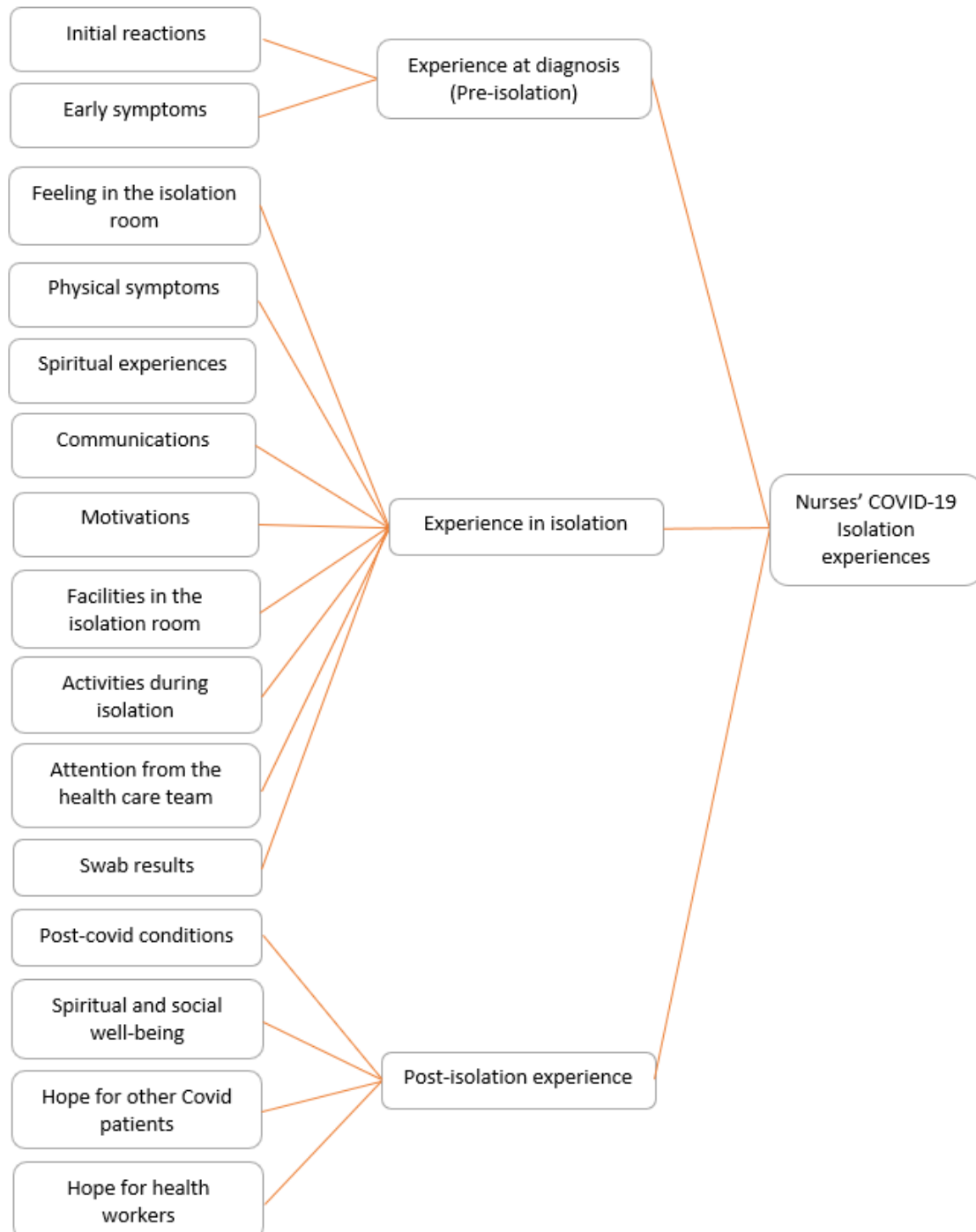
No.	The Questions
1	“Please tell me how you felt when you first found out you tested positive for Covid-19?”
2	“Can you share your experience while being treated in the Covid-19 room?”
3	“Describe your experience undergoing Covid-19 therapy?”
4	"Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?"
5	"Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?"
6	“Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?"
7	“If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?”
8	“How do you describe your current quality of life?”
9	"Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?".

**Table 2.** Participants’ characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10



## FIGURE



**Figure 1.** The subthemes and Themes

## The Experience of Nurses Who were Isolated due to COVID-19 Infection: A Qualitative Study

Ernawati Siagian<sup>1</sup>, Gilny Rantung<sup>1</sup>

<sup>1</sup>Universitas Advent Indonesia, Bandung

Corresponding author: [ernawatisiagian@unai.edu](mailto:ernawatisiagian@unai.edu)

### ABSTRACT

**Background:** In their duties, health care workers, especially nurses, have a high risk of being infected with COVID-19, both from patients and non-patients. Some nurses who are infected need to be treated and isolated in the hospital. It is important to understand nurses' experiences during isolation as this could change the way they provide nursing care for COVID-19 patients in the future, and this has not been studied in Indonesia.

**Purpose:** This study aims to explore the experience of nurses who were isolated in the hospital due to Covid-19 infection.

**Methods:** This qualitative research was conducted using a descriptive phenomenological approach. The participants were nurses who had been hospitalized in an isolation room, selected through purposive sampling. Data saturation was reached on the 7th participant, and a total of 7 nurses who were infected with COVID-19 participated. Data was collected through in-depth interviews and analyzed using Colaizzi's phenomenological method.

**Results:** Data analysis resulted in three main themes: (1) Experience at diagnosis (Pre-isolation), with sub-themes: initial reaction, source/origin of infection, early symptoms, and reactions from family and close people; (2) Experiences during isolation, with sub-themes: Feelings in isolation rooms, body reactions to covid-19 therapy, medical response and swab results; and (3) Post-isolation experiences, with sub-themes: post-covid conditions, expectations for other covid patients, and expectations for medical personnel.

**Conclusion:** This study identified nurses' experience of COVID-19 pre-isolation, isolation and post-isolation. Support from family members, colleagues and leaders are essential for their healing process. Appropriate care planning and approaches are expected to support nurses infected with COVID-19. Further research in the larger scope of area and wider range of healthcare professionals is needed.

### Keywords:

COVID-19; descriptive phenomenology; nurse experiences

## BACKGROUND

The fight against the coronavirus disease 2019 (COVID-19) continues in Indonesia and around the world. To date, there are more than 237,348,931 million confirmed cases globally and more than 4,227,038 confirmed cases in Indonesia (Johns Hopkins University Center for Systems Science and Engineering, 2021). The COVID-19 pandemic has greatly affected all aspects of society, while the impact of a pandemic on society and other aspects of life varies from country to country (United Nations Development Programme, 2020). Currently, treatments to fight COVID-19 are still in the process of research and development as well as prevention and control of this disease is the main challenge facing every country.

Patients with COVID-19 experience mild to severe respiratory and non-respiratory symptoms (Huang et al., 2020), along with the symptoms of viral infections that vary from mild to very severe. Signs of infection include fatigue, fever, cough, and difficulty breathing (Wu & McGoogan, 2020). Given the high risk of disease transmission, infected people require isolation (Wang et al., 2020). COVID-19 pandemics, such as severe acute respiratory syndrome (SARS) and the MERS pandemic, have caused severe physical and psychological crises in these patients even after discharge (Park et al., 2020).

Frontline healthcare workers in COVID-19 include doctors, nurses, radiology officers, laboratories and hospital staff in infection control (Cai et al., 2020; Mohindra et al., 2020). In particular, nurses and doctors play a critical role in the treatment of patients with COVID-19. During nursing care, nurses are involved in diagnosis, prevention, control, and direct patient care, making themselves more vulnerable to getting infected (Sun et al., 2020). Moreover, many nurses and doctors are unsure about their safety while caring for infected patients, which creates stress (Aggar et al., 2022; Hendy et al., 2021; Lorente et al., 2021). The fast-changing information related to treatment and disease progression, lack of training, depleted personal protective equipment (PPE), lack of certain medications, workload, lack of staff support, conflict with physician or other nurses were also found as predictive factors that may affect stress and mental distress among nurses caring for COVID-19 patients (Hendy et al., 2021; Lai et al., 2020; Lorente et al., 2021).

Those involved in the treatment of COVID-19 patients have a high risk of exposure. Many healthcare workers worldwide have been infected and died from COVID-19 (Bandyopadhyay et al., 2020; Burdorf et al., 2020; Xiang et al., 2020). This phenomenon has also been reported in Indonesia (Soebandrio et al., 2021). When nurses contracted the virus, their mental burden gets heavier (Moghimian et al., 2022). For example, nurses in Wuhan experience physical and psychological shock (He et al., 2021). They felt lost, frightened, and blamed themselves that they may risk other people's lives and also their own (He et al., 2021). A study in Iran reported that COVID-19 infected nurses and physicians experienced fear, anxiety, feeling abandoned, and denial (Moghimian et al., 2022). Frustration and helplessness seem unavoidable to some nurses (Turale et al., 2020).

However, little is known about the experience of Indonesian nurses when they were diagnosed with COVID-19. In addition, explaining and understanding nurses' experiences in a specific context is important because individual points of view can differ based on their culture and socialization. It can also increase and expand the knowledge of health care providers and nursing managers about the physical, psychological and spiritual needs of nurses who are infected with COVID-19 and how to deal with them in the future. Thus, this study aimed to gain insight into the experiences of nurses who were infected by COVID-19 and had undergone isolation.

## **OBJECTIVE**

This study aimed to explore the experience of nurses who were isolated in the hospital due to Covid-19 infection.

## **METHODS**

### **Design**

This was a qualitative descriptive phenomenological study based on the framework proposed by Colaizzi et al. (1978).

### **Settings and Participants**

This research was conducted at a private hospital in Bandar Lampung City, which is one of the health care and treatment centers for COVID-19 patients in Bandar Lampung, Indonesia. The population of this study was all nurses who worked in a private hospital in Bandar Lampung City. The inclusion criteria in this study were nurses who had been infected with COVID-19, isolated either independently or in a hospital, had completed a 2-week quarantine period, and were not currently experiencing infection or complications from COVID-19 shown with a negative PCR test. Purposive sampling was used to recruit participants. Data saturation were reached from 7 nurse participants.

Research permission was obtained from the hospital director where the authors conducted the research. Researchers received information on the names of nurses who have completed isolation from the hospital's nurse manager. Next, the first author, with the help of a nurse manager, looked for prospective participants by contacting them through WhatsApp and explaining the study's purpose. Some prospective participants refused to join as respondents due to physical and psychological issues. All participants in the study signed written informed consent prior to the interview.

### **Data Collection**

Data collection were conducted from February to May 2021. Data were obtained by face-to-face in-depth interviews. The first author conducted the interviews with Bahasa Indonesia at a time and place of the respondents convenience. The interviewer carried out all the prevention protocols according to the guidelines of the National COVID-19 Committee, and the interview was conducted after the participant's quarantine period ended. The protocol implemented during data collection includes 1-meter physical distancing, respiratory etiquette, and hand washing.

The interviews were conducted after the interviewer introduced herself and explained the research's purpose. There were 9 semi-structured questions used as a guide in the interview and to keep the discussion on the main topic (Table 1). Questions are based on qualitative interview guidelines in the form of a research matrix containing information in making interview guides developed by the author and nursing experts in qualitative studies. All interviews were audio-recorded and transcribed word by word on the same day. The data collection tools used in this study were the researchers themselves, interview guidelines, field notes, and a voice recorder.

## Data analysis

Colaizzi's (1978) seven-step phenomenological approach was used to analyze the data. The seven steps were as follows: 1. Both authors read each participant's transcript to understand the description and make sense of it. 2. Each transcript was reread, and phrases that directly relate to the phenomenon under investigation were extracted. 3. Meaning of each significant statement were formulated. 4. The aggregated formulated meanings were integrated into clusters of themes, for example, 'pre-isolation'. 5. Three themes and 15 sub-themes were identified, and a detailed description was developed. 6. The essential structure of the description of the experience was identified. 7. Finally, the participants validated the findings description and the fundamental structure of the findings.

## Study rigor

To establish this study's rigor, researchers considered each participant's interview's credibility, dependability, and transferability (Lincoln & Guba, 1985). Therefore, we conducted an audit trial to achieve credibility throughout the data collection process. This process was done to ensure that the interpretation was based on participants' reports. In addition, the authors discussed ensuring the selection of the most relevant codes and sub-themes and themes. Furthermore, the dependability of this study was achieved, as we used interview guidelines as interview memoirs to all participants. This process was done to ensure consistency during data collection. Finally, appropriate selection of participants, data collection, and analysis with relevant quotations can be used to judge these findings' transferability.

## Ethical considerations

This study was approved by the Research Ethics Committee of the Adventist University of Indonesia (Approval code: No.132/KEPK-FIK.UNAI/EC/XII/20). Participants were informed of the purpose of the study, voluntary participation, and the right to withdraw from the study. Consent was obtained from each participant.

## RESULTS

Using purposive sampling, seven participants were identified using purposive sampling, consisting of 3 male nurses (43%) and 4 female nurses (57%) aged between 25 and 47 years old. The number of days for treatment ranged from 10 days to 21 days (Table 2).

The initial codes were classified into themes and sub-themes based on their meaning and conceptual similarity. As a result, 3 themes and 15 sub-themes emerged

from the data (Figure 1). The themes are 'Pre-isolation', 'During isolation', and 'Post-isolation'.

## **Theme 1: Experience at diagnoses (Pre-isolation)**

Pre-isolation is participants' descriptions of their experiences before being isolated in the hospital isolation unit. Two sub-themes emerged from the interview data: participants 'initial reactions and early symptoms.

### *Initial reaction*

Participants' reactions when first identified COVID-19 positive were fearful and anxious about their condition, family situation, and the social consequences of the disease. The participants feared death. They perceive death as an unpleasant and unexpected event. (P3) said, "...we often deal with patients who die, especially in the ER. It [the death] all happens so quickly. It's terrifying. I'm afraid that I will end up like that."

Most of the participants were also worried that they would die without their families being present. For example, one participant said, "When I saw the death of another patient, their family were unable to see them for the last time. I was afraid I would die like this" (P6)

Most participants reported fear and worry that they would infect their family members. P4 shared his feelings by saying, "I always think of my children. I'm worried they may also get exposed [by corona virus]." Likewise, (P7) explained how she tried not to pass the disease on to her husband: "... I refused to be held by my husband. I'm afraid of transmitting it [COVID-19] to him" (P7)

Moreover, the majority of participants reported fear of being ostracized by the environment and society. (P2) explained, "It happened in other places. Nurses and their families were evicted from the neighborhood where they lived. I'm terrified to be outcasted and ostracized." This situation makes them unwilling to report their condition to the authorities. One participant said about this issue: "... I was afraid to inform the neighborhood leader, people may know and ostracized me" (P7).

To some participants, being contracted to COVID-19 was hard to believe because they are certain that they have complied with the preventive measure. For example, (P3) reported, "... I had mixed feelings, how could I get covid? I always wear full PPE!". Participants were also trying to digest the surprising information, and not a few of them were getting emotional as they could not accept the COVID test result. (P2) said, "...I didn't believe I got Covid. It was hard to accept being diagnosed positive for covid. I was crying."

### *Early Symptoms*

Participants mentioned several symptoms when they were talking about how their body initially reacted to the infection. The symptoms include body aches, general

weakness, fever, cough, sore throat, loss of taste and smell. Comments below illustrate the initial symptoms reported by participants:

“I was wondered, why I’m not feeling well. I had headache, sore throat, body aches, weakness, [and] nausea. Very uncomfortable.” (P7)

“The first symptoms were just fever, a day of fever and cough. On the fifth day, I lost my sense of smell and lost my taste.”(P3)

## **Theme 2: Experience in the isolation room**

This theme was about participants’ experiences when isolated in the hospital. Participants who have undergone isolation as part of the treatment and spread prevention shared several impressions and experiences include: ‘Feelings of being in isolation room’, ‘Physical symptoms’, ‘Spiritual experiences’, ‘Communications’, ‘Motivations’, ‘Facilities in the isolation room’, ‘Activities during isolation’, ‘Attention from the health care team’, and ‘Swab results’.

### *Feelings of being in an isolation room*

Most participants reported that they were alone, stressed, and frustrated while undergoing isolation treatment. For example, one participant stated, “... I feel like I'm being dumped, no one was there with me in the room except an old woman who can't communicate” (P6). The expression of disappointment was seen from P6. The loneliness made her feel stressed; (P6) added, “I can go crazy if I stay here for a long time. I don't know whom I can interact with.”

For participants who were isolated in the emergency room, the situation became much worst because they were exposed to more COVID-19 patients with various levels of severity. In addition, the busy and loud emergency room environment was not conducive for participants to rest, which eventually created stress and frustration. (P5) explained, “I was treated temporarily in the ER isolation because the inpatient isolation was full. There were a lot of screaming patients, and some of them were in bad conditions. I was so stressed, I cried.”

### *Physical symptoms*

During their isolation period, some participants reported a more deteriorating physical condition. Similar to their initial symptoms, participants in this stage were still experiencing headaches, body aches, general weakness, loss of appetite, loss of taste and smell. In addition, however, they were also experiencing shortness of breath, coughing to the point of urinating, nausea, vomiting, and diarrhea. “My body was frail compared to several days before isolation ... I started to have a bloated stomach, nauseated, vomited, and also a decreased sense of smell” (P4). Likewise, (P5) commented, “...On the 3rd day, every time I came out of the bathroom, I was short of breath, like someone who ran a long distance, I felt very stuffy”. Several participants also stated that enduring these symptoms was very tiring. As (P7) said, “It's tough to endure. That condition made me exhausted.”

## *Spiritual Experiences*

Participants reported that they had spiritual experiences that helped them keep going through the isolation processes. Some participants felt closer to God during their illness and prayed harder. For example, (P7) said, “I prayed more often and drew closer to God.” (P2) also explained that her spiritual practices make her strong to overcome problems experienced while in isolation, “Suffering from COVID-19, I became aware of the importance of having a relationship with God who gives me strength and keeps me healthy” (P2).

In addition, many participants reported that they found peace and power simply by remembering God. As (P4) said, “I believe that God will not give anything that is something we cannot bear, and it will not exceed our own strength.”

## *Communications*

Communication was an important point that participants often reported—particularly communication with other patients, health workers, and families. Many participants conveyed that communication with other patients in the isolation unit was excellent and supportive. (P6), for example, was glad to be able to communicate and create a friendship with other patients. She said, “It's nice to have roommates to share with finally. We talked and got to know each other” (P6). Another participant commented: “ By chance, I share my room with my coworkers who also get COVID. We encourage each other to stay motivated” (P4). To some participants, maintaining communication with their loved one were significant to help them survive as (P6) said, “While being treated in the isolation room, my sisters always contacted me. They strengthened me.”

## *Motivation*

Several factors motivate participants to recover from Covid and thrive. First, most of the participants realized the significant role and support of family and friends in recovering from the COVID-19 disease and overcoming the psychological stress. According to participants, even though the family was not physically present with them during hospitalization and quarantine, the support of family members, such as nutritional, emotional, and religious support, was very effective in helping them recover and cope. For example, one participant said, “Family, children and coworkers, they prayed together and motivated me through video calls. Everything they did during my isolation had strengthened me through the treatment process.” (P7).

In addition, participants also reported that their family are their reasons to survive and stay alive. As (P1) said, “I have to keep going and motivate myself to recover fast because my mother is widowed and old. I don't want to make her worry about my conditions.” Likewise, R3 conveyed his concerns about his family during the isolation period, “I have two children. They needed me. I need to recover soon.”

Participants also reported high self-motivation to recover, stating that they should not allow life's stresses to harm their health. (P2), for example, said, “I have to be able to motivate myself... So I thought positively and tried to be happy.” Similarly, (P1) revealed, “If I think negatively, I will stay in the isolation room longer” (P1).



## *Facilities in the isolation room*

The majority of the participants reported that the facilities in the isolation room was inadequate, uncomfortable and caused disappointment. (P6) was one of the participants who were not pleased with the facilities due to the unclean environment. He said, "Geez, the room was dirty ... maybe it hasn't been cleaned when the previous patient was discharged" (P6). Another was not fully satisfied, noticing that there was no essential life-saving resource in the room. He said, "The facilities are okay even though oxygen is not available in my room, maybe because this is a newly opened room" (P1)

## *Activities during isolation*

Some participants stated that reporting on their activities gave them energy such as sunbathing, breathing exercises, being independent in meeting physical needs, and helping other patients. For example, (P2) was excited to share her activity during the isolation period. She stated, "I always sunbathe, and in my room, I practised breathing by singing. I felt much better afterwards" (P2).

As nurses, participants also help other patients in their room meet their needs even when they status as patients. For example, (P7) shared, "My roommate, she's elderly, was suffocated, so I helped take care of her." Likewise, (P6) reported, "I'm in a room with an old woman who was short of breath and using oxygen. So I took care of her."

## *Attention from the health care team*

Some participants stated that they received less attention from nurses and doctors. They assumed that this was because of their profession as nurses, so the other health care providers consider them to be able to take care of themselves as long as there are no significant physical problems. As (P3) said, "It's because I am a nurse. So when a nurse or doctor comes, I didn't get a full explanation of my conditions, and they considered that I can take care of myself."

## *Swab results*

Swab results need to be negative before participants are allowed to exit the isolation unit and return home. However, participants stated that the results of the PCR swab took a long time, so their time to come out of isolation took longer. For example, (P2) reported, "The PCR results were too long... I have to wait a few days [after the swab] until I can go home." Not just waiting for a few days, some participants even had to wait weeks. "I waited for the results of the second PCR for two weeks. Hopefully, in the future, the results can be faster" (P6).

## **Theme 3: Post-isolation experiences**

Participants' experiences after the isolation were completed and when they were able to return home had changed many different aspects of their lives. These experiences also created hopes and expectations for other covid patients and health

workers. The post-isolation experience consists of ‘post-covid conditions’, ‘spiritual and social well-being’, ‘hope for other covid patients’ and ‘hope for health workers.’

## *Post-covid conditions*

The physical conditions of participants after the isolation and after their test came back negative did not make their stamina and strength return as normal before they had COVID-19. Many participants reported that the condition of their body post-covid is easy to get tired, especially when doing daily activities. One participant commented, “Although my test was negative, there's a thing called post-covid reaction. My body gets tired easily... Even now, after 2 months, I'm not as fit as I used to be” (P6).

Participants' COVID experiences had changed the way they live and encouraged better discipline in the prevention measurement of COVID-19. They understand the importance of complying with health principles, such as taking the benefit of sunbathing, eating healthy food, washing hands, wearing masks, and social distancing to maintain one's health. For example, (P3) described, “Now I disciplined myself to wear a mask and regularly sunbathe. I'm also trying to have a healthy diet, fruits and vegetables, and regularly consume vitamin supplements.”

## *Spiritual and social well-being*

Participants reported that post-covid experience, they are more spiritually aware and find peace through spiritual activities. “My spiritual life has changed. I have a special prayer time commitment in the morning and evening. I thank God for giving me a second chance” (P3).

Participants also reported that they found happiness to help and support friends who indicated COVID-19. For example, (P6) said, “If I hear a friend has Covid, I'll be happy to send them food. I'll support them.” Another participant echoed this, “Yesterday a friend of mine and his family had a positive Covid-19 test result, so I sent them food supplies... I feel glad doing little things to make them happy and less stress with the situation” (P4).

## *Hope for other covid patients*

Participants reported their experience in getting through the isolation period by emphasizing the importance of motivation, positive thinking, and stresslessness. These are hopes they have for COVID-19 patients. For example, (P2) said, “My message is, I've been through it and recovered, so you do too,” and another commented, “don't stress it too much, keep eating, have lots of rest and make yourself happy” (P7).

## *Hope for health workers*

Participants had different expectations for health workers caring for patients with COVID-19, especially those working in the isolation room. Some participants suggested that nurses need to improve communication with their patients and support patients in hospital isolation; as (P3) argued, “I hope that the nurses can motivate the patient more and have a conversation with them. Try to comfort them. Most of the time,

nurses are the only person they can talk to.” Other participants emphasized the importance of COVID-19 knowledge to nurses so they would provide effective care to their patients. “Nurses who work in the isolation unit need to increase their knowledge and skills related to COVID-19 and its treatments. Hopefully, they can provide the best nursing care” (P5).

## DISCUSSION

This study explored the experience of nurses who were isolated in the hospital due to Covid-19 infection. Three themes were generated from the interviews, those are pre-isolation experiences, experience in the isolation room, and post-isolation experiences.

### **Theme1. Experience at diagnoses (Pre-Isolation)**

Nurses’ initial responses to the fact that they were COVID-19 positive included feared and worried. This study also indicated that COVID-19 patients experience fear and anxiety in several dimensions, such as a terrible fear of death, fear of infection and fear of being isolated by the environment. These results are consistent with data obtained by Taylor et al. (2020), who identified five symptom factors of coronavirus-related stress and anxiety: (1) Danger and contamination, (2) fear of economic consequences, (3) coronavirus-related xenophobia, (4) compulsive examination and reassurance, and (5) symptoms of traumatic stress. In their findings, Taylor et al. (2020) also highlighted that their participants also expressed fear of a hard and painful death as they observed the deaths of other patients, with deteriorating clinical conditions, awareness of the COVID 19 high mortality rate worldwide shown in the media, and being away from family members. Banzett et al. (2020) reported that patients in the acute phase of the disease might often fear death due to worsening clinical conditions. Patients confirmed with COVID-19 tend to experience stress related to the conditions they experience, which can affect their physical, emotional, mental, social, and spiritual state (Roman et al., 2020). The finding related to COVID-19 patients is also accords with that of Sarfika et al. (2021) involved 1,622 participants from 34 provinces in Indonesia and reported that the prevalence of depression in Indonesia was 28.5% mild depression, 18.4% moderate depression, and 24.8% severe depression. In addition, social media exposure (SME), age, gender, occupation, and self-rated health (SRH) was significantly influencing depression ( $p < 0.05$ ) (Sarfika et al., 2021).

Nurses in this study were frustrated by stigmatization and afraid of being ostracized. Research in India shows that some patients are stigmatized because of COVID-19 (Sahoo et al., 2020). Patients with COVID-19 are always stigmatized due to feelings of rejection and the negative view of society towards the disease (Moradi et al., 2020). The negative consequences of the stigma of controlling COVID-19 disease include hiding the condition, avoiding treatment and immediately implementing healthy lifestyle behaviours, and interfering with patient identification and supervision (Asadi-Aliabadi et al., 2020; Bhattacharya et al., 2020).

## **Theme 2. Experience in the isolation room**

As a result of their isolation, the nurses in this study frequently feel frustrated and alone. According to Kar et al. (2020), quarantined COVID-19 people experienced various mental disorders, such as boredom, loneliness, anger, depression, anxiety, rejection, and hopelessness. Nurses in this study were worried about fulfilling their family responsibilities while they were away from family and isolated. This situation also caused sadness, especially when separated from loved ones. The statement of stress experienced by nurses was generated thinking about their health condition that would worsen. This finding is consistent with who reported that patients in isolation might have been affected psychologically due to the number of uncontrolled COVID-19 cases and the death rate.

Spiritual experiences, positive thoughts and perceptions of social support influenced participants' perspectives on this disease and their attitudes towards this disease in the stages of diagnosis, treatment, hospitalization and post isolation. They increased the level of adjustment to the disease condition. Shaban et al. (2020) also found that people diagnosed with COVID-19 modified their behaviors, including healthy eating, positive thinking, lifestyle changes, and becoming more spiritual. The participants' spiritual awakening is a God-centered spirituality that means finding God's meaning as a source of strength in their difficult situation (Shaban et al., 2020). Jesmi et al. (2021) also reported that patients with COVID-19 use religious mechanisms such as religious activities and beliefs to reduce their tensions and worries. Improving and training coping mechanisms according to the patient's culture can positively affect these patients. Striving for recovery shows optimism and hope for the future in patients with COVID-19. Spiritual and religious experiences, as solid sources of adjustment, optimism, hope, and meaning, enable individuals to reduce participants' bitter experiences with their illness.

The positive mood of COVID-19 confirmed patients would increase high dopamine in the blood and will optimize and boost the immune system. So, the strategy to support immunity is to maintain a good mood, such as by video calling family and loved ones, playing with handphones and listening to music. It is known that COVID-19 confirmed for patients undergoing isolation in the COVID-19 ward that listening to music is an effective way to reduce anxiety and hallucinations that cause fear and helps to have a more positive experience (Habib, 2021). Meanwhile, listening to music can reduce psychological problems based on subjective reactions to situations. Listening to music is an interacting component in preventing anxiety, boredom, stress and post-traumatic disorders (Panteleeva et al., 2018). It is stated that worship, prayer and al-Quran reading are good alternatives to treat illness psychological well-being and improve quality of life (Umarella et al., 2020)

Based on research by Aunguroch et al. (2020), support from family members shows that humans are social beings who cannot live without social support. Positive emotions play an important role in recovery and psychological adjustment (Sun, et al., 2020). Support from friends can positively respond to health promotion (Habib, 2021). Support from the medical team is urgently needed for patients with confirmed COVID-19 in undergoing treatment and isolation. The care and intervention that the medical

team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). Improving facilities, especially swab results, are currently still taking a long time. According to the Ministry of Health of the Republic of Indonesia (2020), in cases of investigators who are self-isolating, monitoring is carried out by health workers, and monitoring can be carried out if the results of the RT-PCR examination for 2 consecutive days with an interval of > 24 hours show negative results.

### **Theme 3. Post-isolation experiences**

The post-COVID-19 syndrome experienced by nurses are varied. Some stated that the post-COVID-19 syndrome could still be felt even though it had been declared negative for COVID-19. This is in line with Shah et al. (2021) report that stated that in October 2020, NICE (the national institute for health and care excellence) has recognized the uncertainty of the long-term effects of the SARS-CoV-2 virus and defined post-COVID-19 syndrome as a symptom that lasts longer up to 12 weeks. Long-term physical condition complaints in patients with confirmed COVID-19 vary over time and fluctuate, depending on the severity of the disease and the patient's health status, considering comorbidities and overall weakness. This condition presents with symptoms that can change over time and can affect systems in the body. Common symptoms of the post-COVID-19 syndrome include extreme tiredness and weakness, shortness of breath on light activity, joint pain, persistent low-grade fever, headache, vertigo, runny nose, sore throat, voice changes and difficulty swallowing, loss or change in smell and taste. Prolonged mood swings, hair loss, gastrointestinal disturbances including loss of appetite, abdominal pain, diarrhea, vomiting, inability to concentrate and insomnia (Higgins et al., 2021; Shah et al., 2021).

During post-covid experience, they are more spiritually aware and find peace through spiritual activities. Spirituality can provide hope and meaning in difficult situations, including during the COVID-19 pandemic (Teresa et al., 2021). Spiritual creates positive emotions in a person. Spirituality and religion can help people in grief in times of crisis and can be a useful “sedative” for humans (Fardin, 2020). Support from the medical team is urgently needed for patients with confirmed COVID-19 undergoing treatment in the isolation room. The care and intervention that the medical team provides professionally every day will generate gratitude from the patient (Wang et al., 2020). The provision of care and treatment from the medical team can improve self-management approaches that help patients be more enthusiastic to fight the disease they are suffering from. The satisfaction of clinical interventions received and the quality of care during treatment in the COVID-19 isolation room, as well as the respect received from medical team professionals (Olufadewa et al., 2020).

Dissatisfaction with the clinical intervention received and the quality of care in the COVID-19 isolation room was caused by restrictions on the hours of entry of the COVID-19 medical team into the COVID-19 isolation room. Based on a study by Mitigation team PB IDI (2020), the work shift must pay attention to the duration of work by the regulations, namely Permenkes No. 52 of 2018. Shorter working hours are allowed in conditions of abnormal work pressure or high risk, such as the COVID-19 medical team must wear hazmat continuously throughout the shift. Short shifts are

recommended over long shifts to help protect against the risk of mental fatigue from heavy workloads. Fatigue can increase the risk of injury and worsen health conditions that are prone to infectious diseases, increase psychological stress that affects the health of the medical team and the quality and safety of the care provided. It is necessary to educate the COVID-19 medical team to confirm COVID-19 patients undergoing treatment in the COVID-19 isolation room regarding changes in the rotation and duration of the medical team's work in the COVID-19 isolation room. This was done to reduce the exposure of health workers to viruses aimed at maintaining physical and mental health and maintaining the quality of service for the medical team.

Cabrini et al. (2020) stated that during the COVID-19 outbreak, healthcare providers were recognized as national heroes. Studies show that patients recovering from COVID-19 regard family as the most important source of support (Shaban et al., 2020). Regarding family support, nurses also take advantage of the patient's family support to overcome the psychological damage caused by COVID-19 (Sun et al., 2020). The nurse's motivation for responsibility and calling for caring for patients and a deep feeling of empathy because of the patient's condition and being away from family members affect patient satisfaction when being treated.

## **Implications and limitations**

This study provides insight into the experiences of nurses who were infected with COVID-19 and undergoing isolation in the hospital. Their feelings and needs while diagnosed with COVID-19 and isolated in COVID-19 units are identified in this study. The finding highlights the necessity of family and caregivers' support throughout their isolation period. Useful guidance and training on preventing COVID-19 transmission to nurses are also required, along with regulations related to PPE and how nurses may return to work after recovering from COVID infection. In addition, the study also has implications for nurses. Nurses diagnosed with COVID-19 may use their experience as a lesson when dealing with COVID-19 patients. From their experiences, the nurse can be more empathetic to patients and families and become more sensitive to patients' physical, social, and spiritual needs in isolation.

We acknowledge that this study has limitations. To get information about nurses' experience, we collected qualitative data from one hospital sample. Therefore, the findings may not be generalized as Indonesian nurses' experiences. Additionally, the study is limited by the lack of information on how nurses cope with isolation. Although some information provided may reflect how nurses deal with their situation, the focus of this study was on their experiences only, and results may not reflect actual nurses coping mechanisms towards their isolation treatments. We encouraged further research to be conducted in larger scope of area and wider range of healthcare professionals.

## **CONCLUSION**

This study explored nurses' experiences of COVID-19. It resulted in three main themes: experience at diagnosis (Pre-isolation), experiences during isolation, and post-isolation experiences. It was highlighted from the findings that psychological, social,

and spiritual support from family, fellow nurses and nurse managers were significant for nurses' recovery. By understanding pre, during and post COVID-19 isolation, nursing managers will be able to plan appropriate care and use the proper approach to support infected nurses, and this area needs further research. Moreover, nursing managers can protect the nurses during their duty through infection control education and training, as well as regulations that help nurses work during COVID-19 pandemic.

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## AUTHOR CONTRIBUTION

Both authors participated sufficiently in the concept, design, analysis, writing, and critical revision of the manuscript. The first author conducted the interviews and data collection.

## CONFLICT OF INTEREST

There is no conflict of interest in this research.

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## TABLE

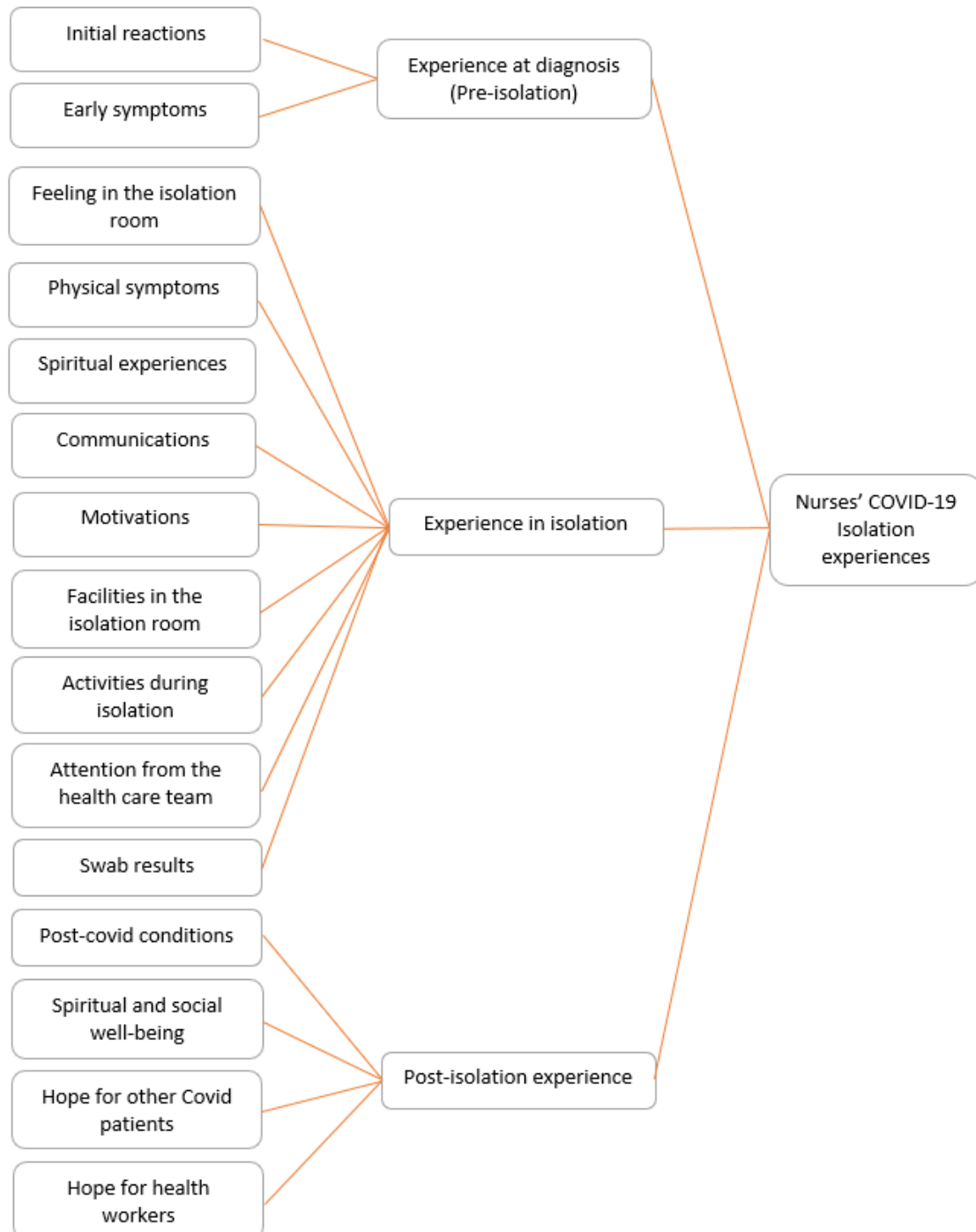
**Table 1.** Interview Questions

No.	The Questions
1	“Please tell me how you felt when you first found out you tested positive for Covid-19?”
2	“Can you share your experience while being treated in the Covid-19 room?”
3	“Describe your experience undergoing Covid-19 therapy?”
4	"Could you please explain what things encourage you to stay motivated while being treated in the Covid-19 isolation room? Why?"
5	"Please explain what things are considered to be obstacles during quarantine while being treated in the Covid-19 isolation room? Why?"
6	“Who has the most impactful role in providing support so that you are able to undergo therapy until it is declared negative for Covid-19? In terms of what?"
7	“If a patient has just started therapy and asks for advice, how would you share the most important thing in undergoing Covid-19 therapy?”
8	“How do you describe your current quality of life?”
9	"Are there other important things that you still want to say to the health workers for them to fulfill in improving services for Covid-19 patients?".

**Table 2.** Participants’ characteristics

Participant Number	Gender	Age (Years)	Isolation (Days)
R1	Female	27	21
R2	Female	30	10
R3	Male	25	21
R4	Male	31	14
R5	Male	47	18
R6	Female	40	12
R7	Female	28	10

## FIGURE



**Figure 1.** The subthemes and Themes