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ARAŞTIRMA MAKALESİ/ORIGINAL ARTICLE

Investigating Nurses' and Nurse Managers' Experiences During the COVID-19 Pandemic: A Phenomenological Study

Hemşirelerin ve Hemşire Yöneticilerin COVID-19 Salgını Sırasındaki Deneyimlerinin İncelenmesi: Fenomenolojik Bir Çalışma

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Abstract

Background: Türkiye is ranked close to last among OECD countries in terms of the 'number of nurses per 1,000 people'. Nurses and nurse managers already devotedly provided services under difficult conditions during normal periods before the pandemic, and this became even harder during the pandemic. Therefore, it is important to investigate the experiences of nurses and nurse managers during the pandemic to make improvement in nursing care for future possible pandemics.

Objective: This study aimed to explore the experiences of nurses and nurse managers during the COVID-19 pandemic.

Method: The study used the phenomenological qualitative approach. The sample consisted of 14 nurse managers and 14 nurses who were working during the COVID-19 pandemic. Data were collected via online voice and video calls using a semi-structured interview form. The findings were reported in accordance with the consolidated criteria for reporting qualitative research.

Results: Following analysis of the data, the attitudes of nurse managers and nurses in Türkiye related to the COVID-19 pandemic challenges and experiences divided into three themes: "Communication", "Training", and "Working Conditions/Environment".

Conclusion: In the study, nurses emphasized that their work environments were negatively impacted during the COVID-19 pandemic. Additionally, it was concluded that nurse managers exerted significant efforts to facilitate communication, to meet nurses' needs for training, and to improve staff nurses' working conditions. Some nurses noted that hospital administrators and nursing service managers provided social and psychological support. The study also revealed that the sensitivity and genuine approach of nurse managers enhanced nurses' resilience. Nurse managers' management skills and nurses' experiences during the pandemic provide valuable insights and evidence for effectively managing future pandemics and similar disasters.

Keywords: Covid-19, Nurses, Nurse Managers, Pandemic, Phenomenology

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Öz

Giriş: Türkiye, ‹1.000 kişiye düşen hemşire sayısı› açısından OECD ülkeleri arasında sonuncuya yakın sırada yer almaktadır. Hemşireler ve hemşire yöneticiler zaten pandemi öncesi normal dönemlerde zor şartlar altında özveriyle hizmet veriyorlardı ve bu pandemi döneminde daha da zorlaştı. Bu nedenle hemşirelerin ve hemşire yöneticilerin pandemi sürecindeki deneyimlerinin araştırılması gelecekteki olası pandemilere karşı hemşirelik bakımında iyileştirme yapılması açısından önemlidir.

Amaç: Bu çalışma, hemşirelerin ve hemşire yöneticilerin COVID-19 pandemisi sırasındaki deneyimlerini araştırmayı amaçlamıştır.

Yöntem: Araştırmada fenomenolojik nitel yaklaşım kullanılmıştır. Örneklemi, COVID-19 pandemisi sırasında çalışan 14 yönetici hemşire ve 14 hemşire oluşturmuştur. Veriler, yarı yapılandırılmış görüşme formu kullanılarak sesli ve görüntülü görüşme yapılarak çevrimiçi olarak toplanmıştır. Bulgular, nitel araştırmaları raporlamak için birleştirilmiş kriterlere dayalı olarak rapor edilmiştir.

Bulgular: Verilerin analizinin ardından, Türkiye'deki hemşire yönetici ve hemşirelerin COVID-19 zorluklarına ve deneyimlerine yönelik tutumları üç temaya ayrılmıştır: "İletişim ve İş birliği", "Eğitim/ Gelişim" ve "Çalışma Koşulları/Çevre".

Sonuç: Araştırma, hemşire yöneticilerin iletişimi kolaylaştırmak, hemşirelerin eğitim ve gelişim ihtiyaçlarını karşılamak ve personel hemşirelerin çalışma koşullarını iyileştirmek için büyük çaba sarf ettiği sonucuna varmıştır. Araştırma ayrıca, hemşire yöneticilerin hassas ve samimi yaklaşımlarının hemşirelerin dayanıklılığını artırdığını buldu. Hemşire yöneticilerin yönetim becerileri ve hemşirelerin pandemi sürecindeki deneyimleri, gelecekte ortaya çıkabilecek pandemi ve benzeri afetler in etkili bir şekilde yönetilmesi için değerli bilgiler ve kanıtlar sunmaktadır.

Anahtar Kelimeler: Covid-19, Hemşire, Yönetici Hemşire, Pandemi, Fenomenoloji

INTRODUCTION

The COVID-19 pandemic, which spread globally throughout the first months of 2020, resulted in great demands for healthcare systems (Maben & Bridges, 2020). This unforeseen demand shifted the focus of nursing services to patient care rather than managerial work (Türk et al., 2021). Governments around the world allocated their healthcare resources to fighting the COVID-19 pandemic, which caused significant stress for the health sector (Palese, Papastavrou & Sermeus, 2021).

Although a considerable number of reports, news articles, and papers were published about COVID-19, information on how nurses and nurse managers experienced and managed the crisis remained limited (Freysteinson et al., 2021). It can be said that the experiences of nurse managers and nurses have been addressed separately in the studies conducted, and the number of in-depth studies focusing specifically on nurse managers is also insufficient. For example, nurses experienced social isolation, loneliness, fear of getting infected, and heavier working conditions, as well as difficulties regarding the provision of personal protective equipment (Butler-Henderson et al., 2021; Muz & Erdoğan Yüce, 2021). As nurses have fought with these challenges, nurse managers have focused on issues such as management of the organizational resources (White, 2021), management of the psychological and physical effects of the pandemic (Catania et al., 2021), new leadership approaches (Freysteinson et al., 2021), and motivation of nurses (Wu et al., 2020). Thus, front-line nurses needed to adopt new approaches to providing qualified healthcare

to patients.

Even developed countries, where the healthcare systems are more robust and the number of health professionals is higher, have occasionally experienced difficulties in managing the pandemic. In Türkiye, a developing country, strategies were followed to make efficient use of available resources during the COVID-19 pandemic. In 2020, there were 198,465 nurses in Türkiye, which ranks 35th among 38 OECD countries in terms of 'nurses per 1,000 population'; Türkiye has 2.3 nurses per 1,000 people (OECD, 2021). Therefore, it becomes more important to understand the experiences of both nurses and nurse managers during the pandemic and how they coped with this crisis.

The first case of COVID-19 in Türkiye was confirmed on March 11, 2020. However, following the huge and rapid increase in the number of COVID-19 cases, various restrictions, such as those related to part-time work, meetings, curfews, and the closure of schools, were applied across the country. The situation gradually returned to normal, but in September 2020 restrictions were reintroduced once more with the commencement of a second wave. This study was conducted following the first wave of the pandemic and aimed to explore what nurses and nurse managers experienced during the COVID-19 pandemic in order to prepare for similar events in the future.

The study focused on the experiences of nurses and nurse managers in Türkiye who worked devotedly, since the beginning of the pandemic. Although the literature included studies that aimed to understand only the experiences of either nurse managers (Bianchi, Prandi & Bonetti, 2021; White, 2021) or nurses (Catania et al., 2021; Freysteinson et al., 2021; Muz & Erdoğan Yüce, 2021) individually, no studies were found during the period of this study that examined the impact of nurse manager's strategies on nurses. However, nurse managers may not be fully aware of all the difficulties that nurses face while providing service, especially during crisis periods. On the other hand, the goals and decisions of nurse managers during the process may not be perceived correctly by nurses. In other words, while one side sees one aspect of the situation, the other side may see a different aspect. Therefore, examining the views and experiences of both parties from the same perspective is valuable in temrs of revealing common perceptions or differences. In light of this, the present qualitative study aimed to investigate and interpret the experiences of both nurses and nurse managers in Türkiye during the pandemic.

METHOD

Type of the Research

This study employed the descriptive phenomenological approach among the qualitative research methods; the phenomenological method provides an in-depth perspective of the participants' experiences (Polit & Beck, 2012). Phenomenology defines the common meaning of individuals' experiences related to a phenomenon or concept and aims to uncover the essence of the perceptions related to these experiences (Creswell & Poth, 2016; Rodriguez & Smith, 2018). Descriptive phenomenological research designs are a recommended method for identifying factors related to the phenomenon and evaluating their impact on people (Creswell & Poth, 2016). Descriptive qualitative research provides a straightforward and direct description of any phenomenon (Lambert & Lambert, 2015), while descriptive phenomenological research describes the essence of the individual's lived experience

(Sandelowski, 2010). In this study, a descriptive phenomenological qualitative design has been employed to examine the "management of the pandemic process by nurses and nurse managers" as a phenomenon. The study data were reported based on the consolidated criteria for reporting qualitative research checklist (COREQ) (Tong, Sainsbury & Craig, 2007).

Universe/Sample of the Research

The study participants were selected from the nurses and nurse managers who were members of the Association of Nurse Managers in Türkiye using the purposive sampling method. The inclusion criteria for this study were: (1) being a member of the above-mentioned association, (2) working as a nurse manager or nurse, (3) having a bachelor's degree or higher education level, (4) actively working in pandemic intensive care units or pandemic clinics, and (5) voluntarily agreeing to participate in this study. During the interviews conducted in the present study, the researchers decided that data saturation was achieved when no new information was obtained and the participants' statements began to repeat themselves; then, the interviews with the 28 participants (14 nurse managers and 14 nurses) were completed.

Data Collection Instrument-Validity and reliability information

The research team consisted of six individuals: a professor with expertise in qualitative research (R1); three academics (one researcher had prior training in qualitative research (R2), and all three researchers had prior experience with qualitative research (R2, R3, R4); and two doctoral nursing students (R5, R6). In the interview process of the research, two researchers were involved (R1, R2), with one researcher (R1) conducting the interview to ensure consistency, while the second researcher (R2) observed and recorded the interview. The transcription was done by these two researchers (R1, R2). The codes determined by the two researchers were compared, and then all the codes were reviewed by two other researchers (R3, R4), and consensus was reached among all the researchers.

The data collection tool was initiated by scanning the existing literature on the phenomenon of nursing management during the pandemic. The literature on this issue is considered to remain largely unexplored; therefore, draft questions have been prepared. The related questions were finalized through the opinions and suggestions of two expert academics who have been experienced in qualitative data collection methods. A semi-structured form was used for the interviews. This form was composed by surveying the literature on nursing management and disaster management and considering the observations and impressions the authors have acquired. The interviews were conducted individually with participants. Probe questions were asked as needed in addition to those on the form. The interview form contains the following questions:

1. Could you briefly introduce yourself? Where did you receive your basic nursing education? How long have you been working as a nurse/nurse manager?

2. Have you received any training related to crises, disasters, or epidemics? Please elaborate on the scope.

3. Could you share your experiences regarding the pandemic?

4. During the pandemic, as an institution/ nursing service,

    o What were your strengths?

    o What aspects do you believe need improvement as a nurse/nurse manager?

    o In what situations did you feel

inadequate as a nurse/nurse manager during the outbreak?

5. Could you discuss the problems you encountered during the pandemic?

6. How would you describe your relationship with nurses/nurse managers during the pandemic?

7. If the outbreak were to occur again, what improvements would you recommend to manage it more effectively?

8. Is there anything else you would like to add regarding the pandemic process?

Before starting data collection, a pilot study was conducted with a nurse and two nurse managers; the data obtained in this pilot study were not included in the main study. The interviews were carried out via an online portal due to the social distancing measures and visiting restrictions that had been introduced as a result of the pandemic (July 15 to August 30, 2020). The participants were contacted three times: first, all potential participants were reached via email, which explained the aim and content of the study, the fact that data would be collected and recorded through online interviews using the in-depth interview method, data privacy and protection, and all other necessary issues. Those who volunteered to participate in the study signed the informed consent form and sent it to the researchers via email. Second, the researchers contacted the participants and scheduled an appointment for the interviews. The conversations were recorded with a voice recorder and then transcribed verbatim by the authors. Each participant was interviewed online individually and only once. The interviews took an average of 41.1 minutes (min = 22, max = 78).

Data analysis

Transcriptions of the recorded interviews were prepared for data analysis. The two researchers who conducted the interviews independently analyzed the data and discussed them until a consensus was reached. Data were analyzed using the content analysis method, following the "descriptive phenomenological analysis steps" proposed by Colaizzi (1978) (Colaizzi, 1978). The data analysis was performed using the MAXQDA 2020 software program.

The present study utilized Colaizzi's (1987) seven-step approach, as illustrated in Figure 1.

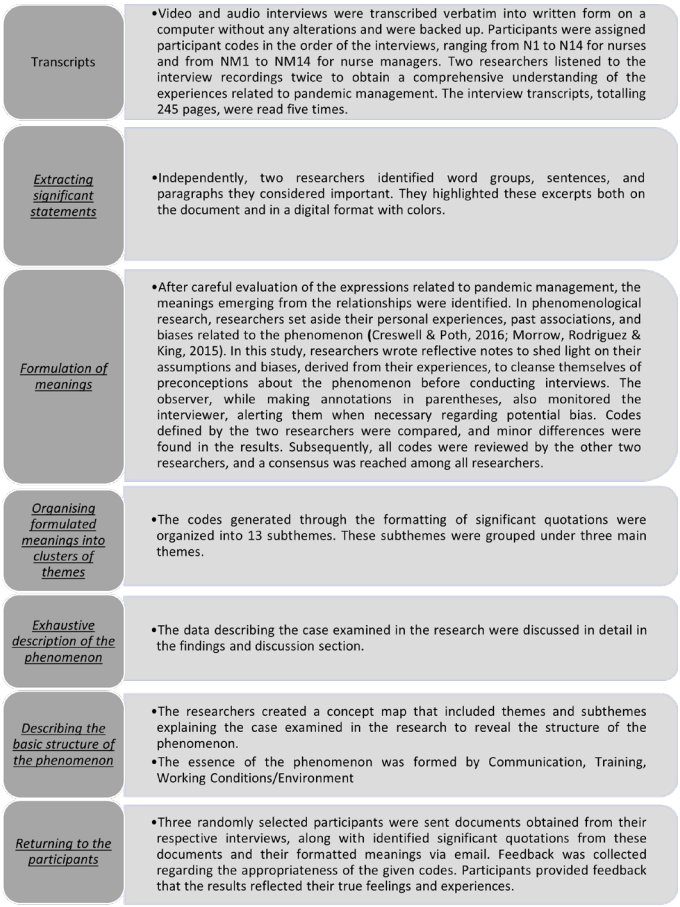

Figure 1. Colaizzi's Analysis Stages

Rigor and trustworthiness

The credibility of the results is considered one of the most important criteria of scientific research. "Validity" and "reliability" are the two most commonly used criteria in research in this respect. While "validity" concerns the accuracy of research results, "reliability" is related to

the replicability of research results (Yıldırım & Şimşek, 2016). At this stage of the research, the criteria suggested by Lincoln and Guba (1985) have been taken into account. Lincoln and Guba (1985) stated that it would be more appropriate to use the concepts of credibility and transferability instead of validity and the concepts of consistency and confirmability instead of reliability (Yıldırım & Şimşek, 2016). Each participant took part in the study voluntarily, and the researcher had no personal or managerial relationship with the participants. Participants were encouraged to openly share their ideas and experiences, taking into account that there were no right or wrong answers to the interview questions. The researchers took notes on participants' gestures, behaviors, reactions, and interview environment, as well as any pauses or breaks occurring during the interviews. To ensure compatibility, the interviews were completed by the R1 and R2. All researchers actively and independently participated in the data analysis process. A semi-structured interview form was used to ensure consistency, and transcripts were sent to the participants for statement approval. Participants' statements were quoted verbatim so that readers may assess whether the study's findings are transferable to their own settings.

Ethical Aspect of the Research

Ethics approval was obtained from the Clinical Research Ethics Committee of Istanbul University Istanbul Faculty of Medicine with date 02.06.2020 and number 2020/90. Written permission was obtained from the Association of Nurse Managers. The individuals who met the inclusion criteria were provided with verbal and written information about this study, and written informed consent was obtained from the association members who agreed to participate in the study. Research and publication ethics were complied with in the article.

RESULTS

Table 1 shows the characteristics of the nurses (N1–N14) and nurse managers (NM1–NM14) who participated in the qualitative interviews. Most of the participants were working in the Turkish Ministry of Health Hospitals and specific units and had graduated from postgraduate programs.

Table 1. The Participants' Characteristics (n = 28)

Code	Sex	Institution	Educational Level	Unit
N1	Male	Private hospital	Undergraduate	Pandemic wards
N2	Female	State hospital	Postgraduate	Pandemic intensive care
N3	Female	State hospital	Undergraduate	Pandemic intensive care
N4	Female	State hospital	Undergraduate	Pandemic intensive care
N5	Female	Private hospital	Postgraduate	Pandemic wards
N6	Female	Private hospital	Postgraduate	Pandemic wards
N7	Male	University hospital	Undergraduate	Pandemic wards
N8	Female	State hospital	Postgraduate	Pandemic intensive care
N9	Female	State hospital	Postgraduate	Pandemic wards
N10	Female	Private hospital	Postgraduate	Pandemic wards
N11	Female	University hospital	Postgraduate	Pandemic wards
N12	Female	University hospital	Postgraduate	Pandemic wards
N13	Female	University hospital	Postgraduate	Pandemic wards
N14	Female	State hospital	Undergraduate	Pandemic wards
NM1	Female	University hospital	Postgraduate	First-line nurse manager

Table 1. (Countinue) The Participants' Characteristics (n = 28)				
NM2	Female	State hospital	Undergraduate	First-line nurse manager
NM 3	Female	Private hospital	Postgraduate	Nurse manager
NM4	Female	State hospital	Undergraduate	First-line nurse manager
NM5	Female	State hospital	Postgraduate	First-line nurse manager
NM6	Female	University hospital	Undergraduate	First-line nurse manager
NM7	Female	State hospital	Postgraduate	First-line nurse manager
NM8	Female	State hospital	Undergraduate	First-line nurse manager
NM9	Female	Private hospital	Postgraduate	First-line nurse manager
NM10	Female	Private hospital	Undergraduate	First-line nurse manager
NM11	Female	State hospital	Postgraduate	Nurse manager
NM12	Male	University hospital	Postgraduate	First-line nurse manager
NM13	Female	University hospital	Postgraduate	Nurse manager
NM14	Female	Private hospital	Postgraduate	Nurse manager

In line with the interviews, the study findings are presented under three themes to answer the research questions (Table 2).

Theme 1: Communication

The nurse managers' and nurses' statements regarding their experiences under the Communication theme were categorized under four subthemes:

Nurse manager–nurse communication

Some nurse managers visited clinics during the COVID-19 pandemic, but some others avoided doing so. However, most of the nurse managers said that they visited nurses working there.

"It was important for them to know that they could contact us 7/24. We visited the clinics. We visited the employees when they had a break." (NM 12).

" ...For example, I got sick. The head nurse and the deputy head nurse called me". (N3).

Nurse–nurse communication

Nurses' and nurse managers' experiences contradicted one another. For example, one of the nurse managers stated that they established a good communication network. In contrast, one of the nurses stated that they were tired and worn out, and that communication deteriorated as a result.

"*Thanks to the various communication channels, nurses could quickly make very good decisions about what they would do." (NM 13).*

Nurse–patient/patient relative communication

There were problems with isolation practices in regard to patients/patient relatives in the health institutions.

"The patients were very panicked and afraid of death or not seeing their family again. They unavoidably reflected their concerns onto the healthcare personnel." (NM 4).

"Patients were shouting, kicking the doors, trying to escape." (N3).

Nurse–other healthcare personnel communication

Some nurses and manager nurses had problems with other health professionals, especially with the physicians. But, some thought that team communication was good.

"Physicians did not want to constantly wear and take off the personal protective equipment. They tried to make nurses do most of the work. This caused conflicts." (NM 8).

"We were good about approaching the patients as a team; no serious problems existed concerning healthcare personnel." (N11).

Table 2. Themes, Subthemes and Phases

Theme	Subtheme	Nurse Manager	Nurse
Communication	Nurse Manager–Nurse	"We were always in the field. We never sat in our room; we constantly walked about while working in the field…We visited all of our friends diagnosed with COVID-19 in the hospital or, if they were at home, we called them to say 'get well soon'." (NM 11). "It was important for them to know that they could contact us 7/24. We visited the clinics. We visited the employees when they had a break." (NM 12).	"It cannot be said that we established good communication; we only saw them once at the beginning and once at the end of the process." (N4). "For example, I got sick. The head nurse and the deputy head nurse called me". (N3). "Our managers regularly visited us and asked about our needs." (N6).
	Nurse–Nurse	"Thanks to the various communication channels, nurses could quickly make very good decisions about what they would do." (NM 13).	"As clinic nurses, we did not have any trouble. We always supported each other." (12). "Everyone was so exhausted and worn out that no one could tolerate and respect each other". (N2).
	Nurse–Patient/Patient Relative	"The patients were very panicked and afraid of death or not seeing their family again. They unavoidably reflected their concerns onto the healthcare personnel." (NM 4). "Conflicts were experienced, especially with patients and patient relatives. Our culture also brings some factors with it; we tell people that visiting was not allowed but 10 people come to visit." (NM 5).	"Patients were shouting, kicking the doors, trying to escape". (N3). "Doors were locked since COVID-positive patients were not allowed to walk in the corridor, climb the stairs, etc." (N4).
	Nurse–Other Healthcare Personnel	"Physicians did not want to constantly wear and take off the personal protective equipment. They tried to make nurses do most of the work. This caused conflicts." (NM 8). "Especially surgery branch doctors did not want to go near the patients. Nurses were always complaining about not being able to contact the doctors." (NM 11).	"We were good about approaching the patients as a team; no serious problems existed concerning healthcare personnel". (N11). "For example, some doctors never came to see the patients. We constantly communicated with them via the Internet, using applications such as WhatsApp". (N5).
Training	In-Service Training	"Attempts were made to provide training during this process, but they were not very effective." (NM 4). "Our infection unit provided us with training, and we trained the nurses; and thus, the training was spread." (NM 2). "We provided training about intensive care nursing since each nurse should have the capacity to provide services in intensive care units." (NM 5).	"We were provided with training; the products we would use were introduced: how to wear and take off the suit, what to do and definitely not to do while approaching the patient, how frequently we will change the clothing, what procedures to be carried out when in contact, which products will we use to disinfect our hands..." (N1). "We received short 'crash' training." (N4).
	Training of Personnel Who Changed Institution/Unit	"We assigned some of the senior group in the intensive care unit and they first trained each new group." (NM 5). "The nurses assigned in the COVID unit came from different units. The isolation rules, equipment, etc. were introduced once again to them." (NM 13).	"Actually, the institution to which we went had prepared for this process well in advance. They welcomed us with a half-day training program." (N8). "The fact that operating room nurses were assigned in the intensive care unit or clinics caused difficulties in adaptation and patient care." (N9).
	Training of the Newly Appointed Personnel	"This process emerged when new nurses were appointed, and we had to train many new nurses." (NM 2). "We both shortened and updated the orientation training." (NM 14).	"New and inexperienced nurses were sent to the clinic for support without any training or information, which made my work more difficult." (N12). "I both provided care for the patients and taught the job to the personnel who did not know it." (N2). "We were newly appointed and started the job in a rush without sufficient training." (N13).
Working Conditions/Environment	Increase in Workload	"We wanted a companion to stay with the patient to reduce the nurses' workload" (NM 2). "Nurses in private hospitals were appointed by the Ministry and quit their jobs. The workload of those who remained in private hospitals increased considerably." (NM 9).	"While normally we should provide care for two patients in the tertiary level under the intensive care unit, we provided care for eight patients on our own." (N2). "We experienced a shortage of personnel when the number of patients increased very rapidly." (N1). "The number of supporting personnel was insufficient." (N4). "We provided care for patients at a ratio of one nurse per 16 patients in the clinic." (N14).
	Working Hours and Leave/Medical Reports	"Many employees were on administrative leave. Those who were pregnant, those with chronic diseases; we always worked with insufficient numbers of personnel; we had difficulty giving time off." (NM 1) "We arranged nurses' working hours as they wanted, they worked in a 24-hour shift and took two or three days off afterwards, and thus they thought that they contacted the patient less often." (NM 2).	"We worked in 24-hour shifts for seven or eight times a month, and we worked once every three to four days." (N9) "While some people were on administrative leave or had medical reports, some people were working in the protective equipment for hours, sweating, and getting sick, yet without taking time off." (N7)
	Assignments	"The Ministry of Health closed some branch hospitals. And assigned the nurses working in these hospitals in pandemic hospitals." (NM 5) "We closed the units such as operating rooms and outpatient services and assigned the nurses working in these units to the pandemic services and intensive care units." (NM 14)	"Our strength was self-devotion; no one said, 'You assigned me there, but I will not go there'. Most people obeyed this rule." (N14) "We were working in a physiotherapy hospital. All patients were very rapidly discharged, and we were assigned to COVID hospitals." (N4)
	Protective Equipment	"The senior managers in the hospital gave the equipment by counting them because they could not see ahead but my nurse teammates conflicted with me as they thought I did not give them the equipment." (NM 6). "As everyone, we also were concerned about finding/not finding the material." (NM 14) "As in hospitals, during the early stages, i.e. first months of the pandemic, insufficient equipment was a great problem for us, too." (NM 4)	"Separate uniforms were arranged for us to use in the hospital. Visors and goggles were provided." (N1) "It was such a difficult process in that equipment… When I took off the equipment, my uniform was completely wet from sweating due to the rush." (N2) "We did not have a second mask or a second apron during a 16-hour shift." (N3)
	Resilience	"We withdrew our friends with chronic diseases from those fields as of the first week." (NM 3) "Our friends were provided with accommodation opportunities because the worst concerns were 'I worry about carrying this disease to home, to my child, mother, father, or spouse.'" (NM 9) "Of course I felt that I was not supported during that process; like while you support everyone, there is no one to support you." (NM 5) "With the help of our psychologist, some online support programs were created for the employees regarding psychological relief or coping with stress." (NM 7)	"Those who could not go to their family or who had a family member with a chronic disease stayed in hotels for a while, and necessary catering was provided to them." (N5) "Recreational areas were restricted. Common rest areas were restricted. Some of our friends were smoking, and the area in the garden allocated for them was removed." (N6) "Since we were used to such difficult working conditions, maybe this process was not challenging for us in that regard compared with other countries." (N3)

Theme 2: Training

The participants' statements regarding the second main theme, training, were evaluated under three subthemes: (1) in-service training, (2) training of the personnel who changed their institution/unit, and (3) training of newly appointed personnel.

In-service training

Both nurses and nurse managers stated that the shorter and faster in-service training reduced its educational effectiveness.

"Attempts were made to provide trainings during

this process, but they were not very effective." (NM 4).

"We received a short 'crash' training." (N4).

Training of the personnel who changed their institution/unit

Managers stated that additional training was required for those nurses. Thus, a few nurses reported that they received short training, while some started working without training.

"We assigned some of the senior group in the intensive care unit and they first trained each new group." (NM 5).

"The fact that operating room nurses were assigned in the intensive care unit or clinics caused difficulties in adaptation and patient care." (N9).

Training of newly appointed personnel

Both managers and nurses stated that the shortened training programs provided were not sufficient for the orientation of the newly recruited nurses.

"This process emerged when new nurses were appointed, and we had to train many new nurses." (NM 2).

"We were newly appointed and started the job in a rush without sufficient training." (N13).

Theme 3: Working conditions/environment

The statements made by nurse managers and nurses regarding the main theme of working conditions/environment were categorized under the following subthemes: (1) increase in workload, (2) working hours and leave/ medical reports, (3) assignments, (4) protective equipment, and (5) resilience

Increase in workload

While the nurse managers working in private hospitals stated that the appointments made to the Ministry of Health from other hospitals (especially from private hospitals) increased their workload, several administrators highlighted that patients' relatives stayed with the patients to reduce their workload. The nurses said that they looked after many patients.

"We wanted a companion to stay with the patient to reduce the nurses' workload" (NM 2).

"We provided care for patients at a ratio of one nurse per 16 patients in the clinic." (N14).

Working hours and leave/medical reports

New working hour regulations have been implemented to minimize the risk of transmission. In addition, pregnant nurses and those with chronic conditions were allowed a leave of absence.

"Many employees were on administrative leave. Those who were pregnant, those with chronic diseases; we always worked with insufficient numbers of personnel; we had difficulty giving time off." (NM 1)

"We worked in 24-hour shifts for seven or eight times a month, and we worked once every three to four days." (N9)

Assignments

Some hospital units were closed, and a pandemic service was provided. Nurses working in the closed units/institutions were assigned to these pandemic clinics.

"The Ministry of Health closed some branch hospitals. And assigned the nurses working in these hospitals in pandemic hospitals." (NM 5)

"Our strength was self-devotion; no one said, 'You assigned me there, but I will not go there'. Most people obeyed this rule." (N14)

Personal protective equipment

Participants talked about the difficulties in

accessing personal protective equipment at the beginning of the epidemic and the effects of working with this equipment.

"As everyone, we also were concerned about finding/not finding the material." (NM 14)

"It was such a difficult process in that equipment… When I took off the equipment, my uniform was completely wet from sweating due to the rush." (N2)

Resilience

Many participants stated that they could not go home because they were exposed to the virus in the work environment and were worried about the health of their family members. In addition, various measures were taken to ensure social distancing in hospitals.

"We withdrew our friends with chronic diseases from those fields as of the first week." (NM 3)

"Those who could not go to their family or who had a family member with a chronic disease stayed in hotels for a while, and necessary catering was provided to them." (N5)

DISCUSSION

It became very important to understand the experiences of nurses, who worked under extraordinary conditions and increased workloads, and their managers during the pandemic to provide improvement for further crises. Therefore, qualitative studies concerning the effects of the pandemic on the health workforce have mainly focused on the front-line experiences of health professionals (Catania et al., 2021; Gao et al., 2020; Liu et al., 2020), since the beginning of the COVID-19 pandemic. Different from the previous ones, this study made it possible to understand how nurse managers managed the pandemic process; three main themes emerged: (1) Communication, (2) Training, and (3) Working Conditions/ Environment.

Communication

Healthcare services managers should make action plans to meet the increasing demand for healthcare services. When these action plans are not made correctly, they are perceived as problems, negatively affecting communication. This study found that the arrangement of the shifts affected the communication between the nurses and nurse managers (Gan, 2019). Arrangement of humanitarian shifts that allow nurses' needs to be met will strengthen communication between nurse managers and the nurses on the front line in the fight against the pandemic. Feelings of trust and commitment will increase when nurse managers come together with nurses and visit the clinics regularly. In this study, the participating nurse managers said they frequently visited clinics and also kept communication open via online platforms. The participating nurses supported the nurse managers with their statements.

The COVID-19 pandemic revealed the importance of teamwork and communication in hospitals to respond to the rapid changes and many complications. Therefore, nurses' efficacious evaluation and patient monitoring, rapid recognition of clinical deterioration, and strong team communication are significant factors in preventing potential complications (Liu et al., 2020). Most of the team members working on COVID-19 services came from different clinics (especially from operating rooms, polyclinics, etc.), and some came from other institutions through assignment. Nurses reported that they found it challenging to communicate and collaborate with new team members when working together. Although working with people with different clinical experiences and from other institutions, differences may be observed between different institutional cultures, procedures, and

instructions, nurses have stated that they solved this problem in a short time to be able to work efficiently (García-Martín et al., 2020; Liu et al., 2020). A study reported that those who worked in COVID-19 services did not communicate as they feared infecting those working in the clean units. However, they were careful about the isolation and protection methods used (Thakur & Jain, 2020).

Beside challenges related to establishing good communication within acutely created healthcare teams, nurses also had difficulty establishing good relationships with their patients during the pandemic (Liu et al., 2020). This study similarly indicated that the nurses complained about the patients and patient relatives because they did not follow the rules, which caused and increased communication problems.

Training

The first COVID-19 case in Türkiye was seen four months later than China. The measures taken in the countries that fought against the rapidly spreading virus, the changes in their health systems, and their guides regarding patient care constituted an example for Türkiye. This time gap ensured a faster adaptation and improved the nature of preparations in Türkiye's Ministry of Health and health institutions compared to other countries. Nurses are among the healthcare personnel working on the front line in the fight against the COVID-19 pandemic. Therefore, the training need of nurses has become one of the most critical problems requiring management.

Thus, the nurses reported that in-service trainings were carried out by providing information. Some supervisor nurses indicated that they tried to ensure nurses followed the diagnosis and treatment instructions by sharing COVID-19 guides updated by the Turkish Ministry of Health. A previous study reported that nurses in China benefited from previous clinical experiences and the news in the press concerning other countries' experiences (Liu et al., 2020). Some of the nurses assigned to the units where patients were diagnosed with COVID-19 had yet to gain experience in intensive care units or providing care for critical patients. The participating nurses indicated that orientation training was short and insufficient. The same study reported that nurse managers tried to increase the competence of the nurses who came from different services and had no experience with infectious diseases by sending them training videos and materials (Liu et al., 2020). The present study highlighted that less experienced nurses in COVID-19 services who were newly designated and/or came from a different service/institution should work with professional nurses to ensure patient safety and quality of care. The participating nurses reported that new nurses had to start to provide care for patients without sufficient orientation training. A study conducted with less-experienced nurses also noted that they had started their duties without proper orientation training (Gao et al., 2020, García-Martín et al., 2020). Considering those points, nurse managers should ensure that nurses are trained promptly to enable sufficient workflow implementation. Furthermore, they should mitigate their workload by supporting nurses with little or no experience through effective training programs (Hofmeyer, Taylor & Kennedy, 2020; Rosen, 2015).

Working conditions/environment

Health systems are under tremendous pressure globally, and nurse managers should address this emergency problem, rapidly assess it in terms of nursing care, and make changes in practice. Providing care for COVID-19 patients is more complex than caring for routine patients. Moreover, the number of nurses is insufficient; therefore, it is reported that the workload has increased in the COVID-19 services compared

to the workloads demanded on routine days and that this increase in the nurses' workload, as well as patient morbidity and mortality as a result of the pandemic, can cause job stress (Lin, Huang & Lu, 2013; Liu et al., 2020). Therefore, among the significant problems concerning the nurses' workforce distribution are working hours and shift arrangements (Gao et al., 2020). In Türkiye, daily shifts are arranged as three eight-hour shifts, two 12-hour shifts, or two shifts, the first from 8 a.m. to 4 p.m. and the second from 8 p.m. to 8 p.m. On the other hand, some hospitals adopted a 24-hour shift arrangement in COVID-19 intensive care units and inpatient services to reduce the contact time due to the low number of nurses during the COVID-19 pandemic. However, a study reported that nurses who worked ≥ 12 hours overtime experienced higher mental and physical fatigue, resulting in lower patient safety and nursing care quality (Griffiths et al., 2014). Considering this fact, nurses' shift hours and overtime should be well arranged to reduce nurses' workload and contact time in COVID-19 services. Thus, nurse managers should evaluate nurses according to specific criteria, such as their professional education levels, field/clinical experience (intensive care, emergency, inpatient clinic, operating room, etc.), position, age, length of service, competence, and having a chronic disease, and should use the existing workforce efficiently. Issuing a circular, the Turkish Ministry of Health reported that all private and public hospitals with tertiary intensive care units were assigned as pandemic hospitals and would only admit patients infected with COVID-19 (Turkish Medical Association, 2020). In this regard, it was reported that hospitals' general administrations arranged their physical structure, closed the units such as operating rooms, outpatient clinics, and polyclinics, and assigned the personnel working in these units to other units for support.

Nursing-services administration is responsible for appropriately positioning the nursing workforce, increasing labour productivity, and ensuring the quality of care. Assigning employees to new units, implementing new protocols and technologies, and changing the working conditions are among the hospital managers' roles regarding human resources management (Liu et al., 2020).

Most of the participating nurses indicated difficulties working with personal protective equipment. The present study and an international study highlighted that nurses had to postpone their need to go to the toilet and did not drink beverages for long hours to prevent the wastage of protective equipment (Gao et al., 2020; Liu et al., 2020). A study conducted in China also indicated that nurses had to use the materials given to them for extended periods due to the shortage of personal protective equipment during the early stages of the COVID-19 pandemic (Gao et al., 2020). In the study by Gao et al. (2020), nurses stated that long shifts may cause a decrease in the use of personal protective equipment; however, shifts of four hours or less may reduce the spread of the infection. Nurses reported that they sweated while wearing the personal protective equipment and that their uniforms got wet but that they could not change them before their shift ended. Liu et al. (2020) also indicated similar statements by nurses in their study.

In the present study, the nurses' perception of personal protective equipment was that it needed to be improved or of better quality. It is considered that hospital administrations chose to use personal protective equipment economically as they saw the news and posts about material shortages around the world during the pandemic and tried to use the existing material in minimum quantities and with maximum efficiency. The ICN (February 2020) highlighted that personal protective equipment

did not seem to reach nurses and other healthcare personnel in China and that there is an urgent need for further information about the current status and provision of personal protective equipment (International Council of Nursing, 2020). In a study conducted in Brazil (Geremia et al., 2020), nurses indicated difficulties obtaining personal protective equipment, which was distributed under control to ensure that they had been used economically. The present study also showed that nurses frequently reported various negative situations about the proper and correct use of personal protective equipment based on the existing stock. Studies conducted in other countries report information about the lack, insufficiency, and improper use of personal protective equipment, highlighting that this caused many nurses to become infected (Catania et al.,2021; Gao et al., 2020; Liu et al., 2020).

Nurse managers are expected to play a role in supporting the clinic nurses who experience anxiety and stress in cases of emergency in nursing services in addition to their managerial roles that require organizational and workforce planning (Huang et al., 2019; World Health Organization, 2021). It is recommended that nurse managers carefully review the existing shift models to guarantee nursing care quality and patient safety during this process and analyze their effects on the physical state of nurses (Stimpfel, Fatehi & Kovner, 2020). During the early stage of the pandemic, nurse managers did not consider the personal needs of the nurses while planning the shifts. However, they were expected to notice that an exhausted workforce negatively affects patients and organizational outcomes (Taylor et al., 2018). In such cases, the arrangement of flexible working hours and shifts that meet the needs of the nurses will help ensure nurses' work-life balance while also helping to motivate them. Providing employees with a place to stay, childcare, transportation and breaks to rest and eat meals, as well as reducing contact with COVID-19 patients during the pandemic, will reduce nurses' fear of infecting their family members. Since nurses spend more time with patients than other disciplines and work in close contact with them, their risk of infection is high. This increased their stress. Nurse managers should address this sudden change and make arrangements to provide nurses with psychological support to help them manage their concerns, fear, and sadness (Rosa, Schlak & Rushton, 2020). A study reported that nurses working during the COVID-19 pandemic stayed in the public housing of the hospital and were provided with complimentary meals by the hospital (Ohta, Matsuzaki & Itamochi, 2020). Such social support is also considered to provide nurses with psychological support. In the present study, nurses and nurse managers indicated that social support, such as accommodation, nutrition, and transportation, was provided. In addition, some nurse managers stated that they offered psychological support.

Limitations

The researchers had difficulty contacting the nurses and nurse managers for this study since this research was conducted during the COVID-19 pandemic itself, with heavy workload in the hospitals. In addition, the results of this study cannot be generalized for all nurses and nurse managers due to the characteristics of the qualitative research method used. The study data were based on the self-reporting of participating nurses and nurse managers. Finally, we can consider it a limitation that the participants did not mention their total professional experience.

IMPLICATIONS FOR PRACTICE

Communication, training, and working conditions/working environment were the three main themes of this study. The feelings, ideas,

and views of nurse managers stated under three themes concluded that the working environments of the nurses were negatively affected during the COVID-19 pandemic. They highlighted their experiences most often under obtaining personal protective equipment, working hours and shifts, less experienced nurses, and communication. In addition, some of the participants stated that hospital administrators and nursing services managers provided social and psychological support.

These conclusions may be beneficial for hospital and nursing service managers to improve and prepare the working environments to cope with problems during crises. Nursing services must be ready to respond quickly to epidemics or pandemics and all other natural or unnatural disasters. The points indicated by nurse managers and nurses in this study should be considered for crisis preparedness in hospital settings. One of the points that both groups emphasize is that during the pandemic, some nurse managers continued their duties in close contact with nurses in the clinical area. Nurse managers visiting clinics and being in the clinical area in times of crisis were evaluated positively by nurses. Therefore, it is important for managers to be present in the same environment as nurses to effectively support and lead them in providing patient care. Another point is that the employment of new nurses by the Ministry of Health during the pandemic created relief for the workforce, but also caused problems related to orientation and training. Meeting the adaptation and training needs of new nurses has created new burdens for both nurse managers and nurses who were already tired of working under a heavy workload. New employees who did not receive appropriate orientation training faced various risks, both to themselves and to the patients. This has emerged as a point that senior decision-makers in the health care system or nursing education programmes should pay attention to. Quick decisions and actions taken during a crisis may cause different problems in the field. For this reason, more comprehensive courses on crisis and disaster management should be included in the vocational training process.

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