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NURSING: EXPERIENCES AND WORKING CONDITIONS IN HOSPITAL CARE FOR PEOPLE WITH COVID-19

ENFERMAGEM: EXPERIÊNCIAS E CONDIÇÕES DE TRABALHO NO CUIDADO HOSPITALAR ÀS PESSOAS COM COVID-19

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ABSTRACT: The objective of this study was to understand the experiences and working conditions of Nursing professionals who worked in hospital institutions providing care to individuals with suspected or confirmed COVID-19. This was a qualitative study conducted with 20 Nursing professionals from two hospital institutions in western Paraná, Brazil, using semi-structured interviews and Thematic Content Analysis. The institutions adapted their infrastructure, carried out emergency hiring, and implemented new demands, protocols, and care flows in their services. Nursing professionals experienced several challenges and difficulties, including extended working hours, prolonged use of personal protective equipment, and increased risks to workers' health due to the complexity of procedures and techniques, all while maintaining their commitment to nursing care. It is concluded that these experiences highlight the role of Nursing professionals in caring for individuals with suspected or confirmed COVID-19, which, although shaped by individual particularities, converge toward common and collective vulnerabilities and risks inherent to the pandemic context.
KEYWORDS: COVID-19. Hospitals. Nursing. Nursing Team. Working Conditions.

RESUMO: O objetivo foi conhecer as experiências e as condições de trabalho dos profissionais de Enfermagem que atuaram em instituições hospitalares, no cuidado às pessoas com suspeita ou diagnóstico de COVID-19. Trata-se de uma pesquisa qualitativa, realizada com 20 profissionais de Enfermagem, de duas instituições hospitalares do oeste do Paraná, com uso de entrevista semiestruturada e Análise Temática de Conteúdo. As instituições adequaram a estrutura, realizaram as contratações emergenciais, inseriram novas demandas, protocolos e fluxos de atendimento em serviço. Os profissionais de Enfermagem experienciaram desafios e dificuldades, como jornada extensa de trabalho, manutenção da paramentação por longos períodos, riscos à saúde do trabalhador diante da complexidade dos procedimentos e técnicas, entre outros, no compasso do compromisso com o cuidado de Enfermagem. Conclui-se que as experiências evidenciaram a atuação dos profissionais de Enfermagem no cuidado às pessoas com suspeita ou diagnóstico de COVID-19, particulares a cada indivíduo, mas com resultados que confluem para as fragilidades e os riscos comuns e coletivos.
PALAVRAS-CHAVE: COVID-19. Condições de Trabalho. Enfermagem. Equipe de Enfermagem. Hospitais.

INTRODUCTION

In March 2021, the World Health Organization (WHO) declared a pandemic due to SARS-CoV-2. This was the sixth public health emergency declared by the WHO, preceded by the Influenza A, subtype H1N1 (H1N1) pandemic in 2009; the international spread of poliovirus; and the Ebola outbreak in West Africa, both in 2014; the Zika virus in 2016; and the Ebola outbreak in the Democratic Republic of Congo in 2018[1].

It should be noted that, in the context of the pandemic, countries have adopted biopolitical and disciplinary strategies to deal with the COVID-19 pandemic, such as health promotion and disease prevention practices, with a view to reducing contagion and social protection measures. However, in countries where the health authorities and/or heads of state have hesitated to recognize the seriousness of the pandemic and/or have not drawn up a structured plan capable of promoting the contingency of contagion and the care of the sick in a coordinated manner between the different federal entities, this has resulted in greater difficulty in dealing with the crisis situation[2].

From this perspective, in the scenario of a shortage of diagnostic tests and intensive care beds, the following were essential health promotion actions carried out in the Brazilian context by primary health care: active search for respiratory symptoms, monitoring of confirmed cases in the territory, social isolation and coordination of care[3].

Faced with the SARS-CoV-2 pandemic, health professionals working on the front line, caring for symptomatic people, were more exposed to physical, biological, emotional, and psychological risks. With long working hours and limited supplies to carry out their work safely, there has been increased concern about their health, and physical and emotional integrity[4].

Faced with the pandemic, health professionals have had to face the challenge of caring for people with suspected or diagnosed COVID-19. They were particularly concerned about avoiding contagion during their professional work, given the high possibility of contamination within the scope of their practice[5]. Among these professionals, nursing stands out due to its role in the care process and the significant number of professionals involved in this process[6].

An Iranian study carried out with nurses who provided care during the COVID-19 pandemic highlighted experiences that showed that, despite the fear of the disease and the lack of ideal protection facilities, nursing professionals reported that they worked with devotion, love, a sense of cooperation, altruism and as part of a multi-professional team. However, they lived with loneliness, despair, the search for support, and the death of the patient they were caring for. In the meantime, they lived with the fear of their own contamination and that of their families and related to the worsening of patients and death, experiencing self-blame and feelings of pity. It should be noted that the sudden onset of the pandemic and the unpreparedness of health systems, as well as the lack of specific treatment, caused confusion and difficulties for the nursing team in providing quality care[7].

In the same vein, a South Korean study of nurses who provided direct care to patients diagnosed with COVID-19 found that they recognized their unique roles in caring for patients with COVID-19 and sought new meanings within their profession, in a precarious working environment, which exacerbated the physical and emotional burden and compromised the provision of quality care[8].

To this end, in the care provided to people with COVID-19, nursing working conditions deserve attention: long working hours, overload, physical exhaustion, stress, and low pay, among others. These conditions are already known in the workplace, in some realities, but they have been made more precarious by the stressors characteristic of COVID-19, such as the fear of contamination linked to the imminent risk of death[9]. Experiencing work is particular to each individual/professional, and it is possible, from the confluence of information from more than one, in a common universe, such as the pandemic,

to know a greater whole. In view of the above, the question arises: what were the experiences and working conditions of nursing professionals caring for people suspected or diagnosed with COVID-19 during the pandemic?

The study aimed to learn about the experiences and working conditions of nursing professionals who worked in hospital institutions caring for people with suspected or diagnosed COVID-19.

METHODS

This is a qualitative, descriptive, and exploratory study carried out with twenty nursing professionals at two public hospitals (municipal and state), located in the Western Macro region of Paraná, responsible for caring for people with suspicion or diagnosis of COVID-19.

To begin data collection, contact was made with the nursing directors of each participating hospital, in accordance with the ethical precepts involving research with human beings. The nurse managers provided a list of names and telephone numbers of nursing assistants and nursing technicians who met the study's inclusion criteria, to begin the interviews.

The inclusion criteria were to be a nursing professional working or having worked directly in the care of people with a suspicion or diagnosis of COVID-19 in a hospital. Nursing professionals who were away from work due to illness, vacation, or on leave during the data collection period were excluded.

The indicated professionals were contacted by audio call or in person to explain the aims of the study and how they would participate. Once they had agreed to take part in the study, a day and time were scheduled for the interview, depending on the participant's availability. The first four interviews were part of the pilot, validating the interview script, and were included in the study.

Data collection was carried out by a master's student. The data was obtained through individual interviews, via audio call by telephone, via WhatsApp calling app, or in person. The interviews were guided by a semi-structured questionnaire, which covered aspects relating to the experiences and working conditions of nursing professionals and began with the following question: Comment on your experience of caring for people with suspicion or diagnosis of COVID-19. Talk about the working conditions you experience.

Twenty interviews were carried out until data saturation was reached - 17 took place via audio connection, electronic application, or telephone, and three in person. A total of 25 nursing professionals were invited to take part in the study. Of these, five did not participate because they did not answer the phone or WhatsApp on the day and time scheduled for the interview, and did not respond to subsequent attempts to contact them. This was understood as refusal.

Both in the interviews conducted by app or telephone and in person, we sought to guarantee the participant's privacy. For the interviews conducted by app or telephone, participants were asked to be alone, as was the interviewer. The face-to-face interviews were carried out with professionals from the state public hospital selected for the study, in a teaching room, with the guarantee of privacy.

The average duration of the interviews was approximately one hour. All of them were audio-recorded, transcribed, and then returned to the participants to check the content of the transcript, by sending a file with the full transcript of the interview via the WhatsApp application. The participants did not return any changes to the text of the interview transcripts. Data collection took place from November 2020 to March 2021 and ended when the data began to repeat itself, reaching saturation.

The data was analyzed using the Thematic Content Analysis technique, according to the stages of pre-analysis, exploration of the material, and treatment of the results. In the pre-analysis stage, a floating

reading and re-reading of the data was carried out to identify the nuclei of meaning. In the exploration of the material, coding and categorization operations were carried out. In data processing and interpretation, the researchers interpreted the content of the statements made inferences, and discussed the data in the light of the literature[10].

The study was approved by the Human Research Ethics Committee of the State University of Western Paraná on August 7, 2020, with substantiated opinion No. 4,200,393. The research was conducted following the ethical standards required by the Ministry of Health, according to Resolutions numbers 466/2012, 510/2016, and 580/2018. After agreeing to take part in the research, when the interview was face-to-face, the participants read and signed the Free and Informed Consent Term (FICT); when the interview was by audio connection, acceptance was formalized by voice recording, by reading the FICT. To guarantee anonymity, the participants were identified with the letter P standing for participant, followed by a cardinal number, according to the order of the interview, a letter representing their profession (N for nurse and Nt for nursing technician), and a letter representing their institution ("a" for state and "b" for municipal). Example: P1Na, P2Ntb.

During the research, there were emotional risks for the participants, such as discomfort, embarrassment, fear, shame, stress, and tiredness when answering the questions. However, the researchers tried to minimize these risks by ensuring the confidentiality and privacy of the data, the possibility for the participant to withdraw from taking part in the research at any time or to stop the interview at any time, and by offering support to the participant when necessary. However, the benefits of the research outweighed the risks, since the results can support health actions to minimize and/or eliminate existing weaknesses in the context of practice, contribute to the planning of quality care, with safety for those who care and those who are cared for, as well as producing knowledge to contribute to public health policies.

RESULTS

Among the participants, 10 were nurses and 10 were nursing technicians. The majority (eight) were aged between 25 and 29, were of the female sex (13), and were in a stable union (10). Concerning the length of time they had worked in nursing, 17 had worked for less than ten years. Of these, 16 had been working in the institutions studied for between one and two years and seven had been working for more than 10 months.

After analysis, the empirical material was structured into four categories: structural adjustments and emergency hiring; competencies and duties in service; challenges and consequences of nursing associated with increased workload and failures in work safety; motivation to work and the challenges experienced at work and in personal life.

STRUCTURAL ADJUSTMENTS AND EMERGENCY CONTRACTS

With the onset of the COVID-19 pandemic, there was a need to care for people affected by the disease and, consequently, hospitals were rapidly adapted to provide care for this public. Concerning the organization of health care, environments were created, others were adapted for care, human resources were hired, and care flows were drawn up.

> [...] they made the whole environment, they created several environments [...] that only serve patients with COVID [...], it all was already created with the necessary conditions, it's a negative pressure issue. (P1Na)

> [...] here at the hospital [...] they found the space to open the Emergency Respiratory Service, they organized the ICU. "They did everything necessary to serve the population with COVID-19. (P8Na)

> [...] creation of physical spaces, furniture, service flows, operational logistics, and human resources." (P11Nb)

> [...] A lot of things were "hack" at first, but today we already have a more organized structure. What started out as a "hack" has now become a definitive sector of work. (P12Nb)

The need to meet the growing demand for patients with COVID-19 meant that new health professionals had to be hired on an emergency basis, even if they didn't have the necessary professional qualifications. The insufficient or absent theoretical and practical knowledge of some professionals, as well as the fact that they have little skill and dexterity in carrying out specific procedures for critically ill patients, were not impediments to immediate hiring.

> [...] new employees who had never worked in an ICU [...] many people had to work in the COVID ICU without ever having worked in an ICU, some even without ever having worked in nursing. (P4Nb)

> [...] I only worked in a health unit, then the pandemic hit and I came to work in a hospital and in the ICU. [...] a difficulty is that a lot of us, like me, have never worked with critically ill patients and we end up giving our colleagues more work to do. (P10Na)

Linked to this is the insufficient training of professionals in the proper use of the resources available for nursing care for people with COVID-19, particularly for new hires. As a result, the improvisation and lack of ability of some professionals to carry out procedures inherent to their practice have had a negative impact on nursing care. This condition has resulted in an overload for workers already working in the service, as well as an increased risk of compromising patient and professional safety.

> [...] they created the Respiratory Emergency Department, the ICU, and telemedicine, but often the team didn't know how to use the resources they had, or they didn't know how to do the procedures they needed [...]. (P7Nta)

> [...] many processes were defined at the moment their demands arose. So many things the team didn't know how to do, and they had to improvise. I know it was all new to many, but life was unique. We wouldn't get another chance at that life [...]. (P15Nta)

> Even though there was a structure and a full team on duty, the necessary procedures were often not carried out due to a lack of skill on the part of some professionals. (P6Ntb)

> [...] many procedures I had never carried out before and I had to overcome my fear, that feeling of: will I be able to do it, will it work? (P2Nb)

> [...] on duty, I saw technicians, doctors, and nurses performing the procedure for the first time in their lives. It had to work! (P12Nb)

SKILLS AND DUTIES ON THE JOB

New demands have been incorporated into the routine of nursing professionals, such as new protocols and flows of care for people diagnosed with or suspected of having COVID-19. It was possible to identify multiple duties for nurses working in services that provide care for people with this disease. Above all, these professionals had to reconcile providing direct care to critically ill patients and managing the COVID-19 unit. The competence of caring, linked to the new work dynamics, proved to be impaired.

> [...] Every day, the experience of caring for these patients is new. New demands, new protocols, new flows [...] every shift, I have to learn or update a lot of what I thought I knew how to do [...]. (P8Na)

> I do everything on duty. I fill in forms, make reports, manage the team, assist the patient with any complications, and assist the doctors [...]. (P11Nb)

> I guide and supervise the technicians and provide patient care. In the case of COVID patients, we have a high demand for respiratory care [...], they are intubated patients with high dependency. (P14Na)

> [...] I don't know if I pay attention to on-call management or patient care. [...] there are so many protocols, scales, systems to fill in, evolutions. When there's a death on duty, it's even worse. There's so much paperwork to fill in about the death, notify, and prepare the body. (P8Na)

> [...] in the case of COVID-19 patients, sometimes we don't have enough time to notice them. [...] we get so lost in the processes that our care, as nurses, is impaired. [...] when a patient of mine died, without me even going to the bedside, I realized that something was wrong [...]. (P17Nb)

In the development of professional competencies and attributions, situations such as the loss of a patient to COVID-19, the limitations of professionals faced with a new disease, without consolidated treatments at the time, the fine line between the process of becoming ill and death have broadened the view of the other, of what previously seemed alien. Revisiting the importance of life and living consequently led to behavioral changes among nursing professionals, probably due to the perception of finitude - the fine line between life and death or the incapacity of the human being. This favored looking at oneself - for oneself, the other - for the other.

> In my experience of caring for patients with COVID-19, loss, disability, the process of becoming ill and death have been present at all times. Learning to deal with these situations on an almost daily basis has made me a new professional. A new vision of being human. A new perception of others and identification with what seemed alien to me. (P13Ntb)

> [...] as a person I have reviewed the importance of valuing life, and so my attitudes and behavior have changed a lot on a daily basis. (P16Nb)

CHALLENGES AND CONSEQUENCES OF DRESSING ASSOCIATED WITH INCREASED LOAD AND FAILURES IN OCCUPATIONAL SAFETY

The professionals pointed out the physical and physiological discomforts inherent in caring for patients with suspected or diagnosed COVID-19, mainly related to the use of Personal Protective Equipment (PPEs), such as restricted mobility during procedures, inhibition of physiological needs (elimination, hydration, food, and rest) and feeling hot. Above all, due to the time spent wearing this equipment on twelve-hour shifts. Working in a closed environment, for long hours, in uniform, led to tiredness, exhaustion, and physical and emotional pressure.

> [...] I had a hard time adapting to working in a closed environment with all that clothing. Spending many hours in that apron, mask, feet protection, and cap isn't easy. (P13Ntb)

> [...] I found it very difficult to stay dressed. Look, those clothes make you very hot, they also limit you, they stop you, for example, from drinking water, having dinner, resting. (P15Nta)

> [...] there are twelve-hour shifts where I only go out once. Then I get tired, very tired. Imagine spending ten or eleven hours in those clothes and not being able to go to the toilet. It's bad, you know? (P9Nta)

> [...] it's exhausting, tiring, and there's a lot of pressure when it comes to taking care to use the equipment, which for me was the worst of all. Working like that, with all those clothes, all that stuff, that was the worst thing for me. (P4Nb)

Due to the high transmissibility of SARS-CoV-2, professionals were aware of the risks to which they were exposed and the impossibility of being free from the risk of contamination during their care. They worked knowing the risks they were taking, while at the same time having poor working conditions. Although caring for the other, in this case, may seem contradictory to caring for oneself, on the other hand, it shows a high degree of sensitivity towards this other, who, at the time, seemed doomed to die.

> [...] with COVID patients, procedures become more complex due to the high risk of infection. The most difficult thing for me is when bathing and when we have to put the patient face down [prone position]. (P7Nta)

> [...] any and all procedures become much more complex, as there is a high risk of contamination [...].(P17Teb)

As for the PPE, the professionals said that the institutions provided it, but in varying quantity and/or quality. Sometimes they were insufficient for several changes during 12-hour working days. During these working hours, there is a need for more than one change, which is not always possible. Regarding the quality of the PPE, they reported that it was variable, sometimes good quality products, sometimes inferior, without standardization.

> [...] Nobody feels 100% safe to be there, for fear of contracting the disease, but I believe that 90% of the PPE was adequate for what we need to work in a COVID-19 unit." (P3Nb)

> The quality is very different at times. I've worked with very good PPE, but also with some very poor PPE. It depends a lot on the batch, how it's obtained and the quantity purchased. (P11Nb)

> Quality varies. It depends a lot on the manufacturer and the batch. I've worked with PPE of very poor quality and other PPE of excellent quality [...]. (P12Nb)

> [...] there were times when they were restricted [...] sometimes we had a certain amount for a 12-hour shift. So, we had to make the ones who were there work. (P17Na)

> [...] On every shift, I had the PPE I needed [...], we often had to ration it, use it very consciously [...]. (P16Nb)

> [...] once in a while, we received inferior quality [...].(P13Ntb)

Due to the variable amount of PPE, professionals mention their restricted or rational use during care. They described the efforts made to maintain safety when caring for people with COVID-19, linked to the need to save on materials. Above all, these efforts involved not meeting physiological needs such as fluid intake, eating, or elimination.

> I've even spent more than seven hours without taking off my PPE so I wouldn't have to wear another one. Imagine that! Seven hours without eating, drinking, or going to the toilet. It was too exhausting. (P14Na)

> [...] sometimes, there may be enough for the whole shift, but then we use them more sparingly. I've even spent eight hours in the department, without even going to the toilet, so I wouldn't have to change my PPE. (P6Ntb)

> [...] sometimes we were forced to stay all night with only two new items of PPE, which meant we had to spend six to eight hours in the ICU, without being able to drink water, eat or go to the toilet. But it wasn't always." (P15Ntb)

> [...] I've been asked to use PPE conscientiously. Now to use them conscientiously is to use them little and using them little is synonymous with spending many hours in the ward. (P17Tea)

Physical, psychological, and emotional strain on nursing professionals was identified concerning caring for people during the pandemic. The tension and pressure involved in caring for people in critical condition, with an unstable and unpredictable clinical picture, had a significant emotional impact, particularly in the face of each death.

> [...] a machine, no matter how powerful, cannot work at high speed continuously. [...] here in this sector, we don't switch off. It's hours of intense tension and pressure, which exhausts us physically and mentally. (P12Na)

> COVID patients [...] die very quickly and that has an impact. Like, the patient is here and two days later they're dead. [...] it's discouraging to keep looking after the next ones." (P10Na)

> [...] in general, COVID patients are very unstable, there's no way we can have an exact diagnosis, it varies from day to day. [...] not all professionals manage to have the psychological and emotional balance to continue working. [...] it's a lot [...] in the last few months and days, my biggest difficulty is working with tiredness. I get very tired [...]. I go home and come back to work still tired. (P1Na)

> I don't have the courage to do anything else. I leave the shift and all I want to do is sleep. If possible, I sleep until it's time to go back on duty again [...]. (P6Nb)

MOTIVATION TO WORK AND THE CHALLENGES EXPERIENCED AT WORK AND IN PERSONAL LIFE

The professionals' motivation for working in a COVID-19 unit caring for people with the disease was based on their choice and commitment to the profession, their desire to help, and to see and believe in people's recovery. A search for meaning on the part of the professional at work, in a period of health emergency. A manifestation and commitment to life and to caring for others. Even though they were exhausted, they were willing to provide care, especially when they saw the recovery of some patients who were able to return home.

> [...] we take an oath to look after patients, to look after their lives, so we have to be there to look after them [...]. I think that's my greatest motivation, to contribute to improving the care being provided [...]. (P1Na)

> [...] I like being there to help people with my work. It's great to be able to see some people recover. Seeing them go home. (P8Na)

> [...] when I saw my first patient being discharged, I started to believe in the process. I realized that what I was doing there was not in vain. It was having an effect. (P11Nb)

The nursing professionals who worked on the front line, caring for people with a suspicion or diagnosis of COVID-19, reported having experienced a double confrontation. The first, at work, in the performance of their duties in caring for those affected by COVID-19. The second, at home, in the relationship with the family, who feared contamination by SARS-CoV-2. Some families, although fearful, supported the professionals. Others opposed their work.

> My family is against it, but it's my profession [...]. It seemed like a sentence that they and I would get COVID too. I had a lot of difficulties at home. For months, there were two battles I had to face: one at work and the other at home [...] I could see their prejudice. (P11Nb)

> I live with my parents and two brothers. Look, they're supportive, but very afraid, very careful when I'm at home. I once said to my mother: I feel like the virus itself here at home. (P17Ntb)

> My uncle got COVID, so all they said was that I passed it on to him. We live on the same plot of land, he went everywhere, often without a mask, but even so, when he got sick it was my fault. (P8Na)

> I had a hard time, it felt like I had COVID. It was hard at first, they wanted to separate everything from me at home. I still live with my parents, so it was worse [...]. (P6Tea)

Social isolation by nursing professionals was used as a measure to prevent the spread of COVID-19, if they became infected while performing their work duties. Moving house and staying isolated from social contact or family members was a prerogative to keep working in the care of patients affected by SARS-CoV-2.

> Look, many people told me to quit my job. They said I was looking for a disease, that I was going to bring something home. They said so much that I tried to leave home and live separately [...]. (P15Nta)

> I had to leave home and live alone. I was very afraid of contaminating them. I might not have been the transmitter, but I would have been weighed down and I know they would have looked at me sideways too. Today, I only talk to them by video call [...]. (P16Nb)

> I had to move out because my family had no peace. They were afraid of catching COVID with me. So I left, [...] it seemed like I was the one who was hospitalized with COVID. (P10Ea)

The professionals opted for social isolation out of respect and love for their loved ones (elderly parents, spouses, and children), and because they knew they were afraid of the risk of infection. Above all, it was possible to see the important commitment of these professionals to nursing care and the care of their own family members - the care of others.

DISCUSSION

A Brazilian study found that the majority of professionals who worked in the care of people with COVID-19 were young women, with an average of one decade of training and work in nursing, and less than one year of work in a COVID-19 unit[11]. As for sex, historically women have predominated in nursing. However, it should be noted that in recent years there has been an increase in the number of men in this profession, especially in urgent and emergency sectors[12]. These sectors receive adults in critical health conditions, which justifies the presence of a significant proportion of males in COVID-19 units.

The need to receive and provide care for people with COVID-19 has led health services to organize their care, which has changed, as well as introducing new workflows and procedures. This has culminated in the need to improve institutional structures and for professionals to acquire new skills[13].

Regarding the structural, personnel, and care flow adjustments made by health institutions, it can be seen that normative-legal acts have been created, and actions have been formalized to expand and make better use of the installed capacity of existing institutions to care for COVID-19 cases[14]. In addition, new care protocols were needed in an attempt to reduce and control the spread of the virus within institutions[15].

The urgency of hiring workers to meet the need for nursing care for victims of the pandemic made the hiring process deficient, as the new professionals were hired without being properly integrated into the service routines and protocols of the institutions under study, as well as adequate health education and training for those hired to care for people with COVID-19[16].

As far as hiring is concerned, it has been pointed out that length of service may indicate that individuals who have been working in the profession for longer when compared to those who have only recently joined, have more knowledge and familiarity with the routines of the service, and better understanding and assimilation of their roles and responsibilities[12]. Therefore, a longer time on the job increases professionals' ability to carry out procedures and techniques, avoiding improvisation and a negative impact on care.

An incipient safety culture and organizational culture can have consequences for patient safety and professional practice[17]. Thus, in addition to compromising patient safety and exposing professionals

to a greater risk of contamination, the quality of care provided has also been compromised, with a high potential for harm to people hospitalized with COVID-19[16].

It is believed that in-service education and training programs for SARS-CoV-2 infection control, promoted regularly by health institutions, are necessary for the health and safety of workers, to reduce the risk of transmission of the virus to patients and other health professionals who interact in the service[18].

The concomitant combination of nursing, care, and management skills[19] can lead to stressful experiences at work, linked to an overload of activities[20], particularly when it involves caring for critically ill patients diagnosed with COVID-19. Stressful experiences make nursing professionals ill, which in turn compromises the quality of care and patient safety[20].

Because of the difficulties pointed out, the high workload, the demand for emotional control and the constant risk of contamination have required health professionals to pay a high physical and psychological price to care for people affected by COVID-19, due to the commitment they have made to their profession[21]. In addition, the fear experienced by professionals of being carriers and possible transmitters of the disease raises the level of stress, particularly due to the condition of asymptomatic transmission[22]. In this sense, there is concern about protecting oneself and others, particularly family members and those close to them[11].

Nursing professionals working on the front line during the pandemic, who received care to ensure their mental health, confirmed the presence of work-related fear and exhaustion, as well as anxiety, sadness, stress, depression, and post-traumatic stress disorder, among others[22].

Psychological interventions and emotional support are appropriate for professionals who experience physical and psychological symptoms because of caring for people infected or potentially infected by COVID-19[22]. When faced with complex or risky situations, professionals need to develop psychological resilience to maintain their mental health. This is a dynamic process that seeks to adapt to stressful situations in an attempt to overcome them[23].

Professional safety is a non-negotiable aspect of the entire care process. The responsible and correct use of PPEs is a measure to prevent and control the transmission of SARS-CoV-2[24]. With the onset of the pandemic, the impact on the provision of care has been notable. The new PPE, while protecting, also imposed restrictions on professionals, causing physical discomfort by reducing mobility and inhibiting the satisfaction of physiological needs[25].

Regarding the quality of the PPEs, although there is a consensus on standardization between national and international bodies, such as the Centers for Disease Control and Prevention, Occupational Safety and Health Administration, National Institute for Occupational Safety and Health, the World Health Organization (WHO) and the Ministry of Health[9], there is variation in the quality of the materials provided by hospitals. This fact increases the insecurity of nursing professionals when caring for people with COVID-19.

The quality of essential materials for preventing and dealing with the disease has an impact on the safety of health care and work, a condition also faced by other countries that demand a fair and sufficient allocation of health resources, given the imbalance between supply and demand for health services during the pandemic[26].

When you count the number of people treated by the pandemic, you immediately notice a significant increase in the amount of PPE needed to care for them. In this sense, to optimize their use, institutional protocols were created, sometimes without scientific evidence or support from international organizations, such as the reuse of N95 masks, a condition that did not value workers' health, but rather cost reduction, putting workers' health at risk[9].

In this study, the complexity of the care provided to patients with COVID-19 by nurses is notorious, as is the risk of exposure to contamination. However, despite being at the forefront of tackling

COVID-19, there are still obstacles to professional recognition. To highlight the profession, the WHO, through the State of the World's Nursing 2020, ran the Nursing Now campaign[1].

Although the social motto shared among professionals was "we're all in this together, let's get through it together" - a motivation to care inherent to the profession - the care provided to people with suspicion or diagnosis of COVID-19 resulted in individual impacts, as the risks, burdens, and experiences were experienced in particular[25].

Dealing with the prospect of finitude on a daily basis was a dilemma faced by professionals, which led health workers to turn their attention to their own process of living, while scholars sought to save humanity from the process of living together[27].

Social isolation was necessary as a measure to combat the spread of the virus. However, isolation from the family was mainly a reality for health professionals. In addition, professionals faced social prejudice, as people close to them or their families distanced themselves from contact with those working on the front line[28]. Therefore, caring for the victims of the pandemic was more than just loyalty to the professional oath, it was also a personal challenge when there was a need to make choices between living with those you love and caring for people with a suspicion or diagnosis of COVID-19.

This challenging reality has led to reflections on the work involved in combating the spread of COVID-19 and the consequent distancing from the family, thus accentuating the emotional strain. It is believed that this prerogative has exponentially accentuated the discontinuity of health professionals' contact with their families during the pandemic[29].

IMPLICATIONS FOR PRACTICE

The results of this research can be used to formulate health policies, maximizing the preparedness of the health system in the face of future similar pandemic crises. Understanding the experiences and working conditions experienced by nurses during the COVID-19 crisis in the Brazilian context allows managers to plan physical and human resources for safer care, and emotional and psychological support for professionals who provide care in pandemic contexts.

FINAL CONSIDERATIONS

The study highlighted the role of nursing professionals in caring for people with suspected or diagnosed COVID-19, resulting from individual experiences, but with results that converge on common and collective weaknesses and risks.

The challenges faced by nursing professionals in caring for people with suspected or diagnosed COVID-19 were greater than expected in their profession. A professional team made up mostly of women of reproductive age had its workforce exhaustively required to implement the new behaviors and processes arising from the care provided to people with COVID-19. This has had a direct impact on the daily lives of these professionals, provoking reflection on the prospect of finitude in the process of living.

It is recommended that, to provide care that is free from harm to the patient and that does not involve recklessness, negligence, or malpractice, it is necessary to have solid, specialized professional training that is underpinned by permanent education for professionals, as well as providing adequate working and care conditions for professionals who care for others.

The results discussed here are relevant to the improvement of nursing training, fundamentally concerning the ongoing education of professionals in service, with a view to guaranteeing patient and

professional safety. The latter includes the importance of managing material resources, such as PPE, in adequate quality and quantity, to ensure the safety, health, and well-being of nursing workers. The mental health of these professionals must be preserved and cared for. To this end, it is recommended to offer psychological assistance to workers in conditions of greater emotional stress, such as during the pandemic.

The study was limited to interviewing nursing professionals from two hospitals in two municipalities that are reference points for patients with suspected or diagnosed COVID-19 in the western region of Paraná, each of which serves one of the five health regions that make up the macro-region. The fact that many professionals, during the research period, were exposed to two or even three working days, may justify their refusal to participate in the study.

REFERENCES

1. World Health Organization (WHO). State of the world's nursing 2020: investing in education, jobs and leadership. Geneva, WHO, 2020. Disponível em: https://apps.who.int/iris/bitstream/handle/10665/331677/9789240003279-eng.pdf?sequence=1&isAllowed=y.
2. Rocha CMF, Mattioni FC, Lena MS, Vieira LA, Brochier LSB. Promoção da saúde ante a pandemia de covid-19: análise das estratégias utilizadas em países selecionados. Disponível em: https://www.conass.org.br/biblioteca/wp-content/uploads/2021/02/L6-cap4.pdf
3. Silva NM, Bastos RM, Conceição VRC, Bastos ASC, Sales GS, Silva TN. Promoção da saúde no Brasil na pandemia por COVID-19: concepções e práticas em atenção básica. Saúde coletiva.2020;10(58):4022-25. https://doi.org/10.36489/saudecoletiva.2020v10i58p4021-4030
4. Hankivsky O, Kapilashrami A. Beyond sex and gender analysis: an intersectional view of the COVID-19 pandemic outbreak and response. PolicyBrief, Londres, 2020:1-5.Disponível em: https://www.qmul.ac.uk/media/global-policy-institute/Policy-brief-COVID-19-and-intersectionality.pdf
5. Dias MO, Souza NVDO, Penna LHG, Gallasch CH. Perception of nursing leadership on the fight against the precarious ness of working conditions. RevEscEnferm USP. 2019;53(e0349):1-8.https://doi.org/10.1590/S1980-220X2018025503492
6. Santana LL, Sarquis LMM, Miranda FMA. Psychosocial risks and the health of health workers: reflections on brazilian labor reform. RevBrasEnferm. 2020;73(Suppl 1e20190092):1-5.http://dx.doi.org/10.1590/0034-7167-2019-0092
7. Khademi Z, Imani E. Frontline Nurses' Experiences of Patient Care in the COVID-19 Pandemic: A Phenomenological Study. J Caring Sci. 2023, 12(1), 42-49. http://dx.doi.org/10.34172/jcs.2023.30327
8. Lee JY, Lee S, Choi H, Geum E. Exploring the experiences of frontline nurses caring for patients with COVID-19. Int Nurs Rev, 2023, 70, 50–58. http://dx.doi.org/10.1111/inr.12801
9. Miranda FMA, Santana L DE L, Pizzolato AC,Sarquis LMM. Working conditions and the impact on the health of the nursing professionals in the context of covid-19.Cogitareenferm. 2020;25(e72702):1-8. http://dx.doi.org/10.5380/ce.v25i0.
10. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14 ed. São Paulo: Hucitec; 2014.
11. Góes FGB, Silva ACSS, Santos AST, Pereira-Ávila FMV, Silva LJD, Silva LFD, et al. Challenges faced by pediatric nursing workers in the face of the COVID-19 pandemic. RevLatAm. Enferm. 2020;28(e3367):1-9. http://dx.doi.org/10.1590/1518-8345.4550.3367
12. Silva MCND, Machado MH. Health and Work System: challenges for the Nursing in Brazil. Cien Saude Colet. 2020;25(1):7-13. https://doi.org/10.1590/1413-81232020251.27572019
13. Sabatino J, Moscatelli S, Rustamova Y, Kotlar I, Avesani M, Brida M, et al.Women's perspective on the COVID-19 pandemic: Walking into a post-peak phase.Int J Cardiol.2021;323:29-33. https://doi.org/10.1016/j.ijcard.2020.08.025
14. Duarte MJA, Santos TBS, Andrade LRD, Pinto ICDM. Delineamentos normativos da contingência hospitalar no enfrentamento da COVID-19 no Brasil. Cadernos do CEAS Revista crítica de

humanidades. 2021;246(252):18-48. https://doi.org/10.25247/2447-861X.2021.n252.p18-48
15. Jorge A, Costa MA, Couto VR. Os desafios para manejo da pandemia da COVID-19 em um hospital de Belo Horizonte e sua relação com a APS. APS em Revista. 2021;3(1):24–31. https://doi.org/10.14295/aps.v3i1.143
16. Backes MTS, Higashi GDC, Damiani PDR, Mendes JS, Sampaio LS, SoaresGL.Working conditions of Nursing professionals in coping with the COVID-19 pandemic. Rev GauchaEnferm. 2021;42(spee20200339):1-8. https://doi.org/10.1590/1983-1447.2021.20200339
17. Silva LCD, CaldasCP,Fassarella CS, Souza PS. Efecto de la cultura organizativa para la seguridad del paciente en el entorno hospitalario: revisión sistemática. Aquichan. 2021;21(2:e2123):1-16. https://doi.org/10.5294/aqui.2021.21.2.3
18. Modi PD, Nair G, Uppe A, Modi J, Tuppekar B, Gharpure AS, Langade D. COVID-19 awareness among healthcare students and professionals in Mumbai metropolitan region: A questionnaire-based survey. Cureus. 2020;12(4:e7514):1-18.https://doi.org/10.7759/cureus.7514
19. Treviso P, Peres SC, Silca ADD, Santos AAD. Competências do enfermeiro na gestão do cuidado**.** Rev. Adm. Saude.2017;17(69):1-15.http://dx.doi.org/10.23973/ras.69.59
20. Dantas HLDL, Santos JMSD, Santos KLAD, Nagliate PDC, Comassetto I, Lúcio IML. Relationship between Burnout in nurses and patient safety: integrative review. RSD. 2021;10(8:e35110815932). https://doi.org/10.33448/rsd-v10i8.15932
21. Pfefferbaum B, North CS.Mental health and the COVID-19 pandemic. N Engl J Med.2020;383:510-512.https://doi.org/10.1056/NEJMp2008017
22. Chew NWS, Lee GKH, Tan BYQ, Jing M, Goh Y, Ngiam NJH, et al. A multinational, multicentre study on the psychological outcomes and associated physical symptoms amongst healthcare workers during COVID-19 outbreak. BrainBehav Immun.2020;88:559-565.https://doi.org/10.1016/j.bbi.2020.04.049
23. Souza DPR, Figueiredo DSTO, Andrade LL, Nogueira MF, Santos NCCB, Andrade LDF. Assistance and management in the context of the Family Health Strategy from the perspective of the nursing assistants. RevEnferm Atenção Saúde. 2021;10(2):1-11, 2021.https://doi.org/10.18554/reas.v10i2.4545
24. Marques LC, Lucca DC, Alves EO, Fernandes GCM, Nascimento KC. COVID-19: nursing care for safety in the mobile pre-hospital service**.** Texto context enferm. 2020;29(e20200119):1-12. https://doi.org/10.1590/1980-265X-TCE-2020-0119
25. Parreira ST, Ribeiro G, Coelho J, Borges L. Nursing care in times of pandemic: A Hospital Reality. Gaz Med. 2020;7(2):165-170, 2020. Disponível em: https://www.gazetamedica.pt/index.php/gazeta/article/view/335
26. Emanuel EJ, Persad G, Upshur R, Thome B, Parker M, Glickman A. et al. Fair allocation of scarce medical resources in the time of COVID-19. N Engl J Med. 2020;382:2049-55, 2020. https://doi.org/10.1056/NEJMsb2005114
27. Nohama N, Silva JF, Silva DPS. COVID-19 bioethical challenges and conflicts: global health context. Rev. Bioét. 2020;28(4):1-10.https://doi.org/10.1590/198380422020284421
28. Paula ACR, Carletto AGD, Lopes D, Ferreira JC, Tonini NS, Trecossi SPC. Reações e sentimentos dos profissionais de saúde no cuidado de pacientes hospitalizados com suspeita de COVID-19. RevGauchaEnferm. 2021;42(spee20200160):1-7.https://doi.org/10.1590/1983- 1447.2021.20200160
29. Tavares CQ. Dimensões do cuidado na perspectiva da espiritualidade durante a pandemia pelo novo coronavírus (COVID-19). J Health NPEPS**.**2020;5(1):1-4. http://dx.doi.org/10.30681/252610104517