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RESEARCH ARTICLE

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Frontline nurses' experiences of working in a COVID-19 ward–A qualitative study

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Abstract

Aim: To explore how nurses experienced working in a newly organized COVID-19 ward with high-risk patients during a new and unknown pandemic.

Design: A qualitative explorative study using a phenomenological-hermeneutic approach.

Methods: Semi-structured individual telephone interviews were conducted in June–July 2020 with 23 nurses working in COVID-19 wards from three regional hospitals in Denmark. The nurses had been transferred from other departments at their hospital to the newly organized COVID-19 wards. Data analysis was influenced by Paul Ricoeur's theory of narrative and interpretation, including three analytical levels: naïve reading, structural analysis and critical interpretation and discussion.

Results: During the structural analysis four themes were generated: (a) Challenging and uncertain situation, but also a positive experience (b) Professional and personal development (c) Lack of nurses' rights during a pandemic (d) Reward in itself or a desire for financial reward.

KEYWORDS

Coronavirus outbreak, interviews, pandemic, phenomenological-hermeneutic, qualitative approach, Ricoeur

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1 | INTRODUCTION

In December 2019, the novel COVID-19 (Coronavirus disease 2019) caused the first cluster of patients with severe pneumonia of unknown cause. The outbreak of COVID-19 was reported in South China and had possible links to Wuhan's Seafood City market in China (Zhu et al., 2020). In Wuhan, the novel COVID-19 placed nursing services under pressure because thousands of people were infected with an unknown but potentially fatal respiratory infection (Catton, 2020). Coronaviruses belong to a large respiratory virus family that causes diseases ranging from a common cold to the Middle East respiratory syndrome (MERS) and severe acute respiratory syndrome (SARS) (Wood, 2020). The newly identified COVID-19 is a highly contagious disease with symptoms such as fever, tiredness, fatigue, dry cough, dyspnoea, lymphopenia and pneumonia (Huang et al., 2020). In March 2020, WHO characterized COVID-19 as a pandemic as it caused infections amongst people in all parts of the world (WHO, 2020b). As of April 2020, COVID-19 became a global health problem, with more than 1.1 million confirmed cases in 208 countries and a total of almost 63,000 deaths (WHO, 2020a). By the end of February 2020, the first COVID-19 case was confirmed in Denmark (Danish Patient Safety Authority, 2020). In March 2020, the Danish government closed restaurants, shopping centres, schools and universities, and people were told to work from home where possible (Danish government, 2020). Based on experiences from China and Italy during the initial COVID-19 outbreak, the Danish healthcare system had to prepare for a substantial number of COVID-19 patients who would require hospital admission. Consequently, there was a need for fast and comprehensive organizational changes within the Danish healthcare system, and within a short timeframe, new wards for patients with COVID-19 were established. Planned operations were postponed, and nurses were transferred from other wards and outpatient clinics to the new COVID-19 wards. The managers and staff members at these newly established COVID-19 wards were needed to cope with a totally new and unpredictable situation. This study focuses on how frontline nurses experienced the relocation and to work at a newly established COVID-19 ward.

2 | BACKGROUND

COVID-19 is a virus that is easily transmitted between persons, and therefore, it has become a severe threat to public health worldwide (Jernigan, 2020). In the first half of 2020, no effective therapy or vaccination had been developed to treat or prevent this new infection (Wood, 2020). In epidemics like this, nurses and other health professionals are on the frontline in the fight against the disease (Eghbali et al., 2020).

Previous research has shown that during the MERS outbreak in Saudi Arabia, healthcare providers had negative attitudes towards the infection, which may have had a negative impact on how they handled suspected or infected patients (Nour et al., 2015). A study showed that during the MERS outbreak in South Korea in 2015, nurses experienced burnout because of the heavy workload, and concerns about their safety and becoming infected (Kang et al., 2018). Unclear and frequently altered guidelines resulted in confusion and fear, creating a need for a supportive work environment for those caring for suspected or infected patients (Kang et al., 2018; Kim, 2018). During the MERS outbreak in South Korea, some nurses were keen to work in infection wards because they sought new challenges, but many were dissuaded by family members (Kim, 2018). These South Korean nurses demonstrated a high level of responsibility in caring for patients with a dangerous virus, and they considered this work to be unavoidable (Kim, 2018). These nurses felt that they were growing as nurses and saw themselves as stronger after they had shown they could overcome extreme situations; however, they expressed disappointment when their efforts were not adequately rewarded (Kim, 2018). A study from the Ebola outbreak in Central Africa revealed the exceptional commitment nurses exhibited to the nursing profession working in a context where their lives were endangered (Hewlett & Hewlett, 2005).

The International Council of Nursing (ICN) emphasizes the importance of nurses to keep themselves as safe as possible through their actions as well as their use of personal protective equipment (Catton, 2020). Giving care during the COVID-19 outbreak has been associated with an occupational risk, and nurses were putting their lives at risk in their duties (Catton, 2020). Nurses and other health professionals working with COVID-19 patients had to face new work routines, new colleagues, new managers and a new disease, they had never heard about just a few months earlier. There is still limited knowledge about how nurses experience working in a COVID-19 ward, which is important for similar future scenarios. Therefore, this study aimed to explore how nurses experienced working in a newly organized COVID-19 ward with high-risk patients during a new and unknown pandemic. Our research question to guide the study was: How do nurses experience working in a COVID-19 ward with high-risk patients during a new and unknown pandemic?

3 | THE STUDY

3.1 | Design

The study had a qualitative explorative design and took a phenomenological-hermeneutic approach influenced by the French philosopher Paul Ricoeur's theory of narrative and interpretation (Pedersen, 2005; Ricoeur, 1976). According to Ricoeur, a narrative is more than a story, it is an interpretation of how the individual experience the past, present and future in a meaningful way (Ricoeur, 1987). Furthermore, Ricoeur stated that the hermeneutical, phenomenological understanding of self emerges through narrative and offers new insight into the self (Ricoeur, 1987).

The study used the Consolidated Criteria for Reporting Qualitative Research (COREQ) as the research reporting checklist (Tong et al., 2007).

3.2 | Methods

3.2.1 | Setting and participants

We conducted the study in three regional Danish hospitals, each with approximately 33,000–60,000 inpatients a year and 3,000–5,000 employees. In the light of COVID-19 outbreak, the three hospitals each established a COVID-19 ward and an additional short training programme for transferred health professionals. Nurses and other health professionals were recruited from other wards and outpatient clinics within each hospital, representing different medical and surgical specialities. Therefore, the nurses recruited to the newly established COVID-19 wards had very different professional backgrounds. All nurses had to work in an unfamiliar ward with new colleagues and new managers, and some were even required to move geographically to a different hospital. Without an option to decline, health professionals were assigned to become part of the new COVID-19 contingency and workforce.

The decision on the number of participants needed was guided by *information power* in order to reach the study's aim (Malterud et al., 2016). A purposeful sampling with a maximum variation of the participants was used in order to explore variations that had emerged in the different hospitals (Patton, 2002). We sampled for maximum variation concerning age, the number of years of nursing experience, and type of previous hospital department. The inclusion criterion was nurses who had worked in one of the newly established COVID-19 wards. No exclusion criteria were imposed. The sampling frame was a list of all nurses who had worked in one of the three newly established COVID-19 wards during the first wave of the pandemic. The nurse managers from the three COVID-19 wards acted as gatekeepers and appointed the nurses eligible for the study based on the criteria of maximum variation. After receiving a list of appointed nurses, the research group sent them an invitation to participate through their work email. The managers were not informed about who responded to the invitations.

Out of approximately 200 eligible Registered Nurses, 36 were invited to participate, seven did not reply, and six declined. Twenty-three nurses were included from the three participating hospitals (A = 8, B = 7, C = 8). The participants came from various departments at the hospitals before being transferred to work in the COVID-19 ward. All participants were females, mean age 41 (26–54) years, and were educated as a nurse for mean 13 (0.5–27) years.

3.2.2 | Data collection

Data were obtained through individual telephone interviews in June–July 2020. The respondents stayed in different places during the interviews. Some were at work at the hospital but stayed in a quiet and undisturbed room, others were at home or in their car. A semi-structured interview guide with open-ended questions was developed based on one focus group interview with four nurses working with COVID-19 patients, observations performed by two nurses from one of the hospitals during the process of establishing the COVID-19 ward, and the literature (Chou et al., 2010; Corley et al., 2010; Kang et al., 2018). The semi-structured interview guide was developed with open-ended main questions for each theme and also with some associated prompt questions to get the themes illuminated from different angles. However, the open-ended questions ensured that the participants had the opportunity to narrate what was the most important to them. During the interviews, we were open to change the sequence and forms of questions in order to further explore the nurses' narratives (Brinkmann & Kvale, 2021). The interviews concerned how the nurses, in general, experienced working in a newly established COVID-19 ward and how it affected their professional identity and work-life balance. An example interview question was "Please, tell me how did you experience working in a newly established COVID-19 ward?" (For more information see Appendix S1). The interviewers (KS, BTR, JP) encompassed two nurses and one with social science background and all were experienced in qualitative research. The interviewers conducted the interviews with the nurses from the three hospitals at random. None of the interviewers knew any of the participants in advance. After the first interviews, the interviewers discussed the interview guide and it was altered to align the interview style and unify the interviews' content. The interviews lasted mean 53 (28–72) minutes, were audio-recorded and transcribed verbatim.

3.2.3 | Data analysis

The software programme NVivo 12 (Alphasoft) was used to systematize data, which was done by two authors (KS, BTR). The data were analysed based on Paul Ricoeur's theory of narrative and interpretation, consisting of three analytical levels: naïve reading, structural analysis and critical interpretation and discussion (Ricoeur, 1976). In the naïve reading, the text was read several times with an open-minded approach to get an initial impression and overall understanding of what the text was about. At this initial level, an understanding was achieved by how the text affected the researchers. Impressions were formulated in writing, and initial identification of the content was defined (Pedersen, 2005; Ricoeur, 1976). During the structural analysis (Table 1), the units of meaning were described (what is said), the units of meaning were reflected upon in relation to the naïve reading and units of significance (what the text speaks about) were formulated (Lindseth & Norberg, 2004; Pedersen, 2005; Ricoeur, 1976). Finally, in the structural analysis, the themes were generated. The themes were described and then discussed by the entire research group (all authors) until consensus was achieved. In Table 1, the arrows illustrate the structural analysis's dialectic process, which means that the analysis and interpretation moved back and forth between understanding and explanation (Pedersen, 2005; Ricoeur, 1976). In the critical interpretation and discussion, the themes were further interpreted and discussed in relation with relevant theory and research. In the analysis, all data were treated as one text, and therefore, the whole interview was treated as a narrative. According to Ricoeur, during the analysis, the author (the nurse) distracts from the text and also from the situation and the original context (Ricoeur, 1973).

TABLE 1 An example of structural analysis

Units of meaning "what is said"	Units of significance "what the text speaks about"	Themes
"You should be rewarded as a nurse for putting an extra effort into this; because it was also a risky job … it is, so Florence Nightingale like. We would really like to help, you just feel that you are not rewarded for it … we would like something other than a box of chocolate for the coffee and thanks for the good treatment" (A8)	Nurses were prepared to take on a risky job and put in an extra effort. However, they could feel a type of injustice	Reward in itself or a desire for financial reward

3.2.4 | Ethical considerations

Interview participants received verbal and written information about the study before written informed consent was obtained. It was stated that participation was voluntary, and study participants had the right to withdraw from the study up until the data were analysed. The Board of Directors at each hospital approved the study and permitted interviewing participants during working hours. An email was sent to the Regional Committees on Health Research Ethics to ask whether the study needed formal approval. According to Danish law, approval was not required (S-20202000, no. 90). Storage and management of data were registered under the Danish Data Protection Agency (Journal No: 20/18090). The study fulfilled the European General Data Protection Regulations (GDPR) and Danish data protection law.

4 | RESULTS

The naïve reading showed that the nurses experienced working with COVID-19 patients as hard and challenging but also as a positive experience.

Four themes were identified during the structural analysis: (a) Challenging and uncertain situation but also a positive experience (b) Professional and personal development (c) Lack of nurses' rights during a pandemic (d) Reward in itself or a desire for financial reward.

In the following, the themes are described and illustrated by quotations. The quotations are marked with A, B and C, which refers to the three hospitals, and the numbers 1–8 which refers to the nurses from each hospital.

4.1 | Challenging and uncertain situation, but also a positive experience

Working as a nurse on the frontline in a COVID-19 ward could be challenging:

> "I felt it (working in a COVID-19 ward) was hard, and it drained me of energy" (B5), and "It (working in a COVID-19 ward) has been extremely challenging" (A4)

Nurses felt pressured in their new job when caring for critically ill patients with new colleagues in a professional area they did not know in advance. This could lead to a feeling of uncertainty amongst nurses. In addition, there were many unknown factors when working in a COVID-19 ward:

> "The uncertainty of what I would be met with (in the ward) today" (B5), and "I was scared that I would be put in a situation that I couldn't handle, that my professional competences wouldn't be adequate" (C3)

Fear of inadequacy when nursing COVID-19 patients occurred, mainly when transferred nurses came from entirely different job functions such as an outpatient clinic. This could give nurses a feeling of being insufficiently qualified to care for and treat COVID-19 patients. Furthermore, the study revealed that this uncertainty was at its worst right after transfer:

> "Before we started, I sat on my sofa and cried all weekend, because I was scared that my skills were inadequate. And it turns out that I need not have (been so upset)" (C2), and "To start with, I was worried about being infected with Corona" (B5)

After the nurses learned how to protect themselves and had cared for the COVID-19 patients for some time, they were less afraid of the

Coronavirus and how to care for the patients. Uncertainty could also occur about the personal protective equipment:

> I think that the guidelines changed all the time in relation to the availability of personal protective equipment (C2)

It provided an unsafe working environment when guidelines for what kind of personal protective equipment to use depended more on availability than what was required for optimal protection.

Before the nurses started to work in a COVID-19 ward, it was difficult for them to know what to expect.

> The only thing we really knew was what we had seen in the pictures from Italy. This scared all of us (B5)

As the COVID-19 was an unknown disease, nurses' knowledge about COVID-19 and the work they had committed themselves to came primarily from the news. The media mainly showed pictures from hospitals in Italy highlighting lack of control, patients lying in corridors, and many patients succumbing to COVID-19. In this way, the Danish media had a considerable influence on the nurses' approach to their work and the quotation indicates that it caused stress and anxiety. Working in Danish COVID-19 wards was not experienced that stressful:

> To start working in the COVID-19 ward was really good, you find out that it's okay and that you can actually manage (A1)

Being present in the wards working with the COVID-19 patients made it less dramatic than what they had seen in the news. Nurses' work in the COVID-19 wards made a difference and it contributed to a feeling of satisfaction.

> It was an exciting challenge to be part of history-in-the-making (C6)

Despite working under stressful conditions, nurses felt they were part of something bigger.

4.2 | Professional and personal development

The work in a COVID-19 ward could bring a sense of development as it was said:

> "Overall, it was a really good experience that I could take with me in the future" (C1), and "I have a good feeling, when I look back, I am proud of myself. And I think I achieved a lot" (A4)

Nurses felt that working in a COVID-19 ward had strengthened them professionally and personally. They had learned how to care for the very ill COVID-19 patients and found out that they could manage the extreme situation. However, working in a COVID-19 ward affected nurses in different ways:

> I was out of my comfort zone … to be the one who had to ask about everything that's difficult, but I came out strengthened (C4)

Nurses who were experts in other specialities in their departments could find it hard to be novices in the new COVID-19 wards, which could cause a feeling of being threatened. The quotation indicated that these nurses took up the challenges and thus developed professionally. Some nurses took part in a training programme, which gave them a feeling of being prepared for the tasks.

> I felt the training programme prepared me well for the work in the COVID-19 ward. (A6)

Whilst others did not get any training.

> "It was just learning by doing" (B3) and "No, no not at all [no training], no, no. We started from scratch with our past experiences" (B4). Furthermore, "I needed that someone could calm me and explain to me; in this department, we do like this" (B5)

The training programme had a positive effect on feeling prepared whilst lack of training gave a sense of insecurity and unpreparedness.

Some nurses volunteered to work in the COVID-19 wards:

> Until the first day of introduction, I was really upset that I had volunteered … after a few shifts, I discovered that I could (manage the work in a COVID-19 ward). Actually, it was exciting. It gave a great feeling of satisfaction … A large professional and personal development (A1)

Despite finding the decision to volunteer difficult, a feeling of development and satisfaction occurred shortly afterwards. Furthermore,

nurses became more aware of their professionalism and found that their nursing competencies were important in coping with the pandemic:

> "I have become much more conscious of my competencies and value as a nurse" (B7) and "On a personal note, some of my own boundaries were shifted"
>
> (C6)

Nurses felt they were growing during their work in a COVID-19 ward and experienced a strengthened professional identity and self-confidence, resulting in new perspectives in their professional and personal lives.

4.3 | Lack of nurses' rights during a pandemic

As the COVID-19 wards had to be quickly established, some nurses were involuntarily transferred:

> I had to meet up (in the COVID-19 ward) with 24 hours warning, then they changed my employment contract again. Actually, I have no choice, I simply can't accept that
>
> (A4)

Some nurses felt unfairly treated as working with risky COVID-19 patients was imposed upon them, and they felt no rights in their working. Besides, rights were taken away from them:

> "So everything that was labelled planned holidays and days off, everything was cancelled" (C1), and "You don't know your shift roster more than a few days in advance"
>
> (A8)

The uncertainty and last-minute work schedules negatively influenced everyday life contributing to uncertainty about work and time off. In addition, there could be an experience of insecurity about when to return to *normal* employment:

> The most distressing has been the uncertainty about when do I return (to my *own* department)?
>
> (A2)

Other nurses had more positive experiences about the working period:

> I said to her (ward manager) 'use me for three months' it was actually an internal arrangement we made with each other. I was happy with it, it gave me some perspective to see that, this didn't just continue
>
> (A4)

The quotation indicates the significance of knowing how long the work would last and envisaging an end to it. Furthermore, there could be a feeling of not being able to decide one's own life and work situation:

> "She (ward manager) could do what she wanted with us, as there were no rules" (B4), "I felt that I was worth nothing. I was just a piece (of a puzzle), you could be moved around (to another department)" (A4) and "it was a force majeure (extraordinary event) situation"
>
> (B3)

The uncertain situation and loss of rights led to feelings of helplessness and less valuable.

4.4 | Reward in itself or a desire for financial reward

Nurses put great effort into their job on the frontline:

> Colleagues were willing to help out, there was a feeling of solidarity as many offered to take extra shifts if needed
>
> (B3)

Nurses took responsibility for making it work in the ward and ensuring work plans were coherent. They saw it as their duty to help in the crisis. Furthermore, nurses became keenly aware of their value during the COVID-19 outbreak:

> Suddenly, we became key players in the community. It's an awesome feeling when people leave with a "thank you for the good treatment" – that is itself like a salary
>
> (B3)

Nurses were ready to help and contribute to whatever was necessary during the pandemic, and for some nurses, the salary was not a consideration. Other nurses expressed the importance of financial reward:

> You should be rewarded as a nurse for putting an extra effort into this; because it was also a risky job … it's so Florence Nightingale like. We would really like to help, you just feel that you are not rewarded for it

> ... we would like something other than a box of chocolates for the coffee and thanks for the good treatment
> (A8)

Nurses were prepared to take on a risky job and put in an extra effort. However, they could feel a type of injustice:

> ... I simply cannot understand that the extra workload is not worthwhile economically. For me, recognition would be if I had seen it on my pay check
> (A4)

Some nurses felt their rights were unimportant, and as compensation for their effort and flexibility, they would have liked extra payment.

5 | DISCUSSION

The study showed that working as a frontline nurse in a COVID-19 ward caring for critically ill patients was experienced as challenging. Some nurses experienced this situation as uncertain, but their confidence grew as they increased their skills whilst caring for the COVID-19 patients. Nurses developed professionally and personally, which gave them new perspectives. Because nurses felt that the organizations could do whatever they wanted about their working conditions, it brought them into an uncertain situation and it negatively influenced their everyday life. Work schedules were released very late and there was no opportunity to say no. Nurses were willing to make an extra effort during the COVID-19 outbreak. For some, the opportunity to help in a crisis was a reward in itself. Other nurses felt reward in the form of a financial bonus was warranted.

Overall, frontline nurses had positive and unique experiences of working in a COVID-19 ward. At the time of the study, the first wave of the COVID-19 outbreak had passed in Denmark and nurses had come to the realization that they could cope with pressure and uncertainty when caring for these ill COVID-19 patients. Similar results were found in China where nurses reported that they felt happy despite difficult conditions and challenges in the fight against the COVID-19 epidemic (Sun et al., 2020). Furthermore, Kim (2018) showed that nurses overcame extreme situations with a feeling that they were growing as nurses and they considered themselves as stronger than before which is in line with the results from this study.

Professionals who regularly confront threats, trauma, death and disorders are at risk of developing stress and traumatic disorders themselves because these types of jobs place statistically significant demands on empathy and dealing with painful emotions (Høgsted, 2020). In the current study, nurses were under physical and psychological pressure as they experienced direct trauma exposure in being placed as the first line helper (Høgsted, 2020) in the COVID-19 pandemic. Everyone has a breaking point about how much pressure they can handle (Høgsted, 2020). When organizations do not place more pressure and demands on staff members than they can handle, then they can benefit from it professionally, which also brings self-confidence (Høgsted, 2020). The study showed that the organizations did not put too much pressure on the nurses working with COVID-19 patients as the work made nurses feel strong enough to try new challenges in their professional lives. Sun et al. (2020) supported these findings reporting that although nurses found the epidemic prevention work hard, they started to self-reflect, and some nurses strengthened their will, discovered their potential and had increased courage to face life.

Under this critical and uncertain situation, nurses in the study took a great responsibility and felt a professional duty to contribute and offer assistance despite uncertainty about the tasks required. Similar results were found in other health threat situations (Hewlett & Hewlett, 2005; Kim, 2018; Liu et al., 2020; Sun et al., 2020). Kim (2018) showed that nurses considered the task and the responsibility unavoidable when faced with MERS-CoV patients requiring care. Likewise, Hewlet and Hewlet (2005) showed nurses' exceptional commitment to their profession during the Ebola outbreak in Central Africa, despite a context where their lives were endangered. Similar results were identified in two studies from the COVID-19 crisis in China; healthcare providers felt full responsibility for patients' well-being and saw it as a duty (Liu et al., 2020), and nurses showing professional responsibility during the COVID-19 pandemic identified more with their profession than before the pandemic (Sun et al., 2020). The pattern found in these studies from around the world emphasizes that nurses show exceptional commitment and responsibility during these health crises. This can be explained by Scrymgeour et al. (2020), who found that nurses that work in healthcare facilities have a robust sense of professional duty. Nurses show personal obligation and responsibility to patients and the organization, which demonstrates the ability to adapt, cope and respond despite diverse personal, structural and organizational barriers (Scrymgeour et al., 2020).

After the first COVID-19 cases in Denmark, the Danish government took a quick decision to shut the country down in March 2020, which prevented many Danish citizens from being infected with COVID-19 and requiring hospitalization at the same time. Therefore, most Danish hospitals could manage the number of COVID-19 infected patients. However, the newly established COVID-19 wards did not know how many patients to expect. This made the scheduling of work plans complicated and was one of many unknown factors for the nurses and entailed uncertainty. Nurses in the study were required to complete new tasks, their days off were cancelled, working hours were changed, and they were required to be flexible. The study showed that sudden changes in nurses' working lives with fewer rights than usual could result in feelings of being less valuable.

Kim (2018) found that South Korean nurses working during the MERS outbreak were disappointed being inadequately rewarded for their work. The present study revealed a difference in Danish nurses' perception of rewarding. Some nurses considered their job a reward in itself, whilst others felt unfairly treated as they felt they were inadequately rewarded for their efforts. The difference between these perceptions might be explained by Carter (Carter, 2014), who found that nurses are shown to hold highly individual and contradictory

views on motivations to work as a nurse as well as on vocation and altruism in their careers. Altruism is shown to enable nurses to motivate them to sacrifice themselves for the patients and do what is best for them (van der Wath & van Wyk, 2020). However, according to Maslach et al. (2001) lack of adequate reward can lead to burnout and experience of unfairness, and in addition, inequity of workload and pay can lead to burnout (Maslach et al., 2001). Colindres et al. (2018) found in a study amongst 333 nurses that imbalance between effort and reward is a unique incremental predictor of exposure to burnout (Colindres et al., 2018). This means that for some nurses, professional development is satisfying and for others an extra reward is needed in order to create fairness and avoid burnout. Furthermore, a mismatch in the feeling of control is another aspect that influences burnout when the individual experiences a level of responsibility exceeding one's authority (Maslach et al., 2001). Some of the nurses who were assigned to work in the COVID-19 wards did not find they had the competencies to handle critically ill patients. However, the training programme helped some of the nurses to gain more competencies. Others did not get any training and the lack of competencies is another element that could cause the risk of burnout.

5.1 | Strengths and limitations

Strengths of the study include a group of participants of different ages and levels of experience and participants from three different hospitals. A limitation of the study could be the selection of eligible participants by the managers of the COVID-19 wards, who acted as gatekeepers. There is a potential risk that this could lead to selection bias, as the managers may have chosen the most positive nurses to give the best assessment of their ward. Based on the nurses' stories we do not find that this was the case. Another limitation may be the inclusion of only female participants, which is due to the imbalanced distribution of gender in the nursing profession in Denmark, where less than 4% of the nursing workforce are male (Danish Nurses Organization, 2015).

The interviews were performed by telephone in order to prevent the spread of COVID-19. Therefore, the interviewers were not able to see the participants' body language and facial expressions, which could be a limitation. However, this method also proved to have strengths as the participants answered very thoroughly and the method did not seem to be negatively affected by the distance but might have contributed to a feeling of safety.

The results may differ from other countries where the COVID-19 had much more severe consequences on healthcare systems than in Denmark so far.

6 | CONCLUSION

The study showed that frontline nurses at COVID-19 wards experienced their work as challenging and with much uncertainty at the beginning of the COVID-19 outbreak. It seemed as if training programmes in advance could help reduce this uncertainty. This gradually turned to experiences of self-confidence and pride as nurses found they could manage the tasks professionally. Working as frontline nurses strengthened them professionally and increased their awareness of competencies and value as nurses. Furthermore, it developed new perspectives on the nurses' professional and personal lives. Nurses experienced that their rights were unimportant in the crisis, which could lead to a feeling of being less valuable. Nurses were willing to contribute on the frontline during the crisis; however, some nurses would have liked to be rewarded economically for the extra effort, and for others, the job was the reward in itself. However, when experiencing unfairness and inequity of workload and pay can lead to burnout. Therefore, it is important to acknowledge that nurses are different and for some, payment is an essential aspect to avoid burnout.

Based on the study, recommendations for similar future health threats include prioritising the elimination of uncertainty as much as possible by ensuring training prior to engaging in the new tasks, updated and valid information about the disease and the treatment. Furthermore, it is essential that nurses can access their work schedules as quickly as possible in order to respect the nurses' private life. Nurses, as a professional group, are ready to engage and take responsibility. However, it is essential to be aware of the limit for how much pressure a person can manage and offer economical rewards for work in risk areas to avoid burnout.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTION

BRT and KS: Study design, data collection, data analysis, interpretation of the results and responsible for the manuscript drafting. JP: Study design, data collection, interpretation of the results and critical modification for the draft, HIJ, ME, EH and LKB: Study design, interpretation of the results and critical modification for the draft. All authors confirmed the final version for submission.

DATA AVAILABILITY STATEMENT

Due to the nature of this qualitative study, participants did not agree for their data to be shared publicly, therefore, supporting data are not available.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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