ORIGINAL RESEARCH

"It never ends…"–A qualitative study of nurses' experience of caring for hospitalised unvaccinated patients with COVID-19 in Sweden

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ABSTRACT

Introduction: COVID-19 was considered a pandemic as of mid-March 2020 until May 2023. The first vaccine against COVID-19 gained approval at the end of 2020. Overall willingness to be vaccinated is high in Sweden, some people have refused the vaccine. The pandemic caused trauma to nurses around the world due to heavy workloads, deaths in the profession, and employers' failure to prioritise nurses' physical and mental well-being. This, together with hesitation to get vaccinated, might have affected nurses' work. Therefore, it is important to investigate how nurses were affected during the COVID-19 pandemic and their work with unvaccinated patients. The aim was to explore nurses' experience of caring for hospitalised unvaccinated patients with COVID-19.

Methods: A qualitative approach was used to describe nurses' perceptions and experiences. Nine semi-structured interviews were conducted in the spring of 2022. The study was set in two departments of infectious care at tertiary care emergency hospitals in Stockholm, Sweden.

Results: The findings are presented with four themes: A difficult work situation; The strength of colleagues; Dealing with different opinions; and Lessons learned from the pandemic. Each theme has two subthemes.

Conclusions: The nurses were often working under stress during the pandemic, and they showed signs of compassion fatigue, which affected the nurses and, by extension, their unvaccinated patients. For pandemics, epidemics and challenges to come, our findings show that there is a need for mandatory reflection and scenario-based training to increase resilience and competence and to prevent compassion fatigue.

Key Words: Nursing, COVID-19, Unvaccinated, Compassion fatigue, Resilience, Experiences

1. INTRODUCTION

COVID-19 was considered a pandemic as of mid-March 2020, when 114 countries were affected by the virus and approximately 4300 persons had died of the disease. The World Health Organization announced the end of the emergency phase of COVID-19 and the end of the pandemic in May 2023, but the coronavirus disease continues to spread worldwide. Since the first recorded case in 2019, there have been more than 770 million confirmed cases of COVID-19 and over seven million deaths because of the virus. The actual numbers are believed to be higher than the official ones.[1,2] After the introduction of vaccines against COVID-19, mortality among the population decreased.[3]

To prevent and contain the spread of a virus requires knowl-

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edge about its structure and the disease that it is causing.[4] Vaccines today are generally highly effective.[5,6] Immunisation may be deficient at a community level, especially when different strains of the infectious disease flourish within the community and it is still in the early days of a new vaccine.[6] However, after immunisation is complete, the risk of serious illness and death decreases.[7] The first vaccine against COVID-19 gained approval at the end of December 2020. As of the end of 2021 there were five approved vaccines against COVID-19 in Sweden.[8] By the end of 2021, the Public Health Agency of Sweden[9] confirmed that more unvaccinated than vaccinated people needed intensive care. The average age of unvaccinated people needing intensive care was 53 years, and for vaccinated people it was 72 years. The average age of unvaccinated people who died of COVID-19 was 78 years and for vaccinated people, 82 years.[9]

Besides immunisation, another action to prevent the spread of disease is to apply a lockdown. Sweden, unlike other countries worldwide, did not do this. Citizens were expected to follow current restrictions and to take care of themselves should they get sick.[10] According to the Public Health Agency,[11] vaccination willingness is high in Sweden, however, some people do not want to be vaccinated because, for example, they perceive COVID-19 as relatively harmless, or they have concerns about side effects or safety of the vaccine. In a study by Ronnerstrand,[12] the majority of the participants had a positive attitude towards the COVID-19 vaccination. Only 4% were planning not to take the vaccine, and this was correlated with distrust in the healthcare system or government.[12] Lockyer et al.[13] suggest that the media and the information that has circulated since the beginning of the pandemic have contributed to confusion and increased distrust within the population. Several people became more inclined to listen to people they trust rather than the official statements from the authorities when they felt overwhelmed by all the information.[13]

Nurses stated that it was a big challenge physically and psychologically to provide care for people with COVID-19 at the beginning of the pandemic.[14–16] According to Sugg et al.,[16] nurses felt that they were unable to provide the same quality of care for patients with COVID-19 as for those with other diseases. In January 2021, the International Council of Nurses[17] concluded that the pandemic had caused trauma to nurses around the world due to heavy workloads, deaths in the profession from COVID-19 and employers' failure to prioritise nurses' physical and mental well-being in the workplace before and during the COVID-19 pandemic. In countries all over the world, the majority of nurses have reported symptoms such as stress, exhaustion, burnout, anxiety and depression. These various components can potentially cause long-term negative effects of COVID-19, including post-traumatic stress disorder.[17]

Vaccine hesitancy and the heavier nursing workload that was experienced worldwide due to COVID-19 have affected nurses' work and working environment in different ways. It is important to further explore how nurses and their working environment were affected during the COVID-19 pandemic. Also, there is a knowledge gap regarding nurses' perceptions of hospitalised unvaccinated patients with COVID-19 and their need for care.

2. METHOD

2.1 Aim

To explore nurses' experience of caring for hospitalised unvaccinated patients with COVID-19.

2.2 Design

According to Polit and Beck[18] and Patton,[19] a qualitative approach is suitable for describing perceptions and experiences around a phenomenon or topic. Therefore, a qualitative method with semi-structured interviews was chosen to describe nurses' experiences.

2.3 Setting

The study was set in two departments of infectious diseases at tertiary care emergency hospitals in Stockholm, Sweden.

2.4 Data collection

Purposeful sampling was used to identify nurses who had experience of the explored phenomenon. The authors contacted the heads of the departments for approval and then presented the study for nurses both orally and in written. Inclusion criteria for the participants were that they (1) were registered nurses and/or postgraduate specialist nurses and (2) had been working at the department of infectious diseases for at least one year. The eligible nurses who were interested in participation contacted the first two authors by email. A total of nine participants were included; seven were registered nurses and two were postgraduate specialist nurses. The participants had graduated from their bachelor programmes during the period 2014 to 2019. All had worked with patients with COVID-19 since the start of the pandemic in 2020. The participants included six women and three men; they were between 25 and 51 years of age, with a median age of 29. All interviews were conducted during the spring of 2022. A pilot interview was conducted to test the interview guide and investigate whether the questions were sufficient and would achieve the purpose of the study. The pilot interview was completed and, as the guide needed no adjustment, the interview was included in the findings.[20] Both authors PV and

FA were present during the pilot interview, and afterwards, each conducted four interviews. All but one of the interviews were held in person; one was held on a digital platform (Zoom). The interviews ranged from 16 to 52 minutes in length; the average length was 29 minutes. The interviews were audio recorded and transcribed verbatim in Swedish. To gather the participants' experiences, the interview guide consisted of questions that gave the nurses opportunities to express both negative and positive experiences, what helped them in different situations and what they might take with them in the future (see Appendix 1).

2.5 Data analysis

The data were inductively analysed through a qualitative content analysis with focus on the latent content of the data. In the present study this involved an analysis and interpretation of the content of the interviews[20,21] resulting in themes that consisted of underlying meanings. The analysis process is described as follows: The recorded interviews were listened to and transcribed verbatim. The transcriptions were read through several times individually by author PV and author FA to gain a deeper understanding of the data. Meaning units were then identified based on questions in the interview guide. Further analysis of meaning units generated codes. The codes were analysed and interpreted and resulted in four themes and eight subthemes as a final result. All authors took part in analysis process by analysing and interpreting the codes and discussing the subthemes and themes until consensus was reached. See Table 1 for an example of the analysis process.

Table 1. An example of the analysis process

Meaning unit	Code	Subtheme	Theme
I think it's important that you maybe air it out with your colleagues, how you feel and then you can actually learn from each other... It's always good to reflect and discuss with your colleagues as well.	Reflect, discuss and learn.	Being able to reflect and evaluate	The strength of colleagues

3. Result

The aim of this study was to describe nurses' experience of caring for hospitalised unvaccinated patients with COVID-19. The findings are presented with illustrative quotes under four main themes – A difficult work situation; The strength of colleagues; Dealing with different opinions; and Lessons learned from the pandemic – plus two subthemes for each theme (see Figure 1).

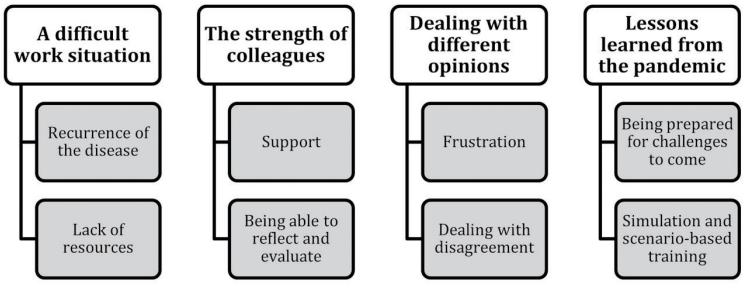

Figure 1. Presentation of themes and subthemes

3.1 A difficult work situation

The first theme portrays how the work environment evolved and changed through the different waves of the pandemic, and the participants' perceptions of it. The subthemes are "Recurrence of the disease" and "Lack of resources".

3.1.1 *Recurrence of the disease*

While participants had varied working situations, all found them to be challenging in different ways. At the beginning of the pandemic, the work tasks were many, intensive and difficult in ways the participants had not experienced before. About a year after the pandemic began, vaccinations were available for the entire adult population, but there was a group of people that did not get vaccinated for different reasons. There was a new wave of patients with COVID-19 entering the departments, and many of them were unvaccinated. This was similar to the first wave, and it was fatiguing.

"There is a sort of frustration in general that it never ends... It feels like we have had mostly unvaccinated [patients] to take care of." -Participant 1

Nurses had worked hard and were striving to provide a high level of care for the patients with COVID-19, working in a solution-oriented manner. After a while, the nurses felt stressed by the unhealthy demands placed on them. After

encountering so many patients who had chosen not to be vaccinated or to otherwise protect themselves and who were now sick and in need of hospital care, the nurses expressed discouragement and exhaustion.

"I could feel such an incredible dullness because it felt like we were getting nowhere." -Participant 6

Nurses were quitting, or were at least thinking about it. New nurses got hired with little or no experience, which affected the personnel group's competence and made the wards unstable. A huge strain was put on the new nurses to provide nursing care for patients.

"Now you're [considered] experienced after six months because you have cared for [patients with] a few crashes." -Participant 7

3.1.2 *Lack of resources*

When a lot of patients with COVID-19 needed care all at once, hospital beds became scarce. Patients had to be prioritised according to harsh criteria based on who had the greatest chance of survival if they were moved to a higher level of care. Some participants indicated that it could feel overwhelming to take care of a patient who was severely ill, or they might feel that the prioritisation was unfair.

"That's not how it's been portrayed for them [the patients]... the lack of care functions would play a role in dying from the disease." -Participant 4

The lack of time during shifts when most patients needed care was exhausting. It was difficult to keep up with the work tasks that were time-consuming and, in the end, nursing for these patients became negatively affected.

"There was never time to slow down because it was full speed all the time." -Participant 5

Besides the large number of patients needing care, another factor contributing to the lack of time was an increase in staff absence, especially at the beginning of the pandemic. Multiple nurses as well as other hospital staff were sick and off work at the same time, which put a huge strain on the remaining personnel. Participants talked about how they and their colleagues needed to work overtime to fill the gaps, but sometimes that still was not enough. To deal with the stress of the heavy workload, some nurses started working part time rather than full time, which further strained the hospital's ability to provide care. The shortage of personnel and the heavy workload meant that less time was available for nurses to talk with the patients and their relatives. In addition to this, because of the visitor bans at the hospitals, the patients' relatives, friends or others of importance to the patients could not visit them. Sometimes nurses did not have time to talk with patients about their treatment, their understanding of the situation, or their psychological well-being. Sometimes there was a need to explain more or argue with the person in need of care about their treatment because, for various reasons, they did not understand.

"And above all, something I have missed... that there were no resources for counselling. Because these patients really needed to talk. And there was no time for that, at all." -Participant 4

3.2 The strength of colleagues

The second main theme is about a valued but fragile resource: colleagues. The subthemes are "Support" and "Being able to reflect and evaluate".

3.2.1 *Support*

Collegial cooperation is an important factor in making patient care and other nursing work easier. The ability to reflect, talk and find support in each other was of great value during the pandemic, both for the participants and their colleagues.

"You don't think about everything and it is good to have colleagues that think differently and can share their point of view." - Participant 2

Support from colleagues made the workload easier to handle, which generated stability and safety. When a feeling of insecurity about work or an uncertain situation arose, the nurses could talk with their colleagues and develop resilience over time. Knowing that they were in the same situation together made them feel less alone.

"We talked with each other and we knew that we were going through this together. I don't think that I... felt alone during the pandemic." -Participant 6

3.2.2 *Being able to reflect and evaluate*

At the start of the pandemic, there were more resources and high competence among the colleagues. As mentioned, nurses quit after a while, which made the working situation harder for those who were left. The level of nursing competence needed to be secured to keep the groups stable and well functioning.

During the pandemic there was a need for the nurses to reflect and discuss what they were going through every day. Group reflection was offered from time to time, and participation was encouraged, but these sessions were often not well attended. This was in part because of a lack of time and energy, but also because some nurses found it difficult to talk about their work situation. On the other hand, participants indicated that they frequently had informal conversations with colleagues in the corridors or during breaks.

"I think that it is important that you talk with colleagues [about] how everything is feeling, because you can learn from each other." -Participant 3

3.3 Dealing with different opinions

The third main theme concerns general frustration about the unvaccinated patients. Subthemes are "Frustration" and "Dealing with disagreement".

3.3.1 *Frustration*

The participants perceived that the overall attitude of hospital personnel was positive towards a vaccination against COVID-19. They observed, however, that the general public's attitude towards vaccination could diverge from the recommendation by the authorities. The nurses stated that it could be frustrating to be confronted with the realisation that some people were choosing not to be vaccinated. At the time, they just did their work, although they did not have enough energy to provide more than the most basic level of care. Nurses might feel frustrated before meeting with unvaccinated patients, since immunisation might have kept them out of the hospital. However, they tried not to show their frustration to the patients. The health care resources were not always enough during this period.

"I feel that no matter what I did, it was never enough." -Participant 6

The participants mentioned feeling frustrated about people who had chosen not to get vaccinated, but it was difficult for them to put it into words. They expressed frustration about their work, and there were many contributing reasons for it. At the same time, they stated that they knew that some patients did not have the opportunity to get vaccinated, or did not dare to get vaccinated. Whereas others did not believe in the vaccine or they did not believe that the disease existed. It was this latter group that was the greater source of frustration.

"[I feel] frustration and irritation that they [patients] do not vaccinate, but live a life where they contribute to the spread of infection." -Participant 2

The participants expressed a concern that discussions about COVID-19 and the vaccine taking place outside the hospital walls were inconsistent and at times incorrect, and yet they were affecting people's decisions and lives. The nurses described feelings of irritation and sometimes sadness that information sources offering no scientific evidence could nevertheless seem credible and influence people's thinking about whether or not to vaccinate against COVID-19.

3.3.2 *Dealing with disagreement*

The phenomenon of patients not taking a vaccine that could prevent them from being severely ill is something that the participants recognised from other infectious diseases, such as tick-borne encephalitis. The phenomenon is known to be challenging in general, but with time and experience it is something that nurses have learned to handle and respond to, partly out of respect for the patients, but also for their own sake as a way to reduce or avoid frustration altogether.

"Clearly there is a certain frustration concerning why they have not chosen to take a vaccine that can save one's life. At the same time, we often meet these types of patients with other types of viral infections." -Participant 3

Patients' vaccination status was usually not discussed with the nurses because it had already been discussed with the physician in charge or with other colleagues. Also, despite their frustrations with all the unvaccinated people now coming to the hospital, the nurses saw no need to express their disagreement with these patients, who were already in a vulnerable state and in need of care. Sometimes the patient chose to explain why they had not been vaccinated without being asked, and the nurse then had a better understanding. In any event, most nurses prioritised their work and did not have long discussions with their patients about their decisions.

"You can be annoyed, but preferably not show it to the patient. Because it should still be health care on equal terms. But in certain situations it is difficult to control oneself, and to not express the irritation and frustration that arises within." -Participant 2

However, there were cases when the patient resisted treatment, either because they lacked confidence in the care or because the oxygen deprivation affected their ability to understand the situation. This was an issue for the participants, and such patients could give rise to irritation and frustration. Despite explanations, the patients would still not understand the gravity of the situation and continuously argue against the need for treatment. That could lead to frustration, when the personnel tried to give the care that the patient clearly needed but were repeatedly resisted. In the long run, this could mean that the care of these patients would suffer in various ways. For example, awareness of the patient's problems was reduced when the nurse-patient relationship suffered because of faulty communication on both parts, which later on could result in the patient not being included in their own plan of treatment.

"There is no [healthcare worker] who has the time, strength and energy to take that argument there and then. Which makes it just such a big frustration and it's hard to care for

such patients." -Participant 4

3.4 Lessons learned from the pandemic

The fourth main theme expresses thoughts regarding the present and the future. The subthemes are "Being prepared for challenges to come" and "Simulation and scenario-based training".

3.4.1 *Being prepared for challenges to come*

The participants described having unprocessed feelings about working in a pandemic and treating patients with COVID-19. They were neither able nor ready to analyse those feelings while in the process of caring for this group of patients. They expressed concerns that their colleagues were in a similar situation. They also professed concerns about their continued work within health care and about what could happen if suppressed feelings and fears about the next potential situation were left undealt with.

"When there has been a period of pause and then it happens again, then I think that these feelings will come back to many people . . . we have no preparation whatsoever for that." -Participant 4

The participants stated the importance of being respectful when meeting with patients in need of care, alongside using the knowledge learned from earlier experiences. They also observed that they had grown more understanding of others – both co-workers and the general public – during the pandemic. They talked about the need to learn from the pandemic experience – to process what had happened and then begin to plan and develop tools and practices with a view to being well prepared for a similar crisis in future.

"And I hope if a similar situation should emerge, that I will always remember not to judge too harshly." -Participant 2

3.4.2 *Simulation and scenario-based training*

The participants emphasised the importance of making time to discuss what has been learned up to now from the pandemic-related experiences while the subject is still relevant. Then, colleagues could work together to compile and design information and training to prepare each other for potential similar situations. Participants emphasised the need for healthcare personnel, even locally at each workplace, to work more preventively by discussing potential infectious diseases and possible disasters that could occur, including those related to conflicts evolving around in the world, and then be able to discuss and reflect on them and create relevant learning opportunities and training. They stated that continuous training – especially simulation and scenario-based training – provides security and increases their competence.

"There is a need for scenario-based training to feel prepared . . . then when it does happen, we will be equipped for the situation." -Participant 7

They pointed out the importance of conversations, reflections and discussions between colleagues and that these sessions further increased knowledge within the profession and at workplaces. There was also a demand for increased opportunities for interprofessional collaboration and interactions for educational purposes. In addition, the participants wished for opportunities to acquire and increase competence with each other's help by exchanging experiences and knowledge in order to better respond to non-evidence-based arguments, both within and outside the workplace.

"As for how we, in our profession, answer non-evidence-based argumentations . . . I think we are in need of more practice on how to discuss this with patients." -Participant 4

4. Discussion

From the early stages and later on during the pandemic, our findings have shown that the nurses were put through a working experience that was somewhat unfamiliar to them. The work conditions and all the different situations that the nurses had endured and witnessed during this period had built up and put pressure on them. The nurses asked for more possibilities to reflect on and evaluate their situation among themselves and with other colleagues. They also asked for more learning opportunities, especially scenario-based training and simulations. These are a few of the main themes in our findings. This study resulted in a great deal of content, organised under the four different themes and their subthemes. The most striking substance of the findings was the unspoken compassion fatigue and that the nurses did not talk with patients about vaccination status.

As our findings have shown, it was at first hard for the participants to distinguish their feelings about the beginning of the pandemic and about patients who had chosen not to get vaccinated and then started coming into the hospitals for inpatient care. In the process of telling their point of view it almost felt necessary for the participants to reflect about the start of the pandemic. After the introduction of the vaccine, the healthcare personnel continued to treat patients with COVID-19. The only difference now was that many of the patients who needed care were unvaccinated. The nurses' frustration and irritation grew because the patients' might have avoided serious illness if they had taken the vaccine.

4.1 Obstacles to conversation

Our findings showed that, from the beginning of the pandemic and again when unvaccinated patients arrived at the departments, it was not possible to give each patient the

time and attention they needed as it would have been before the pandemic. This is due to limited resources and the endless stream of patients that needed the nurses' attention. In addition, our findings mention that relatives, friends or others of importance to the patients were not welcomed to the hospital due to visitor bans during the pandemic. The participants perceived this as trying for the patients, who seemed to need to talk about their situation with someone in order to feel better. When it is not possible for a nurse to exchange information with their patient about their experience, a relationship cannot be built correctly. This is also something that Hugelius, Harada and Marutanis[22] describe – that the consequences of visiting restrictions during the pandemic impacted both healthcare personnel and patients. It disrupted the relationship and trust between patients and the healthcare personnel.[22] This was observed by our participants to be ethically demanding and became a source of stress for the nurses because the patients were perceived as lonely and were isolated while they needed care. Furthermore, even though time was very limited during this period, the healthcare personnel were temporarily replacing patients' family and friends. The consequences of the restrictions may not be fully known and may have continued to affect health care, patients and their loved ones even after the pandemic concluded.

Our findings have shown that vaccination status was a topic that was not explicitly talked about between nurses and patients. The nurses tended to speak of this topic between themselves and share their feelings of irritation, but they tried not to bring these feelings into the patient's room. Sometimes the patient brought up the topic themselves, but because of insufficient or selective communication regarding the subject, it was not mentioned by the nurse. The nurses' irritation was not always the main reason for this; rather, the topic was not discussed to avoid repeating what had already been said elsewhere, or to prevent feelings of shame or defensiveness on the part of the patient. Heyerdahl et al.[23] observe that conflict between unvaccinated and vaccinated is easily triggered. The conflict occurred between healthcare personnel but also between healthcare personnel and patients. The unvaccinated patients tended to avoid the subject to avoid judgement from vaccinated people.[23] This is in line with our findings, that participants expressed sentiment because this perception was often a reason why it was not spoken about for fear of triggering further discomfort. At the same time, the participants stated that when a discussion does not appear to be evidence based, there was a feeling of insecurity about how to respond, for example, to arguments about whether or not to take the vaccine. It is a complex situation that challenged the nurses and their colleagues, both ethically and practically. Berg and Danielson[24] describe how trust can only be built and achieved when both parties are on the same page. Patients who feel disrespected or not cared for feel neglected even if they are given the care they need.[24] Our findings are based on the nurses' perspective of their own and their patients' needs. This study was based on the nurses' experiences; no patients were interviewed, and therefore it is impossible to know how patients felt about not talking about their vaccination status. For some, it may have been a good thing, but others might have felt relieved to talk about it with someone other than the physician. Therefore, when a subject that may be central for the patient is not spoken about, the relationship – or worse, the patient – could suffer. This is a subject that needs to be further investigated.

4.2 Compassion fatigue

Our findings show that the participants had a difficult work situation on different levels and had concerns for themselves and also their colleagues. Irritation towards patients and their unvaccinated status might be a bit of an unusual reaction, as patients have been known to reject other disease-preventing vaccines, yet the same irritation does not occur. A point of view according to our findings as to why irritation occurred in this case is that the nurses were overwhelmed and exhausted from the prolonged stress, and the heavy workload did not let up. This irritation that the participants expressed has also been shown in other studies. For example, Caspi et al.[25] found that vaccine hesitancy affected the healthcare personnel's perceptions negatively, which could affect patient care negatively. The participants in our study asked themselves whether the quality of care given to unvaccinated patients was at the same level as that for vaccinated patients. They tried to give equal care, but they might not always have succeeded.

What happens when nurses have no compassion left to give, and how does it affect their work? According to International Council of Nurses,[26] nurses carry personal responsibility to provide ethical and competent nursing care. They demonstrate values such as justice, respect, responsiveness, empathy and compassion. Nurses support and respect the dignity and universal rights of patients, colleagues and families. Nurses should also value their own dignity, well-being and health; to achieve this requires positive practice environments.[26] As Coetzee and Klopper[27] describe it, it is necessary to be able to use oneself to aid, reduce or remove the pain a patient feels.[27] To have compassion – to care and to show empathy – is a central ethical value in nursing. When a nurse feels that they lack any of those ethical values, a feeling of failure can occur because it is a fundamental part of being a nurse. Our findings show that the personal responsibility described by

International Council of Nurses[26] may have been negatively affected, largely because of the strained work situation that occurred before vaccination was available. This could affect the quality of patient care, whether it is intentional or not. But it is something that the participants needed to mention. According to Gustafsson and Hemberg,[28] compassion is an empathic gift and central in nursing, and it is often a personal trait. But when difficult situations arise, the outcome might lead to compassion fatigue.[28] The participants did not use the expression "compassion fatigue", but it describes their experience. Signs of this can include an inability to aid, weariness, inability to share suffering, irritability, loss of strength, apathy or burnout.[27] The complexity of this situation is that, to be able to work as a nurse, it is necessary to provide aid and share suffering; to be unable to show the patients compassion is unethical.

Another aspect that the participants did not explicitly bring up in the interviews but that could have a bearing on the findings is their age and their years of nursing experience. They did bring up the aspect of their colleagues' years of experience, or lack thereof, and how novice nurses had to do the work of experienced ones. The knowledge and action that is acquired with time and experience give wisdom, and with more experience in a field, confidence grows exponentially. A pandemic profoundly alters everyone's perspective and requires different working methods with limited resources, all of this because of a new strain of virus. Encountering the new challenges that arose during the pandemic forced health personnel to quickly acquire new sets of skills in order to continue providing patient care. Boyden and Brisbois[29] also mentioned that even the most experienced nurses were challenged by the pandemic. New nurses in particular might have had a harder time adjusting to the pandemic working conditions, as they would not likely have developed the resilience that often comes with experience.[30] This also goes in line with Labrague and de Los Santos's[30] findings: nurses' tendency to experience compassion fatigue decreases with age and work experience. To continue to care for patients and witness the suffering and death associated with COVID-19, healthcare personnel will likely suffer significant levels of compassion fatigue.[29] This is in line with our findings that the pandemic was hard to overcome and work through, which might have resulted in feeling less compassion for individuals who refused vaccination because of disbelief or lack of trust in the vaccine itself. This is an alarming situation for patients and their process of recovery, both physical and mental, and also for nurses, their well-being, their workplace and, last but not least, their ability to provide compassionate and effective care.

5. Conclusion

The nurses were challenged and adapted their work from the start of the pandemic and continuously thereafter when the unvaccinated patients needed care. It was challenging and it forced nurses to increase their resilience during this period of time. The experiences also pushed nurses too much and they showed signs of compassion fatigue, which affected them and, by extension, their unvaccinated patients. Nurses need to continue to have discussions with their patients even if they do not always agree with them. For pandemics, epidemics and challenges to come, our findings show that there is a need for mandatory reflection and scenario-based training to increase resilience and competence and to prevent compassion fatigue. It is important to further investigate how unvaccinated patients who had COVID-19 during the pandemic experienced their care.

5.1 Strength and limitations

The strengths of this study are that it is of a qualitative approach, built on the interviews of nurses with first hand knowledge of working with patients with COVID-19. The participants were included from two hospitals and had worked over multiple waves in the pandemic which gave them the experience to answer the aim. The limitations of this study are that it was a small study with few participants and the included nurses had worked a few years.

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Authors contributions

PV and FA performed the conceptualisation of this study, data collection, data curation, data analysis, preparation of the manuscript and revision of the manuscript. KM performed data analysis, preparation of the manuscript and revision of the manuscript. All authors read and approved the manuscript.

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Conflicts of Interest Disclosure

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

INFORMED CONSENT

Obtained.

ETHICS APPROVAL

The study was conducted within the Specialist Nursing Programme in Infectious Diseases Care as a masters' degree project. According to the Swedish Ethics Review Act, no further approval was needed.[31] Ethical considerations have also been taken regarding the Helsinki Declaration.[32] Before the initiation of the study, written consent from the heads of department was collected. Participants in the study gave written consent to participation after they had been informed about the study's purpose, method and data analysis. The written information to the participants also emphasised that participation was voluntary and that the participants could withdraw at any time, without a specified reason. Participants were informed that the interviews might awaken repressed memories and feelings and that in such an event they would be directed to the appropriate resources to help them process those feelings.

The Publication Ethics Committee of the Sciedu Press. The journal's policies adhere to the Core Practices established by the Committee on Publication Ethics (COPE).

PROVENANCE AND PEER REVIEW

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on reasonable request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

DATA SHARING STATEMENT

No additional data are available.

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