

Faculty of Medicine and Health Sciences

Exploring the Psychosocial Lived Experiences of Nurses During the Pandemic in Sarawak: A Hermeneutic Phenomenology Study

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Exploring the Psychosocial Lived Experiences of Nurses During the Pandemic in Sarawak: A Hermeneutic Phenomenology Study

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DECLARATION

I declare that the work in this thesis was carried out in accordance with the regulations of Universiti Malaysia Sarawak. Except where due acknowledgements have been made, the work is that of the author alone. The thesis has not been accepted for any degree and is not concurrently submitted in candidature of any other degree.

……

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The journey of writing this thesis has been akin to that of a solitary mariner; marked by moments of excitement and discovery, yet often accompanied by periods of isolation, uncertainty and anxiety. It would not have been possible without the unwavering support, guidance and encouragement of many individuals, to whom I am deeply grateful.

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ABSTRACT

Introduction: This study explores the psychosocial lived experiences of nurses caring for COVID-19 patients in Sarawak, Malaysia. It aims to understand the emotional landscape, social disconnection, adaptation and commitment amidst the pandemic. The unprecedented crisis placed immense pressure on nurses, requiring them to address both professional and personal challenges while ensuring quality patient care. **Materials and Methods:** This qualitative study employed Heidegger hermeneutic phenomenology to uncover the meaning embedded in nurses' psychosocial lived experiences. Ten nurses working in the Infectious Disease ward at Sarawak General Hospital were purposefully selected. Data was collected through semi-structured interviews and analysed thematically to identify and interpret patterns within the narratives. The emerging themes were further examined through Van Manen's four existential structures: lived body, lived time, lived space and lived other, offering a comprehensive lens for interpreting the nurses' experiences. **Results:** Five key themes were identified: navigating the emotional and physical landscape of COVID-19 nursing care, experiencing social disconnection and isolation, adapting to workplace challenges, strengthening camaraderie in the healthcare environment, and upholding commitment and professionalism. **Conclusion:** The findings underline the significant psychological impact of the pandemic on nurses, emphasising the need for systemic improvements in healthcare policies, nursing education and mental health support. Strengthening resilience, encouraging teamwork and integrating crisis management training into nursing curricula are crucial steps. Additionally, prioritizing mental health support systems is essential to mitigate the long-term emotional burden on healthcare workers. This study provides beneficial information in relation to developing a more supportive and sustainable healthcare environment.

Keywords: Psychosocial lived experiences, nurses, hermeneutic phenomenology

Meneliti Pengalaman Hidup Psikososial Jururawat Semasa Pandemik di Sarawak: Satu Kajian Fenomenologi Hermeneutik

ABSTRAK

Pengenalan: Kajian ini meneroka pengalaman hidup psikososial jururawat yang merawat pesakit COVID-19 di Sarawak, Malaysia. Tujuan kajian ini adalah untuk memahami landskap emosi, pengasingan sosial, penyesuaian diri, dan komitmen dalam kalangan jururawat semasa pandemik. Krisis yang belum pernah berlaku sebelum ini telah memberikan tekanan hebat kepada jururawat, memaksa mereka mengharungi cabaran profesional dan peribadi sambil memastikan penjagaan pesakit berkualiti tinggi. **Bahan dan Kaedah:** Kajian kualitatif ini menggunakan fenomenologi hermeneutik Heidegger untuk menyingkap makna yang terkandung dalam pengalaman psikososial jururawat. Seramai sepuluh orang jururawat yang bertugas di Wad Penyakit Berjangkit di Hospital Umum Sarawak telah dipilih melalui persampelan bertujuan. Data dikumpul melalui temu bual separa berstruktur dan dianalisis secara tematik bagi mengenal pasti serta mentafsir corak dalam naratif. Tema-tema yang muncul kemudiannya diteliti melalui empat dimensi eksistensial Van Manen: tubuh yang dialami, masa yang dialami, ruang yang dialami dan orang lain yang dialami, yang menawarkan lensa menyeluruh untuk mentafsir pengalaman jururawat tersebut. **Keputusan:** Lima tema utama telah dikenal pasti: mengharungi cabaran emosi dan fizikal dalam penjagaan kejururawatan COVID-19, mengalami pengasingan sosial, menyesuaikan diri dengan cabaran tempat kerja, memperkukuh semangat setiakawan dalam persekitaran penjagaan kesihatan, serta mengekalkan komitmen dan profesionalisme. **Kesimpulan:** Penemuan kajian ini menonjolkan impak psikologi yang signifikan akibat pandemik terhadap jururawat, serta menekankan keperluan untuk penambahbaikan sistemik dalam dasar penjagaan kesihatan, pendidikan kejururawatan, dan sokongan kesihatan mental. Memperkukuh daya tahan, memupuk kerjasama berpasukan, dan mengintegrasikan latihan pengurusan krisis dalam kurikulum kejururawatan merupakan langkah penting. Di samping itu, keutamaan harus diberikan kepada sistem sokongan kesihatan mental bagi mengurangkan beban emosi jangka panjang terhadap petugas kesihatan. Kajian ini memberikan pandangan yang bernilai ke arah membina persekitaran penjagaan kesihatan yang lebih menyokong dan mampan.

Kata kunci: *Pengalaman hidup psikososial, jururawat, fenomenologi hermeneutik*

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LIST OF SYMBOLS

Keys or symbols	Meaning(s)
Comma (,)	Used to indicate a short pause of about 1-3 seconds
Ellipses (...)	Used to indicate when the participant is trailing off or has a longer pause (more than 3 seconds) at the beginning of the sentence
Brackets [ ]	Used to indicate words added to the transcription that the interviewee did not mention, to explain certain abbreviations
Slashes //	Used to show that the participant and interviewer overlap in the time when they talked to each other
Quotes (“ ”)	Used to demonstrate what someone said

Adapted from Peraza (2019)

FOREWORD

I am a Chinese, born and raised in Sarawak, the largest state in Malaysia. My primary and secondary education was completed in the Kuching Division of Sarawak. In 2005, I earned a Diploma in Nursing and subsequently worked as a registered nurse in Gynaecology for four years. Motivated to further my education, I completed my Bachelor of Nursing at the University of Malaysia, Sarawak (UNIMAS) in 2013. Following this, I specialised in Haematology for a decade before joining UNIMAS as a Clinical Instructor (CI) in 2019. In this role, I gained extensive experience in delivering patient care and mentoring new nurses while supervising nursing students' clinical practicums. Later, I was promoted to lecturer, a role that inspires me to bridge the gap between theory and practice by approaching nursing education from a fresh perspective.

Researcher Positionality Statement

As a researcher with a professional background spanning both clinical and academic settings, my approach to studying the psychosocial experiences of nurses caring for COVID-19 patients in Sarawak is profoundly influenced by my philosophical, personal and theoretical beliefs. Having worked as a nurse in various fields for over a decade, I have witnessed firsthand the physical, emotional and psychological strain that healthcare providers endure. These experiences have not only nurtured my empathy and understanding, but they have also placed me in a position to engage authentically and respectfully with the participants' narratives.

My experience conducting qualitative research during my master's degree was fundamental in shaping my research philosophy. During that time, I developed an inherent appreciation for understanding human experiences beyond numerical data. This passion for exploring lived experiences, narratives and the rich context of human emotions has encouraged me to

adopt a qualitative approach in this study. By way of phenomenological methodologies, I seek to explain the essence of nurses' experiences, striving to remain faithful to their voices while critically reflecting on my role in determining the research analysis.

This research is also profoundly personal, rooted in both my professional journey and family history. The loss of my grandmother to COVID-19 in 2023 significantly impacted my perspective on the pandemic's multifaceted toll; not only on patients and their families but also on the caregivers at the frontline. This personal connection situates me uniquely as both an insider, sharing a nursing background and an outsider, seeking to explore experiences beyond my own. As such, I remain conscious of the balance between my empathetic engagement with participants and my academic responsibility to interpret their narratives with critical rigor.

The participants in this study are my professional peers, connected through the shared cultural, social and healthcare contexts exclusive to Sarawak. This shared background allows me to approach the research with cultural sensitivity and a considerable appreciation for the experiences of working in resource-constrained environments. Conversely, I am also aware of my dual role as both a researcher and an academic, which necessitates a careful balance between being an empathetic listener and a critical analyst of their lived experiences.

The COVID-19 pandemic has been a defining event in my lifetime. While I previously encountered the SARS outbreak during my student years, this is the first pandemic of such scale and impact that I have witnessed as a healthcare professional and researcher. Beyond the clinical aspects of COVID-19, my aim is to interpret how nurses, as human beings, tackled the challenges associated with the pandemic while balancing their professional and personal lives.

By positioning myself within the research context, I endeavour to assure that my findings respect the participants' stories and contribute meaningfully to understanding and supporting the nursing profession, both in Sarawak and a wider context. Via this research, I hope to explain the resilience, struggles and transformative experiences of nurses during the COVID-19 pandemic, advocating for their well-being and professional recognition.

Philosophical Beliefs

My research is grounded in a constructivist paradigm, which postulates that reality is not a fixed entity but is constructed through human interactions, social processes and lived experiences. This paradigm stresses that knowledge is subjective, dynamic and co-constructed between the researcher and participants. As a researcher, I acknowledge that my own perspectives, experiences and interpretations influence the research process, creating a shared space where meaning is collaboratively developed.

The constructivist paradigm is particularly relevant to understanding the psychosocial experiences of nurses during the COVID-19 pandemic, as it prioritises the individual contexts and personal narratives that influence their experiences. This approach acknowledges that their challenges, resilience and coping strategies are thoroughly embedded within cultural, social and institutional frameworks, which vary across individuals and settings. By embracing this paradigm, I aim to respect the participants' voices and perspectives, viewing them as active contributors to the co-creation of knowledge rather than passive subjects of an investigation.

Through this lens, my research endeavours to uncover the difficulties connected with their lived experiences, paying attention to how their identities as nurses, individuals and members of a broader community are formed by their interactions with patients, colleagues and the healthcare system during the pandemic. By situating their narratives within a constructivist

framework, I aim to generate information that not only convey their experiences but also contribute to an innate, contextually rich understanding of the psychosocial dimensions of frontline healthcare work. This philosophical perspective underlines my commitment to promoting a respectful, reflexive and empathetic research process.

Personal Beliefs and Experiences

Having worked as a nurse in a hospital setting, I possess personal experience of the complexities and emotional demands pertaining to nursing care. This background provides me with a distinct insider's perspective, enabling me to empathise considerably with the nurses I am studying. My transition to a nursing educator has further strengthened my commitment to improving the well-being and professional development of nurses. These personal experiences drive my passion for this research, as I have witnessed the resilience and dedication of nurses, as well as the profound impact of the COVID-19 pandemic on their psychological and emotional health.

Family's Influence

The inspiration for this research is also closely tied to my family's history in the nursing profession. I come from a family of nurses, with three generations before me working in various capacities within the healthcare system. My grandmother, a retired community nurse, and my mother, a retired assistant nurse, were significant influences in my decision to pursue nursing. Their dedication and compassion, as well as the challenges they encountered, have always been a source of inspiration for me. My grandmother, who passed away in 2023 due to complications caused by COVID-19, frequently accentuated the importance of giving back to the community, a value that has acutely influenced my career and research aim.

Theoretical Perspective

This research is grounded in by Lazarus and Folkman's Stress and Coping Theory (1984), which provides a framework to understand how individuals evaluate and respond to stressful situations. This theory is instrumental in identifying the sources of stress and the coping strategies employed by nurses, predominantly in high-stress environments such as the COVID-19 pandemic. From this perspective, the study examines how nurses assess the demands of their work and use coping mechanisms to manage the intense physical, emotional and psychological stress associated with their roles during the pandemic.

Additionally, the study draws on Albert Bandura's Social Cognitive Theory, which alludes to the dynamic interplay between individual cognition, social interactions and environmental influences. Social Cognitive Theory is particularly relevant in this context given that it explains how nurses' interpersonal relationships, mental states and self-concept interact to determine their responses to the challenges associated with the pandemic. By examining nurses' experiences from this perspective, the study aims to explore how nurses' perceptions of self-efficacy, social support and observational learning influence their ability to tackle the crisis effectively. This includes how nurses' confidence in their competencies, the support they receive from colleagues, together with their adaptability in changing environments impact their resilience and coping.

Concurrently, these theoretical frameworks provide a comprehensive foundation to analyse the psychosocial experiences of nurses, describing both the internal and external factors that influence their responses. This approach permits a detailed examination of how nurses perceive, cope with and adapt to the unprecedented demands of their profession during the COVID-19 crisis, contributing to a comprehensive understanding of the psychosocial resilience and adaptability required in such high-pressure settings.

Professional Experience as a Nurse

My professional experience as a nurse has had a profound impact on my research interests, specifically in relation to understanding and interpreting the challenges nurses are subjected to during disease outbreaks. In 2003, as a student nurse, I was quarantined after being exposed to the SARS outbreak. This crucial experience ignited my curiosity concerning how nurses cope with crises. Simultaneously, my mother, a nurse on the frontline during the SARS pandemic, experienced the emotional and physical toll of being separated from her family to care for patients, leaving a lasting impression on me regarding the personal sacrifices nurses make in these challenging situations.

These formative experiences, coupled with 14 years of nursing practice in Sarawak in various specialties, have broadened my interpretive understanding of the psychosocial and professional obstacles nurses endure, notably during pandemics. Working within diverse clinical environments has allowed me to personally witness the resilience, solidarity and emotional distress that typically arise in the face of overwhelming challenges. This idiosyncratic perspective inspired my research to explore how nurses construct meaning and address their lived realities during crises such as COVID-19, with the aim of amplifying their voices and contributing to a more detailed, contextually rich understanding of their experiences.

Research Lens

By way of my study, I aim to intensify the voices of nurses, focusing on their personal narratives to understand their psychosocial experiences in a holistic manner. I employ qualitative methods to obtain the richness of their stories, whilst acknowledging that quantitative data alone cannot fully convey the depth of their experiences. My insider perspective as a former nurse, in conjunction with my academic background, places me in

an exceptional position to conduct this research with sensitivity, empathy and an enhanced understanding of the nursing profession.

Positionality and Reflexivity

I am acutely aware of the potential biases my background may introduce into the research process. My prior experiences as a nurse and my current role as a lecturer provide me with an insider's (emic) perspective that enhances my understanding of the challenges encountered by nurses. Conversely, this familiarity may also impact my interactions with participants and influence my interpretation of their narratives. To balance this, I adopt the lens of an outsider (etic), determined to view the data objectively and critically, while respecting the participants' individual lived experiences.

To mitigate biases, I engage in continuous reflexivity, actively examining my assumptions, beliefs and positionality throughout the research process. This entails maintaining a reflexive journal, seeking feedback from peers and consistently questioning how my professional background informs my interpretations. By critically reflecting on both my emic insights and etic distance, I aim to ensure a balanced and detailed analysis.

I also concentrate on creating a collaborative and respectful research environment, encouraging participants to share their stories openly and authentically. By promoting trust and emphasising their voices, I aim to respect their lived experiences while maintaining a rigorous, interpretive approach that integrates both emic and etic dimensions into the research process.

Conclusion

My positionality as a researcher is fashioned by my professional experiences, personal beliefs and theoretical commitments. I approach this study with a deep respect for the participants and a commitment to acquiring valuable data that can inform and improve

nursing practice and education, particularly in the context of the unprecedented challenges posed by the COVID-19 pandemic. This study employs a phenomenological approach, as it is particularly suited to understanding the lived experiences of nurses, recognising the complexity of human feelings, thoughts and behaviours in response to the pandemic.

CHAPTER 1

INTRODUCTION

This chapter presents the background to the problem identified in this study, which specifically outlines the COVID-19 pandemic which has affected both Malaysia and the remainder of the world and adversely affected the nurses in Sarawak. This is subsequently followed by a description of the research questions and objectives, importance of the study, along with the conceptual definitions.

1.1 Study Background

Infectious diseases are ranked as the third leading cause of death globally, underlining their significant impact on human health and healthcare system (Verikios, 2020). These diseases may manifest as endemic, epidemic or pandemic events, with their scale and severity determined by factors such as pathogen intensity, transmission mode, herd immunity and disease prevalence within communities. The World Health Organisation (WHO) defines a pandemic as the global spread of a new disease, capable of affecting multiple countries and continents over varying timeframes (Honigsbaum, 2019). Pandemics represent unavoidable threats that not only disrupt healthcare systems but also evoke universal fear and uncertainty.

The term “Pandemic” derived from the Greek words pan (meaning “all”) and demos (meaning “the people”), denotes the widespread transmission of a contagious disease throughout continents (Honigsbaum, 2019). Historically, pandemics such as Spanish flu, Hong Kong flu, Avian Influenza (H7N9), Severe Acute Respiratory Syndrome (SARS), Ebola and Zika have caused widespread illness and death, severely disrupting societal,

political and economic structures (Maurice, 2016; Rewar et al., 2015; WHO, 2011b). The risk and frequency of pandemics are increasing, particularly in regions with rapid population growth. Rapid urbanisation, population growth and increased human-animal interactions have increased the frequency and risk of pandemics (Madhav et al., 2017), straining global healthcare systems, particularly regarding nursing personnel.

The COVID-19 pandemic, which emerged in late 2019, has brought unprecedented challenges to healthcare systems worldwide. Nurses, as a core component of the healthcare workforce, had wide-ranging responsibilities, including diagnosing, treating and providing care under resource-limited conditions (Newby et al., 2020). The pandemic significantly affected their psychosocial well-being, highlighting the urgent need to comprehend their experiences to improve future healthcare responses.

1.2 Research Problem Statement

Nurses form the backbone of the healthcare system, delivering essential services across all levels of care (Fawaz et al., 2018). Their primary mission is to assist individuals and communities in achieving their optimal mental, physical and social well-being within their daily environments. This mission embodies the essence of the nursing profession, acting as the foundation for its diverse roles and responsibilities.

In the 21st century, nursing practice faces numerous challenges, including the rising numbers of elderly and critically ill patients, increasing healthcare costs, in addition to the emergence of infectious diseases (Fawaz et al., 2018). These demands necessitate a dynamic and adaptable nursing workforce capable of addressing complex healthcare needs. The COVID-19 pandemic further accentuated these demands, introducing unprecedented challenges that transformed nurses' professional and psychosocial experiences.

Caring, the foundation of nursing (Morrow, 2013), requires both emotional and technical skills (Rogers, 1992). During the pandemic, nurses not only provided direct care under hazardous and resource-limited conditions but also had to acquire new technical skills and adapt to high-dependency care settings. This intensified their workloads and psychosocial burdens, as they contended with the persistent threat of infection, fear of transmitting the virus to family members and the emotional strain of caring for critically ill patients (Arnetz et al., 2020; Rodríguez & Sánchez, 2020).

The COVID-19 pandemic placed immense psychological burdens on nurses, who faced emotional and social challenges while delivering care in high-risk settings and uncertain settings. According to the International Council of Nurses (ICN), more than 1,500 nurses across 44 countries lost their lives, while millions were infected, accentuating their vulnerability (ICN, 2020). Nurses endured anxiety, depression and moral distress, driven by fear of infection, grief and witnessing widespread suffering and death. In China, 60% of healthcare workers reported anxiety symptoms, whilst 40% displayed depressive symptoms (J. Lai et al., 2020).

In Malaysia, the surge in COVID-19 cases following a religious gathering in March 2020 overwhelmed the healthcare system (Che Mat et al., 2020). Sarawak reported its first COVID-19 cases on March 13, 2020, followed by its first death on March 17 (Sipalan, 2020). Nurses there faced additional challenges due to geographical barriers, limited resources and the state's cultural diversity. Caring for critically ill patients, conducted screenings and preventing nosocomial infections often involved navigating language and cultural differences among indigenous groups such as the Iban, Bidayuh and Orang Ulu (Board, 2024).

The pandemic also disrupted nurses' family and social lives. Many isolated themselves to protect loved ones, leading to loneliness and emotional strain. Prolonged separation, extreme workloads and fear of transmission compounded stress while public stigma further alienated nurses. In some cases, they were denied access to public transportation, evicted from their homes or ostracized by communities fearful of infection (Bagcchi, 2020; Rodríguez & Sánchez, 2020). Similar stigma was reported globally such as in Spain, where healthcare workers experienced significant social exclusion (Molero et al., 2022).

Despite these challenges, many nurses demonstrated resilience, motivated by professional duty and loyalty to patients (Liu et al., 2020; Pogoy & Cutamora, 2021). However, others experienced resistance due to inadequate resources and a heightened risk of infection (Chau et al., 2021; Góes et al., 2020). The psychosocial impacts of the pandemic, including depression, dysphoria and moral distress, disrupted nurses' sense of self, professional identity and societal roles (Fan et al., 2020).

While quantitative studies have documented the psychological impact of the pandemic on healthcare workers (Arnetz et al., 2020; Leng et al., 2021), qualitative research on the lived experiences of nurses remains scarce, particularly in Sarawak. A recent hermeneutic study by Alrasheeday et al. (2023) and Tamayo et al. (2024) provides a degree of insights, but significant gaps persist in understanding the psychosocial experiences of Malaysian nurses.

This study aims to address these gaps by exploring the lived experiences of nurses in Sarawak during the COVID-19 pandemic. Understanding these experiences is essential to promote empathy, humanise the nursing profession and to develop targeted mental health

interventions to improve the well-being of nurses. An understanding of the coping mechanisms can inform strategies to develop resilience among healthcare professionals, enhancing preparedness concerning future crises. Additionally, this knowledge is essential for policymakers and administrators to implement supportive measures, such as policy adjustments, resource allocation and educational initiatives, ultimately contributing to a more resilient and effective healthcare system. By comprehending the challenges nurses are subjected to, this research attempts to contribute meaningfully to nursing management and support systems, which, in turn, will improve the quality of healthcare delivery during crises.

1.3 Research Questions

The following research questions were developed:

i. What are the psychological experiences of nurses during the pandemic in Sarawak?
ii. What are the social experiences of nurses during the pandemic in Sarawak?
iii. What are the repercussions on the lives of nurses during the pandemic in Sarawak?

1.4 Research Objectives

This study aims to explore the psychosocial lived experiences of nurses during the pandemic in Sarawak. The specific research objectives formulated:

i. To examine the psychological experiences of nurses during the pandemic in Sarawak.
ii. To identify the social experiences of nurses during the pandemic in Sarawak.
iii. To understand the repercussions on the lives of nurses in Sarawak during the pandemic.

1.5 Significance of The Study

Pandemics place significant strain on healthcare systems, with frontline healthcare workers, particularly nurses, bearing the brunt of these crises. The World Health Organisation (2018) asserts that during infectious pandemics, nurses experience an increased risk of infection and mortality, specifically in under-resourced healthcare systems (WHO, 2018). These unrelenting challenges are compounded in countries where health services are strained, making the retention and protection of healthcare workers crucial in regards to maintaining a functional healthcare system. The information gleaned from this study is invaluable to address these challenges and improve the preparedness, resilience and well-being of nurses in future pandemics.

1.5.1 The Nursing Profession

This study provides an exhaustive understanding of the lived experiences of nurses during the COVID-19 pandemic, particularly in the high-risk, life-threatening conditions of Sarawak. By exploring these experiences, it identifies the personal, institutional, professional and governmental factors that impacted nurses' attitudes, practices and coping mechanisms during the pandemic. This information is instrumental in enhancing nurses' preparedness and resilience in similar crises.

Moreover, the findings will strengthen nurse-patient and nurse-nurse relationships by nurturing empathy and mutual understanding, essential components of effective care delivery during pandemics. Aimed at nurses in Sarawak and elsewhere, the study stresses the importance of personalized protective measures, culturally sensitive interventions and strategies to support nurses' physical and mental well-being (Kollie & Winslow, 2016).

1.5.2 Nursing Practice

By considering the challenges associated with nurses' experiences during the COVID-19 pandemic, this study supplements the nursing profession's understanding of the human experience in diverse and challenging settings. It spotlights how individual backgrounds, cultural backgrounds and environmental conditions influence decision-making, resilience and change during crises (Thrysoee et al., 2022).

The findings deliver practical implications intended for nursing practice, emphasising the importance of recognising and addressing the myriad of challenges nurses experience. By appreciating the depth of influences on nurses' actions and emotions, this study encourages a more compassionate and holistic approach to patient care, even in high-pressure situations. Essentially, this greater understanding can inform educational curricula, in-service training and mentorship programmes empowering nurses with the skills and perspectives they require to succeed in complex healthcare environments.

1.5.3 Healthcare Preparedness

Nurses are central to pandemic response efforts, yet their voices are repeatedly overlooked in disaster preparedness planning (Oh & Gastmans, 2015). This study addresses that gap by encapsulating the perspectives and behaviours of nurses in Sarawak during the COVID-19 pandemic. The findings make a valuable contribution to improving pandemic preparedness strategies, particularly in regions with limited resources and diverse cultural contexts.

In Sarawak, where emergency preparedness training and education may lag behind global standards, this study provides a critical understanding to bridge those gaps. It determines the importance of including nurses in disaster preparedness planning, ensuring

that they are provided with the necessary skills, knowledge and resources to effectively manage future healthcare crises effectively. The findings can guide the development of targeted training programmes, improve resource allocation and changes in policy to better support nurses in their positions during pandemics.

By amplifying the voices of nurses and exploring their lived experiences, this study not only informs nursing practice and healthcare policy but also contributes to the broader goal of generating a more resilient and responsive healthcare system. This knowledge is essential for policymakers, administrators and educators to implement measures that prioritise the well-being and professional growth of nurses, and in due course, enhance the quality of healthcare delivery in the face of future global health challenges.

1.6 Conceptual Definitions

The following conceptual definitions are outlined.

1.6.1 Psychosocial

Psychosocial refers to the relationship between the social and psychological components pertaining to the human experience. It explains how people's behaviour, affect and thought processes are all influenced by the society or culture in which they were raised (Berger & Archer, 2015). In the context of this study, it denotes the nurses' thoughts and behaviour during the COVID-19 pandemic.

1.6.2 Lived experiences

Lived experience is personal knowledge relating to the world gained via direct involvement in everyday events (Chandler & Munday, 2011). This study focuses on the

immediate, everyday activities and interactions of nurses providing direct care to COVID-19 patients in hospitals.

1.6.3 Nurses

Nurses are certified and registered healthcare personnel who have completed at least three years of diploma-level training on a nursing programme. A number have also earned a bachelor's degree in nursing, in addition to their nursing diploma. The International Council of Nurses (ICN) states the nurses are on practically every hospital care unit or ward (ICN, 2020). With respect to this study, it signifies the nurses who worked in hospitals who performed direct nursing care to COVID-19 patients.

1.6.4 Pandemic

A pandemic refers to the widespread transmission of a contagious disease across multiple countries or continents. In this study, the Coronavirus disease (COVID-19) is used as the example of a pandemic. COVID-19, caused by a novel coronavirus, spread primarily through respiratory droplets or nasal discharge when an infected person coughs or sneezes. At the onset, there were no specific vaccines or treatments; nonetheless, within months, vaccines were developed in China, Russia and the United Kingdom, such as CanSino, Sputnik V and Pfizer-BioNTech vaccines (WHO, 2020). In the context of this study, it suggests a person who contracted the COVID-19 disease and was admitted to hospital.

1.7 Summary

This chapter has addressed the research problem including the need for the study to explain what nurses experienced during the COVID-19 pandemic in Sarawak while attempting to meet the needs of COVID-19 patients. The main research questions and objectives of the study were presented and key terms were defined. The significance of the

study was also identified. Subsequently, the conceptual definitions and conceptual framework were explained. The following chapter provides a literature review of the research topic.

CHAPTER 2

LITERATURE REVIEW

This chapter examines the literature relating to the psychosocial experiences of nurses during the outbreak of a highly contagious disease known as COVID-19. It focuses on the Coronavirus, its history and its origin. There are a limited number of studies specific to COVID-19, seeing as it is a relatively new disease. Consequently, the researcher broadened the scope of the literature review to collect information from other disease outbreaks and the experience of nurses in providing care.

2.1 Introduction

This study employed qualitative research methods to investigate the experiences of nurses in Sarawak in responding to the COVID-19 pandemic. Relevant studies were identified using a combination of Medical Subject Headings (MeSH) and keywords, including "coronavirus," "pandemic," "nurse," "healthcare worker," "psychosocial experience," "Sarawak," and "qualitative". The search timeline spanned from March 2020 to the time of writing this thesis. The literature review was limited to peer-reviewed primary or secondary articles written in English and published within the last 10 years.

The database research included the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, together with ProQuest Dissertations and Theses Global (PQDT Global). Additional relevant studies were identified through smart text searching of university repositories. Unpublished works such as dissertations were retrieved using Ethos. Grey literature was also explored by means of searches on Google and Google Scholar.

Finally, reference lists of selected articles were manually reviewed to identify additional sentinel literature.

The study selection process is detailed in the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2020 flow diagram (Figure 2.1), based on the guidelines outlined by Page et al. (2021). The use of the PRISMA flow diagram aids the transparent and comprehensive reporting of systematic reviews. From an initial total of 1,489 records identified by way of database searches, 241 unique records were screened at the title and abstract level. Of these, 90 records were deemed potentially relevant and were submitted to a full-text review. Ultimately, 26 studies met the eligibility criteria and were included in the final review.

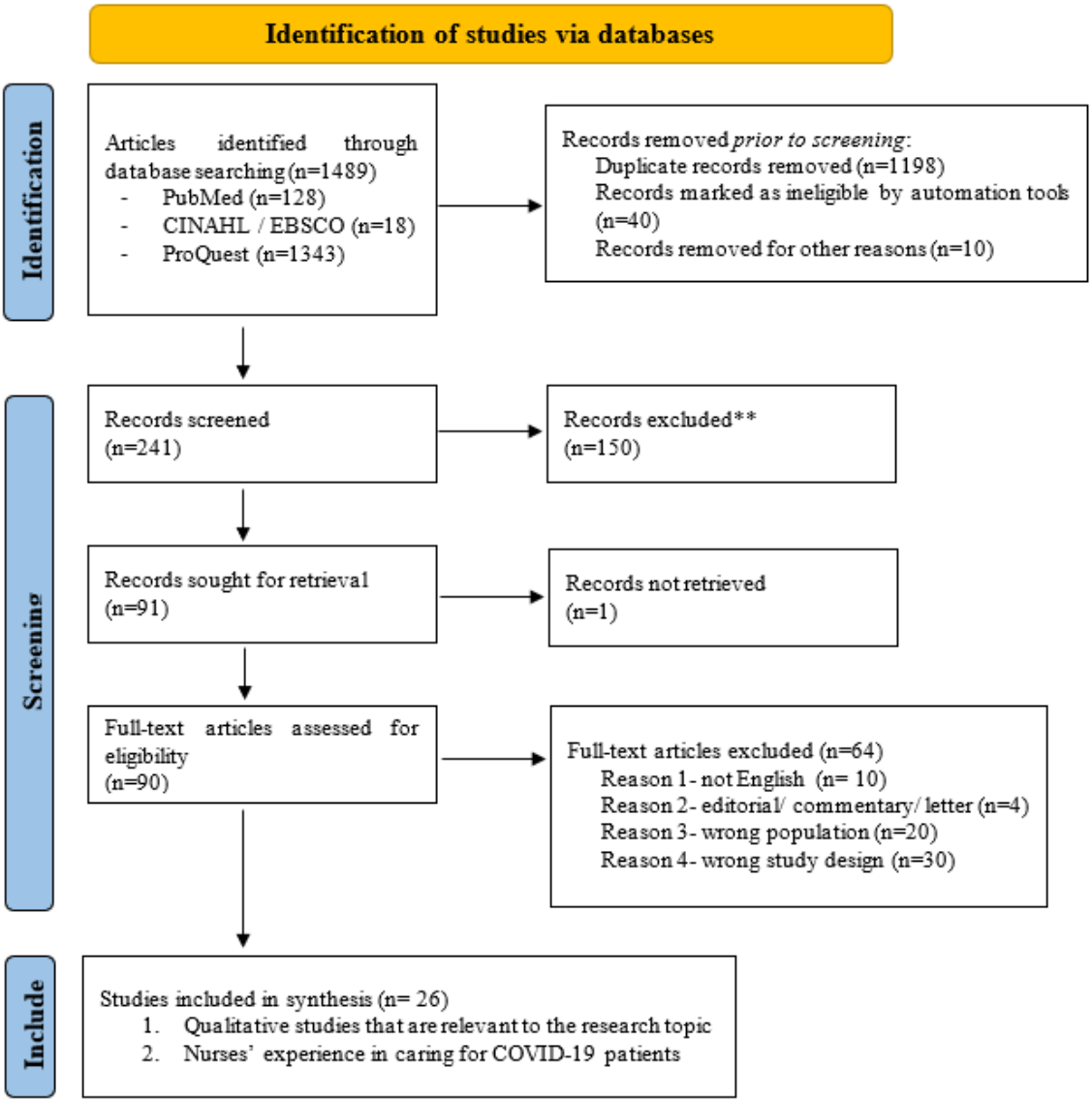


Figure 2.1: Literature Search Using PRISMA 2020 Flow Diagram

2.2 History and Origin of the Coronavirus Disease

Throughout history, pandemics have frequently been shrouded in uncertainty, giving rise to conspiracy theories and social unrest. During the 14th century, the plague devastated Europe, and the lack of understanding as regards its transmission led to speculative accusations against Jewish communities, resulting in violent pogroms and expulsions. Similarly, during the 1918 Spanish flu pandemic, which claimed an estimated 25 to 50

million lives, theories emerged that the virus had been engineered by the German army as a biological weapon. These historical examples demonstrate the challenges presented by pandemics in relation to understanding their origins and mitigating misinformation (Nehring, 2020).

Coronaviruses, belonging to the order Nidovirales and the family Coronaviridae, derive their name from the crown-like spikes on their surface (Shereen et al., 2020). These viruses are small, with diameters ranging from 65 to 125 nanometres, and contain a single-stranded ribonucleic acid (RNA) genome of approximately 26 to 32 kilobases. Coronaviruses are separated into four subgroups: alpha (α), beta (β), gamma (γ), and delta (δ). Alpha and beta coronaviruses primarily infect mammals such as bats, while gamma and delta coronaviruses are associated with birds and fish. Environmental factors, for instance climate change and viral mutations may enhance the adaptability of certain viruses to humans, posing a significant global health threat (Caminade et al., 2019; Goneau et al., 2018).

In 2003, a novel coronavirus (SARS-CoV) occured in Guangdong Province, China, causing severe acute respiratory syndrome (SARS). This Beta-coronavirus infected over 8,000 individuals and resulted in 776 deaths worldwide (Pyrc et al., 2007). Patients exhibited pneumonia symptoms and acute respiratory distress syndrome (ARDS). A decade later, another Beta-coronavirus, the Middle East Respiratory Syndrome Coronavirus (MERS-CoV), was identified in Saudi Arabia (Rahman & Sarkar, 2019). MERS-CoV caused over 2,428 confirmed cases and 838 deaths, with symptoms similar to SARS-CoV, including ARDS and kidney failure (Memish et al., 2013).

At the end of 2019, an outbreak of pneumonia of unknown origin linked to the Huanan Seafood Market emerged in Wuhan, China. By January 2020, over 50 cases had been reported to the World Health Organisation (Wang et al., 2020). The virus, identified as a novel coronavirus, was later termed SARS-CoV-2, while the illness it causes became known as COVID-19 (Cui et al., 2019; J. Lai et al., 2020). Initial theories suggested that SARS-CoV-2 originated from live animals sold at the market; however, subsequent research confirmed human-to-human transmission via respiratory droplets, aerosols and close contact. The virus rapidly spread to over 100 countries, prompting the WHO to declare a global pandemic on March 11, 2020.

2.2.1 Global Pandemics

Human history has been repeatedly shaped by pandemics, which have caused immense loss of life and disrupted societies. Smallpox, cholera, the plague, dengue fever, AIDS, tuberculosis and influenza are among the most significant pandemics recorded (Piret & Boivin, 2020). Influenza pandemics have occurred cyclically, with notable outbreaks in the 20th century, including the “Spanish flu” in 1918, “Asian flu” in 1957, and the “Hong Kong flu” which emerged in 1968. The “Spanish flu”, commonly regarded as the deadliest pandemic, claimed an estimated 20 to 50 million lives globally (WHO, 2011b).

The 21st century has also witnessed significant outbreaks, including H1N1 influenza, Ebola, Zika virus, and hantavirus pulmonary syndrome (Qiu et al., 2016). The 2009 H1N1 pandemic, the first of the century, resulted in over 18,000 deaths worldwide. Similarly, the Ebola outbreak claimed over 11,000 lives and caused an estimated USD 2 billion in economic damage. These pandemics underline the recurring threat posed by infectious diseases and the need for global preparedness and response mechanisms (Rewar et al., 2015).

The COVID-19 pandemic epitomises the devastating potential of emerging infectious diseases. First reported in December 2019 in Wuhan, China, the virus quickly spread across the globe. By February 2020, the WHO officially named the disease COVID-19, and within a month, it was declared a global pandemic. Governments and health organisations around the world mobilised resources to contain the spread, aiming to reduce the number of cases and fatalities. Notwithstanding these efforts, the pandemic caused unprecedented strain on healthcare systems and stressed the need for coordinated global health strategies to mitigate future outbreaks (WHO, 2020).

2.2.2 COVID-19 Pandemic in Malaysia

The first confirmed case of COVID-19 in Malaysia was reported on January 25, 2020 (Sipalan, 2020). Initially, the number of reported cases remained relatively low (Amaran et al., 2021). However, a significant surge occurred in March 2020, largely attributed to a religious gathering in Kuala Lumpur held in late February and early March. Within weeks, Malaysia became the Southeast Asian nation with the highest total number of confirmed infections.

Malaysia's response to the pandemic was coordinated by the Crisis Preparedness and Response Centre (CPRC), under the leadership of Datuk Seri Dr. Noor Hisham Abdullah, Director-General of Health. Established under the 9th Malaysia Plan (2005–2010), the CPRC manages health-related disasters, epidemics and emergencies (Hisham, 2014). Operating primarily in passive surveillance mode, the CPRC shifts to active surveillance during major disease outbreaks, monitoring cases and providing periodic reports to stakeholders (Hisham, 2014).

Efforts to control the outbreak in Malaysia followed three specific phases: containment, mitigation and suppression. Attempts at containment included identifying and isolating cases, contact tracing and public health measures such as vaccinations. Mitigation comprised community-based non-pharmaceutical interventions (NPI), including social distancing and hygiene practices. Likewise, suppression measures, for example school closures and movement restrictions, were implemented to curb the spread of the pandemic (Azevedo et al., 2020; Ferguson et al., 2020; Walensky & del Rio, 2020).

Malaysia implemented a Movement Control Order (MCO) on March 18, 2020, marking the first nationwide restriction of its kind under the Prevention and Control of Infectious Diseases Act 1988 (Jayaraj et al., 2021). The MCO included harsh restrictions on public gatherings, school closures, along with the shutdown of most business operations, except essential services such as food supply, healthcare, and utilities. Initially scheduled for two weeks, the MCO was extended in phases in the middle of May 2020. Gradual relaxation of restrictions under the Conditional MCO (CMCO) began in May, followed by the Recovery MCO (RMCO) in June.

Despite early successes, Malaysia experienced a third wave of infections following the Sabah state election in September 2020. Subsequent measures included localised CMCOs and MCO 2.0 in January 2021, as daily cases rose (Muhamad Khair et al., 2021). By mid-2021, the emergence of new variants and increased strain on healthcare capacity necessitated rigorous measures, culminating in MCO 3.0 and a nationwide total lockdown in June. Throughout the pandemic, Malaysia also launched a robust vaccination programme, significantly reducing severe cases and enabling a transition to the endemic phase by April 1, 2022.

2.2.3 COVID-19 Pandemic in Sarawak

Sarawak reported its first COVID-19 cases on March 13, 2020, followed by its first death on March 17 (Sipalan, 2020). By the end of 2020, the state had recorded 1,117 infections and 19 deaths, representing roughly 1% of Malaysia's total cases at the time. The Sarawak Disaster Management Committee (SDMC) managed the state's response, implementing containment measures tailored to the region's distinct geographic and demographic challenges.

In early 2021, the situation deteriorated with the emergence of the Pasai cluster, originating from a longhouse gathering after the quarantine of a returning individual from Johor. The cluster, which spanned ten districts, resulted in 2,693 infections and 29 deaths, making it Sarawak's deadliest outbreak (Dzulkifly, 2021). This prompted the SDMC to enforce the MCO from May 29 to June 11, 2021.

Sarawak's vaccination programme, bolstered by federal government support, progressed rapidly. By August 2021, 88.2% of the eligible population had been fully vaccinated, enabling the state's switch to the endemic phase (Goh, 2021). The success of Sarawak's vaccination efforts was attributed to widespread public cooperation and effective coordination by the SDMC.

As of the middle of 2021, Sarawak entered Phase 2 of the National Recovery Plan, gradually reopening sectors while maintaining essential health measures (Bernama, 2021). By positioning public health strategies with vaccination milestones, Sarawak successfully mitigated the pandemic's impact and moved toward endemicity. This approach placed emphasis on the importance of local leadership, community participation and adaptive responses in managing COVID-19 in the region.

2.3 The Role of Nursing in the 21st century

Nurses work as the backbone of healthcare systems worldwide, providing essential services that encompass health promotion, disease prevention and high-quality patient care. Their primary objective is to assist individuals and communities in achieving optimal physical, mental and social well-being within their daily environments. This principal objective underpins the nursing profession, guiding its diverse roles and responsibilities across various healthcare settings.

A fundamental aspect of nursing practice entails assessing patient needs, planning and implementing interventions and collaborating with other healthcare professionals to guarantee holistic care (Sikorska, 2020). A defining characteristic of nursing is its holistic approach, which extends beyond physical care to address patients' psychological, emotional and social needs, as emphasised by the International Council of Nurses (ICN, 2020). This perspective acknowledges that patients are not merely biological entities with medical conditions but individuals with complex emotional experiences, mental health concerns and social circumstances that impact their general well-being. By integrating these aspects into care, nurses ensure a comprehensive and patient-centred approach.

Holistic nursing care comprises several key components. Physically, nurses provide essential medical interventions, for instance administering medications, monitoring vital signs, assisting with wound care, in conjunction with managing acute and chronic illnesses. However, their responsibilities extend beyond these tasks to include psychological care. Patients frequently experience anxiety, fear or depression due to illness, hospitalisation, or treatment outcomes. Nurses offer support through reassurance, active listening, and the creation of a safe environment in which patients feel listened to and understood.

Emotional care is another fundamental element of nursing practice. Patients, particularly those with long-term or terminal illnesses, may struggle with feelings of vulnerability, frustration or loneliness. Through a compassionate presence and empathetic communication, nurses provide comfort and motivation. Simple gestures, for instance words of encouragement, physical reassurance or taking the time to listen to patients' concerns, can significantly boost emotional well-being.

Besides individual care, nurses also address the broader social determinants of health. Many patients face challenges such as financial constraints, lack of family support or limited access to healthcare services. Nurses assess these factors and collaborate with social workers, counsellors, and other professionals to ensure patients receive the necessary resources and support. By bridging the gap between medical treatment and real-world challenges, nurses improve patient outcomes and quality of life overall.

In addition to clinical expertise, nurses incorporate a strong commitment to patient advocacy and education. As highly skilled professionals, they ensure that patients receive ethical, evidence-based care while advocating for their rights and active participation in medical decision-making. Patient education is a crucial aspect of nursing, as many health conditions require long-term management. Nurses educate patients and their families about diagnoses, treatment options and self-care strategies, empowering them to take charge of their health. This emphasis on education contributes to disease prevention, health promotion and the reduction of hospital readmissions.

Nurses maintain accurate records to improve their care while adhering to professional, ethical and cultural standards. Their proactive approach to health promotion lays emphasis on the prevention of illness and improving well-being via the identification of

risk, patient education, and the encouragement of healthy behaviours (Wilandika et al., 2023). Nurses operate in various care settings, each requiring specialised expertise. In primary care, they focus on community outreach, chronic disease management and health education (Griffin, 2017). In acute care, they manage critically ill patients, often employing advanced clinical skills in specialised fields such as intensive care and surgical nursing. Together with direct patient care, nurses contribute to healthcare planning, policy-making and research, advocating for patient-centred care and developing evidence-based practice to improve healthcare outcomes (Karam et al., 2021).

The indispensable role of nurses in modern healthcare is evident throughout various settings, including hospitals, clinics, community health programmes, and home care services. As frontline caregivers, nurses are often the first to detect early signs of patient deterioration, guaranteeing appropriate interventions. Their ability to provide continuity of care across different healthcare settings is essential in improving patient outcomes and facilitating smooth transitions between hospital and home care. Furthermore, nurses assist patients to deal with complex healthcare systems by guiding them through treatment plans, follow-up care and making them aware of the resources that are available.

For example, when caring for a patient with diabetes, a nurse's role extends beyond monitoring blood sugar levels and administering insulin. The nurse also provides psychological support by helping the patient cope with the stress of managing a chronic condition, offers emotional reassurance to maintain motivation and assesses the patient’s social environment to ensure access to necessary medications, nutritional support and family assistance. This comprehensive approach ameliorates not only the patient's physical health but also their overall well-being.

Nurses are more than healthcare providers; they are healers, educators and advocates who ensure that patients receive comprehensive, compassionate, and personalised care. Their holistic approach demonstrates the importance of treating patients as whole individuals rather than merely addressing medical conditions. By combining technical expertise with empathy, advocacy and education, nurses remain indispensable in modern healthcare systems, profoundly impacting the lives of those they care for.

2.3.1 The Role of Nurses in Malaysia

Nurses in Malaysia are an essential component of the healthcare system, delivering services across hospitals, clinics and community health settings. As one of the largest healthcare workforces, they play a fundamental role in promoting health, preventing disease, and establishing quality care for the population (Mohd Ali et al., 2024).

In urban areas, nurses work in multidisciplinary teams, supporting advanced medical procedures and post-treatment care. In rural and underserved regions, for instance parts of Sarawak, they are regularly employed as primary healthcare providers, addressing the needs of communities with limited access to physicians and specialists. This includes managing maternal and child health programmes, immunisations, chronic disease care and health education tailored to local needs.

Over the years, the nursing profession in Malaysia has significantly evolved. The introduction of diploma and degree programs, alongside postgraduate opportunities, has boosted the educational qualifications of nurses and expanded their professional scope (Mohd Ali et al., 2024). Similarly, specialisations in areas such as critical care, mental health and pediatrics have further improved healthcare delivery.

Regardless of these developments, challenges persist. Nurses in Malaysia often experience a lack of autonomy and professional recognition, and restricted career progression (Balang & Fradelos, 2021). Nursing is still perceived as a subordinate role within the healthcare hierarchy. Addressing these challenges via advocacy for better working conditions, policy reforms and leadership opportunities is essential to empower nurses and increase their contribution to the healthcare system.

As Malaysia's healthcare needs continue to grow, driven by demographic changes and advancements in medical technology, nurses remain at the forefront of attempts to improve public health. Their dedication to delivering compassionate, evidence-based care assures that they are integral to the nation's attempts to improve access to healthcare and quality.

2.3.2 The Role of Nurses in Infectious Diseases

Nurses are crucial in managing infectious diseases, fulfilling roles in direct patient care, infection prevention and public health. Their responsibilities include assessing, diagnosing and managing symptoms, educating patients and families concerning prevention measures and enforcing infection control protocols in healthcare settings (Newby et al., 2020).

During outbreaks, nurses play a key role in public health response efforts. They conduct screenings, administer treatments, monitor patient conditions and provide education on hygiene, respiratory etiquette, as well as the benefits of vaccination (WHO, 2020). Infection prevention is central to their work, requiring strict adherence to personal protective equipment (PPE) protocols and isolation procedures to safeguard patients, colleagues and the broader community (Jernigan, 2020).

In long-term care settings, nurses protect vulnerable populations, such as the elderly and immunocompromised, by developing care plans, educating staff and guaranteeing policies minimise infection risks. In acute care, they manage critically ill patients with conditions like pneumonia or acute respiratory distress syndrome, coordinating multidisciplinary care to assure optimal outcomes (C. C. Lai et al., 2020).

Despite resource constraints and psychological stress during pandemics, nurses have demonstrated extraordinary resilience (Liu et al., 2020; Muz & Erdoğan Yüce, 2021; Pogoy & Cutamora, 2021; Schroeder et al., 2020). Their ability to adapt and maintain continuity of care demonstrates their crucial role in mitigating the impacts of public health crises and stresses the need for continuing support and recognition of their contributions.

In summary, nurses play an indispensable role in health emergencies, serving as frontline responders who provide direct care, infection prevention, patient education, and community outreach while sustaining healthcare systems under extreme pressure. In resource-limited settings such as rural Sarawak, they often act as primary healthcare providers, combining clinical expertise with advocacy and education to meet diverse community needs. However, these critical responsibilities expose nurses to significant psychosocial strain, including anxiety, grief, moral distress, social stigma, and isolation from loved ones. Recognising and supporting nurses' psychosocial well-being is therefore vital, as their resilience directly influences the quality of holistic, compassionate, and sustained care during pandemics and other crises.

2.4 An Introduction to Psychosocial

The term "psychosocial" encompasses a wide range of concepts within health research, particularly in fields such as social epidemiology. It is applied in various contexts,

including causes and risk factors ("psychosocial causation," "psychosocial influences," "psychosocial risk factors"), mediating factors and contexts ("psychosocial mechanisms," "psychosocial environment," "psychosocial context," "psychosocial resources," "psychosocial support"), as well as outcomes ("psychosocial distress," "psychosocial well-being," "psychosocial health") (Martikainen et al., 2002). In this study, the focus is on examining psychosocial well-being, using a broad perspective that includes both the emotional and social aspects of a nurse's well-being. The psychosocial and experiential dimensions of nurses' experiences encompass a wide range of factors that influence their interactions, general well-being and success in their professional roles.

For the purpose of this study, psychosocial experience is defined as the subjective experiences, perspectives, feelings and perceptions that influence a person's mood, cognitive-behavioural responses and social factors (Suzuki & Takei, 2013). The term "psychosocial" considers the close interrelationship between psychological and social factors. Psychological factors comprise emotions and cognitive development, including the abilities to learn, perceive and remember. Social factors, in contrast, pertain to the capacity to form relationships with others and to adhere to culturally appropriate social norms (Loughry et al., 2003).

Nurses are committed to providing competent and compassionate care to patients with a diverse range of often complex needs. While many nurses view their profession as a calling, nursing is inherently a demanding field (National Academies of Sciences et al., 2021). Nurses encounter numerous challenges, including ethical, emotional, and physical difficulties throughout their careers. These challenges may entail the risk of infection, exposure to verbal or physical abuse, meeting physical demands, managing and assisting

with the care of several patients with complex conditions, engaging in difficult conversations with patients and their families, and tackling challenging social and ethical issues, depending on the nurse's role and work environment. These pressures and expectations can significantly impact nurses' health and well-being, which, in turn, can affect their work by increasing the likelihood of medical errors and compromising patient safety and care (Melnyk et al., 2018).

2.5 Review of Previous Studies

This section provides a comprehensive review of the literature on the psychosocial experiences of nurses during a pandemic, examining the emotional and social challenges they are subjected to while caring for patients in times of crisis.

2.5.1 Nurses' Psychological Experiences During a Pandemic

The COVID-19 pandemic placed extraordinary psychological burdens on nurses, who confronted a range of emotional and social challenges while delivering patient care during uncertainty and in high-risk settings. According to the International Council of Nurses (ICN), over 1,500 nurses from 44 countries lost their lives to COVID-19, with millions more were infected globally, accentuating the acute vulnerability of healthcare workers during this period (ICN, 2020). Driven by grief, fear of infection, and moral distress, the emotional toll on nurses was monumental. Witnessing widespread patient suffering and death led to heightened anxiety levels, as witnessed in China, where 60% of healthcare workers reported anxiety symptoms, whilst 40% displayed depressive symptoms (J. Lai et al., 2020).

Nurses experienced "secondary fatigue," a form of emotional distress arising when they were unable to provide the level of care they deemed necessary due to scarce resources. This moral conflict regularly resulted in feelings of guilt, helplessness and emotional fatigue, compounding the existing mental health challenges (Griffin et al., 2024). The relentless

demand for healthcare, combined with insufficient resources, caused widespread burnout among nurses. In the United States, over 40% of nurses reported burnout symptoms (Wood et al., 2022). Limited access to PPE increased stress, as nurses worked in unsafe conditions, which increased their infection risk and sense of vulnerability at the beginning phase of COVID-19. Moreover, the prolonged exposure to high-risk environments and inadequate safety measures impacted their psychological well-being, leading a number of nurses to leave the profession and further straining healthcare systems further.

The psychological experiences of nurses during the pandemic were profoundly affected by heightened levels of anxiety, fear and emotional strain. Nurses faced significant mental health challenges owing to increased workloads, fear of contracting the virus, besides concerns about transmitting the virus to their families. Many reported symptoms of depression and exhaustion (Correos & Magnaye, 2018; Kollie & Winslow, 2016). Notwithstanding attempts to minimise exposure, nurses' vulnerability and uncertainty concerning their safety compounded these feelings of fear and anxiety, increasing the emotional toll (Lippi et al., 2020; Puradollah & Ghasempour, 2020).

Isolation became another key factor in nurses' psychological experiences, as separation from loved ones and the intensity of their work gave rise to both physical and emotional disconnection. Many felt powerless as they struggled to meet escalating demands under high-risk conditions with insufficient resources, contributing to a pervasive sense of helplessness and exhaustion (Rodríguez & Sánchez, 2020). The emotional consequences of witnessing patient suffering without sufficient means to provide optimal care compounded their distress, particularly for nurses who experienced moral distress due to resource limitations (Griffin et al., 2024).

For some nurses, the psychological impact of the pandemic was severe, manifesting as symptoms of secondary trauma from the trauma of caring for critically ill patients while fearing for their safety (Fan et al., 2020). The combination of high job stress, resource inadequacies and uncertainty related to the pandemic's progression caused significant psychological distress, declining morale, and, in several cases, resentment toward the perceived lack of recognition from employers (Galehdar et al., 2020; Lee & Lee, 2020; Rathnayake et al., 2021).

Fear of the unknown, compounded by the constant exposure to COVID-19 patients, further intensified nurses' feelings of distress and helplessness. They were required to put their own well-being aside to care for patients, but the lack of sufficient PPE and the threat of infection increased their psychological strain (Correos & Magnaye, 2018; Marshall & Smith, 2015). Likewise, nurses repeatedly struggled with the discomfort and inefficiency of PPE, while concerns about supply shortages added to the emotional anxiety (Chau et al., 2021).

The pervasive fear of infection was further intensified by insufficient PPE, which left healthcare workers vulnerable. PPE shortages in countries like Italy and the United States added to the mental strain, as demand for masks and respirators far exceeded supply (Balmer & Pollina, 2020; Bradsher & Alderman, 2020). In Malaysia, despite government funding for the procurement of PPE, shortages persisted, leading various organisations and individuals to contribute to production efforts for frontline workers (Ain Umaira Md et al., 2020; Chalil, 2020; Cheong, 2020; Yusof, 2020).

The pandemic's psychological harm on nurses extended beyond individual stress, affecting their ability to work effectively. In specific cases, fear of infection and inadequate

planning affected nurses' willingness to engage in pandemic response efforts, underscoring the importance of tackling staff attitudes, education, and organisational support (Chau et al., 2021; Schroeder et al., 2020). Conversely, the crisis also promoted personal and professional growth, with collaborative work in high-pressure environments increasing nurses' confidence and encouraging a stronger sense of professional responsibility (Coşkun Şimşek & Günay, 2021; Deliktas Demirci et al., 2021; Rathnayake et al., 2021; Sadati et al., 2021; Sun et al., 2020).

Despite the severe psychological challenges, many nurses exhibited resilience and dedication, compelled by a strong moral duty and commitment to patient care (Aliakbari et al., 2015). The experiences of nurses during the pandemic, marked by the complex interaction between fear, stress, moral distress and exhaustion, underlined the critical need for adequate support systems and resources to safeguard healthcare workers' mental health during future crises. These challenges, while profound, were diminished in various cases by resilience, professional growth, and a strong sense of duty, illustrating the importance of improving mental health resources for healthcare workers.

2.5.2 Nurses' Social Experiences During a Pandemic

The social experiences of nurses during the COVID-19 pandemic were profoundly influenced by the immense professional responsibilities they bore and the broader societal impact of the crisis. As frontline workers, nurses experienced increased demands in regard to caring for critically ill patients, preventing nosocomial infections, conducting screenings and delivering essential health education. These responsibilities placed immense strain on their social interactions both within the workplace and at home, as they struggled to manage

overwhelming workloads while grappling with the constant fear of transmitting the virus to their families (Chen et al., 2020; Lippi et al., 2020; Puradollah & Ghasempour, 2020).

Gender-based discrimination further affected nurses' social experiences, particularly male nurses, during the pandemic. A study conducted by Zhou et al. (2021) revealed that male nurses in China experienced discrimination within healthcare settings, stemming from entrenched traditional gender roles. Participants reported that nursing continues to be perceived as a predominantly female profession, leading to the perception that male nurses are less competent or committed. This bias not only affected their professional relationships but also influenced their broader social interactions, contributing to feelings of exclusion and professional invalidation.

Social isolation emerged as a significant consequence of these pressures, as nurses often had to distance themselves from loved ones to reduce the risk of viral transmission. The emotional effect of prolonged separation, compounded by extreme workloads, contributed to a pervasive sense of loneliness. Additionally, nurses were subjected to stigma from the public because of their exposure to COVID-19 patients, provoked alienation within their communities. In some cases, this stigma escalated to ostracism within communities, with reports of healthcare workers being denied access to public transportation or even facing eviction from their homes (Bagcchi, 2020; Rodríguez & Sánchez, 2020). The fear-driven perception of nurses as potential virus carriers exacerbated their social exclusion, particularly in countries like Spain, where healthcare workers reported significant social strain due to the nature of their work (Molero et al., 2022).

The pandemic also strained nurses' family dynamics, as they took extensive precautions to prevent exposing their loved ones to the virus. This fear led many nurses to

live separately from their families or limit contact with them, a decision that resulted in prolonged periods away from their children and partners. Combined with the pressures of work, these separations triggered severe mental health challenges, including stress, anxiety and burnout (J. Lai et al., 2020; Mo et al., 2020; Sun et al., 2020).

Irrespective of these societal hardships, nurses attained strength through their commitment to patient care and a sense of duty to their colleagues (Liu et al., 2020; Rathnayake et al., 2021; Schroeder et al., 2020). Solidarity within healthcare teams became a crucial source of emotional support, as nurses supported one another, sharing their thoughts and feelings through diaries, letters and informal conversations. This camaraderie helped alleviate the emotional strain and strengthened workplace unity (Kang et al., 2018; Sun et al., 2020). Similarly, financial incentives and the sense of professional pride provided further motivation, empowering nurses to persevere despite the risks and emotional challenges they encountered (Gavrić et al., 2023; Kiwanuka et al., 2024).

Resilience was a further defining aspect of nurses' social experiences during the pandemic. Many adopted self-directed coping strategies, including physical exercise, meditation and spirituality, to help manage the social and emotional effect of their work. These coping mechanisms, chiefly spirituality and faith-based practices, offered nurses comfort and purpose, contributing to their emotional resilience in a time of crisis (Borges et al., 2021; Demir & Şahin, 2022; Safdar et al., 2023; Upenieks, 2022).

Thus, nurses' social experiences during the COVID-19 pandemic were marked by stigma, isolation and significant challenges in maintaining personal relationships. Nevertheless, in the middle of these hardships, they demonstrated remarkable resilience and dedication, drawing strength from their duty, camaraderie with colleagues and coping

strategies. These factors were essential to sustain their well-being and enable them to continue their vital work throughout the global health crisis.

2.5.3 The Repercussions on The Lives of Nurses During the Pandemic

The COVID-19 pandemic had an acute impact on nurses' lives, both professionally and personally. The psychological and emotional pressure was significant, with many nurses experiencing heightened anxiety, fear, depression and stress. These emotional burdens were primarily driven by increased workloads, the fear of contracting the virus, besides concerns regarding transmitting the virus to their families. The overwhelming nature of the situation, combined with moral distress due to inadequate resources and overwhelming patient needs, further exacerbated the psychological strain (Chau et al., 2021; Góes et al., 2020; Goh et al., 2021). This generated high burnout rates, post-traumatic stress disorder (PTSD), and feelings of isolation and powerlessness, which adversely affected their overall well-being (Kollie & Winslow, 2016; Sun et al., 2020).

The increased demands of the pandemic resulted in a significant work-life imbalance for nurses. Long working hours, extended shifts and unrealistic workloads left barely any time for rest or personal activities, playing a role in physical exhaustion and emotional fatigue. Nurses struggled to balance the pressures of patient care with their personal and family responsibilities, giving rise to heightened stress and a drop in social interactions outside of work (Shechter et al., 2020). These challenges were compounded by the strain on family relationships, as nurses worried about exposing their loved ones to the virus. This fear led some to isolate themselves from family members or even live apart to reduce the risk of transmission, bringing about feelings of guilt and emotional distress, also known as “secondary fatigue” (Griffin et al., 2024).

Social isolation was another significant consequence of the pandemic for nurses. Quarantine measures and social distancing, along with the stigma associated with being a healthcare worker during the crisis, induced a sense of alienation. Compounding their existing challenges, public fear and distancing triggered increased isolation and loneliness among nurses (Rodríguez & Sánchez, 2020). The stigma surrounding the pandemic on occasion escalated to extreme forms of discrimination, such as denial of access to public transportation and eviction from homes in some countries, heightening the emotional burden on healthcare workers (Bagcchi, 2020).

Notwithstanding these negative consequences, the pandemic also produced some positive changes in nurses' professional lives. Many nurses reported a strengthened sense of responsibility and loyalty to their colleagues, with a renewed sense of purpose in their roles. The challenges of working under pressure created a sense of solidarity, which helped them cope with the emotional strain (Muz & Erdoğan Yüce, 2021). For some, the shared experience of managing the crisis together led to professional growth, increased satisfaction at work and greater confidence in their abilities (Borges et al., 2021). Nurses discovered that their commitment to patient care intensified and that they developed a stronger professional identity, which helped them persevere during the challenging circumstances (Muz & Erdoğan Yüce, 2021).

In conclusion, while the pandemic had significant negative effects on nurses' lives, including psychological distress, physical exhaustion, social isolation and strained family dynamics, it also highlighted their resilience and dedication to patient care. Many nurses adapted by furthering solidarity with their colleagues, developing personal and professional growth, and finding new sources of motivation through their sense of duty and loyalty to the

profession. These experiences establish the need for better support systems and resources to help healthcare workers manage the emotional and physical demands of future crises.

2.6 Theoretical Framework

This study is grounded in two key theoretical frameworks: Lazarus and Folkman's Stress and Coping Theory and Albert Bandura's Social Cognitive Theory (SCT) (see to Figure 2.2). Stress and Coping Theory serves as a lens to understand how individuals appraise and respond to stressful situations. It provides awareness as regards the sources of stress and the coping mechanisms employed by nurses in highly stressful environments, such as the COVID-19 pandemic. This theory elucidates how nurses evaluate the demands of their work and employ adaptive strategies to manage the physical, emotional and psychological challenges they encounter.

Social Cognitive Theory (SCT) developed by Bandura (1977), complements this perspective by emphasising the role of self-concept, social relationships and cognitive processes in determining individuals' interactions with their environment. SCT theorises that individuals actively construct their learning experiences by interpreting the outcomes of their actions, which, in turn, influence their environment, personal factors and subsequent behaviours. The theory identifies the reciprocal interaction between personal factors, environmental influences, and behaviour in forming thoughts, emotions and actions within social settings (Schunk, 2012).

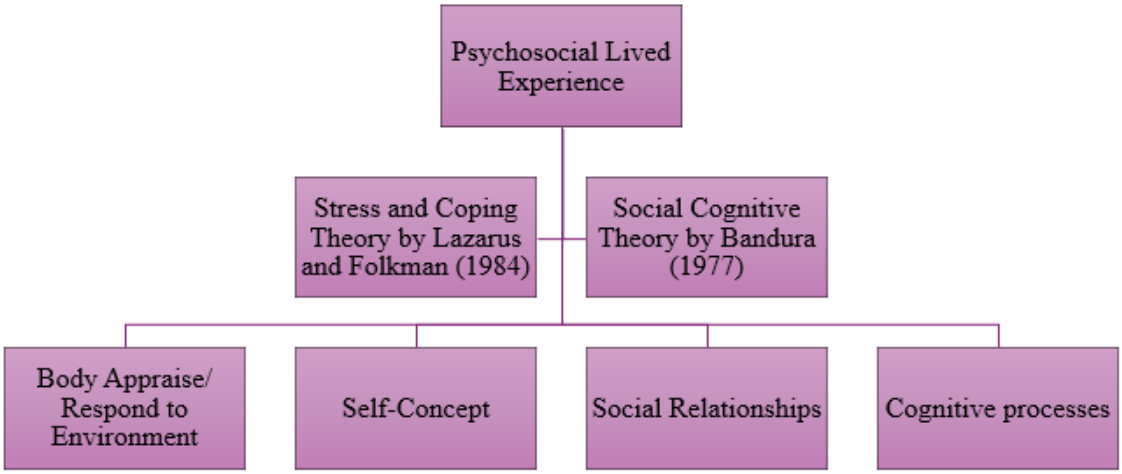


Figure 2.2: Theoretical Framework

2.6.1 Stress and Coping Theory

The Stress and Coping Theory by Lazarus and Folkman (1984) asserts that stress arises from the interaction between individuals and their environment, particularly when individuals perceive a situation as challenging or beyond their resources (Bhattacharjee & Ghosh, 2022). The theory highlights two key processes: appraisal and coping. Appraisal comprises how individuals interpret and evaluate the significance of a stressful event, while coping encompasses the strategies used to manage the emotional and practical demands associated with the stressor.

This theory provides a valuable lens to comprehend how nurses perceive and manage the intense pressures associated with their work environment (Maben & Bridges, 2020). In the context of the COVID-19 pandemic, the appraisal stage was particularly detailed, as it impacted how nurses interpreted and responded to unprecedented challenges. This stage consists of two components: primary appraisal, where individuals assess the demands of a

situation, and secondary appraisal, where they evaluate their resources and ability to cope with those demands (Landy et al., 2022).

For example, a nurse working in a COVID-19 isolation ward might appraise the situation as highly demanding due to factors such as the high volume of critically ill patients, stringent infection control protocols, as well as the constant risk of infection. If the nurse perceives these demands as exceeding their resources, for example inadequate PPE, inadequate training or a lack of support, they may classify the situation as a threat to their physical and mental well-being. This negative appraisal typically triggers stress responses, including fear, anxiety and feelings of helplessness (Maben & Bridges, 2020). Conversely, if the nurse perceives the situation as manageable or views it as an opportunity to make a significant impact, they may appraise it as a challenge rather than a threat. This positive appraisal encourages emotional responses, for instance determination and resilience, enabling proactive coping strategies such as seeking support, advocating for resources, or developing new skills.

The appraisal stage is critical because it directly influences how nurses respond to stressors both emotionally and behaviourally. Nurses who perceive stressors as threats are more likely to engage in avoidant coping strategies, such as emotional withdrawal or detachment, which can negatively impact their mental health, performance at work and patient outcomes. Equally, those who appraise stressors as challenges commonly employ constructive coping mechanisms, such as improving time management, seeking peer support, or adopting mindfulness, which boost their resilience and ability to deliver high-quality care.

According to Stress and Coping Theory, coping strategies are categorised into problem-focused and emotion-focused approaches. Problem-focused coping entails taking direct action to deal with the stressor, such as enhancing teamwork, improving infection control protocols, or optimising time management. Emotion-focused coping, on the other hand, helps manage the emotional response to stress and includes methods such as seeking social support, engaging in self-care or using mindfulness techniques.

Stress and Coping Theory also highlights the dynamic relationship between nurses' perceptions of the crisis and their coping strategies. By addressing the specific stressors faced by nurses during the pandemic, this framework identifies the importance of both personal resilience and systemic psychosocial support. The ability of nurses to adapt and alleviate stress through these coping mechanisms illustrates the critical need for supportive interventions, for instance stress management training and institutional support systems, to improve their well-being.

By providing knowledge on how nurses appraise and cope with stress, Stress and Coping Theory provides a framework to understand the specific challenges experienced by healthcare workers during crises. It points out the importance of encouraging resilience and increasing psychosocial support to sustain the mental health and professionalism of nurses in highly-stressful environments.

2.6.2 Social Cognitive Theory (SCT)

This study applies to Albert Bandura's Social Cognitive Theory (SCT) to examine nurses' psychosocial experiences during the COVID-19 pandemic. SCT highlights the reciprocal interaction between personal factors, environmental influences, and behaviour, drawing attention to individuals' ability to influence their own experiences and exert agency

over significant life events (Schunk & DiBenedetto, 2019). This agency is expressed through cognitive and self-regulatory abilities, such as setting goals, implementing strategies and modifying behaviours to achieve the desired outcomes. By incorporating concepts such as self-efficacy, observational learning and reciprocal determinism, SCT provides a holistic framework to recognise how individuals behave within their social environments.

A central component of SCT is self-efficacy, which represents an individual's belief in their ability to perform tasks and manage challenges (Bandura, 1977, 1986; Bandura et al., 1999). During the COVID-19 pandemic, self-efficacy was imperative for nurses coping with the demands of patient care, complex safety protocols and rapidly changing clinical practice. Nurses with higher self-efficacy demonstrated resilience, persistence and resourcefulness, enabling them to adapt effectively to these unprecedented challenges. Conversely, those with lower self-efficacy experienced greater stress and reduced coping strategies, underlining the importance of confidence in managing demanding roles during crisis conditions.

Observational learning, a fundamental principle of Social Cognitive Theory (SCT), occurs when individuals acquire knowledge and skills by observing others. For this process to be effective, individuals must focus on a model, cognitively retain the observed behaviours, be capable of reproducing them, and feel motivated to do so (Bandura, 1989). During the COVID-19 pandemic, nurses extensively relied heavily on observational learning to adapt to rapidly evolving work environments. By observing colleagues and leaders, they learned to implement safety protocols, manage unpredictable patient conditions and build emotional resilience in highly-stressful settings.

Peer support further reinforced this learning process by promoting emotional resilience and teamwork. By means of mutual encouragement, shared coping strategies and open communication, nurses provided reassurance and strengthened their collective sense of purpose. Experienced nurses modelled stress management, emotional regulation and mindfulness practices, promoting debriefing sessions and peer discussions to alleviate distress (Dullius et al., 2021). This supportive environment reduced burnout, heightened adaptability, and strengthened healthcare teams during the crisis.

Reciprocal determinism, another key concept in SCT, describes the continuous interaction between personal factors (for instance beliefs, emotions, and cognitive abilities), behaviour (actions taken by individuals), and environmental influences (external conditions or social contexts) (Bandura, 1989). These components interact bidirectionally; for example, a nurse's emotional resilience (personal factor) influences their behaviour, such as seeking peer support or withdrawing from social interactions. These behaviours, in turn, influence the workplace environment, generating either collaboration or tension, which subsequently affects individual coping strategies.

During the pandemic, reciprocal determinism was evident in how nurses' resilience or anxiety influenced their actions and the surrounding environment. Supportive workplaces and cohesive teams reinforced positive behaviours, such as collaboration and mutual support, promoting well-being and adaptability. Observing empathetic interactions among colleagues further strengthened resilience, mitigated stress and enabled nurses to manage their responsibilities more effectively during the crisis. This dynamic highlights the fundamental role of a supportive work environment in nurturing adaptive behaviours and safeguarding nurses' emotional and professional well-being.

As a conclusion, by integrating Lazarus and Folkman's Stress and Coping Theory with Bandura's Social Cognitive Theory (SCT), this study offers a comprehensive lens to understand the psychosocial lived experiences of nurses in Sarawak during the COVID-19 pandemic. Stress and Coping Theory explains how nurses appraised demanding situations and used problem-focused or emotion-focused coping strategies, while SCT highlights their active agency through self-efficacy, observational learning, and reciprocal determinism. Together, these frameworks project how nurses managed stress, adapted to challenges, and drew on resilience and social support within their unique cultural and healthcare contexts.

2.7 Summary

This chapter has explored the history and origin of the coronavirus. The chapter also discussed the roles and functions of nurses in caring for patients during the pandemic. This was followed by reviewing the literature on nurses' psychosocial responses during a pandemic. To conclude, theoretical frameworks were explained.

CHAPTER 3

METHODOLOGY

This chapter addresses the research design, which provides the framework with respect to the collection and interpretation of the data. Additionally, it provides a detailed explanation of the research setting, population and sampling methods, ethical considerations and measures to assure trustworthiness. It further explain the data collection procedures, data analysis methods, and concludes with a summary.

3.1 Philosophical Framework

To understand the psychosocial lived experiences of nurses during the pandemic, I recognized the need to exploit philosophical frameworks that provide a better understanding of this phenomenon. Grounded in the principles of qualitative research, I accentuate the importance of studying phenomena within their natural surroundings, where they occur organically, without manipulation or artificial interference to authentically capture their spirit.

As a naturalist, my research philosophy is consistent with the naturalistic paradigm. It acknowledges that reality is subjective, multi-layered, constantly changing and that it is influenced by individual perceptions, social contexts and lived experiences (Roberts, 2020). This perspective contrasts sharply with the positivist paradigm, which assumes that reality is objective, measurable, and stable, existing independently of human interpretation.

By embracing the naturalistic approach, I am able to explore how individuals construct meaning within their specific contexts. This viewpoint enables for a deeper understanding of complex phenomena, such as the emotional and psychological challenges

experienced by nurses during a health crisis. Immersing myself in this paradigm has heightened my ability to appreciate the dynamic and complex experiences encountered by healthcare professionals, promoting a more empathetic and holistic approach in relation to my research.

Essentially, the naturalistic paradigm supports my belief that to genuinely understand the lived experiences of individuals, one must embrace the subjectivity and fluidity of reality, allowing it to unfold authentically in its natural setting (Roberts, 2020). This approach is crucial in portraying the depth and richness of human experiences, particularly in times of profound crisis.

3.1.1 Constructivism

As I approach this research from a naturalistic perspective, I acknowledge that data are records of actual events, inherently interpreted through prior knowledge and experience. This perspective is in keeping with the constructionist view, which asserts that knowledge is co-constructed by way of interaction between the interviewer and the interviewee (Brinkmann & Kvale, 2014). The interview process therefore becomes an active collaboration, allowing participants to critically examine their experiences, articulate their thoughts and rationalising their responses. Through this shared dialogue, I facilitate the co-construction of knowledge, presenting a greater understanding of the lived experiences under investigation (Brinkmann & Kvale, 2014).

This research is grounded in the constructivist paradigm, emphasizing the active role of individuals in determining their reality by way of cognition and interaction with their environment (Chand, 2024). Constructivism hypothesises that knowledge is not passively received but actively created through interpretation, prior experiences and social engagement

(Resnick, 2018). In nursing, clinical experiences, professional discussions and cultural contexts significantly influence how knowledge is constructed and applied in patient care. Seeing as meaning is subjective, individuals may interpret the same experience differently based on emotions, values and societal influences. By incorporating this paradigm, this research aims to explore and explain the complexities of human experience, that are produced by these dynamic interactions.

Constructivist theories provide a specific understanding of epistemology (the theory of knowledge) and learning theory, explaining not only what people learn but also how they learn. Honebein (1996) highlights that individuals actively construct their own understanding and knowledge of the world through experiences and reflection, integrating new information into existing frameworks to construct meaning. This process stresses the importance of active participation, social interaction, prior knowledge and reflection in determining understanding. Hein (1991) emphasises this point, asserting that learning is fundamentally the process of creating meaning—a notion encapsulated by the Chinese philosopher Confucius who stated: "I hear and I forget. I see and I remember. I do and I understand." Learning is most effective when individuals engage in active discovery through experimentation and the practical application of knowledge (Dogru & Kalender, 2007).

Knowledge within the constructivist framework is inherently subjective and influenced by perceptions and interpretations. Mogashoa (2014) asserts that knowledge is demonstrated through practical activities and discovered by acting, interacting with the environment, relating to others, whilst engaging in embodied and temporal experiences. Non-verbal cues, such as body language, facial expressions, tone of voice and eye contact, further convey how individuals perceive and interact with their environment. In this context,

truth is not absolute but relative, formed by individual perspectives (Denzin & Lincoln, 2017).

In research, constructivism aids the examination of individual perspectives and the co-construction of meaning, eventually revealing the real meaning of phenomena (Adom et al., 2016). By adopting this framework, I aim to authentically represent the lived experiences of nurses and provide a rich, detailed understanding of their psychosocial experiences during the COVID-19 pandemic.

My extensive experience as a registered nurse, spanning 13 years, provides a valuable foundation for this study. It allows me to understand the complexities connected with the nursing profession and appreciate the challenges nurses face, particularly during the pandemic. This depth of experience, coupled with my understanding of life's purpose, informs how I engage with participants and interpret their accounts, ensuring a thoughtful and empathetic evaluation of their lived experiences.

As an insider within this research context, I am well-positioned to understand the concerns raised by participants regarding their duties, responsibilities and daily lives. The insider's (emic) viewpoint enables me to communicate effectively, using shared language, whilst appreciating local values and dealing with participants' concerns (Khaliza & Aizan, 2017). Direct engagement with participants provides beneficial information of their psychosocial experiences, enabling a comprehensive examination of how they make sense of their experiences. This emic approach affirms that sense and experience are key sources of reality (Denzin & Lincoln, 2017).

While my insider's (emic) perspective provides an appreciation of participants' lived experiences, I also adopt an outsider's (etic) lens to guarantee objectivity and methodological

rigor. By maintaining a critical distance, I aim to minimise personal biases and uphold the integrity of the research process. This dual perspective enables me to balance familiarity with analytical detachment, ensuring that the depth and richness of participants' narratives are accurately represented. The ability to navigate between emic and etic positions permits a more holistic examination of the research focus, integrating contextual depth with critical analysis. This approach is in keeping with the principles of qualitative research, where reflexivity and several perspectives are conducive to a more thorough and credible interpretation of lived experiences (Creswell & Poth, 2024).

To achieve this balance, I engage deeply with participants' narratives through active listening, reflexive journaling, and continuous self-awareness. I also employ methodological strategies for instance member checking, peer debriefing and triangulation to validate the findings and ensure the participants' voices are authentically represented. This assimilation of emic and etic perspectives allows a holistic understanding of the psychosocial experiences of nurses.

This study prioritises in-person communication and participants' views, particularly during the interview process, agreeing with the principle of axiology, which underlines the integration of ethics and values in research (Saunders et al., 2015). Conducted within a value-laden context, the research is inherently fashioned by the values, beliefs and experiences of both the participants and the researcher. I critically acknowledge how my professional background as a nurse influences data collection and interpretation while assuring that the participants' voices remain central. By transparently recognising and considering my own values and potential biases, I uphold ethical integrity and increase the depth of understanding

regarding nurses' psychosocial experiences in Sarawak during the COVID-19 pandemic. This reflexive approach strengthens the authenticity and rigor of the study's findings.

By adopting a constructivist framework, this study acknowledges that knowledge is actively constructed through interactions, experiences and reflections. This approach guarantees that the voices and experiences of nurses during the pandemic are authentically represented, providing a significant contribution to understanding their psychosocial experiences.

3.1.2 Qualitative Phenomenology

This study employs a qualitative phenomenological approach to illustrate the lived experiences of nurses during the COVID-19 pandemic, providing significant findings into their individual opinions, behaviours, and responses (Tenny et al., 2020). Phenomenology is particularly appropriate to explore the personal and complex impact of the pandemic on nursing practice, as it provides an in-depth view of human experiences within the healthcare system (Safazadeh et al., 2018). Similarly, recognising the complex and dynamic nature of human experience, phenomenology acknowledges that experiences are interpreted within specific contexts (Streubert & Carpenter, 1995).

The core focus of phenomenological inquiry is to explore lived experiences as they present themselves, free from preconceived interpretations or categorisations (Streubert & Carpenter, 1995). This approach allows a deeper understanding of the subjective meanings and interpretations that individuals, such as nurses, attribute to their experiences. "Life context" is central to this approach, referring to the intricate matrix of human-environment relationships that have an influence on individual perceptions and reactions (Beanland, 1999). Each nurse's experience in caring for COVID-19 patients, therefore, is distinctive and

can only be fully understood within the context of their own life and professional background.

Phenomenology, as a qualitative research tradition, stems from the philosophical work conducted by Edmund Husserl and Martin Heidegger in the 20th century. Husserl (1859–1938), a German mathematician, established phenomenology as a means to study consciousness and the meanings emerging from individual experiences. He introduced "intentionality," the directed awareness or consciousness of individuals toward events, thoughts and emotions. Husserl's descriptive phenomenology emphasises "bracketing" prior beliefs to focus purely on phenomena as they are experienced (Dahlberg et al., 2008), aiming to answer, "What do we know as persons?" (Creswell, 1994).

Martin Heidegger (1889–1976), Husserl's student, expanded phenomenology by shifting from epistemology to ontology, focusing on "Being." His approach, known as hermeneutic or interpretive phenomenology, surpasses description to discover deeper meanings (Papp et al., 2003). Heidegger argued against bracketing assumptions, proposing instead that prior knowledge and preconceptions are part of understanding. In his view, researchers' perspectives inevitably determine the interpretation of human experiences (Dahlberg et al., 2008), underlining that the researcher and participants collaborate to reveal inherent meanings (Lauterbach, 2018). Heidegger's concept of "Dasein" describes the fundamental condition of human existence, illustrating the inseparability of the researcher's "Being" from the phenomenon being studied (Friesen et al., 2012; Lauterbach, 2018). This underscores the need for researchers to acknowledge their participation in the interpretive process, as their own experiences and perspectives are integral to the phenomena they study.

Furthermore, Heidegger introduced the concept of "Scheinen" (seeming), which distinguishes between appearances and underlying experiences. For example, symptoms like fever and rash are superficial signs of a deeper illness (Heidegger, 1962). Rejecting the separation between appearances and reality, Heidegger maintained that phenomena exhibit their true meanings through self-display rather than superficial aspects (Polt, 1999).

Accepting phenomenology's diversity, Heidegger (1962) remarked that academics have developed varying approaches to phenomenological inquiry. Academics like Gadamer (1975), Van Manen (1990) and (2011) contributed distinct typologies, indicating different applications as regards phenomenology in research. Van Manen (1990), for instance, combines descriptive and interpretive phenomenology, emphasising “lifeworld,” a concept developed by Merleau-Ponty (1962), and focusing on the textual expressions at the core of lived experiences. He identifies four existential themes: corporeality (lived body), relationality (lived relationships), spatiality (lived space), and temporality (lived time), as a framework to explain the fundamental components of human experience.

In his later work, Van Manen (2017) describes interpretive research as a skill, developed through exposure to phenomenological texts and a "turning towards" the topic with wonder. He stresses writing and rewriting as crucial to analysis, not merely to record findings but to extract a more comprehensive meaning.

In this thesis, Heideggerian, hermeneutic and interpretive phenomenology are used interchangeably to underline the interpretive process aimed at finding deeper meanings in participants' lived experiences. This approach surpasses description, emphasising that the researcher’s own Being and perspective are fundamental to understand these experiences.

3.1.3 Justification for Using Interpretive Research

In this study, I employ hermeneutic phenomenology, guided by Max Van Manen (2017) methodology, to acquire and interpret the lived experiences of nurses during the COVID-19 pandemic. Grounded in hermeneutic and phenomenological traditions, this approach aims to unearth the deeper meanings embedded in these experiences, presenting useful information into how nurses perceive, interpret and make sense of their roles, responsibilities and personal struggles in the context of an unprecedented global health crisis.

A cornerstone of hermeneutic phenomenology is the recognition that the researcher's own experiences and prior knowledge are integral to the interpretive process. Bynum and Varpio (2018) assert how pre-existing knowledge and personal history have an impact on interpretations, emphasising the interconnectedness between the researcher's perspective and the participants' experiences. As a researcher, I maintain self-awareness and reflexivity throughout the study, critically examining how my professional nursing background informs my interpretations.

This hermeneutic approach is consistent with the aim of this study: to explore the subjective meanings and experiences of nurses during the pandemic. Hermeneutic phenomenology supports the in-depth examination of the emotional, cognitive and behavioral elements of their roles by immersing themselves in and documenting their narratives. This methodology is particularly suited to exploring how thoughts, emotions and actions connect within the broader human experience, allowing a better understanding of the profound challenges faced by nurses during this extraordinary period.

This hermeneutic framework, influenced by Heidegger (1962), Gadamer and Linge (1977), and Van Manen (1990), examines human experiences within the lifeworld.

Historically, hermeneutics was developed to clarify Biblical scriptures and divulge symbolic meanings (Gelven, 1989), but it has since evolved to include understanding an individual's intentions, a person's worldview, and socio-linguistic contexts. This development is particularly beneficial in the context of my study, where understanding the experiences of nurses requires an interpretive approach that considers their professional ethos, cultural contexts, in addition to the shared language of caregiving.

In its contemporary application, hermeneutics explains the empirical world as a "text" (Barritt et al., 1985). This is in keeping with my study's aim to treat the narratives of nurses as texts to be interpreted. Through this lens, the lived experiences of nurses are not merely described but further analysed to determine their emotional, cognitive and behavioural aspects. This enables an understanding of how nurses constructed meaning during the pandemic, as they balanced their professional responsibilities with the immense psychosocial challenges presented by the crisis.

A key concept in hermeneutic phenomenology is the "hermeneutic circle," which proposes that understanding is an iterative and circular process. As articulated by Heidegger, Gadamer and Van Manen, this concept illustrates the relationship between the parts and the whole of an experience. Polifroni and Welch (1999) describe interpretation as a collaborative endeavour where researcher and participants develop a mutual understanding of the phenomenon. Koch (1995) further elaborates on this as a "fusion of horizons," where the knowledge, preconceptions and interpretive frameworks of both the researcher and participants intersect to co-construct meaning. Through continuous interaction and conversation with participants, I engage in significant conversations to explore and interpret their experiences. This ongoing dialogue allows participants to communicate their

interpretations of their circumstances, enabling the iterative cycles of reading, reflective writing and interpretation (Gadamer, 2004).

Participant selection in this study was informed by the need to balance homogeneity with expected variations, including nurses from diverse ethnic and cultural backgrounds. This inclusivity guarantees a comprehensive view of their experiences (Burmeister & Aitken, 2012). Furthermore, I adopt an open-minded approach, acknowledging that the phenomenon may simultaneously reveal and conceal itself, thus allowing new findings to arise through participant collaboration (Vagle, 2018).

Data collection entailed in in-depth interviews designed to acquire the depth of nurses' experiences. Analysis followed an iterative process, beginning with the examination of individual experiences to identify shared themes. Subsequently, this evolved into a broader thematic analysis (Idczak, 2007). Throughout this process, I remained focused on participants' underlying themes while considering my own experiences to assure transparency and rigor (Neubauer et al., 2019). Likewise, biases were explicitly addressed by acknowledging preconceptions and revising interpretations as necessary (Heidegger, 1962; Lauterbach, 2018).

In conclusion, hermeneutic phenomenology provides a justified and robust methodology for this study. Its emphasis on co-constructing meaning, respecting the complexity of human experience, and engaging genuinely with participants' narratives permits a comprehensive investigation of nurses' lived experiences during the pandemic. This approach provides helpful information into the emotional and professional experiences of nurses, shedding light on their resilience and challenges in a rapidly changing healthcare environment.

3.2 Research Setting

This study was conducted at Sarawak General Hospital, the largest hospital in Sarawak and the primary referral centre for the region. Sarawak, the largest state in Malaysia, has a diverse, multicultural population, with healthcare services extending throughout both urban and rural communities. The hospital plays a crucial role in the state's healthcare system, particularly in managing infectious diseases, and functioned as a frontline facility during the COVID-19 pandemic. Its well-equipped Infectious Disease (ID) ward and adaptive strategies guaranteed the delivery of quality care, making it an appropriate setting to study the psychosocial experiences of nurses on the frontlines.

Concerning this study, participants were selected from the ID ward at Sarawak General Hospital between July 2021 and November 2021. Interviews were conducted in a quiet, private room within the ward to enable a focused, in-depth conversation. At the time of each interview, the participating nurse was a team leader for their shift, ensuring they could fully engage in the discussion without distractions. Each interview was conducted face-to-face, with only the participant and myself present, to maintain confidentiality and allow for a comprehensive examination of their experiences.

3.2.1 Overview of Sarawak

Sarawak, located on the northwest coast of Borneo, is Malaysia's largest state. It lies between latitudes 0° 50' and 5°N and longitudes 109° 36' and 115° 40' E, just north of the Equator (Government, 2018). The state covers approximately 800 kilometres along Borneo's northwest coast, covering a total area of 124,171 square kilometres. The South China Sea separates Sarawak from Peninsular Malaysia by a distance of 600 kilometres, and it shares

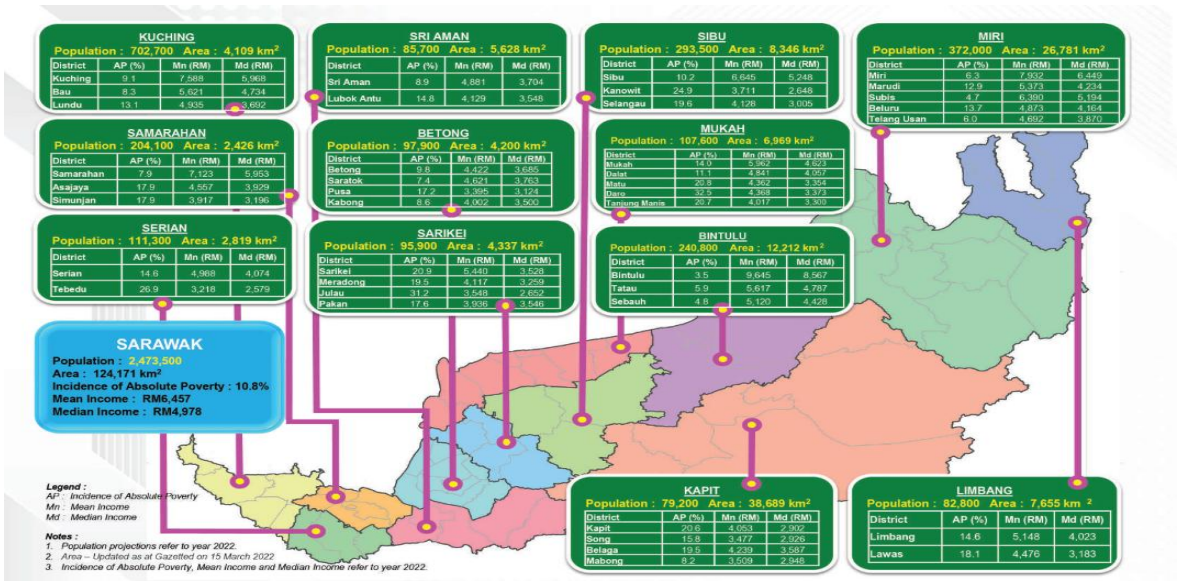
the island of Borneo with Sabah to the east. The state borders Indonesia to the south and surrounds the independent nation of Brunei.

Figure 3.1: Sarawak Geographical Location



Source: Economic Planning Unit Sarawak (2023)

Figure 3.2: Overview of Sarawak Population



Source: Economic Planning Unit Sarawak (2023)

3.2.1.1 Geography and Climate

Sarawak is often referred to as the "Land of the Hornbills," a name that hints at the cultural significance of these birds, particularly among the Dayak people who believe they are symbols representing the spirit of God. Out of 54 species worldwide, eight hornbill species are found in Sarawak, with the Rhinoceros hornbill recognized as the state bird ("The magnificent hornbills of Sarawak," 2015).

The state capital, Kuching, which operates as the economic and administrative centre of Sarawak, is the largest city with a population of 702,700. Other major cities include Miri (372,000), Sibu (293,500), and Bintulu (240,800). As of 2022, Sarawak's total population stood at approximately 2,473,500, with a female-to-male ratio of 1,197,400 to 1,276,100, and an annual growth rate of 0.2% (Sarawak, 2023).

Sarawak enjoys an equatorial climate characterised by tropical rainforests with rich biodiversity. The mean daily temperature remains consistent year-round, ranging from 33°C in the afternoon to 22°C at night (Government, 2018). In highland areas, such as Bario, temperatures range from 16°C to 25°C during the day, occasionally dropping to 11°C at night. The state experiences two monsoonal shifts: the West Coast East Monsoon, from November to February, which brings heavy rainfall, and the relatively drier South West Monsoon. In general, the average annual rainfall is around 3,965 millimetres.

3.2.1.2 Natural Resources and Attractions

Sarawak is renowned for its abundant natural resources, including pepper, cocoa, palm oil, timber and oil. It boasts a diverse landscape, with verdant jungles, the world's largest cave chamber at Gunung Mulu National Park, the Rajang River (Malaysia's longest river), and the Bakun Dam, one of Southeast Asia's largest dams, located on the Balui River.

The state's highest point is Mount Murud. These attractions, together with its rich cultural heritage, make Sarawak an increasingly popular travel destination, delivering a mix of history, natural beauty, festivals, modern city life and indulgence.

3.2.1.3 Cultural Diversity

Sarawak is home to 34 distinct ethnic groups, with the largest being the Iban, Chinese, Malays, Bidayuh, Melanau, Orang Ulu, Penan and Kayan communities. Irrespective of their distinctive cultural identities, these groups coexist peacefully, demonstrating tolerance and a profound understanding of each other's heritage (Board, 2024).

The Ibans, constituting over 30% of Sarawak's population, are well-known for their historic longhouses and rich cultural traditions. They celebrate “Gawai Dayak,” a festival of thanksgiving for the harvest, with traditional dances such as the "Ngajat" and rice wine "tuak". Iban crafts are highly valued, with “pua kumbu” blankets, wood carvings and ironware gaining popularity as souvenirs.

Approximately 25% of Sarawak’s population are Malays. Traditionally coastal inhabitants and fishermen, they have since migrated to urban areas. Their clothing includes the "baju Melayu" for men and the "baju kurung" for women, often accompanied by traditional martial arts performances like “pencak silat.” The Malays are also recognised for their wood carvings, and textile weaving using gold and silver threads.

The Chinese form the third-largest ethnic group in Sarawak, having initially migrated during the Brooke era to work in gold mines. Sarawak was settled by the Brooke family and subsequently became a British Crown colony. They continue to celebrate major cultural festivals, such as the Chinese New Year and the Mid-Autumn Festival, with traditions like

lion and dragon dances. The Chinese are known for their artistic legacy in calligraphy, ceramics and pottery.

Other ethnic groups include the Bidayuh, predominantly residing in Lundu, Bau, Penrissen, Padawan, Siburan and Serian. They are known for unique architectural structures, for example the “baruk” roundhouse and cultural dances such as the Eagle Dance or "Rejang Beuh." The Bidayuh also produce intricate rattan “tambok” baskets.

3.2.1.4 Religion

Christianity forms the largest religious group in Sarawak (Herald, 2020), followed by Islam, Chinese folk religions; a syncretic blend of Buddhism, Taoism, Confucianism and ancestor worship, alongside indigenous animistic beliefs. Religion plays a significant role in moulding moral values, promoting modesty and decency, and reinforcing cultural identity among the diverse communities in Sarawak (Then, 2014). Religious affiliation in the state is closely intertwined with ethnic identity: Islam is predominantly associated with the Malay community, Chinese religions with the Chinese population, and Christianity with many of the indigenous groups.

At the national level, Islam is the official religion of Malaysia. Article 3 of the Federal Constitution affirms that "Islam is the religion of the Federation, but other religions may be practised in peace and harmony in any part of the Federation" (MyGovernment, 2024). Additionally, Article 11 guarantees freedom of religion, stating, "Every person has the right to profess and practise his religion and, subject to Clause (4), to propagate it." These constitutional provisions uphold religious freedom and protect the pluralistic nature of Malaysian society.

Notwithstanding Islam's status as the official religion, Malaysia remains a multicultural and multi-faith nation, where people are free to follow their respective religions. This inclusive approach has contributed to inter-religious harmony and national unity, as corroborated by the relatively peaceful coexistence among diverse ethnic and religious communities throughout the country.

3.2.1.5 Languages and Education

Sarawak's multicultural society is exhibited in its linguistic diversity. The national language is Malay (Bahasa Malaysia), but English remains an official language, as Sarawak has not adopted the National Language Act 1963/1967 (Tawie, 2012). "Bahasa Melayu Sarawak," a local dialect, is distinct from standard Malay. Other widely spoken languages include the Iban language and various Chinese dialects.

In terms of education, Sarawak has a literacy rate of 92%, slightly lower than Malaysia’s national average of 93.5% (Chua, 2023). The literacy rate across Malaysia reached 95.71% in 2021, indicating improvement in recent years.

3.2.1.6 Healthcare Infrastructure

Healthcare in Sarawak is provided by three major government hospitals: Sarawak General Hospital, Sibu Hospital and Miri Hospital. These facilities, along with district hospitals, public health clinics and rural clinics, deliver comprehensive medical services ranging from palliative care to emergency triage. In addition to government-run facilities, Sarawak is also home to several private hospitals, guaranteeing a broad spectrum of healthcare services for its population.

To conclude, Sarawak is a region of incredible cultural diversity, natural beauty and rich resources. With its distinct ethnic groups, vibrant traditions and modern amenities, it

continues to be a place of fascination for both residents and visitors, symbolising the essence of Malaysia's multicultural heritage.

3.2.2 Sarawak General Hospital

Figure 3.3: Location of the research setting



Source: Economic Planning Unit Sarawak (2023)

The Sarawak General Hospital (SGH), located in Sarawak, Malaysia, is the largest hospital in the state and operates as the main tertiary and referral hospital in East Malaysia. With a total capacity of 1,005 official beds (Dason, 2023), SGH plays a vital role in providing comprehensive healthcare services for the population.

3.2.2.1 Infectious Disease (ID) Ward

The Infectious Disease (ID) ward at Sarawak General Hospital officially commenced operations on December 15, 2009, following its relocation from the Medical Isolation inpatient block. The ward primarily focuses on treating and caring for patients requiring barrier nursing. Initially, the ward was a converted houseman quarters, renovated into a

facility with eleven single rooms, each furnished with attached bathrooms and toilets. These rooms are designed with a Negative Pressure system, permitting 6–12 air changes per hour. They are essential for controlling the spread of infectious agents.

The ID ward covers two floors, with six rooms on the lower level specifically designated for unstable patients who require closer monitoring and access to ventilation facilities. Each room is equipped with essential monitoring features, including telephones for communication between patients and staff, heart monitoring equipment, as well as a CCTV system linked to the nurse's station for effective patient surveillance.

On admission to the ID ward, patients receive an orientation outlining the ward's facilities and guidelines, including policies on family visits. As frontliners in infectious disease management, all staff members are required to strictly adhere to PPE protocols. Additionally, they must be proficient in using Powered Air Personal Respirator (PAPR) systems. New staff members and house officers undergo training in handling specimens, as well as in how to correctly put on and remove PPE.

3.2.2.2 COVID-19 Management and Response

Sarawak General Hospital was classified as a "dirty hospital" during the COVID-19 pandemic, meaning it was equipped to receive and treat suspected and confirmed COVID-19 cases (Health, 2020). SGH provided numerous care settings for COVID-19 patients based on the severity of their conditions. A specialised infectious disease team assessed the COVID-19 patients to categorise them according to the severity of illness, underlying medical conditions, and symptom presence.

Patients requiring intubation were admitted to either the Infectious Disease ward or the COVID-19 Intensive Care Unit (ICU). Those needing oxygen supplementation or high-

flow nasal cannula support were admitted to the female medical ward (Batumalai, 2021). During the pandemic, nurses were frequently redeployed to different wards or quarantine centres, whilst newly graduated nurses were recruited to strengthen the healthcare workforce.

3.3 Population and Sampling

This study employed purposive sampling to recruit participants. In purposive sampling, participants are intentionally selected based on their ability to provide relevant data concerning the phenomenon under investigation. This approach ensures that individuals with the necessary knowledge or experience are included, thus augmenting the depth and relevance of the information gathered (Etikan, 2016). For this study, nurses who had experience caring for COVID-19 patients were specifically selected, as they were considered capable of providing valuable knowledge that could not be obtained from other sources (Martínez-Mesa et al., 2016).

To guarantee credibility, participants were identified and described with accuracy. Potential participants were selected according to explicit inclusion and exclusion criteria, which were clearly outlined to maintain methodological rigor and prevent selection bias (Suri, 2011). This selection process assured that the sample comprised a diverse group of nurses from various cultural backgrounds who lived and worked in Kuching, Sarawak. The criteria for participant selection are specified in Table 3.1.

3.3.1 Determining Sample Size

In qualitative research, saturation is a hallmark of qualitative rigor and a key indicator of sample adequacy in qualitative research. It signifies that the collected data have encapsulated the diversity, depth and distinctions of the studied phenomenon, ensuring

content validity (Morse, 2015). Moreover, as a critical component, saturation strengthens the robustness and validity of data collection.

In phenomenological research, the emphasis is on the depth and value of data rather than the number of participants. The goal is to uncover the real meaning of lived experiences through in-depth examination of participants' narratives (Creswell & Creswell, 2018). Consequently, smaller sample sizes are typically sufficient, as data quality and depth of engagement take precedence over quantity. Open-ended, in-depth interviews promote a closer examination of each participant's narrative, encouraging a deeper grasp of their experiences (Roberts, 2020). The iterative nature of phenomenological research, where themes are continuously refined through ongoing engagement with the data, further underlines the significance of depth. Each participant's individual viewpoint is conducive to the co-construction of meaning, supporting a comprehensive examination of the phenomenon under study.

For this study, ten participants were recruited, with data collection continuing until no new themes or insights emerged, indicating data saturation (Creswell & Creswell, 2018). The number required to attain saturation depends on several factors, including data quality and richness, the scope of the study, research topic, the volume of beneficial information provided by each participant, frequency of the interviews and the use of supporting data (Morse, 2015). These factors must be carefully evaluated to confirm the sample size is adequate to conduct a comprehensive investigation of the phenomenon.

Morse (1995) suggests that six to ten participants may be adequate to achieve saturation in phenomenological studies, where no new themes emerge from the data. Creswell (2013) expands this range, recommending five to twenty-five participants

depending on the complexity of the phenomenon being studied. In educational studies, Guetterman (2015) established that the average sample size is approximately fifteen participants, while in health research, where diversity and contextual factors often play a significant role, the average is closer to twenty-five participants. Creswell and Creswell (2018) provide a broader guideline, suggesting that ten to fifty participants may be appropriate, while emphasising that the sample size should be in accordance with the research questions and focus of the study.

Qualified nurses were approached in person between March 2021 and June 2021. Their consent was obtained before commencing data collection. The inclusion and exclusion criteria guaranteed that participants met the study's objectives and were capable of providing pertinent information. The criteria are as follows:

Table 3.1: Inclusion and Exclusion Criteria for the Participants

	Inclusion criteria
1	Age 18 years old and above
2	Ability to communicate in Malay or English language
3	Registered nurses with 12 months or more experience in a clinical setting
4	Registered nurses who worked in the isolation unit and provided direct care to patients confirmed with COVID-19 infection
	Exclusion criteria
1	Registered nurses who were only temporarily deployed without providing consistent, direct care to confirmed COVID-19 patients
2	Registered nurses in supervisory, managerial or administrative roles who did not engage in direct patient care

3.4 Ethical Consideration

The ethical considerations for this study are as follows.

3.4.1 Ethical Approval

The study was registered under the National Medical Research Registry (NMRR) of the Malaysia Ministry of Health, under the reference number NMRR-21-127-58279 (IIR). It underwent review by the Malaysia Research Ethics Committee (MREC) and was subsequently submitted to the National Institute of Health (NIH), where it received final approval on February 25, 2021 (see Appendix C). Additionally, ethical approval was obtained from the Research and Ethics Committee of the Faculty of Medicine and Health Sciences, Universiti Malaysia Sarawak, on July 27, 2021 (see Appendix A). Permission to recruit nurses as participants was granted by the Head of the Infectious Disease Department and the Director of Sarawak General Hospital (SGH) on February 3, 2021 (see Appendix B).

Before the interviews commenced, a formal notification letter was delivered to the chief nurse supervisor and ward manager of the Infectious Disease Ward at SGH, informing them of the intended interviews. Participants were provided with both oral and written informed consent before each interview, ensuring they were fully informed as regards the purpose of the study, procedures, as well as their rights as participants.

3.4.2 Participant Recruitment and Informed Consent

After obtaining ethical clearance, eligible participants were selected from the nurses on the Infectious Disease Ward at SGH. Once participants agreed to participate, arrangements were made for the interview to be conducted. Informed consent was obtained from each participant using a participant information sheet (PIS) (see Appendix F) before

conducting any interviews. Participants were thoroughly informed in relation to the research process, the reason for the study, the type of information being sought, and their right to withdraw from the study at any point without providing a reason. They were also informed as regards how the collected information would be used and the implications of their contribution to the research. Permission to record the interview sessions digitally was obtained prior to commencing the interviews.

3.4.3 Anonymity and Confidentiality

To maintain confidentiality, each participant was assigned a distinctive research identifier in the order of their acceptance into the study, ranging from P01 to P10. These identifiers were used solely for research purposes. Participants' real names were not recorded on their transcripts. Pseudonyms were employed for each participant to ensure their identities remained confidential. Additionally, citations from the original data were authenticated using an established coding system (Kyngas et al., 2020).

The research materials, including transcripts and interview notes, were securely stored in a locked office to maintain data integrity and confidentiality (Williams, 2015). Digital files and voice recordings were stored on a password-protected computer, with a backup saved in OneDrive, a secure, password protected cloud-based service (Jordan et al., 2021). These measures safeguarded the data against unauthorised access and accidental loss.

In compliance with data protection regulations, data will be retained for the duration required for analysis and publication. It will be permanently deleted five years after the completion of the research and publication process. Access to the data was strictly limited to the researcher and study supervisors, maintaining confidentiality.

By implementing these measures, the study upholds the ethical research standards, prioritising participants' rights, safety and comfort while maintaining the integrity of the research process.

3.4.4 Ensuring Participant Wellbeing

Conducting interviews focused on psychosocial lived experience requires careful consideration, as the disclosure of personal experiences may expose participants to emotional distress. However, emotions expressed during interviews are invaluable, offering profound information regarding participants' lived experiences and holding significant epistemological value combined with other forms of data (Dempsey et al., 2016). These emotional disclosures permit a more profound understanding of the participants' lifeworld, enriching the research findings.

Acknowledging the sensitive nature of this study, I anticipated that certain interview questions might evoke distress (Dempsey et al., 2016). To address this concern, participants were fully informed as regards the potential sensitivity of the questions prior to the interviews. At the beginning of each session, I reiterated their rights to decline answering any question or to terminate the interview at any point, without the need to provide an explanation.

During the interviews, I conducted each session with care and sensitivity, employing therapeutic communication skills to manage any emotional challenges that arose (Dempsey et al., 2016). I maintained vigilance and attentiveness to participants' expressions of difficult emotions or thoughts, ensuring that they felt supported and respected throughout the process. By cultivating a safe and empathetic environment, I prioritised participants' wellbeing while enabling the collection of beneficial and authentic data.

3.5 Measures to Ensure Trustworthiness

Qualitative research aims to understand processes and meanings that are not readily explored by means of experimental methods. This approach regularly entails interviewing or observing participants, followed by triangulation with existing literature to develop a meticulous understanding of a given phenomenon. Elo and Kyngäs (2008) claim that the analysis process and findings must be thoroughly described, allowing readers to clearly understand how the analysis was conducted.

Trustworthiness in qualitative research is essential and is evaluated based on the rigor of procedures used to generate findings (Graneheim & Lundman, 2004). Lincoln and Guba (1985) identified four key criteria, specifically credibility, transferability, dependability and confirmability, which are used to assess trustworthiness. These criteria provide a robust framework to evaluate the quality of qualitative studies. The following sections outline how each of these criteria was addressed in this study, guaranteeing a rigorous approach to the investigation and interpretation of the data.

3.5.1 Credibility

Credibility is a fundamental principle in qualitative research, assuring that findings genuinely show participants' experiences. It is established by using strategies such as prolonged engagement, persistent observation, reflexivity and triangulation, all of which enhance the authenticity and trustworthiness of data. Prolonged engagement, where the researcher spends ample time with participants, allows a better understanding of their behaviours, experiences and beliefs (Adler, 2022). Persistent observation requires researchers to remain open and reflective, continuously managing their biases throughout the study (Dodgson, 2019; Gunawan, 2015). Triangulation, which entails using multiple data

sources or methods, further validates findings by incorporating different views, supporting the credibility of the study (Bradley, 1993; Graneheim & Lundman, 2004).

To enhance the credibility of my study, I applied several strategies to ensure a thorough and authentic representation of participants' experiences. I began by spending sufficient time with participants to establish a rapport, which, in turn, allowed me to acquire rich, useful data. Moreover, prolonged engagement permitted me to gain a greater awareness that would not have emerged from brief interactions alone. Reflexivity played a crucial role, as I actively recognised and managed my own biases throughout the research process. I kept a reflective journal to document my insights after each interview, which assisted me to maintain objectivity during data collection, analysis and interpretation. To further encourage openness, I explained to participants that my prior experience as a nurse did not influence my role in the study, guaranteeing safe space for open and honest sharing.

Triangulation was another essential strategy. I applied a combination of interviews and observations, cross-verifying findings and reducing reliance on a single data source. This methodological triangulation minimised potential biases and strengthened the validity of the findings. Purposeful participant selection, confirming diversity in age, ethnicity and gender, also contributed to the credibility of the study. By including participants from a broad range of backgrounds, I ensured that the findings represented varied experiences and views, in line with the guidance documented by Graneheim and Lundman (2004). This variety provided a comprehensive dataset, allowing a more in-depth understanding of nurses' experiences during COVID-19 care.

In the analysis phase, I rigorously organised meaning units, categories and themes to accurately reflect participants' experiences. Each interview was recorded, fully transcribed

and analysed with the research questions in mind. I took care to document codes and interpretations separately, ensuring no relevant information was overlooked during analysis. Observation notes were triangulated with interview transcripts to improve reliability, and representative excerpts were included in the findings to illustrate each category's meaning. Repeatedly reviewing the interviews and collaborating with my supervisor helped validate the categorisation and interpretation of the data, assuring consistency and supporting the credibility (Graneheim & Lundman, 2004).

Preparation for the interviews also contributed to the study's credibility. I practiced my interviewing skills extensively and sought feedback from my supervisor to refine my approach. Using probing questions during interviews, I was able to acquire comprehensive data, revisiting and reframing topics when necessary. Following advice given by Krefting (1991), I employed techniques such as rephrasing, repetition and expanding questions, which allowed me to obtain a fuller, more credible account of participants' experiences.

These particular strategies, from prolonged engagement and reflexivity to methodological triangulation and careful data analysis, basically supported a robust, transparent and trustworthy representation of the study's findings.

3.5.2 Dependability

Dependability in qualitative research determines that findings are stable and consistent over time, providing a foundation to verify the reliability of the study. Achieving dependability requires rigorous documentation of data collection methods, analysis procedures and decisions made throughout the study, creating an audit trail that allows other researchers to replicate the process (Amin et al., 2020; Eryilmaz, 2022; Kakar et al., 2023). Lincoln and Guba (1985) assert that dependability also entails accounting for any changes

in the study's environment and the adjustments made by the researcher during analysis, establishing transparency and consistency in the research process. Clear documentation of these factors strengthens the study's credibility by providing transparency and enabling replication (Graneheim & Lundman, 2004; Polit et al., 2013).

To enhance dependability in my study, I implemented several strategies that ensured consistency and transparency. First, I meticulously documented each step of the research process, providing a detailed account of the data collection and analysis methods. This documentation allowed the replication of the study and helped readers understand the rationale behind each decision made throughout the research. For instance, data collection ceased only after reaching saturation, which I determined after analysing the transcripts from the tenth participant, where no new codes or subcategories emerged. This approach supports comprehensive data collection without redundancy, boosting the strength of the findings.

A structured question guideline was used in each interview to ensure that each participant was questioned on the same key topics, promoting reliability and consistency throughout the interviews. Likewise, I maintained a comprehensive audit trail, which included logs of each of the research decisions, modifications made to the original research design, methods or procedures during the course of the study and the data analysis steps throughout the study. This trail recorded changes to protocols, reflective notes on methodological choices, and a detailed account of coding and categorization decisions. By documenting each stage of the research, the audit trail provided transparency and traceability, providing a better understanding of the processes involved and any modifications that were made. This guaranteed that the findings remained consistent and stable, reducing potential biases, whilst confirming the dependability of the research process.

Through these strategies, principally rigorous documentation, structured interviews and maintaining an audit trail, I made certain that the study's findings were consistent, transparent, and replicable, underlining the reliability of the research.

3.5.3 Confirmability

Confirmability in qualitative research signifies to the objectivity and neutrality of findings, ensuring that the results are free from researcher bias or personal influence (Kakar et al., 2023). To achieve confirmability, researchers use techniques such as peer debriefing, member checking and reflexive journaling to enhance transparency and reduce subjectivity (Amin et al., 2020; Lincoln & Guba, 1985). Peer debriefing entails consulting with colleagues or experts to verify interpretations, while member checking allows participants to confirm the accuracy of the findings. Reflexive journaling helps researchers monitor their thoughts and biases, further supporting transparency. According to Bradley (1993), confirmability is achieved when interpretations of the data can be validated by others, demonstrating internal coherence between the data, interpretations and conclusions, validating that they logically support the findings.

To augment the confirmability of my study, I employed several strategies. I began by engaging in peer debriefing, which involved regular consultations with colleagues and my supervisor to review my interpretations and findings. This allowed me to receive critical feedback on the research process and helped reduce researcher bias. The input from these peer-debriefing sessions provided different viewpoints, increasing the objectivity of the findings and confirming their accuracy. Regular supervisory meetings were crucial in maintaining a strong alignment with the study’s goals, assuring that the findings remained credible and applicable to other contexts.

In addition to peer debriefing, I implemented member checking by asking two participants to review a summary of their transcriptions as recommended by Lincoln and Guba (1985). This process allowed them to confirm that my interpretations accurately represented their viewpoints and intentions. While I did not conduct member checks with every single participant, I believed that my personal engagement, ongoing reflection and the interpretive nature of the data analysis did not require confirmation from every participant. This selective approach permitted a thorough understanding of the data while preserving the integrity of the findings.

Throughout the research process, I also maintained a detailed reflective journal, documenting my thoughts, biases and reflections. The practice of journaling supported to transparency by allowing me to monitor my evolving subjectivity during the study. By discussing the journal entries with my supervisor in regular peer-debriefing sessions, I was able to identify and address any potential biases, enabling a more objective approach to data collection and analysis. The reflective journaling process, accompanied by the regular feedback from my supervisor, played an essential role in supporting the confirmability of my findings.

Through these strategies, peer debriefing, member checking and reflexive journaling, I was able to maintain the objectivity and neutrality of the study's findings. These approaches established that the research remained transparent, consistent and credible, strengthening the confirmability of the study and ensuring a rigorous and unbiased representation of the data.

3.5.4 Transferability

Transferability in qualitative research refers to the extent to which the study findings can be applied to other contexts or situations (Kakar et al., 2023; Riazi et al., 2023). To

improve transferability, researchers provide rich, detailed accounts of the study's context, participants and procedures, enabling readers to assess the relevance of the findings in different settings (Zhang & Wildemuth, 2009). This depth of information allows others to make informed decisions concerning the applicability of the research to their own contexts, strengthening the transferability of the study's findings (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004).

In my study, I applied several strategies to establish transferability. One key approach relates to presenting "thick descriptions", as developed by Geertz (1973). This is an approach that provides detailed interpretations of cultural actions and behaviours. Likewise, this method systematically describes the research context, participants and methods. By offering rich, contextual information related to the study, readers were able to assess the similarities between their own contexts and the research environment. This allowed the readers to assess the applicability and relevance of the findings to their settings. The study comprised a diverse range of participants, including nurses with varying educational levels, ages and clinical experience. This diversity supplemented the data, providing a more in-depth understanding of the phenomenon under study and ensuring that the findings could be relevant to a broader range of situations. Furthermore, the cultural diversity within the nursing workforce in Kuching, Sarawak, aided the depth of the findings, making them more likely to be transferable to similar healthcare settings, both locally and internationally.

In addition to thick descriptions, I focused on clearly articulating the sampling strategies and criteria used to select participants. The sampling process was transparent, and the criteria for participant inclusion were explained in detail, enabling readers to evaluate whether the findings could be applicable to similar populations or settings outside the

research context. This transparency in the sampling methods further supported the transferability of the study's findings. Furthermore, I provided detailed excerpts from the data, pointing out the original segments from the transcripts from which categories and themes were formulated. This detailed presentation of the data collection and analysis processes ensured that the methodology was clear, enabling other researchers to understand how conclusions were drawn and to assess whether similar findings might emerge in different contexts.

By providing thick descriptions of the study's context, participants, and procedures, and by clearly explaining the sampling strategies and data analysis methods, I strengthened the transferability of my study. These strategies ensured that the findings could be assessed for applicability to other settings, thus enhancing the broader relevance and utility of the research.

3.6 Research Instrument

In this study, I served as the primary research instrument, conducting semi-structured interviews to explore the lived experiences of nurses during the pandemic. This interview format offered flexibility to elicit rich narratives while ensuring systematic coverage of key topics. The interview guideline (see Appendix E) adapted from Lam and Hung (2013) and Liu et al. (2020) were refined through pilot interview, supervisory feedback, and iterative adjustments during data collection to probe emerging insights and enhance depth (Malmqvist et al., 2019). To ascertain the accuracy of the data collection, I used both audio recordings and field notes, which allow comprehensive and reliable analysis.

Semi-structured interviews are well-suited to qualitative research for the reason that they allow participants to articulate their experiences in their own words and express the

meanings they assign to their lived experiences (Charmaz, 2014). My role as the interviewer was to facilitate this process, making certain that the focus remained on the participants' perspectives while also acknowledging the context and significance of their experiences. This approach supported the investigation of numerous experiences, which increases the depth of the collected data (Roberts, 2020).

To establish the rigor and structure of the interview guideline development process, I apply the Interview Protocol Refinement (IPR) Framework, developed by Castillo-Montoya (2016b). This framework consists of four systematic phases (see Figure 3.1) designed to improve the effectiveness of the interview guidelines. The first phase concentrated on aligning the interview questions with the overall research objectives, verifying that the questions were relevant and coherent. The second phase emphasised balancing structured questions with natural conversation, allowing participants to engage in open discussions while assuring that the required data was collected. The third phase includes obtaining expert feedback on the interview guideline from peers, advisors or qualitative research experts. This step confirmed that the questions were clear, appropriately sequenced and methodologically thorough. The fourth and final phase consisted of conducting a pilot interview to assess the effectiveness of the interview guide. This phase permitted the identification of potential issues related to question phrasing, sequencing and clarity prior to formal data collection begins.

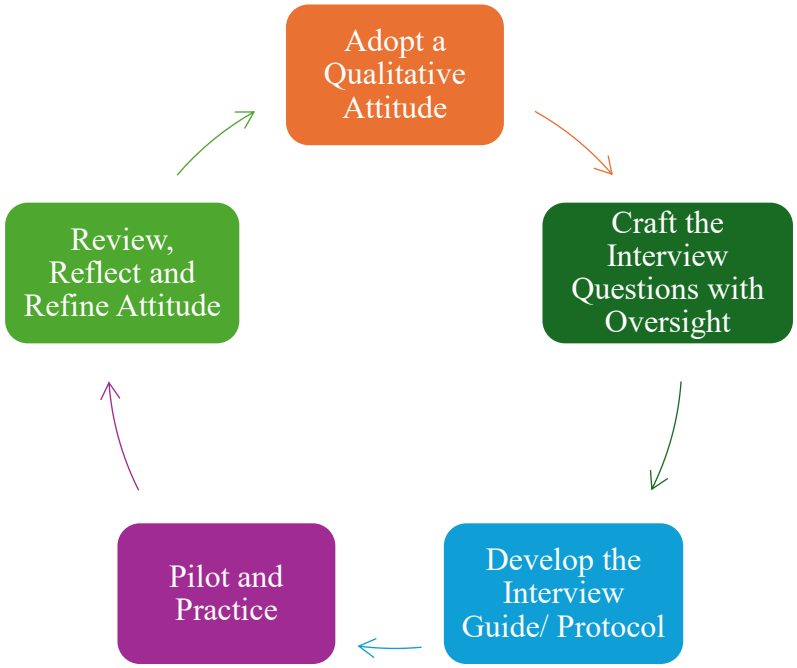


Figure 3.4: Interview Protocol Refinement (IPR) Framework (Castillo-Montoya, 2016b)

Two pilot interviews were conducted to refine the interview guideline, time management and the overall flow of the conversation, while also identifying and rewording ambiguous questions to confirm clarity (Mohd Aliff et al., 2017). Pilot participants were excluded from the main study. These interviews allowed prompts to be tested to elicit beneficial responses and assess the suitability of the interview environment, tackling factors such as privacy, comfort and potential distractions. The pilot phase increased my confidence and interviewing skills, helping me establish a natural rhythm to my questioning, manage pauses and encourage an empathetic dialogue. Equally, engaging with participants in a realistic setting improved my ability to build rapport and create an open discussion space, ultimately strengthening the credibility and trustworthiness of the study.

The findings highlighted the need for more specific phrasing, as broad questions often elicited brief responses. For example, “Can you tell me about your experience working

during the pandemic?" was revised to "Can you describe how working in the COVID-19 ward has affected you emotionally?" Additional probing prompts, such as "How did these experiences influence your relationships with colleagues or family members?" were also added to elicit richer narratives.

To encourage participants to share authentic and detailed narratives, I used broad, open-ended questions that allowed them to express their personal experiences without the constraints of leading or assumption-based questions (Charmaz, 2014). Follow-up questions, such as "Can you describe what that was like for you?" were used to clarify responses and encourage deeper reflection. The interview guide acted as a structured framework to make sure that critical topics were covered while allowing flexibility to explore emerging themes as they occured (Corbin & Strauss, 2015).

Active listening was essential in this process. I remained attentive to both verbal and nonverbal cues, for example tone, body language and pauses, to fully engage with the participant's narrative. To encourage a better understanding, I incorporated verbal probes such as "Can you give me an example?" or "That's interesting—could you elaborate?" and nonverbal probes, including nodding, gestures or purposeful silence to encourage participants to elaborate and provide more information (Roberts, 2020).

By employing these strategies, I created a supportive and open environment that encouraged beneficial dialogue and allowed participants to share their experiences freely. This approach enables a deeper understanding of the psychosocial experiences faced by nurses during the pandemic, assuring that their voices are accurately and thoughtfully represented in the research findings.

3.7 Data Collection Procedures

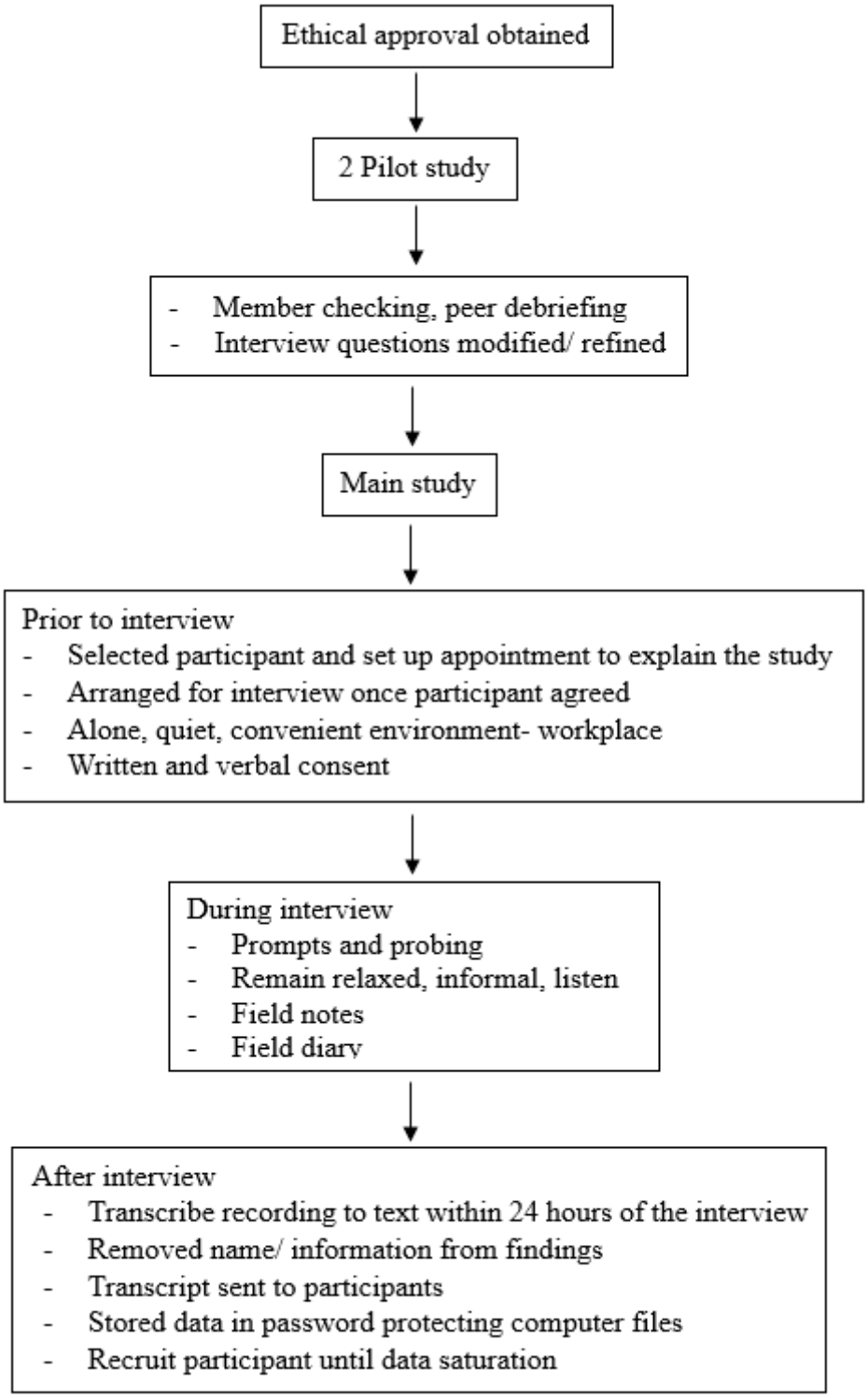


Figure 3.5: Procedures for Recruitment, Participation and Collection of Data

3.7.1 Preparation for Interviews

Although I had prior experience conducting qualitative interviews during my master's degree, I recognised the need to further refine my interviewing skills to ensure methodological rigor. As Brinkmann and Kvale (2014) stress, qualitative interviewing requires a high level of skill, necessitating both subject knowledge and familiarity with methodological approaches, as well as an understanding of the conceptual process of generating knowledge through conversation.

To improve my ability to conducts interviews, I focused on acquiring the necessary skills, selecting appropriate methods and developing a structured interview guide that was consistent with the study's overall methodology, objectives and purpose of the study (Castillo-Montoya, 2016a). In preparation, I attended workshops, reviewed literature on qualitative interviewing techniques, and sought guidance from my supervisor. Additionally, I conducted practice sessions by interviewing friends using a structured question guide. As a result, I became familiar with the questions and improved my ability to recall them during the actual interviews. During the data collection process, I kept a notebook to ensure that all key topics outlined in the interview guide were addressed systematically. This comprehensive preparation strengthened the reliability and depth of the interviews, guaranteeing that participants' perspectives were obtained effectively.

After each interview, I took time to reflect on my performance to identify areas for improvement. My supervisor provided constructive feedback, emphasising that moments of silence during interviews are often beneficial, as they give participants the time to think and express themselves fully. He explained that pauses could lead to participants sharing

significant or unexpected information, and that I did not need to feel obliged to fill these moments with additional questions.

Once eligible participants were selected, I arranged suitable times to approach them. Interviews were scheduled during their working hours, preferably after doctors' rounds and when there were no major procedures for patients, to reduce any potential distractions during the process of obtaining informed consent and conducting the interviews.

Establishing trust and rapport with participants was essential to acquire their genuine experiences and ensured their willingness to share openly. My previous role as a nurse in the hospital facilitated this rapport, as it allowed me to understand their work environment and routine, creating a sense of connection and empathy with the participants.

3.7.2 Reflexivity Measures

Accepting the potential for bias, especially as a nurse, I took deliberate steps to make certain that the research findings remained true and unbiased. This required implementing measures to promote honesty and transparency among participants while collecting data.

After identifying eligible participants, I approached each one personally with a respectful greeting and introduction. I arranged an appointment to explain the study's purpose and objectives. Dates and times for face-to-face interviews were scheduled based on the participants' responses and interest in the study. During this contact, participants were informed about the reasons for their selection and how their contributions would be valuable for the study. I reassured them of the confidentiality of the information provided and detailed the measures taken to protect their privacy. Participants were also given the opportunity to refuse participation, ensuring they were genuinely willing to contribute and prepared to

provide information spontaneously. Subsequently, they were asked to sign the informed consent form.

The interviews were conducted in quiet, convenient environments, such as designated private rooms within the hospital ward, to guarantee an uninterrupted and effective conversation. These venues were carefully selected to be familiar and comfortable for participants, reducing potential anxiety and allowing them to express their thoughts in a candid manner. To maintain focus and privacy, each interview was conducted in a face-to-face setting, with only the participant and the interviewer present. Measures such as setting mobile phones to silent mode and scheduling interviews during less busy hours were implemented to decrease interruptions (Elley-Brown, 2015). These precautions ensured a controlled and distraction-free environment, promoting in-depth discussions.

At the beginning of each interview, I promoted an atmosphere of openness by building a rapport and encouraging participants to share their experiences honestly. This was achieved by using a warm and empathetic tone, engaging in active listening and expressing genuine interest in their narratives. I assured participants that, despite my background as a nurse, my role in this context was solely to understand their experiences and that their responses would have no impact on their professional roles. To further promote candidness, I emphasised that there were no right or wrong answers, highlighting that their opinions were valuable. Additionally, I reminded them of their right to withdraw from the study at any time without the need to provide an explanation. This ensured that the interviewees felt comfortable and in control throughout the interview process.

In my approach, I prioritised listening over questioning, allowing participants to guide the flow of the conversation. This approach enabled me to remain focused on their

feelings, responses and thoughts, which facilitated the collection of data in a reflexive manner. As I listened to participants' stories, I became aware that my interpretation was already beginning to bear fruit, and as the interview progressed, additional questions evolved naturally. This process illustrates Gadamer's concept of the "fusion of horizons," where understanding emerges collaboratively through dialogue (Spence, 2001a).

To further ensure honesty and clarity, I employed probing questions to elicit more detailed responses. When participants mentioned specific issues, I would rephrase or revisit the topic to extract additional relevant data, as suggested by Brinkmann and Kvale (2014). This method of reframing, repetition and the development of questions was instrumental in gaining useful information.

Reflexivity also extended to my epistemological stance, necessitating an ongoing examination of how knowledge was constructed throughout the research process (Day, 2012). I consistently established that the study's theoretical foundation was in accordance with the research questions, maintaining coherence between the philosophical underpinnings and the inquiry process. Methodological decisions were carefully justified to uphold transparency and rigor, making certain that each step of the study was methodologically sound and appropriate for an interpretive phenomenological approach. Additionally, the research context was clearly described to provide a comprehensive understanding of the participants' lived experiences within their socio-cultural and professional environments. Furthermore, I remained mindful of how the findings were presented, making certain that the results section fairly reflected both the participants' perspectives and my interpretative understanding as a researcher. This commitment to reflexivity and methodological integrity,

as outlined in Section 3.5: Measures to Ensure Trustworthiness, strengthened the reliability of the study's findings.

It is crucial for me to acknowledge that my values can change over time because positionality is dynamic and structured by evolving experiences, knowledge and contextual influences. The preconceptions I brought into this study stemmed from my prior professional and personal experiences, pre-existing beliefs, motivations and theoretical perspectives (Malterud, 2001). However, as I engaged with participants, immersed myself in the data and critically reflected on my role in the research process, my perspectives changed. Consequently, my positionality, or "situatedness," was not fixed but fluid, affected by subjective and contextual factors (Rowe, 2014). This change influenced my methodological choices, interpretation of findings and ethical considerations. By maintaining a reflexive approach, I remained aware that my positionality was context-dependent and subject to change, ensuring that my changing perceptions were acknowledged and critically examined. Likewise, this reflexivity strengthened the credibility and transparency of the research by allowing for a deeper engagement with participants' lived experiences while recognising my own influence on the study's processes and outcomes.

As a researcher, I acknowledged and disclosed my role in the study, striving to understand how my presence might influence or have a bearing on the research process (Cohen et al., 2011). I accepted that, as part of the social world I was researching, this world had already been interpreted by existing social actors, making it impossible to approach the study from a purely objective stance. According to Berger and Archer (2015), a researcher's prior experiences, identity and positionality inevitably impact the research process, influencing interactions with participants, data collection and interpretation. Given my

background as a former nurse, I found myself naturally attuned to issues commonly encountered in the profession, such as understaffing and overwork.

To mitigate this, I maintained a critical awareness of my preconceived notions and biases, making conscious efforts to separate them from participants' descriptions. I strove for mutual openness, acknowledging and managing my biases while allowing participants' voices to emerge authentically. This process required letting go of my past experiences to move forward in the research journey. Finlay (2009) claims that reflexivity requires researchers to critically engage with their own subjectivity, recognising its influence while actively working to minimise its impact on data interpretation. This process necessitated the continuous self-examination and monitoring of my assumptions, establishing that my perspectives did not overshadow participants' lived experiences.

While reflexivity is crucial, an overemphasis on the researcher's reflections could give rise to "navel-gazing," where too much attention is placed on the researcher's perspective at the expense of the participants' opinions. The main objective is to accurately obtain and convey the participants' views and experiences, resulting in the co-creation of knowledge between the researcher and the participants (Finlay, 2009).

During the data analysis phase, I experienced uncertainty and vulnerability, notably when influenced by others' opinions. Data analysis is inherently complex, demanding and time-consuming, and it took me a year after data collection for me to understand how to analyse the data effectively. This delay, however, does not imply a lack of credibility or competence; instead, it is in line with the position of Lynch (2000), who asserts that reflexivity is an unavoidable feature of qualitative research. Overusing reflexivity could be likened to being trapped in a hall of mirrors.

I utilised field notes to document key observations, including vocal intonations, body language and environmental cues that may not have been portrayed in the audio recordings (Phillippi & Lauderdale, 2018). As an essential tool in qualitative research, field notes enable the systematic documentation of observations, nonverbal cues, sensory details and researcher reflections, which permit a more comprehensive understanding of participants' experiences. They also aid in identifying biases, refining study design and enhancing the rigor and trustworthiness of the research process. By preserving contextual details, field notes provide critical information that strengthen data analysis and interpretation. Additionally, after each interview, I incorporated personal reflections into my field notes, allowing me to evaluate my approach to interviewing and subsequently make the required refinements (see Appendix I).

Similarly, I engaged in discussions with my research network, including my supervisor and peers, to balance participants' statements with my descriptions of the findings (Holmes, 2020). This collaborative process helped to normalise reflexivity, focusing on both the uncertainties and errors in the research process. I acknowledged that research outcomes are constructed and evaluated rather than merely "emerging" (Varpio & Meyer, 2017). By providing transparency regarding the source, interpretation and application of the data, I assured that the research maintained rigor and authenticity.

3.7.3 The Actual Interviews

According to Van Manen (1997), interviews serve two primary functions in hermeneutic phenomenology methods: (1) to explore and develop a deep understanding of the phenomena; and (2) to encourage a debate regarding the meaning of experience. Semi-structured interviews assist this process by allowing participants to reflect on and revisit their

experiences (Crotty, 1998). These semi-structured conversational interviews, as recommended by Van Manen (1997), were employed in this study to effectively obtain the participants' lived experiences.

Face-to-face, in-depth individual interviews were conducted using semi-structured, open-ended questions, provided by the interview guideline provided in Appendix D. This guide was adapted from journal articles related to the COVID-19 pandemic, with modifications made upon obtaining permission from the original authors (Lam & Hung, 2013; Liu et al., 2020) (see Appendix E). The interview guideline comprised a written list of open-ended questions designed to address the study's objectives and research questions while allowing flexibility in the responses. Although the guide provided a structured framework, the order and wording of questions varied depending on the participant, supporting a more natural and context-sensitive dialogue. The semi-structured interview approach established both focus and flexibility, incorporating prompts to generate deeper responses and allowing further exploration of the emerging themes (Forero et al., 2018). This method promoted productive, in-depth discussions, making certain that participants' lived experiences were comprehensively acquired.

I personally conducted all of the interviews to maintain consistency, allowing me to gather personal information and deepen my understanding of the study. During each interview, I remained respectful, non-judgmental and non-threatening, as advised by Merriam (1998), who pointed out that an interviewer's role is to gather data, not to change participants.

The interview process itself was the essential context where the interpretive and listening process began. During the recruitment phase, potential participants were informed

about the focus of the research, which gave them time to consider their experiences before the actual interview. Simultaneously, the researcher and participant selected a natural setting free from constraints, supporting the participant to feel comfortable and at ease when sharing their story. The interpretive process commenced immediately after informed consent was obtained.

The researcher reminded the participant of the reason for the interview and encouraged questions before the consent form was signed in the presence of one another. Permission to audio-record the interview session was also sought prior to commencement. Throughout the session, I employed active listening skills and flexible responses to make the participant feel as comfortable as possible, maintaining a relaxed, informal atmosphere and listening with intent. Interviews were conducted primarily in Malay and Sarawak Malay language, with occasional explanations in English. I am fluent in both languages, which facilitated a closer connection and encouraged participants to share their innermost feelings and experiences.

All interviews were transcribed verbatim in Bahasa Melayu to preserve the authenticity of participants' narratives. For analysis and presentation, key segments relevant to the study objectives were subsequently translated into English by the researcher. This approach ensured that the meaning of participants' words was retained in the original language during analysis, while enabling the findings to be communicated in English for reporting purposes.

The interviews began with greetings and casual conversations, such as "apa khabar hari ini" and "sudah makan ka belum?" Once participants were ready, the interview and recording began, guided by the interview questions developed earlier. Participants were

asked open-ended questions in relation to their experiences in a relaxed manner. Although a list of questions was available, I did not ask them in any particular order. The interview began with a brief introduction, for example:

"… My name is ___ and I would like to ask you some questions about your experiences working during the COVID-19 pandemic in Sarawak. Please briefly tell me about yourself and your background. How many years have you worked as a nurse?

I utilised a few direct questions to remain as close as possible to the participants' lived experiences, ensuring that their responses were not influenced or manipulated. By employing open-ended questions, I allowed the nurses to express in their own words, their experiences, emotions, challenges and their coping mechanisms related to caring for COVID-19 patients in their own words. For example, I asked, "What are the kinds of things that might worry you about working during the pandemic?" and "How did you feel on the first day of caring for a COVID-19 patient?" These questions encouraged rich, detailed narratives that captured the depth of their experiences.

The goal was to co-construct the findings with the participants, adapting a collaborative and engaged conversational interview to explore the phenomenon together (Crist & Tanner, 2003). This dialogical process facilitated a "fusion of horizons" (Gadamer, 1975), where both the researcher's and the participants' perspectives interacted dynamically to generate deeper understanding. Understanding, in this context, is not simply obtained but emerges through interactive dialogue, requiring openness, reflexivity and flexibility on the part of the researcher. As Crist and Tanner (2003) explain, this approach shifts participants from being passive subjects to active contributors in the meaning-making process, confirming that their lived experiences are authentically represented.

A small Android phone with a recording application was used for the recording, ensuring high-quality recordings. I made sure that the phone was fully charged and functioning correctly before each interview. On average, the interviews lasted for roughly 30 to 76 minutes. As per Jacob and Furgerson (2015), the interviews did not exceed 90 minutes, respecting the participants' other commitments. Each participant took varying amounts of time to express their feelings. Each interview was recorded to verify no information was missed. I conducted only one interview per day to allow time for reflection, making notes on my impressions, ideas and interviewing skills. I transcribed the interview data immediately after each session while my memory remained fresh.

When the Sarawak region entered Phase 2 of the National Recovery Plan on July 14, 2021, I commenced my first interview on July 16, 2021. I adhered to safety precautions, including wearing PPE such as a face shield and mask, as required by the nurse manager. While this made observing non-verbal cues challenging, it was necessary for the safety of both the participants and myself.

During my first interview with a 43-year-old registered nurse with 21 years' experience, I used simple affirmative comments, such as "ahhah," "ya," "ok," and "ohh" to exhibit attentiveness and encourage her to share her experience.

I encountered a few challenges during some interviews. In the second interview, a 28-year-old nurse became emotional when discussing her parents, requiring a brief five-minute pause for her to regain composure. She later explained that she had suppressed her feelings for a long time and finally found an opportunity to express them during the interview. I reassured her that it was perfectly acceptable to share her emotions and that she

should not feel guilty. I emphasised my role as an external, non-judgmental listener, which appeared to provide her with the comfort she needed to continue.

Similarly, with the fourth participant, despite conducting the interview in a private room, there were occasional interruptions due to phone calls. On that day, she was working as the team leader and was responsible for managing her subordinates during the shift. As a result, junior nurses would occasionally seek her guidance. Each time the interview was interrupted, I paused momentarily and resumed once the interruption had concluded. To maintain the continuity of the conversation, I reinforced and summarised the previous discussion points, enabling the participant to recall and effortlessly continue with her responses.

However, after my second interview on July 30, 2021, a sharp increase in COVID-19 Delta variant cases in Kuching led to the temporary suspension of data collection. Data collection resumed in October 2021 following official clearance.

Subsequent participants shared detailed accounts of their experiences. To gather beneficial information, I used probing questions such as "What do you mean by that?" and "Could you explain more about that?" Probing facilitates access to an additional level of detail and depth by using vocal prompts designed to clarify, elaborate, illustrate or expand upon a participant's previous response (Robinson, 2023).

They exhibited their willingness to share their experiences. When necessary, I would review what they said during the interview to establish my understanding and interpretation. I took notes throughout the interviews. When an interview ended, I did not rush to stop the recorder, instead I asked, "is there anything else you would like to share?" and "any last

word from you to summarise your experience?". As a token of appreciation, I provided each participant with a cotton scrub cap for their participation.

I transcribed each of the audio-recorded interviews verbatim, making certain that all of the identifiable information was removed. I handled the transcriptions personally, within 24 hours of each interview, ensuring data security. The data was stored in a password-protected laptop, accessible only to me, while printed data and consent forms were locked securely in my office cupboard. All identifying information was removed from the findings to protect participants' identities.

After analyzing the transcribed data from the tenth participant, no new codes or subcategories emerged, indicating code saturation. To further verify the depth and robustness of thematic analysis, I conducted an additional interview, which similarly did not yield any new codes or subcategories (Hennink & Kaiser, 2022). In this study, codes refer to individual issues, topics or key elements identified within the data, while categories represent higher-order groupings that encapsulate broader themes, meta-themes or conceptual patterns (Hennink et al., 2017).

At this stage, I determined that the full range of thematic issues relevant to the study had been identified, and that additional interviews would not contribute significant new facts. The data collected provided a comprehensive understanding of the nurses' experiences and sufficiently addressed my research questions. Consequently, I concluded that data saturation had been achieved and stopped further interviews. Similarly, Hennink et al. (2017) found that code saturation was reached by the ninth interview, suggesting that a smaller number of interviews may be adequate to obtain the core themes of a study.

3.8 Data Analysis Method

In this study, a two-stage analytical process was employed to explore the psychosocial lived experience of nurses. The first stage involved thematic analysis, guided by the Model of Phenomenological Process (Table 3.2) by Van Manen and Van Manen (2021). This model, which emphasizes the reflective interpretation of lived experience, offers a structured yet flexible framework for engaging deeply with participants' narratives and uncovering meaning. To enhance the depth of interpretation, the second stage applied Van Manen's lifeworld existentials: lived body, lived space, lived time, and lived other as a theoretical lens. This dual-stage approach integrated descriptive thematic analysis with existential interpretation, thereby illuminating both the tangible challenges and the deeper meanings embedded within nurses' experiences during the COVID-19 pandemic.

Table 3.2: Model of the Phenomenological Process adapted from Van Manen and Van Manen (2021)

Turning to the Nature of Lived Experience	1. Orienting to the phenomena 2. Formulating the phenomenological question 3. Explaining assumptions and preunderstandings
The Existential Investigation	4. Exploring the phenomena generating "data" - Using personal experience - Obtaining experiential descriptions from subjects 5. Consulting phenomenological literature
Phenomenological Reflection	6. Conducting thematic analysis - Uncovering thematic aspects - Isolating thematic statements - Composing linguistic transformations 7. Determining essential themes
Hermeneutic Phenomenological Writing	8. Reading - Attending to the speaking of language - Varying examples 9. Reflective writing - Writing - Reflective journal - Revising 10. Conferring with participants

With respect to the data analysis in the phenomenological reflection phase, thematic analysis was seleted. The six-step inductive thematic analysis of the interview transcripts was guided by Braun and Clarke (2021) approach, which includes the following stages: (i) familiarising oneself with the data, (ii) generating initial codes, (iii) searching for themes, (iv) reviewing themes, (v) defining themes, and (vi) producing the report.

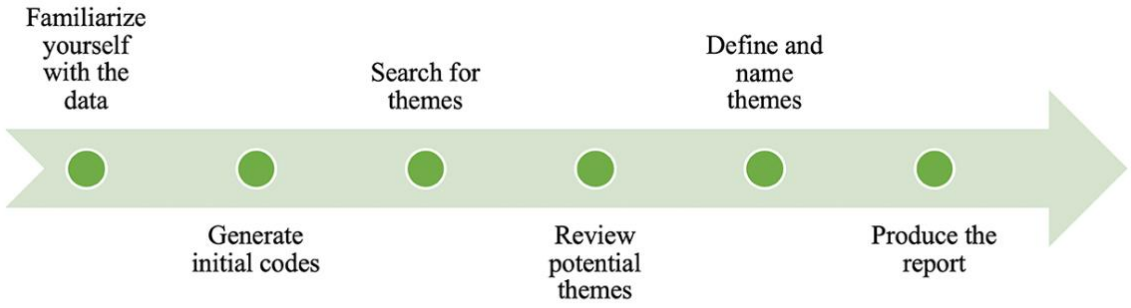


Figure 3.6: The Six Phases of Thematic Analytic process (adapted from Braun and Clarke (2021)

I personally transcribed the ten recorded interviews, establishing accuracy and comprehensiveness. The data collected from the audio recordings were manually transcribed word-for-word into Microsoft Word to prevent data loss (see Appendix L for a sample transcript). While this process was challenging and time-consuming, it allowed me to become exceedingly familiar with the data and recognize verbal nuances such as pauses and intonations. Throughout the transcription process, I received guidance and support from my supervisor, who provided feedback on formatting and structure. We worked closely, reviewing and discussing the transcripts to increase the accuracy and analytical depth. After completing the transcription, I returned the transcripts to two participants to conduct the member checking, enabling them to review and confirm the accuracy of their responses.

Data analysis commenced concurrently with data collection to enable an iterative and evolving understanding of emerging themes. Early engagement with the data assisted me to refine the initial interpretations as new information emerged, ensuring a more detailed analysis. This approach also identified gaps or areas requiring further exploration, allowing adjustments in subsequent interviews. After completing all of the transcripts, I conducted a rigorous analysis, reading each numerous times to fully immerse myself in the data. I then examined discrete phrases and sentences, or “meaning units” to extract key insights, assuring a comprehensive and contextually grounded interpretation of participants' lived experiences (Burnard, 1994).

These meaning units captured specific aspects of nurses' experiences of being "in-the-world" while caring for COVID-19 patients. Given the substantial volume of data collected, I utilised Atlas.ti version 9.0, a qualitative data analysis software, to store, sort, retrieve and code the data systematically, supporting greater engagement with the transcripts. Each transcript was analysed by categorising meaning units and grouping those with similar meanings under broader categories to identify emerging patterns and themes. To enhance the analytical depth, I developed detailed analytical memos, describing the implicit meanings and underlying interpretations within each category. This process required iterative engagement with the data, moving fluidly between the raw field text and structured narrative to guarantee transparency and verification in interpretation. The hermeneutic process of meaning-making entailed multiple readings without a fixed sequence, allowing themes to emerge organically (Van Manen, 1984) (see Appendix H for examples of meaning units, codes, and subcategories illustrating nurses' experiences).

After transcribing the interviews, I applied existential themes during phenomenological reflection to guide a line-by-line analysis of the transcripts. This process integrated hermeneutic phenomenological writing, where I considered how time (lived temporality), space (lived spatiality), physicality (lived corporeality), and interpersonal interactions (lived relationality) emerged in the participants' discussions of their experiences.

By means of the analysis, I identified the predominant themes in the participants' experiences and narrowed them down to focus on the most relevant to answer the research question: "What are the psychosocial lived experiences of nurses during the pandemic in Sarawak?" The central themes that emerged were " embodied fear and anxiety" and "physical and mental strain." I highlighted statements corresponding to these themes, reordered them, and combined them into an integrated description of how each nurse conceptualised their psychosocial experiences with COVID-19 patients. This comprised connecting the nurses' words with my interpretation, creating a comprehensive description of their lived experiences.

This approach adhered to Heidegger (1962) concept of the hermeneutic circle of understanding, which postulates that interpretation is always circular and dynamic, making it impossible to render completely explicit. To ensure the accuracy of my interpretations, I engaged in regular discussions with my supervisor and colleagues who have expertise in phenomenology. They provided invaluable feedback on my interpretations of the collected study data, helping to refine and validate my analysis.

This method of obtaining feedback is in keeping with the approach applied by Nelms (1996), who also sought input from colleagues experienced in phenomenology. Additionally, Cohen et al. (2000) emphasised that regular discussions with research team

members, such as supervisors and colleagues, concerning field experiences and emerging findings could challenge the researcher and supplement the interpretation, thus contributing to a more rigorous and credible analysis.

3.9 Summary

This chapter has discussed the research paradigm and has provided a description of the phenomenological method and how the method fits the study. It also includes the study setting, population and sampling, ethical consideration, data collection and data analysis.

CHAPTER 4

UNDERSTANDING HUMAN EXPERIENCE

This chapter incorporates the philosophical underpinnings of Heidegger's concepts with the lived experiences of nurses, underlining how Being, temporality and relationality come together to form their professional and personal experiences. By situating nursing within the broader framework of human experience, the discussion pinpoints the profound connections between existential philosophy and practical caregiving.

Regarding nurses, the world of caregiving is an intricate tapestry woven with their personal and professional experiences. The lived experiences of nurses, specifically during moments of crisis such as the COVID-19 pandemic, exemplify the complexity of human experience. The phenomenological lens exhibits the relationship between their emotional resilience, physical endurance and personal connections with patients, colleagues and the broader healthcare system. Through this lens, the study of nurses' experiences not only improves our understanding of their unique challenges but also sheds light on the universal aspects of human existence, including meaning-making, relationality and adaptation in adversity.

4.1 The Interpretation of Human Experiences

The interpretation of human experiences is a sophisticated process moulded by the dynamic interplay between perception, emotions and cognition. These interconnected elements form the foundation as regards how individuals make sense of the world, determining their responses to external environments, internal states, and relational contexts. Concurrently, they emphasise the complex and deeply personal nature of human experience.

Human experience is not a static or linear phenomenon but a continuous process in which perception provides sensory input, emotions imbue it with personal significance, whilst cognition organizes it into coherent narratives. This dynamic correlation is evident in various life situations, such as traumatic experiences. A traumatic event, for instance, might be perceived as overwhelming, triggering emotions like fear or helplessness. These emotions then influence how the experience is cognitively processed and remembered, frequently resulting in vivid and persistent recollections.

4.1.1 Perception: The Gateway to Experience

Perception is the first step in interpreting experiences, encompassing the reception, organisation and interpretation of sensory information from the external environment. It acts as a lens through which individuals encounter the world, affecting what is noticed, how it is understood, besides its impact on the individual.

Far from being a passive process, perception is influenced by prior knowledge, expectations and cultural frameworks. For example, two individuals observing the same event may perceive it differently due to their unique contexts and lived experiences. This subjective nature of perception is in accordance with the principles of Gestalt principles, which suggest that humans seek coherence and patterns, often filling in gaps to create meaning.

Neuroscience underlines the interdependence of perception with memory and emotion. For instance, the amygdala, a brain region associated with emotion, can influence the perception of stimuli as threatening or comforting (Pessoa, 2008). This relational aspect illustrates how perception functions as both the foundation and filter for human experience.

Perception also corresponds with cognitive dissonance theory, first proposed by Festinger (1957), which explores the relationship between perceptions, motivations and cognitions. Cognitive dissonance occurs when individuals face conflicting cognitions, prompting discomfort that motivates them to resolve the inconsistency. For example, when an individual's perception of an event contradicts their past experiences or cultural norms, they may reinterpret the event to align with their existing beliefs (Harmon-Jones & Mills, 2019).

The subjective nature of time further illustrates how perception varies with context. Research suggests that time can appear to "fly" during enjoyable experiences or "drag" during unpleasant ones (Marman, 2018). This relational and contextual aspect of time perception highlights the fluidity of human experience, impacted by interactions and emotional states.

4.1.2 Emotions: The Colour of Experience

Emotions bring depth and significance to human experiences, influencing how events are remembered, valued and acted upon. They are not merely reactions to stimuli but integral components of experience-making, determining perception and cognition. For instance, fear may heighten awareness of potential dangers, while joy amplifies the positive aspects of an experience, often overshadowing its negative details.

Neurobiological evidence demonstrates how emotions influence memory and perception. The role of dopamine, for example, in reinforcing rewarding experiences suggests that emotions modulate how events are encoded and recalled (Adcock et al., 2006). Positive emotions expand cognitive resources, allowing individuals to derive more complex meanings from their experiences, as proposed by Fredrickson (2001) broaden-and-build

theory. Conversely, negative emotions can narrow focus, highlighting threats or challenges, which may overshadow other aspects of an event.

Emotions also act as motivators and decision-making tools, providing immediate feedback that informs judgments and actions, particularly in uncertain or high-pressure scenarios. Similarly, emotions has a dual role, chiefly to help assess or judge a situation and to guide behaviour or decisions.

4.1.3 Cognition: The Architect of Meaning

Cognition creates human experiences by permitting individuals to process, analyse, and organise their perceptions and emotions into coherent narratives. Cognitive processes, such as memory, reasoning and problem-solving, allow individuals to draw from past experiences and combine them with present experiences to inform future actions.

Piaget's constructivist theory pinpoints that humans actively develop their understanding of the world based on prior knowledge and experiences. Memory plays a fundamental role in this process, as past experience influences how current ones are framed and interpreted. Cognitive biases, for example the heuristic method, is an approach to learning or problem solving. It helps to make judgement, but at the same time can cause cognitive bias further manipulate the interpretation of experience by emphasising readily accessible memories, which may distort an individual’s understanding of an event.

Cognition also interconnects with attribution theory, which explores how people attribute causes to events. These attributions, regularly influenced by personal or cultural contexts, significantly impact how individuals experience and respond to outcomes (Weiner, 1986).

4.1.4 Dimensions of Human Beings

The dimensions of human beings encompass various aspects through which we understand and experience our existence. The term "human being" refers to homo sapiens, distinguished by advanced cognitive abilities, abstract reasoning, language skills and self-awareness. The concept of "being" denotes the essence and fundamental nature of existence, presenting a framework to understand human life in its entirety (Gilson, 1949).

To comprehend human existence, it is essential to examine the diverse dimensions that interact to create identity, experience and behaviour. These dimensions include the physical, emotional, cognitive, social, spiritual and temporal aspects of life, each contributing uniquely to the richness and complexity of human experience. Simultaneously, they form an interconnected web that influences how individuals perceive themselves, interact with others and engage with the world around them.

4.1.4.1 Physical Dimension

The physical dimension of human existence encompasses the body as a medium of interaction, providing the sensory and motor capabilities that are essential to engage with the world. Maurice Merleau-Ponty depicts the body as a "lived body," emphasising its integral role in impacting human experiences and interactions within the physical both and social environments (Landes, 2012). Through its sensory and motor functions, the body facilitates the perception of and engagement with the world, underlining its basic importance to human existence.

The body's physical condition, health, strength and fatigue, plays a crucial role in determining an individual’s capacity to participate in daily activities and maintain relationships. Good physical health enhances the ability to interact with the world, while

illness or injury can restrict engagement and lead to isolation. Heidegger highlights this centrality of the body in his concept of "Dasein," or being-in-the-world, asserting that our existence is always rooted in our bodily presence (Heidegger, 1962). This embodiment effetcs how individuals experience and relate to their environment.

Aspects of the physical dimension include the body's physiology, genetics, sensory perception, and the relationship between inherited and experiential factors. For instance, phylogenetic memory, which includes inherited connections between stimuli and responses, along with ontogenetic and genetic memory, is conducive to the formation of mental identity by linking past events and environmental interactions with current experiences (Ryznar, 2023). These factors illustrate the intricate connections between the physical and psychological aspects of human existence.

For professionals such as nurses, physical well-being is a fundamental prerequisite for the effective performance of their duties. The demanding nature of the nursing profession, especially during extended shifts on exceedingly stressful environments like those experienced during the COVID-19 pandemic, demands physical stamina and resilience. Challenges such as exhaustion, heightened susceptibility to infection and the cumulative strain of wearing PPE significantly impact both the effectiveness and health of nurses. Addressing these physical challenges is crucial to ensure not only the well-being of healthcare workers but also the quality of care they provide.

In brief, the physical dimension of human existence draws attention to the body's essential role in determining experiences and interactions. Its condition profoundly influences an individual's capacity to engage with the world, highlighting the interconnectedness between physical health, identity and general well-being.

4.1.4.2 Emotional Dimension

The emotional dimension is a fundamental aspect of human existence, influencing relationships, motivation, decision-making and the interpretation of experiences. Emotions are not merely passive reactions to stimuli but are genuinely connected with human intentionality and reflective engagement with the world. Jean-Paul Sartre positions emotions as active and intentional aspects of consciousness, forming how individuals interpret and respond to their environment (Steelwater, 2012). Emotions arise from these interpretations, consciously or unconsciously influencing how individuals experience and interact with the world around them.

The role of emotions in relationships is profound, enabling individuals to connect with others, express empathy and cultivate emotional bonds. Feelings such as love, compassion, anger and sadness significantly shape communication and interpersonal interactions (Newmark, 2013). Emotional intelligence, which encompasses the ability to understand and manage one's emotions as well as those of others, is paramount in creating and sustaining successful relationships. This capacity for emotional awareness and regulation boosts relational dynamics, encouraging collaboration and mutual understanding.

Emotions also have a powerful impact on motivation, often driving individuals to pursue goals and engage in meaningful activities. Positive emotions, such as joy and excitement, can inspire creativity, productivity and perseverance. Conversely, negative emotions, such as fear or frustration, can perform as signals to avoid harmful situations or reevaluate strategies. The balance between positive and negative emotions helps individuals cope with personal and professional challenges, supporting resilience and well-being.

In decision-making, emotions play a key role along with reasoning and logic. While cognitive processes provide structure and analysis, emotions deliver immediate feedback that informs preferences, judgments and actions. In uncertain or high-pressure situations, emotions can guide decisions by highlighting potential risks or opportunities. For instance, feelings of anxiety may encourage caution, while confidence might prompt decisive action. This relationship between emotional and cognitive abilities illustrates the inherent role emotions play in impacting human behaviour and responses.

The emotional dimension is therefore essential to understand human experience, as it drives connection, inspires action and influences decision-making. It highlights the dynamic interplay between emotions, cognition and consciousness, revealing how individuals handle their inner and outer worlds. By determining relationships, motivation and choices, emotions profoundly contribute to the richness and complexity of human life.

4.1.4.3 Spiritual Dimension

The spiritual dimension of human existence addresses the search for meaning, purpose and existential understanding. It is acutely influenced by personal beliefs, philosophical frameworks and individual reflections on life's ultimate significance. This dimension invites individuals to consider their values, sense of purpose and the broader context in which they live, promoting a deeper connection to themselves and the world around them. By aligning one's actions with personal beliefs, the spiritual dimension encourages authenticity and fulfilment.

At the core of the spiritual dimension is the process of self-reflection and the investigation of life's ultimate meaning. Martin Heidegger's concept of Being-towards-death highlights the profound role that the awareness of mortality plays in influencing human

existence. Heidegger asserts that human beings live with the constant knowledge of their finite nature, a reality that deeply influences their search for meaning and authenticity (Heidegger, 1962). This awareness prompts individuals to confront the transience of life, encouraging them to focus on what truly matters and to make choices that are in keeping with their core values.

The spiritual dimension extends beyond formal religious practices, encompassing a broader search to understand life's purpose and the pursuit of personal growth. Spiritual fulfilment can be achieved through various means, including meditation, philosophical inquiry, engagement with nature, or nurturing meaningful personal relationships. These practices generate a sense of connectedness and purpose, developing the individual's ability to cope with life's complexities with clarity and resilience.

By providing a framework to contemplate life and encouraging a connection to one's values, the spiritual dimension plays a crucial role in creating a fulfilling and authentic life. It emphasises the importance of introspection, the pursuit of purpose and the recognition of human mortality as a catalyst to live with intentionality and depth. This dimension reveals the profound ways in which individuals strive to understand their place in the world and the broader significance of their lives.

4.1.4.4 Social Dimension

The social dimension of human existence stresses the inherently relational nature of human beings. Humans are fundamentally social creatures, forming connections and relationships that profoundly impact their identity, experiences and collective understanding of the world. Heidegger's concept of relationality points out that human existence is defined

by interactions with others. As beings-in-the-world, humans are embedded in relationships networks that determine their thoughts, actions and emotional well-being (Heidegger, 1962).

Human beings do not exist in isolation but within a web of familial, platonic, professional and societal relationships. The quality of these relationships significantly impacts an individual's sense of belonging, security and self-worth. Communities, cultural norms and social interactions further contribute to affecting identity and developing shared values, accentuating the fundamental role of social connections in human life. Through engagement with others, individuals develop a greater understanding of themselves and the world, as their perceptions, values and decisions are influenced by these interactions.

The social dimension also stresses the importance of empathy, communication and cooperation in nurturing meaningful relationships. These qualities are essential not only for personal growth but also for societal development, as they enable individuals to work collaboratively in forming social institutions, establishing norms and pursuing collective goals. By way of these interactions, humans create and sustain the social structures that define their communities, strengthening the interconnectedness of individual and collective experiences.

By focusing on the relational aspect of human existence, the social dimension reveals the profound impact of relationships on establishing identity and fostering a sense of purpose. It highlights the importance of connection, mutual understanding and shared responsibility in both individual and societal contexts, illustrating that human existence is deeply rooted in the bonds we form with others.

4.1.4.5 Temporal Dimension

The temporal dimension of human existence refers to the experience of time as a dynamic and integral aspect of being. Heidegger emphasises temporality as central to human existence, highlighting how individuals continuously navigate between their past, present and future. This temporal awareness impacts how humans consider past experiences, make decisions in the present, and orient themselves toward future possibilities, influencing both personal development and collective experiences (Heidegger, 1962).

Heidegger's concept of temporality is fundamental to comprehend the temporal dimension. According to Heidegger, human existence is intrinsically linked to time, characterised by a constant projection toward the future while being grounded in past experiences. This correlation between past, present and future provides structure and meaning to human life, defining how individuals perceive and respond to the world. The past offers context and lessons that inform current actions, while the future represents a horizon of possibilities that motivates and guides decisions.

Unlike a mere chronological sequence of events, time in the temporal dimension is experienced as a dynamic and lived phenomenon. The past is not static but continually reinterpreted, guiding how individuals understand their current circumstances and envision their future. The present acts as the point of engagement where reflections on the past and aspirations for the future converge, allowing individuals to act meaningfully and authentically in the moment.

For example, individuals often draw upon past knowledge and experiences to contend with current challenges and inform their choices. At the same time, future goals and aspirations inspire actions and provide a sense of direction. This dynamic relationship

between past, present and future is essential for personal growth, enabling individuals to learn from past mistakes, seize opportunities in the present, and pursue significant and fulfilling futures.

The temporal dimension draws attention to the interconnectedness between time and existence, demonstrating how human life is determined by the continual interaction between what has been, what is and what is yet to come. By placing decisions and actions within this temporal framework, individuals are better able to understand their place in the world and make choices that are in line with their values and aspirations. This awareness of time deepens the human experience, supporting a greater sense of purpose and authenticity.

4.1.4.6 Moral/Ethical Dimension

The moral or ethical dimension in terms of human existence centres on the principles and values that guide individuals to discern right from wrong and shape their actions and decisions. This dimension corroborated how ethical considerations influence human relationships, decision-making and societal interactions. It explores the development of moral judgments, the assumption of responsibility for one's choices, as well as the engagement in ethical reasoning to handle the complexities associated with society.

Ethical responsibility has a crucial role to play in this dimension, governing how individuals treat others and satisfy their moral obligations. These concerns arise across different settings, from personal relationships to broader societal issues, influencing how people contribute to the well-being of others while upholding justice, fairness and mutual respect. Ethical behaviour comprises not only adherence to abstract principles but also the lived reality of making complicated choices that affect others, highlighting the relationship between individual desires and collective needs.

Emmanuel Levinas, a prominent thinker in ethical philosophy, accentuates that human existence is inherently ethical. According to Levinas, every encounter with another person imposes an "infinite responsibility," obligating individuals to care for and respond to the needs of others (Perpich, 2008). This ethical duty transcends legal or contractual obligations and is intrinsic to human existence, emphasising the relational and selfless nature of ethical behaviour. Levinas' philosophy maintains that ethical responsibility is not optional but fundamental to the human condition.

The moral or ethical dimension also underlines the challenge of balancing personal desires with the rights and needs of others. Ethical reasoning requires managing tensions between competing values and interests, whether in resolving interpersonal conflicts, making decisions pertaining to justice and equality, or contributing to societal harmony. This process highlights the importance of moral reflection and decision-making in creating a just and equitable society.

Additionally, this dimension considers the influence of cultural, religious and societal norms on moral development. While certain ethical principles, for example fairness and compassion, may be universal, their interpretation and application typically vary across cultures and communities. These differences result in diverse ethical perspectives, influencing how individuals and societies approach moral questions.

In brief, the moral or ethical dimension of human existence displays the central role of ethics in moulding human behaviour and relationships. It highlights the importance of responsibility, reflection and empathy in dealing with complex social and moral landscapes, furthering harmonious coexistence and advancing the collective well-being of humanity.

4.1.4.7 Cultural Dimension

The cultural dimension of human existence emphasises how individuals are significantly influenced by their cultural environments, encompassing aspects such as language, traditions, social norms, art, religion and shared practices. Culture shapes the framework through which people perceive themselves and the world, influencing their values, worldviews and behaviours. It provides the lens through which individuals understand their identity, interact with others and handle their experiences.

Culture is not merely an external influence; it is embedded in every aspect of human life, from communication to the interpretation of ethical and social norms. It profoundly affects personal and collective identities, impacting both individual behaviors and the shared practices that bind communities together. These cultural rituals and traditions supporting continuity, connection and a sense of belonging among generations.

Heidegger's concept of thrownness (Geworfenheit) is fundamental to understanding the cultural dimension. Thrownness denotes the idea that humans are "thrown" into specific cultural and historical contexts without their choosing, and that these contexts significantly affect their existence (Heidegger, 1962). From birth, individuals inherit pre-existing cultural frameworks that influence their opportunities, challenges, and perspectives. While individuals do not choose these conditions, they must manage and make sense of them within the confines of their cultural environment.

This interaction between individuals and their cultural contexts illustrates that culture is not static but dynamic. Human beings are both formed by cultural forces and active participants in establishing them. As individuals engage with their cultural environment, they

continuously reinterpret and reconstruct their understanding of the world, contributing to the evolution of cultural norms and values.

The cultural dimension highlights the interconnectedness of individual identity and collective heritage. It indicates the dynamic relationship between human beings and their cultural contexts, revealing how culture functions as both a foundation and a transformative force in determining human existence. This perspective provides a better understanding of the complexity of human life and the shared practices that define communities.

4.2 Heidegger's Concepts: Being and Phenomena of the World

Martin Heidegger's existential phenomenology, particularly articulated in his unfinished seminal work Being and Time (Sein und Zeit), introduces fundamental concepts exploring the nature of human existence. Central to his philosophy are the notions of Dasein, being-in-the-world, thrownness, care, authenticity and being-toward-death. Heidegger's work shifts focus from traditional object-centred approaches to an existential investigation into the interconnectedness of Dasein (human existence), the world and the entities within it. His philosophy points out the ontological question related to what it means to be and how Dasein interprets its existence within the phenomena of the world.

4.2.1 What is "Being"?

Heidegger's ontological inquiry centres on the question of "Being"—what it means to exist. He positions Dasein, meaning "being there" or "presence," as the cornerstone of his philosophy. Heidegger asserts,

> *"We are ourselves the entities to be analysed. The being of any such entity is in each case mine. These entities, in their being, comport themselves towards their being. As*

entities with such being, they are delivered over to their own being. Being is that which is an issue for every such entity." (Heidegger, 1962)

This reflexive nature of Dasein sets it apart from other entities, as it uniquely possesses the capacity to reflect on its own being and question the essence of existence.

Dasein is not an abstract entity but is always situated within a specific context, engaging dynamically with the world and others. This interaction both shapes and is shaped by Dasein's experiences, forming the foundation of the existential condition of being. Central to this understanding is the concept of being-in-the-world (In-der-Welt-Sein), which accentuates the inseparable unity between Dasein and its environment. Heidegger rejects Cartesian dualism, which isolates the mind from body, in favour of a holistic approach that regards human existence as fundamentally embedded within a web of relationships, meanings and contexts. To comprehend oneself, Heidegger argues, is to simultaneously understand one's environment and interactions within it. This relational framework is integral to the human condition and depicts the dynamic nature of existence.

4.2.1.1 Thrownness: The Context of Existence

The concept of thrownness (*Geworfenheit*) conveys the contingency of existence; the idea that individuals find themselves "thrown" into particular situations or contexts that they did not choose. These circumstances include one's family, culture, sociohistorical environment, besides other aspects of life that are beyond individual control yet profoundly influence one's existence. Thrownness emphasises the facticity of human life: the given conditions of existence that Dasein must navigate and engage with despite its lack of choice in determining them. This concept reflects the inherent unpredictability and constraints of human life while also highlighting Dasein's responsibility to respond to these circumstances.

4.2.1.2 Care: The Structure of Concern

For Heidegger, the structure of Care (*Sorge*) forms the essence of Dasein's being. Care is not an emotional state but an ontological condition that underlies all human actions and engagements with the world. Heidegger conceptualises care through three interconnected dimensions: (1) Ahead-of-itself: Dasein projects itself toward its future possibilities, defining its being through actions and choices; (2) Being-already-in-the-world: Dasein exists within a pre-established context, determined by its past and the conditions into which it was thrown; and (3) Being-alongside-others: Dasein interacts with other beings, forming relationships and situating itself within a shared world.

These dimensions illustrate that Dasein's existence is oriented toward the future, grounded in its past, and actively engaged in the present. Via this structure of care, Dasein engages implicitly with the world, demonstrating its capacity to relate to both its being and its environment.

4.2.1.3 Authenticity and Inauthenticity

Authenticity (*Eigentlichkeit*) in Heidegger's framework involves living in accordance with one's "ownmost" potential for being, embracing the finite nature of existence and making choices that are genuinely one's own. To live authentically, Dasein must acknowledge its thrownness while taking responsibility for its life and future. Authenticity entails a conscious awareness of one's finitude and freedom, enabling individuals to live with intentionality and purpose.

Conversely, inauthenticity is marked by passivity, conformity and the avoidance of existential truths. Inauthentic individuals follow societal norms and expectations, permitting external influences (das Man or "the they") to dictate their actions and decisions. This

avoidance of responsibility prevents Dasein from fully confronting the realities of its existence.

4.2.1.4 Being-toward-Death: Confronting Mortality

Central to Heidegger's examination of authenticity is the concept of being-toward-death (*Sein-zum-Tode*), which emphasises the need to confront one's mortality. Death is described as the "ownmost," non-relational, and inevitable possibility for each person. Unlike other possibilities, which may or may not come to pass, death is an absolute certainty that points out the finiteness of existence. Heidegger argues that authentically encountering the reality of death compels individuals to live more meaningfully and responsibly, as they become acutely aware of their limited time and the importance of their choices.

Avoiding or denying death leads to inauthentic living, where individuals avoid fundamental questions concerning existence and settle into passive conformity. However, by embracing mortality, Dasein can achieve a heightened sense of purpose and awareness, living authentically in the face of life's uncertainties.

Heidegger's concepts of Dasein, being-in-the-world, thrownness, care, authenticity and being-toward-death are significantly interconnected. Dasein's engagement with the world is constructed by its thrownness, which forms the contextual backdrop of its existence. Through care, Dasein manages its relational and temporal dimensions, actively engaging with its environment and others. Authenticity arises when Dasein takes responsibility for its thrownness and lives in accordance with its own potential, fully aware of its finitude. This awareness is intensified through an authentic confrontation with death, which stresses the finite nature of existence and the obligation to live with purpose and awareness.

In exploring these themes, Heidegger offers profound observations into the existential conditions of human life, emphasising the interconnected and dynamic nature of being. His ontological framework challenges traditional notions of objectivity and subjectivity, providing a comprehensive understanding of the relational, temporal and finite dimensions of existence.

4.2.2 Phenomena of the World

Heidegger defines a phenomenon as "that which shows itself in itself," accentuating the importance of allowing phenomena to reveal themselves without the imposition of preconceived interpretations. This phenomenological approach is fundamental to comprehending the nature of the world and being.

Heidegger's exploration of the "world" and "worldhood" provides a profound rethinking of how humans engage with their surroundings, moving beyond traditional notions of objectivity and detachment. For Heidegger, the "world" is distinct from the physical "universe." While the universe consists of atoms, particles and material entities studied by the natural sciences, the world, as Heidegger conceives it, is a human-centred and significant structure. It is not merely a collection of physical objects but a framework determined by human practices, cultural contexts, along with relationships. For instance, expressions such as "the business world" or "the world of basketball" do not refer to physical attributes but to the cultural practices, relationships and meanings embedded within these domains. These specialized "sub-worlds" are components of a wider world, whose structure Heidegger examines through the concept of "worldliness"—the relational and existential framework that gives the world its meaning.

Heidegger's concept of being-in-the-world (*In-der-Welt-sein*) is central to his philosophy, underlining that the world is not a passive backdrop to human activity but an active, interpersonal context. Dasein, or human existence, does not exist independently of the world but is fundamentally embedded within it. This inseparability of Dasein from its environment reveals the dynamic and worthwhile interactions that define human existence. Heidegger redefines spatiality, arguing that it is not a matter of measurable distances or physical containment but of the relevance and significance of entities within Dasein's projects. For example, a carpenter does not perceive a hammer as a mere physical object with measurable properties; instead, the hammer is encountered as ready-to-hand, a tool integrated seamlessly into the carpenter's activity. This dynamic interaction highlights the relational nature of human existence and how the world reveals itself through practical engagement.

The concept of worldhood further illustrates this relational understanding. Worldhood refers to the structural characteristics that allow Dasein to encounter the world meaningfully (Duvisac, 2014). Regarding Heidegger, the world is not an assemblage of isolated objects but a web of interrelated entities that gain significance through their roles in human activity. This idea is exemplified in Heidegger's notion of equipmentality (*Zeughaftigkeit*), which describes how entities are encountered based on their function and relevance. A hammer, for instance, is not primarily understood as an object with physical attributes such as weight or shape; rather, it is encountered through its purpose within the act of hammering. Similarly, a hospital is not merely a physical structure but a meaningful environment influenced by caregiving responsibilities, professional tools and the relationships between colleagues and patients.

Heidegger distinguishes between two modes of interacting with entities: ready-to-hand (*Zuhandenheit*) and present-at-hand (*Vorhandenheit*). Entities that are ready-to-hand are logically integrated into Dasein's practical concerns and activities, where their significance lies in their function. For example, a pen used in writing is seen as ready-to-hand, directly assisting the writer's intentions. In contrast, when an entity is removed from its functional context and examined for its inherent properties, such as material composition or weight, it is experienced as present-at-hand. This shift from ready-to-hand to present-at-hand often occurs when an object becomes unusable or problematic, forcing Dasein to confront its properties objectively rather than through practical engagement. This distinction brings to light that entities gain meaning not from their inherent attributes but from their roles within Dasein's purposeful engagement.

Heidegger also critiques traditional Cartesian notions of spatiality, which perceives space as a neutral container for objects. Instead, Heidegger emphasises that spatiality is defined by the relevance and significance of entities within Dasein's world. For instance, a chair's spatiality is not merely its location in a room but its readiness-to-hand in supporting human activities such as sitting or working. This relational understanding of space challenges the idea of space as a passive vessel and redefines it as a dynamic and meaningful context moulded by Dasein's interactions and projects. Similarly, the spatiality of a hospital is distinguished by its readiness-to-hand to undertake caregiving tasks, reflecting the functional and relational significance of its environment.

Central to Heidegger's ontology is the idea that the world is a dynamic field of meaning, shaped by Dasein's interactions and pre-understanding. He stresses the hermeneutic circle, wherein Dasein's prior understanding influences how phenomena are

revealed, while subsequent experiences process those preconceptions. This ongoing interplay reveals the evolving nature of Dasein's relationship with the world, demonstrating that meaning is continually negotiated and redefined via engagement.

In Heidegger's framework, the world is not a static collection of objects but a lived and dynamic network of meanings, relationships, and contexts. Through the concepts of being-in-the-world and worldhood, he challenges traditional distinctions between subject and object, accentuating the interconnectedness of Dasein and its environment. Entities gain their significance through their roles in Dasein's projects and relationships, placing emphasis on the relational and purposeful nature of human existence. By situating Dasein within a dynamic and meaningful world, Heidegger provides an ontological framework that delivers profound observations of the interaction between individual existence and the broader relational structures of the world.

4.3 Summary

This chapter has bridged the theoretical and the practical, demonstrating how Heidegger's concepts illuminate the complexities of human experience while providing a framework to understand the complex world of nurses. By examining both the philosophical foundations and the lived experiences of caregiving, the discussion not only deepens our appreciation of nursing as a profession but also contributes to the broader understanding of what it means to exist, relate and find meaning in the world. Through this synthesis, we recognize the transformative potential of philosophical investigation in enriching our understanding of human life and professional practice has been acknowledged.

CHAPTER 5

RESULTS AND FINDINGS

This chapter describes the psychosocial lived experiences of nurses during the pandemic in Sarawak. Close examination of the participants' interviews revealed five interrelated and interdependent themes. Each of the themes describes part of the participants' feeling, thinking and behaving: the experience will be evident when each theme is combined together as a whole. However, for the purpose of analysis and textual description, the themes are presented as Navigating the Emotional and Physical Landscape of COVID-19 Nursing Care, Experiencing Social Disconnection and Isolation, Adapting to Workplace Challenges, Strengthening Camaraderie in the Healthcare Environment, together with Upholding Commitment and Professionalism During the Challenges.

5.1 Respondents Socio-Demographic Profile

This section provides the detailed socio-demographic information in relation to the respondents who participated in the study. The details of respondents' backgrounds are presented in Table 5.1.

Table 5.1: Socio-Demographic Profile of the Participants

Sample	Acronym	Gender	Age	Race	Education	Marital status	Children	Post basic	Working experience in ID
P1	Laura	Female	43	Chinese	Diploma	Married	3	Midwifery	21 years
P2	Naomi	Female	28	Malay	Diploma	Single	-	-	6 years
P3	Amanda	Female	29	Bidayuh	Diploma	Married	1	-	4 years
P4	Teresa	Female	38	Malay	Diploma	Married	3	-	12 years
P5	Malik	Male	33	Bidayuh	Diploma	Married	0	-	9 years
P6	Imran	Male	34	Malay	Diploma	Married	2	-	9 years
P7	Felicia	Female	29	Bidayuh	Diploma	Single	-	-	4 years
P8	Wendy	Female	31	Malay	Diploma	Married	0	-	9 years
P9	Umaira	Female	36	Malay	Diploma	Married	1	Intensive care	14 years
P10	Claudia	Female	41	Bidayuh	Diploma	Single	-	Infection Control	18 years

A purposive sample size of ten participants was selected for this study based on the inclusion and exclusion criteria outlined in Section 3.3. Data saturation was attained after interviewing the tenth participant. Each participant was assigned a unique serial number ranging from P01 to P10. Pseudonyms replaced their actual names in the transcribed transcripts to safeguard anonymity throughout the interview process.

As outlined in Table 4.1, the participants, aged between 28 and 43, represented a diverse range of ethnic backgrounds, including Chinese, Malay and Bidayuh. All the nurses held a diploma in nursing, with grades ranging from U29 to U32. Moreover, three participants had acquired specialised training. Specifically, eight out of the ten respondents had more than five years of nursing experience. Their work experience varied significantly, spanning from four to 21 years and played a crucial role in determining their ability to handle the physical demands of caring for COVID-19 patients.

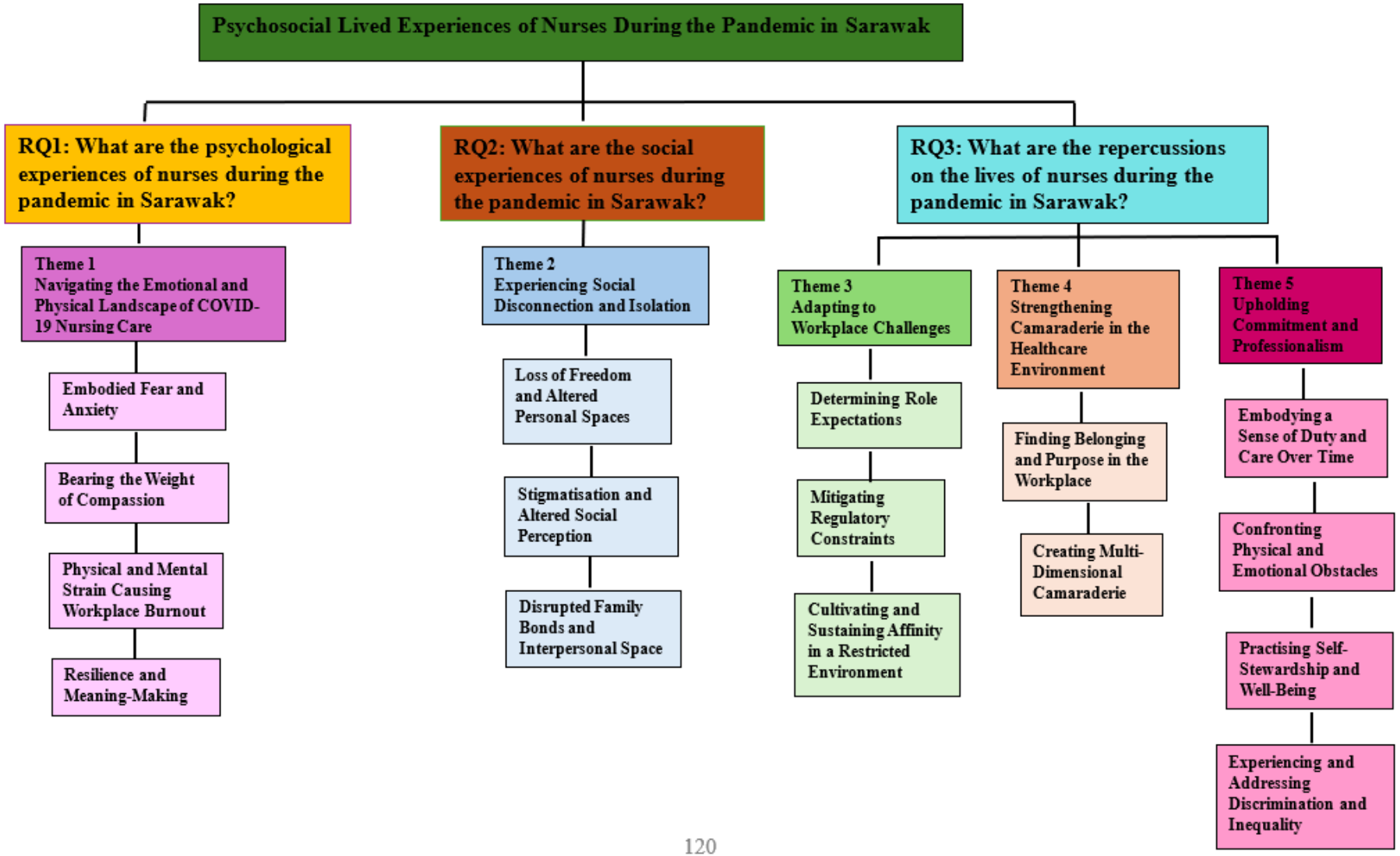
The interviews were primarily conducted in Malay, with certain terms explained in English when necessary. As I am proficient in both languages, this approach allowed for clear communication and assured the participants felt comfortable. Conducting the interviews in their preferred language was intended to create a sense of closeness and trust, encouraging each person to express their innermost feelings and experiences. This approach is further elaborated upon in Chapter 3, Section 3.6.3. The duration of each interview ranged from 30 minutes to 1 hour and 16 minutes. The total duration of all the interviews was 8 hours, 35 minutes and 9 seconds. As described in Chapter 3 (Methodology, Section 3.6.7), each of the interview transcripts were thematically analysed and original common phrases were formulated. The total number of words for the interview transcripts is 66,785 words.

5.2 Overview of Themes and Sub-themes

The findings of this study were organized according to the research objectives, highlighting the psychosocial experiences of nurses during the pandemic in Sarawak, which varied among the participants. As presented in Table 5.2, a total of five themes emerged from this study.

Table 5.2: Overview of Theme and Sub-themes

Objectives	Theme	Sub-themes
To examine the psychological experiences of nurses during the pandemic in Sarawak	Navigating the Emotional and Physical Landscape of COVID-19 Nursing Care	1. Embodied Fear and Anxiety 2. Bearing the Weight of Compassion 3. Physical and Mental Strain Causing Workplace Burnout 4. Resilience and Meaning-Making Through the Body
To identify the social experiences of nurses during the pandemic in Sarawak	Experiencing Social Disconnection and Isolation	1. Loss of Freedom and Altered Personal Spaces 2. Stigmatisation and Altered Social Perception 3. Disrupted Family Bonds and Interpersonal Space
To understand the repercussions on the lives of nurses during the pandemic in Sarawak	Adapting to Workplace Challenges	1. Determining Role Expectations 2. Mitigating Regulatory Constraints 3. Cultivating and Sustaining Affinity in a Restricted Environment
	Strengthening Camaraderie in the Healthcare Environment	1. Finding Belonging and Purpose in the Workplace 2. Creating Multi-Dimensional Camaraderie
	Upholding Commitment and Professionalism During the Challenges	1. Embodying a Sense of Duty and Care Over Time 2. Confronting Physical and Emotional Obstacles 3. Practising Self-Stewardship and Well-Being 4. Experiencing and Addressing Discrimination and Inequality



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Figure 5.1: Overview of Themes and Sub-themes

5.2.1 Theme 1: Navigating the Emotional and Physical Landscape of COVID-19 Nursing Care

This theme (see Figure 4.1) demontrates the intense emotional and physical challenges that nurses experienced while caring for COVID-19 patients. The unprecedented nature of the pandemic placed enormous demands on nurses, requiring them to confront not only the medical complexities of the virus but also the profound emotional and psychological toll as a result of their work.

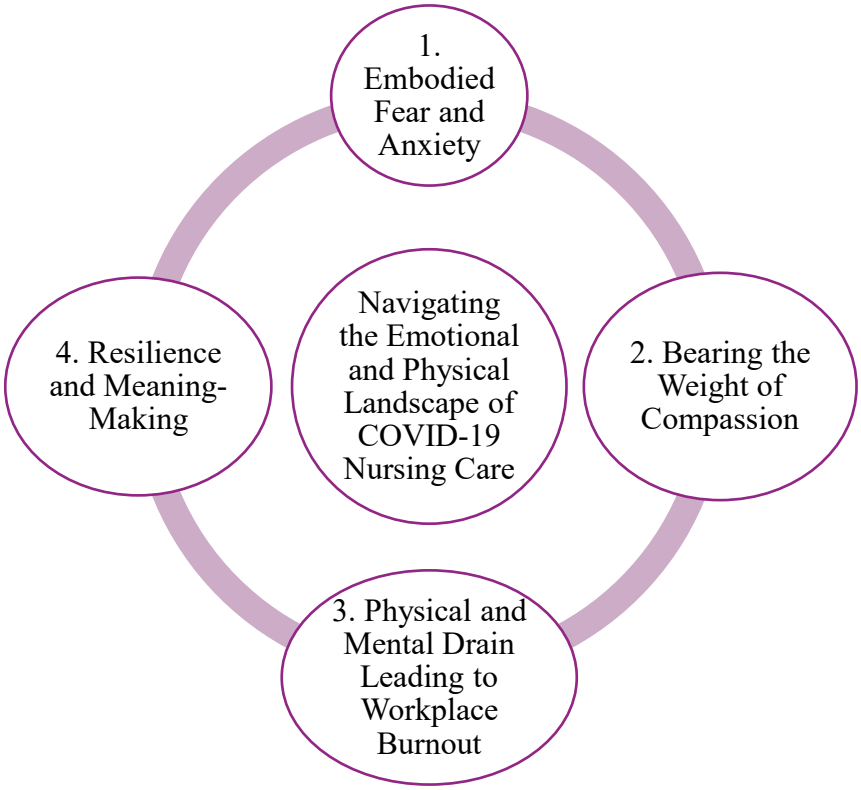


Figure 5.2: Sub-themes relating to Theme 1

5.2.1.1 Sub-theme 1: Embodied Fear and Anxiety

Fear emerged as the predominant and immediate response expressed by all respondents when asked about their concerns regarding working during the pandemic. The nurses communicated a profound sense of fear and anxiety related not only to their own

health and safety but also to the potential risk of transmitting the virus to their loved ones or colleagues. This sense of fear was palpable in the excerpts shared by the participants:

Laura (P.1) expressed,

"... I'm afraid that I won't be able to spend time with my family. //... I'm most worried that I might get infected by COVID-19. //... I'm afraid. I'm afraid to die. Plus, I don't have any vaccines either."

Similarly, Naomi (P.2) stated,

"... It's really scary. Scared because I'd never had the experience of dealing with COVID-19. At that time, the Infectious Disease ward had no experience of handling this disease yet, plus the ward was not fully prepared to receive the COVID-19 cases. I was told to wear full PPE when handling the patient."

The fear and uncertainty were consistent in all of the respondents, as Amanda (P.3) noted,

"... from what we know that COVID-19 patient is not the same as MERCOV. We are afraid."

Teresa (P.4) succinctly exhibited this fear by stating,

"takut" (afraid) because we don't know how severe the effect is on us. Will we spread the disease to our friends or take it home?"

This apprehension was not only personal but also extended to their professional responsibilities. For instance, Malik (P.5) revealed his anxiety in significant detail:

"... errrr the first time my heart was pounding. I had palpitations because we faced something new. Mostly errr the way we treat a COVID-19 patient and the time we treat a TB patient RV is really different. So that's what we fear. //... Saya takut (fear) to attend patient, takut (fear) to be near patient, takut (fear) of getting infected. I want to go inside, want to handle it, want to breathe the air, but also I am afraid."

Other respondents echoed similar fears, with Imran (P.6) voicing concerns about his family's safety,

"...I'm really afraid because I'm afraid my wife and children will be infected, I'm afraid it's contagious, I'm afraid the illness will cause mortality, I heard the news that many people have died. So I'm not lying, I'm scared."

Felicia (P.7) described her experience:

"...Because COVID-19 is really scary from the beginning. We don't know what it's like, we really feel very scary, dirty. We are afraid to bring the disease to the family."

Wendy (P.8) also conveyed her undoubted fear, particularly regarding the risk of transmission and the responsibility of caring for COVID-19 patients,

"... isshh takut (fear). Read from the news and paper that COVID-19 is dreadful and can cause mortality. All kinds of things in my mind, with the management first time handling it and disorganised. //... Afraid it will infect me. I'm afraid I've infected myself, then I'll infect other people. Ermm feeling so insecure. //... ermm at that time I felt like I was unlucky because I was working and then the case came. I was assigned to be in charge. So it's like ishhh a burden for me, and then I'm afraid. What if I do something wrong? "Ehhh, if the patient is ill, what am I going to do? //... I think a

lot. Who wants to help me later ahh, if anything happens? It's because, at that time, we can't have a lot of contact exposure, only one nurse and one doctor are allowed to come in at one time."

Umaira (P.9) and Claudia (P.10), who were the pioneer nurses in the Infectious Disease ward, expressed their fears related to the correct use of PPE:

"...the feeling of fear is more about self-control. Because we know there is no cure for covid. Afraid of getting infected. Is our PPE correct? Is the way we open correct?" (Umaira, P.9)

"... Fear because this disease is easily contagious. After all, there is no cure, so we are afraid. And one thing, I'm afraid when wearing PPE, we can make a mistake when removing it. Afraid of making a mistake on our own because we are attending patients, right?" (Claudia, P.10)

Out of the ten respondents, Laura (P.1), Umaira (P.9) and Claudia (P.10) were the pioneer nurses who were working in the Infectious Disease ward. This particular ward was officially opened in 2009. They had previously dealt with the H1N1 Influenza (Swine Flu) pandemic, although its severity was not as critical as COVID-19. The remaining respondents had managed epidemics such as Tuberculosis, Ebola and Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in the past. However, their previous experiences did not fully prepare them for the unprecedented challenges posed by the COVID-19 pandemic.

The initial lack of understanding of COVID-19 contributed to increasing fear among the nurses. For instance, Amanda (P.3) compared MERCOV with COVID-19, emphasising the extreme severity and mortality associated with the latter. This uncertainty created anxiety

and unease as the nurses faced an unknown enemy. Given that the Infectious Disease ward managed all the COVID-19 cases in Sarawak, the nurses had to continuously wear full PPE, which heightened their stress and pressure to perform faultlessly.

Fear frequently acts as a natural motivator, prompting individuals to take actions that ensure survival. Nonetheless, it can also lead to behaviours that may hinder personal well-being and effective functioning. In this case, fear had both protective and distressing effects on the nurses. As previously documented (see p.117), Malik (P.5) exhibited a classic fight-or-flight response, physically and mentally avoiding patients, even fearing to breathe in their presence as a protective measure against what he perceived as a life-threatening situation.

Regardless of undergoing regular PPE training, certain nurses remained doubtful concerning their actions, heightening their anxiety in high-stakes situations. Claudia (P.10) expressed uncertainty and concern as regards potentially making mistakes while removing PPE despite being the trained infection control link nurse in the ward and regular training sessions were conducted every Wednesday to prepare staff. Imran (P.6) expressed a persistent fear of making mistakes whilst using his PPE, generating a constant fear of death as a consequence:

> *"... How do you know if we forget, or when accidentally removing PPE? //... what will happen if you get COVID-19 because not following the PPE steps correctly? I just thought of death, nothing else."* (Imran, P.6)

Similarly, Wendy (P.8) admitted that in an actual stressful situation, she felt as though she had forgotten everything she had learned, her fear overshadowing her confidence in her training:

"... Indeed, we have learned about PPE. But when the patient is in there, it seems like everything is lost, it's like I do not remember what I learned." (Wendy, P.8)

These shared experiences of fear and anxiety reflect the tremendous psychological burden nurses were subjected to while working during the COVID-19 pandemic. Their concerns encompassed personal safety, the well-being of others, together with the uncertainty associated with this unprecedented health crisis, emphasising the profound emotional challenges they encountered on the frontline.

5.2.1.2 Sub-theme 2: Bearing the Weight of Compassion

This theme illustrates the profound emotional and physical strain experienced by nurses as they continuously bore witness to the suffering, deterioration, and in some cases, death of patients infected with COVID-19. Central to this experience was compassion fatigue—a form of emotional distress that emerged when nurses were unable to provide the level of care they believed their patients deserved, often due to shortages in resources, time or manpower. This dissonance between their professional values and the reality of care delivery created a sense of moral conflict, repeatedly resulting in guilt, helplessness and emotional exhaustion. Nurses described feeling overwhelmed by profound sadness, hopelessness and a persistent sense of inadequacy, all of which intensified as the pandemic progressed. The cumulative weight of these experiences contributed to the erosion of their emotional resilience and exacerbated existing mental health challenges.

Respondents described how the emotional burden of their role not only affected their psychological well-being but also manifested physically, often leaving them feeling overwhelmed, disheartened and exhausted. These experiences articulate the immense

challenges nurses encountered as they dealt with the demands of their profession while coping with the emotional weight of patient suffering.

For instance, feelings of hopelessness and regret toward their profession were voiced by several nurses, as shown in the excerpts below:

Naomi (P.2) stated,

"... I regretted choosing nursing as a profession. //... the main reason I stay is that this is our work, a source of nourishment, right? It means that if I don't work, I won't be able to pay, or get a salary. I have my own commitment with a car, a house, and then to help the family as well."

Similarly, Amanda (P.3) expressed her sense of despair:

"... if I'm was still on Medical 4 ward, I would not be struggling with all these things."

Laura (P.1) shared her frustration and fatigue:

"... why does COVID-19 never end? I'm fed up, I'm fed-up taking care of these COVID patients."

Imran (P.6) echoed this sentiment with a profound sense of exhaustion and fear:

"... fed-up because of the disease. I feel like moving (transfer) somewhere else, looking for a clean ward where we can have contact with the patients as usual but there is no need to wrap up (Tyvek suit) like that. Indeed, I am afraid of death, anyone would be afraid of death. //... Even from the patient, we can see how they are all afraid of COVID-19. From there I feel affected and exposed. They are far away from

their family and are afraid that they will not see their family after this. That's how I thought at that time. Would I be able to see my family after this? Who knows if I get COVID-19 and kiok (die)? (Imran, P.6)

These expressions of remorse, the use of terms like "if," in addition to phrases like “fed-up” demonstrate the nurses’ sense of being trapped in their profession. They felt stuck, unable to escape their roles despite the overwhelming challenges they underwent. For example, Amanda (P.3) started her nursing career on the Medical 4 ward before being transferred to the Infectious Disease (ID) ward in 2017. Naomi (P.2) and Imran (P.6) were assigned to the ID ward as their first posting, while Laura (P.1) has been working on the ward for 21 years. Their long-standing commitment to their roles intensified their sense of helplessness.

Another aspect of this emotional impact was the sense of vulnerability nurses felt when basic necessities, for instance supplies of mineral water, were in short supply for their patients. Teresa (P.4) shared her experience:

“... patients didn't bring anything during admission (Sehelai sepinggang). We want to give them something to eat. At least we have prepared some dry foods like biscuits. At first, it was quite difficult because no one had given any donations yet. We just put enough mineral water in the room. The difficult thing is that sometimes things are not there. We have to wait for people to donate. We can't even afford to give it to everyone as there are many patients.”

The emotional impact of being away from family added to the strain. Naomi (P.2), who is from Limbang, a small district in Sarawak, expressed her sadness and apprehension regarding her family members being far away:

"... That time was sad because I kept thinking about my family members. //... I was worried as I'm far away from them. I'm afraid anything will happen to my family in my hometown."

Similarly, Amanda (P.3) shared how COVID-19 restrictions prevented her from returning home, which added to her sense of sadness and isolation:

"... When we were inside the patient's room, we had to resist hunger, drinking, urination and defecation. Hmm, it was a sad time. //... Like me, I commute from home daily. It's sad that I can't go back."

The emotional toll of caring for COVID-19 patients was compounded when nurses formed emotional connections with their patients. Naomi (P.2) recalled a particular male patient from the first wave of COVID-19 (religious "tabligh" gathering) who reminded her of her father:

"... I remembered his name because that patient was very good to us. He was old, I think he was the same age as my own father. That uncle is very good, he always recites the Quran. He told us if he could turn back time, he would not want to go to the religious gathering. It's a pity because I still imagine that uncle can speak to me, in the end he passed away."

Naomi's emotional response was intensified by the fact that the patient reminded her of her own father, deepening her sense of loss when he passed away. This connection amplified her empathy and emotional burden.

Similarly, Malik (P.5) described how caring for elderly COVID-19 patients triggered concerns about his own parents:

"... when you see a COVID-19 patient, especially the elderly, it reminds us about our parents. We are worried about our family members in the village. But at the same time, we have to take care of the patients in the ward. So ermm, it makes the worry even worse because the first thing is that we don't know how our parents are doing in the village. What they want, how they go to the market. So that makes us worry. //... For example, if they are sick or have a fever, it is difficult for us to visit them because of the Movement Control Order. We communicate through phone and video calls; but it is difficult to know the real situation. Watch from the phone, video calls are not enough."

Malik (P.5), who works alongside his twin brother in the same hospital, used the pronoun "we" to express his shared concern for his parents in their village. The restrictions on movement prevented them from visiting their parents, adding to their unease. Although they could communicate through phone calls, it was not sufficient to understand their parents' real situation.

Witnessing the suffering of elderly COVID-19 patients can be emotionally taxing, as it triggers worries about their own aging family members. This creates a conflict between professional duty and personal concern, leading to potential emotional exhaustion. The emotional impact is often long-lasting, as illustrated by Naomi's (P.2) lingering sense of grief and stress, also known as "emotional residue." This enduring emotional burden can significantly affect nurses' emotional well-being, as they continue to grapple with the suffering they witness and the personal connections they form with their patients.

5.2.1.3 Sub-theme 3: Physical and Mental Drain Leading to Workplace Burnout

The theme "Physical and Mental Drain Leading to Workplace Burnout" encompasses the intense experiences faced by nurses as they coped with high workloads, inadequate resources and organisational challenges while caring for COVID-19 patients. This theme exhibits the complex nature of stress and burnout experienced by the nurses, encompassing changes in their work environment, prolonged shifts, physical exhaustion, besides emotional fatigue. Additionally, the continuous exposure to patient suffering and death further intensified their sense of burnout. These cumulative factors not only strained the nurses physically but also took a profound toll on their mental well-being, identifying the significant challenges they encountered in their professional roles during the pandemic.

One respondent, Laura (P.1), recounted how her workplace dramatically changed after being summoned back from a Chinese New Year vacation in January 2020:

> *"... Sister told me to go to work. So I'm thinking how? I was on the Chinese New Year holiday at that time. After the week off, I went back to work. When I saw that the atmosphere really changed, I got scared. We have to use PPE to cover everything, very hot. You have to wear a mask and frequently handwash. After that, we worked for 12 hours, it was really tiring. //... When the COVID-19 ward was newly set up, some staff were angry, as some did not want to take care of COVID-19 patients. There is stress, there are fights. If the PPE supplied was not adequate, arguments occurred among staff. "Where to find it". The doctor was angry "why aren't all the items there?" Because this is the first time COVID is in Malaysia, right?"*

The unfamiliarity of the situation and the extensive use of PPE created a tense work environment. Laura (P.1) noted that arguments would arise when resources were insufficient, whilst the high-pressure environment resulted in staff blaming one another

when things were not in place. These challenges were exacerbated by the 12-hour shifts, which added to the fatigue and stress.

Naomi (P.2) echoed similar sentiments about the changing work environment:

> *"... The environment has changed a lot, even in the patient's room and outside, the way we get along, with the management means the superiors who organize us are also different. Management means the roster. Sometimes there are friends who need to be quarantined, anytime our roster can be changed. Right now if we have symptoms we will be swabbed and then quarantined. So the roster is not permanent, it's a mess. //... even if we eat, there needs to have a divider. Even at the nurse's counter, you can't be very close."*

The rapidly changing work environment, frequent changes to duty rosters, as well as social distancing measures added to Naomi's stress, as it disrupted the usual sense of order and familiarity in the workplace.

The mandatory quarantine measures further intensified workplace stress. Nurses were required to stay in "anjung kasih," accommodations provided by the hospital. Moreover, they were not permitted to leave until the patients they were caring for tested negative for COVID-19. Teresa (P.4) described this situation:

> *"... During the first wave, we can't go home, everyone just stays here in "anjung kasih". Go back and forth at "anjung kasih". You can't go home until the result of the patient you are taking care of is negative. We always call up the ward to ask what the patient's results so that we can go home. For example, when taking care of suspected COVID-19 patient, we will be quarantined for three days after finishing*

three working days. The first day, second day, third day, as long as there are no results, we cannot go home."

The long 12-hour shifts were another major source of stress and burnout. Seven respondents (Laura (P.1), Naomi (P.2), Amanda (P.3), Teresa (P.4), Malik (P.5), Felicia (P.7) and Wendy (P.8) agreed that the extended working hours induced stress. Initially, nurses were required to work 12-hour shifts for seven consecutive days, which was later reduced to 12-hour shifts for three days, followed by three days off. This shift pattern was physically exhausting, as Teresa (P.4) described:

"... we are really tired working for 12 hours. There was one time they work up to 7 days. //... Maybe some are okay with 7 days, but once already working for the sixth or seventh day, they give up, exhausted. The 12 hours for seven days shift lasted for one week. Those who work during the day may be okay, they don't feel "huyung hayang". Those who work at night "mabuk".

In the local dialect, "huyung hayang" and "mabuk" are terms used to describe looking awful and shattered due to sleep deprivation.

Likewise, Laura (P.1) expressed the physical and emotional strain:

"... it was very stressful at that time. And then we can't go back home. //... Imagine working for 12 hours, can't pee, I can't even drink, really thirsty and hungry. //... Everything needs to be fast at that time."

Malik (P.5) also communicated how overwhelming the workload became:

"... I'm too stressed and depressed with the work, workload. COVID-19 is very cruel to people. That made me very depressed with the situation at that time."

Felicia (P.7) and Wendy (P.8) further emphasised the emotional strain from the long shifts, which caused them to feel imprisoned and stressed.

The overwhelming demands led to burnout, which was evident in the behavioural changes and emotional outbursts reported by four of the respondents. For example, Wendy (P.8) noted:

> *"... I feel like I get angry quickly if there is something irritating. Last time we were ok, for example the doctor asked us all if we are ok. "If you want this stuff, it's all near here". Ermm but now when the doctor or anyone else calls, what's more when we are busy doing all the work, then he asks us all kinds of things "oh doctor can't you look around there ahh". Now I'm a little quick to answer all of this. I don't know, maybe it's because of the pandemic, everyone wants to be fast, everyone wants this."*

Similarly, Claudia (P.10) observed:

> *"... Now I'm quick to get angry, quick to get wound up too but because of the right things. I just got reprimanded, but I didn't get angry. I don't know why I feel like I'm getting wind of it. Maybe it's because I'm tired of COVID-19, like there's nothing else."*

Umaira (P.9) also shared how the extended working hours impacted her temperament:

> *"... I get angry easily because of work stress. Yes, I am quick-tempered. If you ask my sister (nursing manager), she feel the same. Now when the staff is COVID-19 positive, Sister says works for 12 hours. I get angry with no reason. I can't work 12 hours, because 12 hours is torturous."*

Malik (P.5) demonstrated the severe effects of burnout, experiencing symptoms like depression, irritability, and even lashing out at patients. He recounted:

> *"... I really needed counselling at that time. I was really depressed. Very depressed with the situation. At that depressed level, sometimes I can scream honestly. I can eat but I can't. What was I thinking at that time? Work, work, work. There is a lot of work and I am thinking "Oh when will my work be finished, when will that be finished, when will this be settled."*

Malik's case of burnout was severe, as he admitted to being rude to patients and colleagues, demonstrating how the relentless pressure of the pandemic had affected his ability to maintain compassionate care. This change in behaviour and the need for counselling indicate the critical need for mental health support to address burnout among healthcare workers.

The emotional exhaustion, in conjunction with the constant stress of caring for critically ill patients, caused some nurses, such as Naomi (P.2), to reach breaking point:

> *"... biar saya yang dapat COVID-19 dan saya rest, biarlah orang yang jaga saya" (let me contract COVID-19 so that I can rest and let others take care of me). //... Like before, whenever I want, I can go back, ask for leave and I can go back. Now it's not like it used to be. Sometimes it makes me feel sad. I feel jealous especially when I see other friends can meet their family members regularly during the Movement Control Order. It makes me wonder during this COVID time we always take care of people's parents while it is hard to see our family. Before COVID I always went back when there was a chance to go back, so it felt like it."*

This statement notably encapsulates the extreme burnout and mental fatigue that Naomi (P.2) was experiencing. Her sadness and frustration over longing for familial connection intensified her distress, demonstrating the profound emotional impact the pandemic took on her well-being.

Additionally, seeing many patients die from COVID-19 heightened the stress for the nurses. Umaira (P.9) described:

> *"... stress during the first wave, many patients died. After the patient is admitted he/she will die. There is no hope. As long as I was working, when we took care of a TB patient who was intubated, some extubated and they recovered. This (COVID-19) is not the same. When you are intubated you know you will die."*

This sense of hopelessness, as patients succumbed despite the nurses' best efforts, added to the tremendous stress. Wendy (P.8) and Laura (P.1) also echoed similar sentiments as regards the high mortality rate and the resulting emotional distress:

> *"... cluster Italy causes stress because the patients are all in bad shape. Some of them end up dying on the ward or died on the general ward. So, we are sad and sorry because it involves family and outside contacts. If the patient deteriorates and then ends up not being in good shape, we're sad too."* (Wendy, P.8)

> *"... one of the patients was on the ventilator for a long time, almost a week, and died anyway. Most of the time no one survives after being ventilated. Actually, the survival rate is futile if on a ventilator."* (Laura, P.1)

It is an obvious illustration of how the challenges of a high workload, inadequate resources, extended shifts, the emotional impact of patient suffering, plus organisational

stressors triggered significant stress and burnout among the nurses. These factors underline the urgent need for workplace interventions and mental health support to address the challenges faced by frontline healthcare workers during the pandemic.

5.2.1.4 Sub-theme 4: Resilience and Meaning-Making

The theme " Resilience and Meaning-Making" captures how, despite the immense challenges brought on by the COVID-19 pandemic, nurses discovered moments of optimism, fortitude and purpose in their profession. Through their experiences, they ascertained ways to become agents of change, develop resilience and cultivate a greater appreciation for life.

A meaningful life is often connected with a sense of coherence, purpose and significance. Coherence comprises making sense of one's life, purpose relates to having goals and direction, and significance pertains to recognising life's inherent value and worth. These components were evident in the experiences shared by the respondents.

Naomi (P.2) considered how her experience with COVID-19 patients transformed her from a person who would often cry under stress into someone more resilient and emotionally strong. She learned to manage her emotions better, particularly the feeling of homesickness. She also found herself becoming more confident and capable of dealing with stressful situations:

> *"... I think the stronger I am, the stronger it is to hold my heart. Before this, little things made me cry, stress made me cry. However, after dealing with COVID-19 patients for a long time, I feel that I am more confident than before as we are used to dealing with stress. It means that I can control the feeling of missing my family."*

This transformation illustrates how Naomi developed inner strength and confidence in the course of adversity, leading to a more hopeful and empowered outlook. Her experience exemplifies how challenging circumstances can increase resilience, allowing individuals to emerge stronger and more self-assured.

Similarly, COVID-19 acted as a turning point for Malik (P.5), who used to be a reserved and quiet individual. He described how the pandemic made him more outspoken and assertive, aiding him to confidently voice his opinions and correct mistakes fearlessly, even when interacting with doctors:

> *"... Before the pandemic I was not the type of person who likes to talk. I'm the quiet type. I'm the quiet type and I'm not the strict type. Not the type who can't easily see things that are wrong. At that time my sister (nursing manager) scolded me why I didn't talk much. I was silent, then my voice was not very loud. //... Now it's different. It was the first time I started talking a lot. At that time, my mouth never stopped talking. And then ahh I started to be very strict. And then even now after COVID-19 even with the doctor. I reprimanded the wrong things. I dare not to talk to people. I'd say, "sorry, can you do that like this". No, now it's different. I keep talking and reprimanding". Can you do that properly, don't play around like that ahh". The change is okay because I can shape me into a new me."*

Malik's newfound assertiveness and ability to voice his thoughts demonstrate how adversity can bring about personal growth and transformation, enabling him to find strength and purpose in his role as a healthcare professional.

Several respondents, including Laura (P.1), Amanda (P.3), Teresa (P.4), Malik (P.5), Wendy (P.8), and Claudia (P.10), agreed that the pandemic instilled a sense of caution and

responsibility. They developed a greater awareness of health protocols, which impacted both their professional and personal lives:

> *"... After this pandemic, we are more responsible, vigilant, always use masks. Right now no farewell party anymore. There is no karaoke."* (Laura, P.1)

> *"... I really take care of myself. At work, wear a mask, use a face shield. Eating time is ok because the ward has a partition near the pantry. When chit-chatting with friends, keep the distance and wear a mask because we don't know our friends. There are also staff who caught COVID-19 positive on this ward. //... we have to adhere to certain rules. Like before we go back, we take a shower first and wash hands. The important thing is to wash your hands frequently."* (Amanda, P.3)

> *"... we are more careful than before. In the past, maybe because we were free, it was easy for us to go out. But now, if we want to go anywhere we are afraid. If we want to go somewhere we will think "can we?", "is that place safe", "is that place okay or not". We go looking for a place that is not crowded."* (Teresa, P.4)

> *"... I am very worried about my wife working at OT. I always tell her to please practice social distancing with hand hygiene, everything is important. Before returning take a shower, clean your body. So far everything is going well, everything is going well."* (Malik, P.5)

> *"... I have become a very clean person. Like when a parcel comes, I would spray it and then I'm very particular about hygiene. Has to do hand rub when touch something. When you leave the house, you have to take a shower, you have to wash your feet, you have to wash your hands, you have to handrub."* (Wendy, P.8)

"... every time I go back, I check the rapid test kit (rtk) first, then I go back. If not, I will not return." (Claudia, P.10)

This shift towards more cautious behaviour, such as wearing masks and avoiding social gatherings, illustrates a collective effort to adapt to the challenges associated with the pandemic. The nurses' commitment to following standard operating procedures (SOP) underlines how their experiences with COVID-19 have promoted a sense of responsibility and a greater appreciation for health and safety.

The pandemic also led to a deeper appreciation for life and relationships among the respondents. Wendy (P.8) shared how her experience made her realise the importance of cherishing life and her relationships with family and friends:

"... we only live once. Appreciate life more. Appreciate family and friends more. Because this pandemic is bad, it can hurt a lot of people."

Similarly, Umaira (P.9) expressed a newfound understanding of the value of loving the people around her:

"... The lesson for my life is to love the people around me. When I see a COVID-19 patient, if infected with COVID-19, if sick, the chances are 50-50. From that experience I learned to love the people around me."

Amanda (P.3) and Felicia (P.7) echoed this sense of appreciation for life's unpredictability. Amanda reflected on how suddenly situations can change, saying:

"... one minute you look at the patient, he's okay. Then suddenly he desaturated. At the same time everything dropped then there is a referral plan to intubate. You hope like today, that you are okay at work, then you end up very busy."

Felicia (P.7) shared a similar perspective, acknowledging the unpredictability of life:

"... there were unpredictable circumstances that happened during the 12-hour shift. There are calm days and on certain days, the storm will come."

These reflections explain how the nurses developed a greater appreciation for life's uncertainties and established meaning in valuing their relationships, resilience and adaptability.

Despite the ups and downs during the pandemic, some respondents shared moments of joy and progress in their personal lives. Amanda (P.3), for example, experienced the challenges of marriage and pregnancy during the pandemic:

"... January 2020, that time I was not the first standby because I just got engaged. I had been off for 2 weeks. Then right after, I was put on standby mode. //... I'm far from my husband, he works in Belaga. //... It was really sad when I went to the check-up alone. It's like I want to eat some food, craving for it, it's sad. I see others go for a check-up they are accompanied by their husband, and I feel sad. I was heavily pregnant and still going to work, driving alone day and night. It was really tiring because at that time we were short of staff. //... Since we got married last year, I can count how many times I met my husband. Until I wanted to give birth in April. He came back on the day I delivered, when I had already been admitted to the hospital."

Amanda's experience of experiencing pregnancy alone and managing a long-distance marriage clarifies the pandemic's impact on her personal life. In spite of the difficulties, she demonstrated resilience, finding hope and joy in her journey through motherhood.

Conversely, Wendy (P.8) communicated the challenges she faced in planning her wedding:

> *"... There was a little clash with my fiancée because we planned to get married last year (2020). And when it's a pandemic, we can't go back. Because my fiancé is from the other side (peninsula). When it's a pandemic, annual leave has to be frozen. Then I have to work 12 hours, there is no time to spend together. Like before we could send messages or Whatsapp video calls; it's like being a little far from the fiancée. So there are always a little disagreements with the fiancé. He might not understand my work and then, when I come home tired, he wants to discuss the marriage. In the end, the marriage has had to be postponed. There was a MCO at that time so we couldn't continue. So we ended up having to postpone it. That is also an issue because all our things have been booked. We have invited everyone. There is a financial loss because certain deposits are not refundable."*

Despite the setbacks, Wendy ultimately married in October 2021, revealing her ability to move forward and find happiness in the midst of uncertainty.

The reflections of Naomi, Malik, Laura, Amanda, Teresa, Wendy, Claudia and Umaira reveal how the pandemic encouraged resilience, adaptability, appreciation for life and personal growth. These experiences confirm that even in the middle of adversity, individuals can find hope and meaning, turning challenges into opportunities for transformation. By adapting to new experiences, strengthening relationships and finding purpose, the nurses demonstrated the human capacity to evolve and maintain a sense of hope, even in the face of enormous obstacles.

5.2.2 Theme 2: Experiencing Social Disconnection and Isolation

Theme 2 (see Figure 4.2) substantiates the profound impact of the COVID-19 pandemic on the social lives of the nurses in Sarawak. This theme encapsulates the isolation or estrangement from social relationships, networks or communities that many nurses experienced during this period. Social disconnection refers to a lack of meaningful connections with others, producing feelings of being misunderstood, unsupported or isolated. It manifests in various ways, affecting both emotional well-being and behaviour.

A nurse's social life, like that of anyone else, includes forming and maintaining bonds with family, friends, colleagues and members of the wider community. These interactions can be measured by the duration and quality of social connections experienced regularly, whether in person or online. However, during the pandemic, these connections were severely disrupted, giving rise to a sense of disconnection.

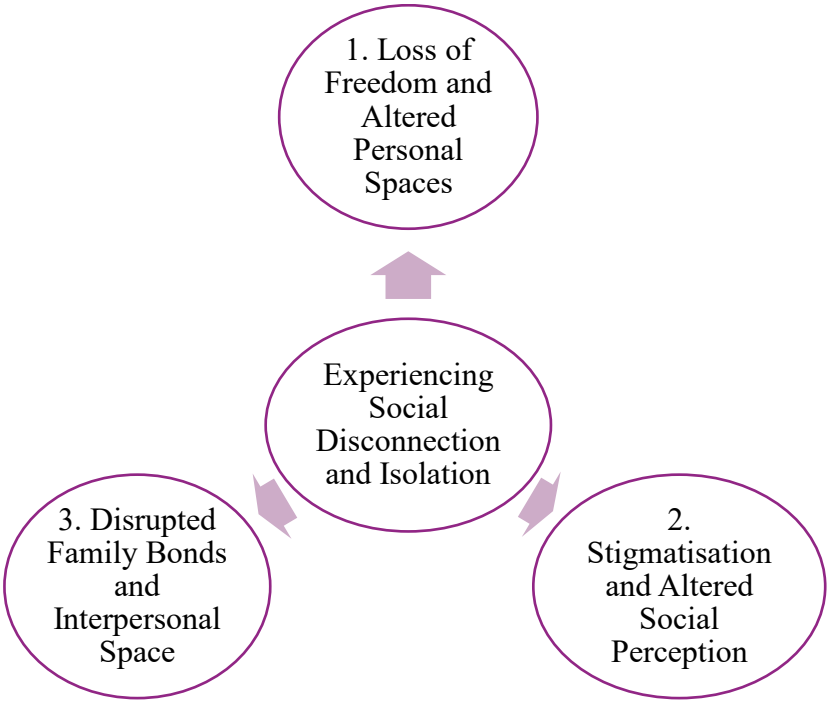


Figure 5.3: Sub-themes relating to Theme 2

5.2.2.1 Sub-theme 1: Loss of Freedom and Altered Personal Spaces

One of the most significant changes during the COVID-19 pandemic was the restriction placed on personal freedom, particularly during the first wave when Movement Control Orders resulted in widespread closures of businesses and public spaces. These restrictions disrupted the social lives of nurses, who previously had the flexibility to engage in leisure activities after work. Wendy (P.8) vividly described how these limitations affected her routine and overall well-being:

> *"... before this, we could have a day off, we can go to release tension because we don't want to think about work, right? But when there's a pandemic, we work 12 hours and then it's like we go to work and return to work, we don't have shopping. Shopping online does not give you satisfaction because you can't look at the items or feel the texture."*

Wendy's account presents how the inability to engage in normal activities, such as shopping, generated a sense of isolation and disconnection. Shopping, beyond being a transactional activity, regularly acts as a form of leisure, stress relief and emotional escape, commonly referred to as retail therapy. The inability to experience this sensory engagement—the act of touching, seeing and feeling items, left her feeling deprived of a crucial aspect of her social life.

The pandemic imposed demanding work cycles on nurses, with long shifts and little opportunity for relaxation or personal activities. The repetitive routine of "going to work and returning home" without access to leisure or social engagement led to a monotonous lifestyle that severely restricted their ability to unwind. This loss of work-life balance further intensified feelings of isolation and emotional exhaustion.

Felicia (P.7) echoed this sentiment, describing the psychological pressure as a result of the confinement:

> *"Staying at the hostel feels like being locked up, as I cannot go out freely. After finishing my shift, I just slept at the hostel and didn't talk to anyone."*

The pandemic not only limited physical mobility but also diminished the quality of social experiences. The inability to engage in routine activities, for example meeting friends, spending time with family, or even simple acts like shopping, had a profound impact on people's emotional and psychological well-being. As social beings, humans thrive on interaction and sensory engagement. The absence of these experiences exacerbated feelings of loneliness and disconnection.

With respect to nurses like Wendy, the lack of real-world interaction resulted in dissatisfaction and a diminished sense of fulfilment. Activities that once provided an escape from workplace stress were no longer accessible, making it difficult to relax or maintain a healthy work-life balance. As Wendy pointed out, online shopping could not replicate the tactile experience or the sense of freedom she had before the pandemic. This disconnection from normal social routines heightened feelings of estrangement, making it even more challenging for nurses to cope with the emotional burdens of their roles.

This theme of social disconnection shows the basic human need for interaction, physical engagement and the freedom to participate in activities that bring joy and fulfilment. The absence of these elements during the pandemic emphasised the importance of social connections in maintaining emotional well-being, particularly for frontline healthcare workers who endured unprecedented levels of stress and isolation.

5.2.2.2 Sub-theme 2: Stigmatisation and Altered Social Perception

This theme explains nurses' experiences of stigma, discrimination and negative societal perceptions while providing care for COVID-19 patients. The stigma surrounding healthcare workers, particularly those working on infectious disease wards, is rooted in fear of the unknown and the invisible threat posed by the virus. This fear produces negative social experiences such as isolation, rejection, marginalisation, and discrimination, affecting nurses' interactions within their communities and social circles.

Stigma is affected by cultural and contextual value systems that vary over time and across contexts. It manifests as a barrier to social inclusion, frequently resulting in emotional and behavioural isolation for the affected individuals. During the first wave of the COVID-

19 pandemic, nurses in this study experienced an acute sense of stigmatisation, which brought about heightened feelings of paranoia, fear and social disconnection.

One of the most immediate responses to stigma was the excessive hygiene practices adopted by the nurses. The constant fear of being carriers of the virus drove them to take extreme precautions, even when they were not actively caring for patients. Teresa (P.4) described her struggle with compulsive showering at that point:

> *"... even though we return home, we feel paranoid, we have to take an extra shower. When we reach home, we're afraid of everything. That's why before returning, we take an extra shower up to 3 or 4 times. Like before one shift we can shower up to 5 to 6 times. Every time we leave a patient's room, we have to take a shower. Then we have to shower again before going home. //... even if we feel like we have a little flu, we feel like "ehh am I okay, am I okay. We all used to check our temperature every time we entered the ward."* (Teresa, P.4)

Teresa's version corroborates the heightened anxiety and fear of contamination that became engrained in the nurses' daily routines. These practices were not only precautionary but also a response to the societal perception that healthcare workers, particularly those working with COVID-19 patients, were potential vectors of infection. This internalised fear significantly impacted their psychological well-being, leading to behaviors rooted in paranoia and anxiety.

The fear of transmitting the virus extended beyond the workplace, affecting nurses' interactions with their families. Amanda (P.3) expressed her apprehension about being close to her family after returning from work:

"... When we come back from work, we are afraid to be close to our family."

This fear of potentially infecting loved ones resulted in emotional and physical distance, even within their homes. This describes the personal toll that the stigmatisation and responsibilities of being a frontline worker had on their sense of connectedness and support from their families.

i. Social Stigma and Rejection from the Community

Social stigma became increasingly apparent as several respondents shared similar experiences of being treated differently because of their work. The rejection and isolation were not only experienced on a personal level but were also evident in interactions with the wider community. Amanda (P.3) remarked:

"... People know that we work here so people are paranoid sometimes by saying, "ehh ID ward."

Umaira (P.9) confronted a particularly harsh form of discrimination when her daughter was denied treatment at a private medical centre:

"... One time I took my daughter to a private center when she was sick. My daughter was denied the treatment when the centre found out I was a nurse working on an infectious ward. Even though I told them that I wear full PPE when nursing patients."

These experiences corroborate how the stigma directed at healthcare workers during the pandemic extended to their families, further isolating them and reinforcing their sense of rejection. Malik (P.5) also encountered stigma from his family:

"... Some of my family members did not invite me to an event whenever I was in the village. They closed all the doors and windows because they were afraid. They fear that I will bring back the disease."

This example underlines how even familial bonds were strained due to fear and misunderstanding, resulting in feelings of exclusion and marginalisation.

ii. Public Misconceptions and Perceived Stigma

In addition to facing stigma, the nurses also dealt with misconceptions related to their work. Laura (P.1) observed that people were afraid to visit the Infectious Disease (ID) ward, indicating a broader societal fear of healthcare environments associated with COVID-19:

"... Everyone outside is afraid of the ID ward, they don't dare to come here."

Felicia (P.7) mentioned that initial fears and stigma began to subside as people became more aware of the safety protocols and guidelines in place:

"... In the beginning when people knew we were taking care of COVID-19 patients, we were looked at as in a different way; as people to be really afraid of. But when people started to understand that we have guidelines and standard operating procedures to abide by, such as showering after nursing patients, everyone understands and accepts it."

Irrespective of the improvement in public understanding, Claudia (P.10) pointed out that misconceptions concerning the workload in the ID ward persisted:

"... Outsider assume ID ward does not have many patients and is more relaxed whilst in actual fact, we have the same workload as other wards in the hospital."

In essence, the stigma and negative perceptions experienced by nurses during the COVID-19 pandemic significantly impacted their social connections, resulting in a profound sense of isolation, rejection and disconnection from their communities and even their families. This experience exhibits the broader societal challenges in understanding and supporting frontline workers during times of crisis.

5.2.2.3 Sub-theme 3: Disrupted Family Bonds and Interpersonal Space

The COVID-19 pandemic brought about significant disruptions to family dynamics, forcing nurses to contend with the complexities of balancing their professional responsibilities with the need for family engagement. This theme presents the emotional impact of being away from loved ones during such a critical time, as well as the strain placed on familial relationships. For many, the experience of family bonding was affected by the pandemic, leading to either strengthened ties or a sense of disconnection, primarily when it came to their children who were growing up and needed the presence of their parents.

i. Balancing Professional Duties with Family Needs

Imran (P.6) candidly shared the struggle of being away from his family due to work demands:

> *"... there wasn't much time together at the beginning of COVID-19. //... From the beginning, I felt that I lacked time with my children and wife. They need us very much but we are not with them. I think it's not enough until now, we're busy, we go home, we rest. But for a long time now, I feel that it's ok, I can arrange a little time with my family, time with myself. Now it's ok. //... Have a video call with them, always call because the children are always looking for us. There is a sad feeling in my heart*

that I am far from my family. I can't be away from my family, I'm not lying, I'm going to cry. That's just our way of connecting with each other."

Imran's experience reveals the profound sense of sadness and longing that accompanies being away from his family. Notwithstanding the demands of his job, he adapted by arranging video calls and frequent communication to stay connected, although the emotional impact of physical separation remained evident.

Likewise, Laura (P.1) faced challenges in maintaining a connection with her family while working extended hours:

"... My husband does not agree that I work for 12 hours, away from my family. My daughter doesn't want to be away from me either. I told them, I have to do my job as a nurse. My daughter will video call every day and say, "Is mom back yet? Sharon video call later". Ahh later, mom is busy right now". //... Ermm... video call them, send a message and then talk to the kids to be patient, I'll be back soon."

Laura's experience as a mother of three growing daughters further illustrates the emotional strain experienced by nurses. Her daughter frequently video-called her to check on her return, underlining the sense of disconnection experienced by both Laura and her family. These video calls and messages became their way of maintaining a bond during a time when physical presence was not always possible.

Imran and Laura's experiences convey the emotional struggle parents faced as regards separation from their families whilst working long hours during the pandemic. Both parents emphasised the problems of balancing their demanding professional roles with the emotional needs of their families, depending on virtual communication to maintain their relationships.

ii. Long-Distance Marriages and Isolation

Amanda (P.3) shared her experience of being apart from her husband because of work and quarantine restrictions:

> *"... Like I'm far from my husband. He wants to go back but can't, we have MCO MCO MCO. He works in Belaga. If he comes to Kuching, I will not be able to see him. For example, when he came to Kuching for a meeting or seminar, I couldn't see him because we stuck to our quarantine rules. //... Since last year when we got married, I can count how many times I have met my husband. Until I was going to give birth in April. He came back on the day I delivered when I had already been admitted to the hospital."*

Amanda's experience gives emphasis to the impact of inter-district restrictions and quarantine measures on her marriage, resulting in very few opportunities to see her husband. This sense of isolation and separation added to the emotional burden of working during the pandemic.

Similarly, Malik (P.5) expressed the strain on his marriage:

> *"... it's not enough. because during the first wave, time for family for my own wife was not enough. That's why my wife also complained. She complains and is not satisfied, there is not enough time together. And then that thing was also one of the factors that made me depressed. The other thing is we still don't have a baby yet. So that thing also made me depressed. I did a lot of thinking about the quality of time together. //... Annual leaves is on hold, so we just use our days off to be together. It's like you just open your eyes at 7 in the morning and then you just wake up for breakfast, it's already 7 in the evening."*

Malik's experience of not being able to spend quality time with his wife, along with the added pressure of not having a child after nine years of marriage, contributed to feelings of depression and dissatisfaction. The inability to spend time together as a couple strained their relationship, and Malik felt disheartened by the situation.

iii. The Impact on Parent-Child Relationships

Umaira (P.9) expressed the profound sadness at being separated from her daughter:

> *"As a wife, I spend less time with my husband because of working 12 hours a day. There is no time to hang out watching television like before. //... My child was sent to the village as me and my husband were under quarantine. While it's been two months since I saw my daughter. I saw death. I didn't expect the patient I attended that day to be positive. He dies without his family by his side. At that time, I thought if I was infected I would not be able to see my family members and I would die without seeing my daughter. Ahh, I'm not ready, I have not said goodbye to her properly. //... When I was able to meet my daughter after three months, as soon as the inter-district crossing allowed, she didn't want me. She seemed sullen. She doesn't want it when I want to take her home. It's that moment that has an impact. If I were told to do it again, I really wouldn't want to. Until the extent that she refused and did not want me to take her. That's what I find challenging as a mother. As a new mother, when in that situation, I really lose."*

Umaira's narrative reveals the heartbreaking experience of being apart from her daughter for an extended period. Her daughter's rejection upon their reunion accentuates the emotional cost of separation, leaving Umaira with a profound sense of guilt and helplessness.

Her experience exemplifies the psychological cost the pandemic had on family bonds, particularly between mothers and young children.

Teresa (P.4) and Laura (P.1) also experienced emotional challenges when caring for children admitted with COVID-19:

> *"... There used to be many kids admitted here, together with their mothers. Luckily they are all cute ones. They are the kind who are not afraid so we are ok too. Ahh, I really miss that time as it makes me remember my child. But it's a pity to see that they all had to be swabbed."* (Teresa, P.4)

> *"... I took care of a patient and saw that there were children sharing the room. Her son is small, it's a pity he's in quarantine. Sometimes he needs… the relatives are far away, and there is no one to send food. I was quite moved. After that, he called his family members and asked when he could go back? I can't stand being here anymore, I've been here for a long time. I empathise. We supported him to be patient."* (Laura, P.1)

These experiences triggered feelings of empathy and longing for their own children, intensifying the emotional impact of their work during the pandemic.

iv. Preserving Family Bonds and Trust During Isolation

Malik (P.5) also touched upon his sense of family bonding:

> *"... I didn't share because it was a problem at work and I didn't bring it home. I didn't bring it home because you know right caring, professional. Professional means you can't bring problems home. //... the person who is the closest to you is the one who can support you the most. If other people find it hard to trust. Because if that*

person is not your family member, he/she can stab you in the back. So that's why I'm mostly with my wife but I'm less with my wife. The people I trust the most are my mother and my father. That's why if there is a problem or anything, I will directly call or video call them because they are the only ones I trust. I don't trust other people."

Malik's account shows that while he maintained a sense of professionalism by not discussing work-related matters at home, he found solace and trust in his parents. This reiterates the importance of family bonds in providing emotional support, even when faced with the challenges of social disconnection.

The experiences shared by the nurses demonstrate the profound impact of the pandemic on family relationships, with many facing the challenge of balancing demanding work hours with the need for family engagement. While some maintained connections through video calls and messages, the emotional pressure of being physically distant remained significant, causing feelings of sadness, guilt and disconnection. The strain on marital relationships, the challenges of parenting from afar, together with the dependence on virtual communication spotlight the difficulties connected with maintaining family bonds during the pandemic.

5.2.3 Theme 3: Adapting to Workplace Challenges

Nurses demonstrated remarkable adaptability in responding to the demands of caring for COVID-19 patients despite handling immense challenges and stressors. This process involved learning new skills, developing various coping mechanisms and implementing resilience strategies to cope with the evolving demands of their roles. The pressures of the pandemic also led to the establishment of support systems that empowered nurses to manage

their responsibilities effectively while maintaining their emotional well-being (see Figure 4.3 for the details of this theme).

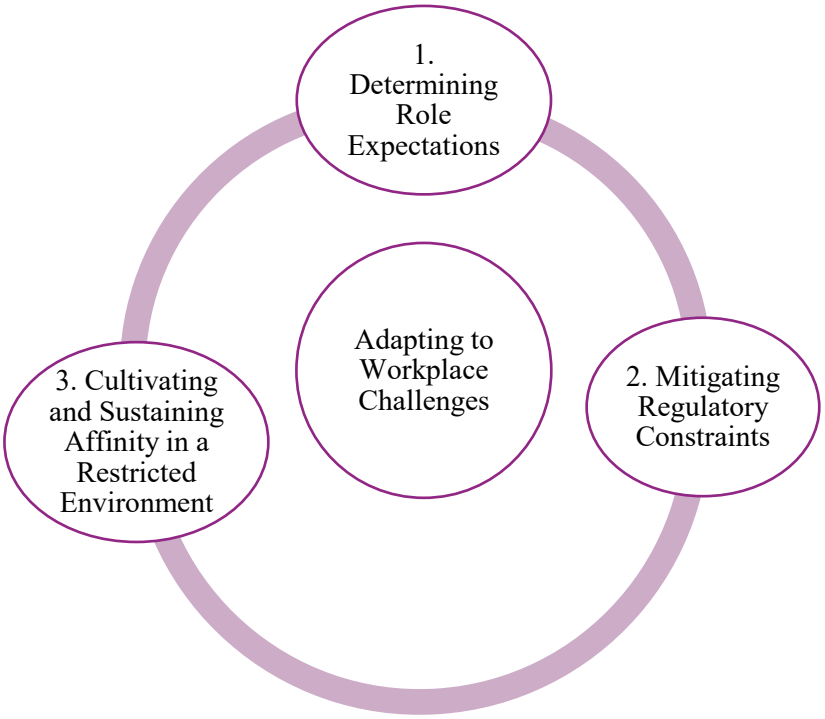


Figure 5.4: Sub-themes relating to Theme 3

5.2.3.1 Sub-theme 1: Determining Role Expectations

The rigid role expectations during the COVID-19 pandemic placed nurses under immense psychological strain. Despite their adherence to demanding protocols, many felt overlooked and underappreciated, creating burnout and disappointment.

The rigid role expectations led to emotional strain and a sense of being undervalued. Despite their strenuous efforts and adherence to strict protocols, nurses often felt that their hard work went unrecognised, bringing about feelings of burnout.

Claudia (P.10) expressed her feelings of being unappreciated:

"... at times tears come out. Crying, not feeling appreciated. What we are doing is nothing but the work is half-dead."

Claudia's emotional response points out the emotional toll that the rigid role expectations had on the nurses. The lack of appreciation for their hard work, despite the demanding nature of their roles, contributed to a sense of disillusionment and emotional exhaustion.

These experiences demonstrate the need for more adaptable and supportive systems in healthcare settings, allowing nurses to manage their roles more effectively and reduce the emotional impact in relation to their responsibilities. By encouraging a more flexible and responsive environment, healthcare systems can better support nurses to fulfil their roles, guaranteeing they feel valued and equipped to handle the challenges they encounter in the workplace.

5.2.3.2 Sub-theme 2: Mitigating Regulatory Constraints

Nurses had to manage a wide range of responsibilities within a regulatory environment that demanded strict adherence to rules and guidelines. This rigidity and the extensive roles they had to assume acknowledged the complexity and inflexibility inherent in their professional context, significantly influencing their day-to-day experiences and decision-making processes during the COVID-19 pandemic.

The rapid evolution of protocols and procedures presented a major challenge for nurses, who were expected to instantly adapt to new guidelines. This constant flux made it difficult for them to gain mastery over new practices, giving rise to confusion and frustration.

Wendy (P.8) shared her experience of grappling with the frequent changes:

"... many new things. When we have practised like this and then there's something new, we can't adapt. You haven't mastered certain things yet, then there are new things. So we were like " eh mana satu ni", and then it changed again. //... For example, when sending the lab sample, for a second it says like this, then it says like that, so we are confused."

Wendy's statement demonstrates the overwhelming nature of attempting to adapt to continuously changing protocols. The inability to fully grasp one set of guidelines before another set was introduced left her feeling disoriented and uncertain. This situation not only impeded her ability to perform her duties effectively but also added to her stress and anxiety.

Imran (P.6) echoed the need to constantly adjust to changing guidelines:

"... we just got to know the disease; we will follow the guidelines provided. Maybe tomorrow there will be a new guide that we can follow, a better one. For now, we just follow."

Imran's experience draws attention to the sense of unpredictability that characterised the early stages of the pandemic. While he acknowledged the need to follow updated guidelines, this process added to the uncertainty and complexity of his role. The constant learning curve demanded flexibility, which was often hampered by the rigid structure of the workplace environment.

In addition to adapting to changing guidelines, the nurses were subjected to extremely strict working conditions, which further compounded their sense of rigidity and pressure. These constraints often required them to perform their duties in a highly controlled manner, with scarcely any room for flexibility.

Teresa (P.4) described the meticulous workflow and the inflexible nature of regulations:

"... The way of working during the first wave was too strict. Meaning that if you entered, you could not exit. Once you enter you must manage everything."

Amanda (P.3) pointed out the restriction on staff members allowed inside patient rooms:

"... when you go inside, you want to wait for everything to finish before exiting from the patient's room. At that time, the rules were that only staff nurses were allowed to go into a patient's room."

These excerpts accentuate the rigidity of their work environment, where nurses were required to manage each task during a single entry into the patient's room, regardless of the challenges or duration. This rigid requirement increased the physical and mental burden on the nurses, often resulting in exhaustion and frustration.

5.2.3.3 Sub-theme 3: Cultivating and Sustaining Affinity in a Restricted Environment

The COVID-19 pandemic highlighted the profound impact of connectivism, signifying how technology and digital communication bridged the physical distance created by lockdowns. This connectivity provided emotional support, maintained family bonds and offered relaxation and mental health benefits to nurses and their loved ones during an exceptionally challenging time.

i. Maintaining Family Bonds Through Video Calls

Digital communication became a vital tool to maintain family relationships and providing reassurance during periods of separation. Video calls helped nurses stay connected with their families, extending a sense of presence and comfort despite being physically apart.

Laura (P.1) shared her experience of how her daughter relied on video calls to stay connected:

> *"... my daughter will video call me every day to know if mom is back yet? Sharon video call later. I will answer ahh later, mom is busy right now."*

Laura's daily video calls with her daughter illustrate how technology helped bridge the emotional gap caused by her demanding work schedule. Despite her absence, these calls enabled Laura to maintain a sense of closeness and connection with her child, alleviating some of the stress and anxiety that both might have felt owing to their separation.

Naomi (P.2) also used digital communication to reassure her concerned mother:

> *"... at first, my mother was extremely worried. My mom always calls to say hello. I keep saying I'm ok because I don't want her to worry so much. If I always say, I'm ok, mom will call me less frequently. Mom used to always call (every day) to ask are you ok there? You must take care of your health. I said I was okay even though I wasn't okay at that time."*

Naomi's frequent calls to her mother emphasise the role of digital communication in providing reassurance and maintaining family ties. By staying in touch regularly, Naomi managed to ease her mother's concerns, even when she herself was struggling.

Teresa (P.4) drew attention to the advantages of modern technology in enhancing communication:

> *"... at least now it's modern times and you can make video calls. It's not like it used to be that you only use hello hello on the phone."*

Teresa's evidence demonstrates how the shift from traditional phone calls to video calls allowed more worthwhile and interactive communication. This technology provided a crucial way to maintain human connections during the pandemic, delivering a richer experience compared to mere voice communication.

Wendy (P.8) explained how her family used group video calls to celebrate important occasions:

> *"... what strengthens us as a family is because we always video call. We didn't see each other much. Raya time we do group/family video call. Even if we can't celebrate raya together, we able to celebrate raya through video call. Then, always call to say hello to each other."*

Wendy's experience proves how technology allowed families to preserve traditions and social connections despite the physical separation. By adapting to the circumstances, her family could still celebrate Raya together, demonstrating how digital platforms helped sustain a sense of community and togetherness.

ii. Harnessing Digital Technologies for Relaxation and Emotional Relief

In addition to strengthening connections, technology played a crucial role in providing relaxation and mental health support for the nurses. Engaging with digital

platforms and using their mobile devices for entertainment and stress relief afforded a welcome escape from the pressures of the pandemic.

Malik (P.5) shared how he used technology for relaxation:

> *"... after the pandemic I always take my earphones because I try to listen to songs. I open Youtube on how to relax, how to relax mind. I listened to the music and it did help a little. When I listen to music, I really feel relaxed and I do deep breathing exercises. Do deep breathing to cool down a bit."*

Malik's strategy of using YouTube for relaxation exercises and music highlights how digital content became an indispensable resource for managing stress and anxiety. This form of connectivism provided him with a way to unwind, promoting mental well-being amongst the challenges of the pandemic.

Laura (P.1) also discovered comfort in listening to the radio and singing with friends:

> *"... there's entertainment after... listening to the radio in the hostel. But there is less internet. //... And then to forget the longing, we look at the mobile phone, sing with friends in the place where we spend the night together."*

Despite the limited internet access, Laura and her friends used shared digital activities, such as listening to the radio and singing together, to create moments of camaraderie and relaxation. These activities not only provided entertainment but also fostered a sense of connection and support within the group.

The significance of connectivism during the COVID-19 pandemic are evident in how technology and digital communication played a decisive role in maintaining emotional support, family bonds and mental health for nurses. Laura's, Naomi's and Wendy's use of

video calls illustrates how these digital tools helped sustain relationships, affording a sense of presence and reassurance in times of separation. Teresa emphasised the importance of modern communication, while Malik and Laura stressed how digital platforms offered relaxation and stress relief.

By enabling families to celebrate special occasions, stay connected and find moments of calm amongst the chaos, technology became a lifeline for nurses, helping them cope with the challenges of their profession while maintaining their well-being. These experiences portray the importance of digital connectivity in supporting resilience, providing comfort and sustaining relationships in times of crisis.

5.2.4 Theme 4: Strengthening Camaraderie in the Healthcare Environment

The shared experiences of working during the pandemic nurtured a strong sense of camaraderie and mutual support among nurses. These bonds promoted a pleasant attitude and teamwork, increasing their ability to cope with the pressures of their work. By finding meaning in their roles and developing a sense of belonging to their workplace, nurses were able to develop a collaborative environment and bond that helped them continue through the challenges of the pandemic (see Figure 4.4 for the details of this theme).

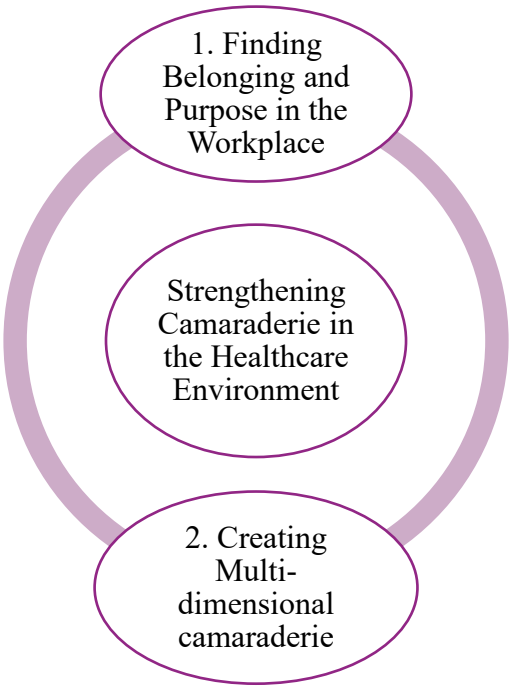


Figure 5.5: Sub-themes relating to Theme 4

5.2.4.1 Sub-theme 1: Finding Belonging and Purpose in the Workplace

The findings from participants in this study revealed positive factors in connection with frontline teamwork during the COVID-19 pandemic, indicating the importance of feeling connected, respected and having a sense of belonging among team members. Working on the frontline helped nurses and their interprofessional coworkers' bond and form stronger workplace relationships. Every professional contributed to patient care, irrespective of how small or whether it fell outside their usual responsibilities. This interprofessional collaboration exhibited humble and respectful relations among all of the team members when delivering care.

The nurses experienced highs and lows together throughout the pandemic, taking care of COVID-19 patients and exposing themselves to the virus. As part of their responsibilities, they regularly had to quarantine when they came into close contact with

COVID-19 patients; a cycle that was repeated as the ward continued to receive new cases. These shared experiences encouraged a sense of acceptance, inclusion and identity within the workplace, making the nurses feel more secure and supported. This sense of belonging and resilience was crucial in helping them manage the daily challenges associated with their roles.

Wendy (P.8) and Umaira (P.9) illustrated the strong sense of camaraderie that developed among team members:

> *"... We support each other, we go in together, we go out together, hard times together, happy together."*

Their words emphasise the solidarity and mutual support that personified their work environment. This shared experience of facing challenges together bolstered their sense of belonging and made them more resilient as a team.

Teresa (P.4) also shared an emotional aspect of this bond:

> *"... Crying together. People won't know how we feel. We are the one in this together, so we know the feeling. We people are always like that. Even though we are going to take over (pass over report), some of the nurses are crying while writing a report. We just keep quiet and wait for her to finish crying before we ask her."*

Teresa's account illustrates the deep emotional connection and empathy among nurses, demonstrating how they provided a supportive space for each other to express emotions. This level of understanding created a sense of belonging and unity, reinforcing their bond as they confronted the hardships of the pandemic.

Amanda (P.3) emphasised the importance of helping one another:

"... You can't survive alone. We can't be selfish. People help us we have to help back. Because later on, we will ask people to help us, right?"

Amanda's evidence highlights the need for collaboration and mutual assistance, further strengthening the team's sense of belonging and shared responsibility. This mindset of cooperation became essential in dealing with the high-pressure environment, as nurses relied on each other for both emotional and practical support.

Participants also elaborated upon the value of interprofessional collaboration, which was contributory in providing patient care and maintaining a sense of belonging. Nurses and doctors worked closely together, learning to support one another and adapt to the challenges posed by the pandemic.

Teresa (P.4) described an experience with a rather anxious medical officer (MO):

"... So the medical officer (MO) who wants to attend to a suspected COVID-19 patient is just very nervous. The patient is categorised as high-risk with a history of travelling to Wuhan. The doctor was extremely nervous. I had to calm her down, I said, relax doctor. If you are nervous, I will be nervous too. How to do this? How to do this? She seems to have lost her mind. It's a pity to see her, until she adjusts her mask dozens of times. I told her, just be careful, don't talk too much. I tell her that we are in this together and both of us are going into the room. I have to calm the doctor down, her hands are shaking holding the stick used to take swabs."

Teresa's experience demonstrates the fundamental role that nurses played in providing emotional support and reassurance to other healthcare professionals. This instance of teamwork and mutual encouragement communicates how each member's contribution was crucial in maintaining a sense of stability and confidence in highly stressful situations.

Umaira (P.9) emphasised the interdependence between doctors and nurses:

"... We go in together. If one of us is not there or we go in alone, unable to work. Furthermore, doctors really depend on us when donning and doffing PPE, they will consult us."

This interdependence boosted the sense of togetherness among healthcare workers, as they appreciated the significance of their roles in supporting one another and safeguarding patient safety. This teamwork was not just functional but also encouraged a sense of pride and respect among the team members.

Malik (P.5) conveyed on the importance of communication and shared learning:

"... So far okay. good communication. We do practice that communication and interaction must be the same. Same line, same channel, must be the same because we can't make mistakes. It's a new thing and we're still learning."

Malik's observation underlines the importance of consistent communication and shared learning, which were essential to prevent errors and adapt to the challenges of caring for COVID-19 patients. This shared learning process helped to cultivate a collective sense of competence and trust within the team, further strengthening their sense of belonging.

Claudia (P.10) shared how the sense of teamwork extended beyond just nursing responsibilities:

"... If a doctor asks to take a blood sample from the patient, we will help since we are in the room."

Claudia's willingness to assist with tasks beyond her typical nursing duties exemplifies the collaborative spirit and willingness to support colleagues, regardless of job

titles. This adaptability and teamwork was conducive to a strong sense of unity and purpose among healthcare workers.

The excerpts from Wendy, Umaira, Teresa, Amanda, Malik and Claudia highlight a strong sense of togetherness and teamwork among healthcare workers during the COVID-19 pandemic. These accounts demonstrate how shared experiences, mutual support and interprofessional collaboration generated a deep sense of connection and solidarity within the workplace. By working together, facing challenges and supporting each other emotionally and practically, nurses and doctors developed an environment where they felt respected, valued and cohesive. This sense of belonging and camaraderie was influential in helping them address the pressures and uncertainties connected with their roles, and in turn, enhanced their resilience and effectiveness in delivering patient care during a crisis.

5.2.4.2 Sub-theme 2: Building Multi-dimensional Camaraderie

During the demanding COVID-19 period, the respondents relied considerable on a variety of social support systems to manage the various stressors they faced. This support proved to be a crucial channel for stress relief and originated from various sources, including family members, colleagues, organisations, and the public. The multi-dimensional camaraderie provided a safety net that helped nurses handle the unprecedented challenges of the pandemic.

i. Family Support

Family members and partners were paramount in providing emotional support and encouragement, helping nurses cope with the pressures of their profession. This familial backing, encompassing emotional reassurance and psychological support sustained their mental and emotional well-being during such a challenging time.

Imran (P.6) considered the support he received from his wife and parents:

"... my wife and parents always give advice, give words of encouragement."

Equally, Wendy (P.8) recounted how her family members shared a similar concern for each other's safety:

"... they (mother and father) worry about me, I'm worried about them too. So, we advise each other. You need to take a bath and change clothes before going home. Don't shake hands, always remind each other to be vigilant."

Umaira (P.9) emphasised the understanding and cooperation she received from her husband:

"... Husband knows I work so he understands. I'm a nurse so he understood. And I work in the infectious disease ward. He didn't stop me from working. And he cooperates. He understands that when I go back to work, I won't cook, to be honest. Haven't cooked, still resting. There is no complaining. He understands. He said he understood. So the support from him is really strong."

These excerpts illustrate the fundamental role of family support in helping nurses address the challenges of working on the frontline of the COVID-19 pandemic. By providing a safe space to communicate, emotional expression, offer encouragement and assist with daily responsibilities, family members helped reinforce a sense of purpose and stability. Their familial backing provided strength and comfort while promoting resilience, enabling nurses to manage the demands of their profession. These accounts focus on how emotional reassurance, practical assistance and guidance from loved ones were essential in sustaining nurses' well-being and allowing them to persevere in their roles during this critical period.

ii. Support from Colleagues and Friends

In addition to family, the nurses found significant support from their colleagues, who communicated similar experiences and challenges. The camaraderie in the workplace established a sense of solidarity and provided a much-needed emotional outlet.

Wendy (P.8) mentioned the strong bonds she formed with colleagues:

"... I'm alone here, so I really have a lot of support from my friends here. Because support through Whatsapp through call/video call is different from the support that we are here together. //... I'm closed with "kak" sil. So it's like she's the one who supports me. I have no one here. She said "it's okay, be patient, maybe you can go back later, maybe there is light at the end of the tunnel. //...shared friends at work even if there is something that is not the best, but at least we are there for each other."

Claudia (P.10) shared a similar experience, pointing out the understanding she found among her housemate and best friend:

"... I have a friend from the same house so we both share our problems. I don't want to disclose to my family because I don't want them to be upset. I just chat with friends, friends on the ward, sisters, housemate. My best friend is my neighbour. She is also taking care of COVID-19 patient in Samarahan at PJHUS, so with her I talk about COVID-19 patients. That's when we know the problems, we have all faced."

These explanations highlight the beneficial role that colleagues played in providing emotional support, practical advice and companionship. The ability to share experiences with those who understood the challenges personally created a sense of belonging and

comfort, helping the nurses manage the stress and uncertainty relating to their work environment.

iii. Support from Deployed Nurses

The involvement of deployed nurses from other wards was another vital source of support during the pandemic. These nurses offered assistance, often without prior experience in infectious diseases, and their willingness to learn and contribute eased the regular staffs' workload.

Teresa (P.4) spoke positively as regards the support they received:

"... Fortunately, the deployed group is supportive, very cheerful. Lucky to get the sporting one. They are willing to learn; they are excited even though they are scared. They have their own idea to help us. //... They are always runners. But even if they are runners, they are hardworking."

Wendy (P.8) expressed her gratitude for the assistance provided by the deployed staff, even during critical moments:

"... suddenly the patient was about to collapse because he was so breathless, he needed to be intubated. Thankfully at that time, my team was okay even though there were deployed staff. The deployed staff were unsure, but they are ok and help a lot."

Felicia (P.7) appreciated the support from other wards, which lightened the workload:

"... staff from other places helped us here. I think that is the nice memory because everyone is like being-there to help us. We need help because we are the first ward

that needs to take care of these COVID-19 patients. So when they come in, at least our burden is less."

These excerpts exhibit the appreciation and gratitude for the deployed nurses, whose willingness to help provided much-needed relief and contributed to the sense of camaraderie among healthcare workers during the pandemic.

iv. Support from Medical Professionals and Superiors

Support also came from physicians and superiors, whose thoughtful gestures and leadership boosted morale and created a sense of care and appreciation.

Teresa (P.4) mentioned how Dr. Tonni provided vitamins and bird's nest supplements:

"... Dr Tonni gave us the prescribed vitamin. You have to take up to 10 pills until you take a booster dose. My tongue is too numb to take that many, lol. Sometimes she buys what's the name of the thing... bird's nest to give to the staff."

Wendy (P.8) and Umaira (P.9) appreciated the specialist's efforts to ease their stress:

"... even though she is a bit fierce, a bit strict, but she is good at winning our hearts. For example, eeee don't stress "kakak", we'll eat ice cream later. At least there's a person that cools us down." (Wendy, P.8)

"... we have a specialist who likes to treat us. She is good at winning our hearts, she buys ice cream for us. It feels like we are tired inside, and that people outside care." (Umaira, P.9)

These acts of kindness by medical professionals were paramount in maintaining a positive work environment, making the nurses feel appreciated in spite of the stressful circumstances.

v. Society's Championing of Their Nurses

The increased recognition of healthcare professionals brought about gestures of appreciation from the public, as well as financial incentives from the government, which boosted morale and provided practical support.

Teresa (P.4) alluded to public donations:

"... there are many people who have donated coolers and fans."

Felicia (P.7) appreciated the government's financial support:

"... even our government is very good at giving support. For us the amount of allowance that is being given is quite big. So it helps a lot. //... of course it's the RM600 allowance honestly."

Additionally, Naomi (P.2) welcomed the initiative made by the psychological management section of the public service department:

"... There used to be "Rakan Pembimbing Perkhidmatan Awam" (AKRAB). We used to have to fill out a form about stress. They will divide it, which is mild stress or severe. They will call. I think things like that need to be continued as we can share our problem, right? Sometimes like me there is something I can't share if people don't ask, we don't talk. If people ask, then we let it all out all and felt relief."

These structured support systems and public gestures of appreciation bolstered the sense of unity and camaraderie, demonstrating that the nurses were not alone in their battle against the pandemic.

The multi-dimensional camaraderie experienced by nurses during the COVID-19 pandemic was supplemented by support from family members, colleagues, deployed staff, medical professionals, public gestures and organisational initiatives. These diverse sources of support encouraged a strong sense of unity, resilience and mutual care, which were essential in helping nurses cope with the immense pressures with respect to the pandemic. The collective efforts of these different support networks created an environment of empathy, understanding and gratitude, permitting nurses to handle their challenging roles more effectively.

5.2.5 Theme 5: Upholding Commitment and Professionalism During the Challenges

Regardless of the numerous challenges they had to contend with, nurses demonstrated an unwavering sense of duty, professionalism and commitment to providing care to COVID-19 patients. This dedication was driven by their ethical and moral obligations, which drove them to continue delivering care even in the face of adversity and personal risk (see Figure 4.5 for the details of this theme).

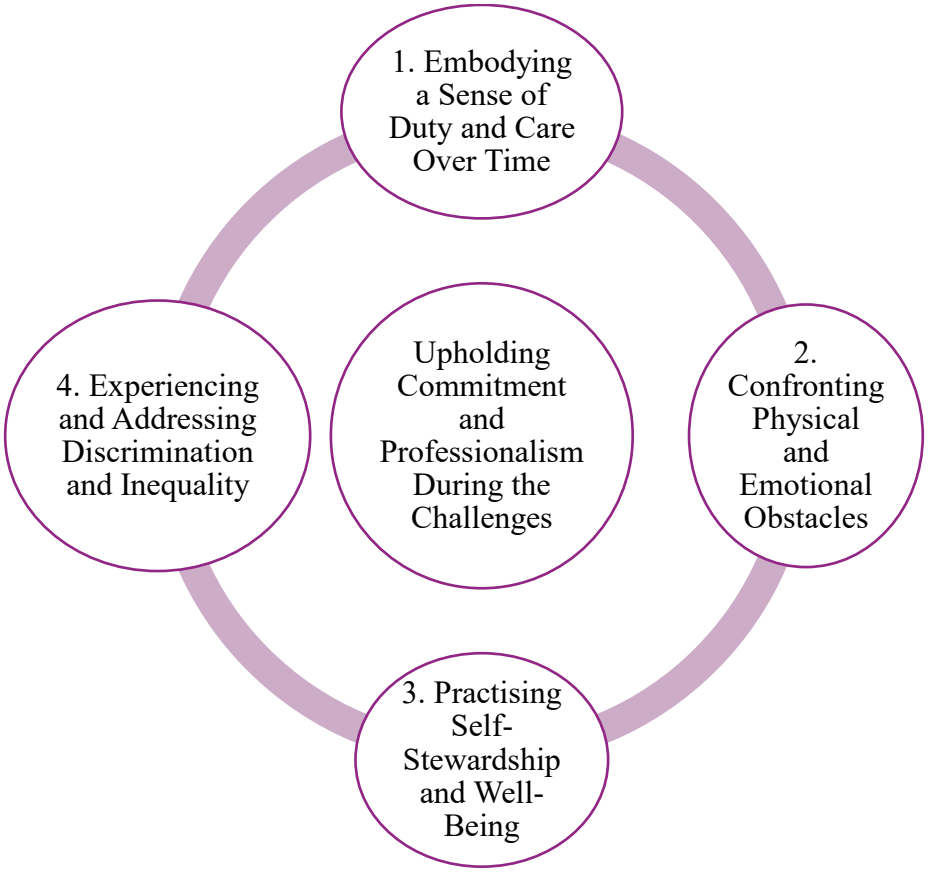


Figure 5.6: Sub-themes relating to Theme 5

5.2.5.1 Sub-theme 1: Embodying a Sense of Duty and Care Over Time

Even with the life-threatening nature of COVID-19, each of the respondents acknowledged their staunch commitment to their duty of care, maintaining their professional obligations toward patients just as they had prior to the pandemic. They perceived their responsibilities as a "trust" or "amanah" placed upon them, demonstrating their calling in caring for COVID-19 patients, even in the face of fear and uncertainty.

Claudia (P.10) encapsulated this sense of duty, articulating,

"... we help people, who know if we'll live okay later, it's like we reciprocate in kind."

This illustrates a deeper understanding of reciprocity in nursing, where helping others becomes a morally and ethically driven act that can, in turn, generate meaning and fulfilment.

Imran (P.6) echoed this, stating,

"... we think back, we help people, we don't want to give up just like that. It's a nurse's job to help patients, it's our job. Think back to who else wants to do it. We are assigned to do it, we are destined to be this nurse."

This suggests how intrinsic the sense of duty is to their identity as nurses. Felicia (P.7) stressed the irreplaceable role of nurses with the rhetorical question,

"... if not us, who else?"

It sums up perfectly the essential nature of their work and the sense of responsibility they felt toward caring for patients during the pandemic.

Meanwhile, Umaira (P.9) shared her experience of readiness and resilience:

"... when COVID-19 is in Sarawak, we're on standby and we're always involved. We don't think about being quarantined, leaving our families, working 12 hours, we don't think that and we're ready. Physically mentally ready for the first wave."

This statement reveals the sacrifice, commitment and preparedness that nurses exhibited, even when it meant being separated from their families and working extended shifts.

Their sense of duty translated into varied and extensive roles. Umaira (P.9) detailed her routine on her 12-hour shift, which involved planning, preparing medication, nursing care, serving meals, and writing reports. She said,

"... Plan what we want to do with the patient. Listen to the doctor's round near the nurse's station. After the doctor's round, we prepare the medicines. At 10 o'clock we go inside to start the nursing care. While waiting for rice (patient's diet) to come at noon, we gave out the medicines. At 4 o'clock we go in again and prepare all the medicines, wait to serve the patient's dinner at 6 o'clock. Go out to write the report, finish at 7 o'clock, then we go back."

This demonstrates the structured, rigorous schedule and comprehensive nature of care that nurses provided.

Working in a high-risk environment meant wearing a Tyvek suit for protection. This suit offered essential safety but also created challenges, such as the inability to eat, drink or use the restroom for several hours. Notwithstanding these hardships, nurses such as Claudia (P.10) continued to perform their duties, stating,

"... Take vital signs, but don't stay close to the patient for too long."

This highlights the balance they had to maintain between providing care and ensuring their own safety.

Felicia (P.7) explained her responsibilities, saying,

"... Monitor the patient, tidy up the patient, give diet, give medicine. From small things to big things all the staff nurse does."

Teresa (P.4) demonstrated adaptability in patient care by innovatively administering medication, disclosing,

"... Prepare the medication early as we can't give it face to face to each patient. We put it in a small plastic bag, label immediately what time the patient will take it, then explain the details through the intercom."

This confirms the adaptability and problem-solving skills that nurses had to employ to continue providing effective care under restrictive conditions.

Imran (P.6) further illustrated the complex nature of their roles:

"... Check vital signs, give the patient food, nursing care, perform an ECG, transfer the patient. The nurse provides emotional support to the patient and cheers the patient up."

His statement expresses how nurses went beyond clinical duties, assuring patients received emotional support and companionship, which was crucial during a time of incredible fear and doubt.

The above quotes depict a profound sense of duty and commitment. The nurses' ability to adapt, their unwavering sense of responsibility, together with their dedication to providing comprehensive care reflect the moral responsibility, professional commitment and personal sacrifices that symbolised their response to the pandemic. Their actions exemplified the core values of nursing—compassion, adaptability, and a profound sense of responsibility, demonstrating an unparalleled level of professionalism and resilience during one of the most challenging times in the history of healthcare.

5.2.5.2 Sub-theme 2: Confronting Physical and Emotional Obstacles

Nurses were subjected to numerous obstacles and challenges while providing nursing care, particularly during the COVID-19 pandemic. These challenges ranged from physical

strain to inadequate resources, changing safety protocols, team conflicts, and even issues with basic necessities such as food.

Felicia (P.7) highlighted the physical toll that caring for COVID-19 patients took on nurses, particularly when handling deceased patients. She shared,

> *"... Only staff nurses and doctors can enter, so when a patient dies, the one who performs the last office (LO) is the staff nurse (SN). At that time, 2 nurses in charge downstairs, one-person upstairs. If a patient died, there were only two SNs who could do the LO. So when the patient is a big size, when we want to place the patient in the sealed bag, that's when I get backache. It's really hard at that time. I'm thin too, the patient was heavy. It's really heavy because it depends on the doctor as well. If the doctor feels like helping, he can help. If he is very busy, he may not be able to help. Because the LO is the job of the SN."*

Felicia's account illustrates the physical strain involved in carrying out the last office duties, chiefly when handling larger patients with limited assistance. The selective involvement of doctors, who were sometimes unavailable to help, left the nurses to manage these laborious tasks independently, often leading to physical discomfort like backache.

Teresa (P.4) described the difficulties of adapting to changing protocols:

> *"... ermm, at first I didn't quite understand because we didn't know what was and what wasn't necessary. There were improvements from time to time, for example, you have to wear a double layer of gloves up to three layers. But it's hard if you want to take blood from a patient. Ahhh we can't feel anything; we sometimes have to poke blindly."*

This quote stresses how the changing safety measures, although necessary for protection, made routine tasks like drawing blood extremely challenging because of the reduced tactile sensation caused by several layers of gloves.

The issue of insufficient PPE was a significant challenge during the initial wave of the pandemic, as Laura (P.1) pointed out:

> *"... the PPE supplies were inadequate in the first wave of COVID-19 pandemic. It was lucky because there are people who want to donate PPE items to us."*

This shortage not only increased the risk for healthcare workers but also added to the stress and unease of working under such hazardous conditions. Community donations were crucial role in supplementing PPE supplies, providing some relief to the staff.

An added significant challenge was the internal team dynamics as a result of the need to divide the ward staff into two separate teams, which affected relationships and team cohesion. Wendy (P.8) explained,

> *"... As colleagues, we do have clashes. //... Group A and group B don't meet much with other teams. As we split into two teams, we started to form groups. Ohh I want to work with that person, I want to work with this person. So it's not good because we used to be a team. When it's split, we can see who wants to work with that person and who wants to work with this person. You tend to be picky and choose people to work with. Maybe because we've worked together for 12 hours, we've been through ups and downs together. //... Maybe this person was not good with that person before, but now they're good. That's the positive impact when grouped together.*

Otherwise, it's kind of awkward when we meet. There's nothing we can talk about with that person because we are not in the same team anymore."

Wendy's version indicates that separating into smaller groups created cliques, which occasionally led to conflicts or feelings of awkwardness among staff members. However, she also noted that this grouping could have a positive impact by improving relationships amongst colleagues who previously did not get along. Additionally, she expressed frustration with doctors and management, stating,

"... because of the pandemic, everyone wants to be fast. Plus, there are different doctors and different management. //... There is a part that feels angry with the doctor."

This quote confirms the heightened stress and tension that arose from working under different leadership styles and protocols in high-pressure situations.

Food quality and safety were also prominent issues affecting the nurses' ability to maintain their energy levels. Teresa (P.4) shared her grievances:

"... the food from the kitchen is bad. "Adohhh ehh". There is time when okay okay. Imagine you get this much. We're tired and hungry, and yet we get only two spoonful's of rice inside. //... It's seriously bad. At the time, we were really frustrated with the kitchen. It's better that we cook ourselves, so we bring the rice cooker inside the quarantine place. There is no choice, I have to eat Maggi. //... The normal white container, yes, they put the side dish on top. If the food comes early, imagine we finish the shift and the food is already cold. We don't even want to eat. //... There is stale rice, even raw rice once. Ever encountered chicken that wasn't cooked. What

can you do, just eat canned food if you have to. Luckily, sometimes people donate canned food. So, I cook my own rice to eat with the canned food."

Teresa's experiences reveal how the quality and timeliness of meals failed to meet the basic needs of nurses, who were already physically exhausted. The lack of adequate and nutritious food added another significant challenge, forcing nurses to depend on their own resources or donations from others.

Hence, the obstacles and challenges experienced by nurses during the COVID-19 pandemic were complex, ranging from physical strain, inadequate PPE, embryonic and restrictive safety protocols, besides internal team conflicts because of the poor quality of food provided. These challenges, compounded by the emotional and physical demands of the job, created a highly stressful work environment that tested the resilience and dedication of healthcare workers to their limits. Despite these challenges, their commitment to patient care remained steadfast, demonstrating their strength and professionalism in the face of adversity.

5.2.5.3 Sub-theme 3: Practising Self-Stewardship and Well-Being

Self-stewardship is the skill of nurturing and maintaining one's well-being. It goes beyond basic self-care, encompassing a higher level of self-regulation and self-awareness to remain healthy and capable of working with others effectively. During the COVID-19 pandemic, self-stewardship became essential for nurses as they managed their physical, emotional and financial needs while caring for patients in a demanding environment.

Naomi (P.2) and Felicia (P.7) articulated how financial stability played an important part in their motivation and ability to continue working. Naomi emphasised the significance of her monthly pay check as a means to manage her financial commitments, stating,

"... this is our job, source of sustenance, right? It means that if I don't work, I won't be able to pay, get a salary. Even now, I have my own commitment with a car, a house, and then to help the family as well. I think that's the main reason. I think while we get the "pahala" (reward from God) right, that's what makes me come to work."

This statement reveals the dual motivations of financial need and spiritual fulfilment in her work.

Additionally, Naomi mentioned the importance of mutual support among housemates, sharing how they supported each other during the quarantine by providing necessities:

"When a friend feels down and is quarantined because of contact with a patient, we give support. For example, if she is quarantined at home, we help send food, we put it on the fence."

Likewise, Felicia acknowledged the financial support provided by the government as a crucial factor in alleviating the financial burdens and stress associated with their demanding work:

"... our government is very good in giving support. For us the amount of allowance that is being given is quite big. So it helps a lot."

Her acknowledgment of this support demonstrates her appreciation for the available resources and her positive outlook further exemplifies mental resilience and adaptability during the pandemic.

Felicia also commented on the pandemic as a valuable learning opportunity, stating,

"Taking care of COVID-19 patients during the current pandemic is a very valuable experience. Not everyone can experience this thing, especially since we are the ones who are the first team to face all of this. There are indeed bad things that make me sad, but then I just take it as a very valuable experience."

This acceptance of adversity underlines her ability to transform challenging experiences into opportunities for personal and professional growth, preparing for future uncertainties.

The practice of self-stewardship among nurses also extended to proactive stress relief and emotional management. Malik (P.5) shared his approach to relaxation and stress management, incorporating music and deep breathing exercises as essential tools:

"... after the pandemic I always take earphones because I try to listen to songs. I opened Youtube on how to relax, how to relax the mind. I listened to the music and it did help a little. When I listen to music, I really feel relaxed and I do deep breathing exercise. Do deep breathing to cool down a bit."

This proactive approach demonstrates his commitment to maintaining his psychological health to cope with the demanding environment.

Laura (P.1) described the role of entertainment and social activities in mitigating feelings of isolation and homesickness, even with limited internet access:

"... there's entertainment after... listen to the radio in the hostel. But there is limited internet. //... And then to forget the longing, we look at the mobile phone, sing with friends in the place where we spent the night together."

Her experience points out the importance of social connection and shared activities in sustaining emotional well-being.

In conclusion, self-stewardship among nurses during the COVID-19 pandemic was characterised by effective financial management, mutual support, mental resilience, and proactive stress-relief practices. By addressing their physical, emotional and financial needs, these nurses were able to maintain their capacity to care for patients while safeguarding their own well-being. This comprehensive approach to self-care guaranteed that they remained resilient and competent in the face of unprecedented challenges.

5.2.5.4 Sub-theme 4: Experiencing and Addressing Discrimination and Inequality

Discrimination and inequality have been persistent issues experienced by nurses, with the COVID-19 pandemic further highlighting these challenges. The experiences of nurses during this period have exposed biases based on social status and marital status, as well as professional hierarchy, leading to unreasonable workloads, miscommunication and a lack of appreciation for the contributions of nursing staff.

One form of discrimination evident during the pandemic was the disproportionate expectation placed on single nurses to care for COVID-19 patients. Wendy (P.8) expressed that single nurses were often assigned to handle infectious cases more frequently compared to their married counterparts. She remarked,

> *"... usually there are indeed many singles who are nominated to take care of patients like that. If a married person has a commitment, as there are small children and families to take care of."*

This mindset suggests that single nurses have fewer personal commitments, therefore making them more available to undertake demanding tasks. Wendy, however, emphasised

that, regardless of one's marital status, it is the professional duty of every nurse to care for patients:

> *"... For me whether or not you have a commitment, whether you're single or have a partner, it's our job, right? We also have to be in charge of the patient. You can't use that as an excuse."*

This practice placed an undue burden on single nurses, generating to feelings of inequality and resentment, as responsibilities were not equitably shared based on professional ability but rather on personal status.

Teresa (P.4) corroborated Wendy's experience, noting that,

> *"... the first to be involved in caring for COVID-19 patients is mostly the nurse who is single. The superior will choose single people first."*

This exhibits a structural bias that prioritises the needs of married nurses over those who are single, without acknowledging the dedication and abilities of all the staff members.

Umaira (P.9) reinforced the need for equitable treatment, stating,

> *"... whether you are married, or you are still single, everyone should be involved. In the first wave, any problem had to be left behind. Only your work matters."*

This discrimination based on marital status is not only unwarranted but also disregards the fact that nursing, as a profession, is rooted in a sense of duty and calling, regardless of one's personal life. Just as soldiers leave their personal lives behind to defend their country, nurses commit themselves to care for patients, irrespective of their social status or personal commitments.

In addition to discrimination based on marital status, the persistent "handmaiden" stereotype continued to manifest in the hierarchical structures within healthcare settings. Teresa (P.4) shared her experience of being expected to follow orders without question, saying,

> *"... Mostly because I had to. We are already in this; we will not be able to get out unless we ask for a transfer. No one likes to work in risky areas, but we have no choice. We need to follow the instructions from the boss. Even if we want to be disobedient, we can't. We are subordinates."*

This rigid hierarchy positions nurses as mere executors of instructions, denying them the autonomy to make informed decisions based on their expertise.

Claudia (P.10) also commented on issues pertaining to miscommunication between doctors and nurses, which often produced mistakes and an increased workload for nursing staff:

> *"... Sometimes the doctor does not inform the staff about the latest plan when the staff is in the patient's room. Then the staff leave the room. The plan should be carried out when staff are inside. Why not notify us from the beginning? It's like there is no communication. Then they are brought forward for the next shift. The staff on the next shift will say, why wasn't the work done? The doctor gave a reason. Ohh it's like this, like this. The nurse explained that the doctor informed us late, when we all went out and showered. The report is not yet ready, it's 1pm, and the afternoon staff have arrived. When you see a colleague coming and your task is not finished, you have to decide what is due on the next shift. Colleagues will ask why you didn't do it earlier. That's how it is."*

This lack of communication resulted in tasks being unnecessarily delayed and carried over to subsequent shifts, creating additional strain on nurses and contributing to a sense of being undervalued.

Imran (P.6) narrated a particularly distressing experience with a doctor who assigned last-minute tasks at the end of his shift, saying,

> *"... The doctor gave me last-minute work when I was about to finish my shift. At that moment, we were tired, we just wanted to rest. She ordered the patient to be for an x-ray. That time I exploded. //.. The patient is not in a stable condition. I understand that it is necessary to send the patient at that time. I was just asking if it could be done after our shift so there's no need to be in a hurry. If the doctor insists on sending the patient, okay I can send him anywhere. Then, the doctor was making a noise. The doctor reported to my matron that I didn't want to do the work, I was lazy. So, I exploded in front of the matron, until the doctor cried. I feel sorry for that doctor. I think she needs to understand us too. We can help her do the work but she needs to understand our work too. We can help their work, can't they make it easier for us?"*

Imran's experience confirms the lack of empathy and understanding from some superiors, contributing to conflicts and emotional distress among nursing staff.

Amanda (P.3) shared a similar experience that drew attention to the disregard for nurses' expertise and physical well-being. She described how, despite her informed advice regarding an issues with a patient's femoral line issue, the doctor insisted on proceeding with a procedure, resulting in extended work hours and physical exhaustion:

"... I still remember that time. At 9 o'clock we entered, at 5 pm to 5.30 pm we came out of the room. My friend who is a deployed male nurse got blisters on his feet from using PPE. "Aduhh" (oh), it was really tiring at that time."

This situation shows a power imbalance where doctors' decisions are prioritised over the practical knowledge and expertise of nurses, resulting in detrimental impacts on their health and well-being.

The lack of empathy and support from superiors extended beyond interactions with doctors. Amanda recalled incidents with her nursing manager, where her requests for leave on account of personal commitments, such as her husband's visit and her pregnancy, were either questioned or denied:

"At least she should consider. As within one week I'm 35 weeks pregnant, I can feel my legs have swollen. At least she gave me a break as I still have a lot of leave. //... Sister, next week, my husband will be back, but it won't be long. I didn't ask for a week off, I asked for four days only. Yet, it's still being questioned, susah la. If my husband is back, there are many things that need to be taken care of."

Her experience illustrates the rigid and unsympathetic approach of certain managers, further exacerbating the feeling of being undervalued and discriminated against.

Imran echoed Amanda's sentiments, calling for a more understanding approach from superiors. He stated,

"... Superiors need to understand what kind of staff this is, how staff work. Don't pinpoint straightway, need to ask first. Please understand us, we do work. They can see us sitting down because that's when we can rest. They don't know how busy we

are. What they see is just us sitting because that's when we can rest. They don't know how busy we are. //… Take care of staff. Whoever needs a break, you give him/her a break. So far there are holidays. If there are not enough staff, ask the higher authority, please give more staff here. All of us who work here are mentally ill if we continuously work without holidays."

His plea indicates the need for management to acknowledge the challenges faced by nurses and to provide adequate support, particularly in a demanding work environment.

In conclusion, discrimination and inequality in nursing during the COVID-19 pandemic were exhibited through unequal workloads, rigid hierarchical structures and a lack of empathy from superiors. These experiences not only impacted nurses' professional autonomy but also led to physical and emotional exhaustion, underpinning their sense of being undervalued. Addressing these issues requires a commitment to equitable treatment, improved communication, and recognition of nurses' expertise and contributions, assuring that all nurses are treated with the respect and dignity they deserve.

5.3 Summary

This chapter has presented five key themes derived from the study's findings, in accordance with the research objectives, to explain the psychosocial experiences of nurses in Sarawak during the pandemic.

CHAPTER 6

DISCUSSION

This chapter presents a discussion of the results and findings which were presented in the previous chapter from the data collected via the interviews. The results and findings were discussed in line with the research questions presented in Chapter 1. The research questions that guided this research were:

1. What are the psychological experiences of nurses during the pandemic in Sarawak?
2. What are the social experiences of nurses during the pandemic in Sarawak?
3. What are the repercussions on the lives of nurses during the pandemic in Sarawak?

The implications and limitations of this study as well as recommendations are presented at the end of this chapter and to conclude this research.

6.1 Introduction

As outlined in Chapter 3, this interpretive study is rooted in Martin Heidegger's philosophical framework, as detailed in Section 3.1.2 (Qualitative Phenomenology). Interpretive research aims to provide rich, phenomenological descriptions that explain the ontological meanings embedded in the day-to-day experiences of a select group of individuals. This is in contrast to quantitative research, which focuses on explanations, predictions and the generation of universally applicable theories. In this case, the study focused on the lived experiences of 10 nurses who cared for COVID-19 patients in the Infectious Disease Ward at Sarawak General Hospital. These nurses, purposively selected,

represented a diverse mix of ethnic backgrounds, including Chinese, Malay and Bidayuh. The participants were relatively young, with a mean age of 31 ± 4 years. Moreover, three nurses had completed additional professional training in specialised courses (post-basic training).

The findings from this interpretive study have significant implications for nursing practice, policy and preparedness, along with future research. Therefore, in this final chapter of the thesis, I will discuss the implications and limitations of the study and present the concluding remarks.

6.2 Interpretation of Findings

This section discusses the findings based on the three objectives identified in this study, providing an in-depth analysis of the data collected.

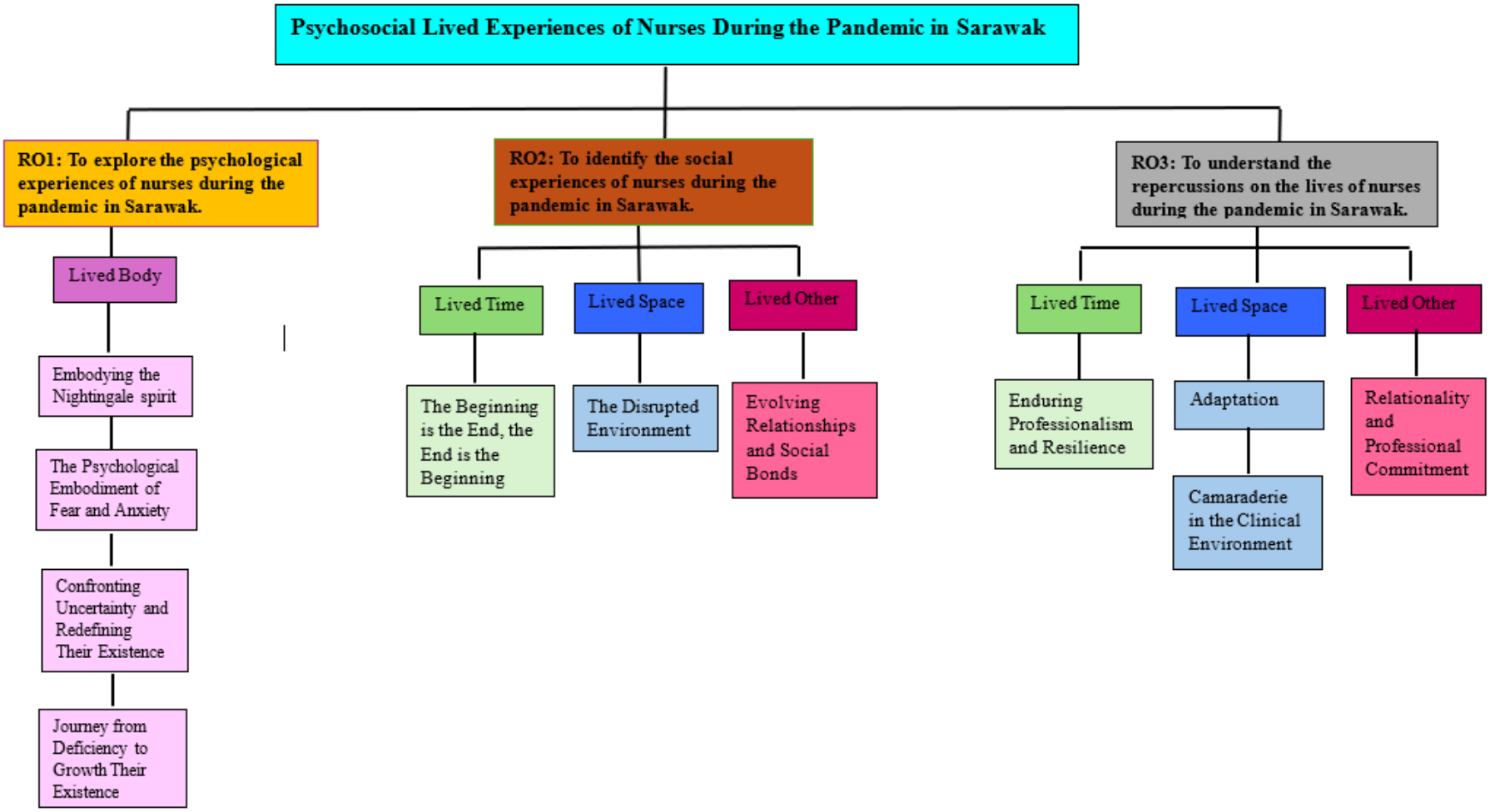


Figure 6.1: Psychosocial Lived Experiences of Nurses During the Pandemic from Van Manen's Perspective

6.2.1 Objective 1: To Examine the Psychological Experiences of Nurses During the Pandemic in Sarawak

As outlined in hermeneutic phenomenology, the psychological experiences of nurses during the pandemic in Sarawak can be profoundly understood through the lens of the lived body. The concept of the lived body demonstrates how nurses' physical experiences, emotions and psychological states were significantly interconnected during the pandemic, leading to a fusion of horizons where past experiences, present challenges and future aspirations combined to affect their understanding and responses.

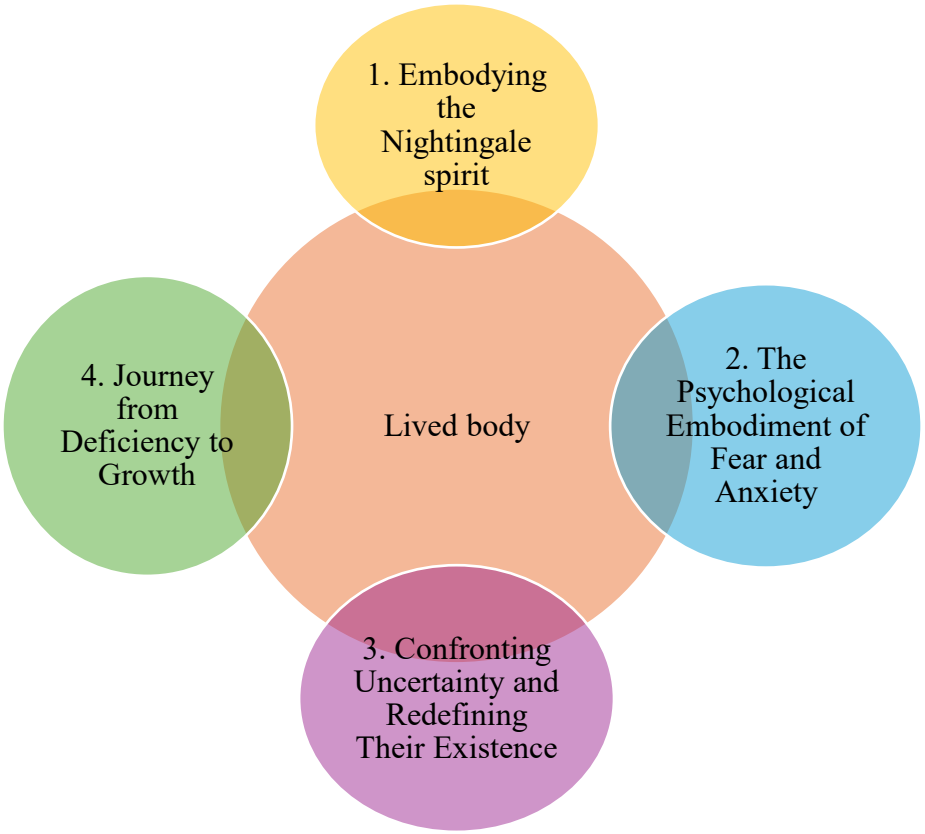


Figure 6.2: The Psychological Experiences of Nurses during the Pandemic in Sarawak through the lens of the lived body

6.2.1.1 Embodying the Nightingale spirit

Throughout the pandemic, nurses embodied the Nightingale spirit, drawing inspiration from Florence Nightingale's dedication, compassion and steadfast commitment to patient care. This embodiment reveals how their physical presence, actions and mindset were moulded by the historical ideals of nursing established during the Crimean War (Wills, 2007). Similar findings were observed in a study by Fan et al. (2020), where nurses exhibited qualities resonating with Nightingale's ethos.

With regards to Nightingale's ethos, nurses connected the past traditions of nursing with the present demands of the pandemic, striving to deliver exceptional care with empathy, resilience, and selflessness. Nurses are transformed into more than mere healthcare providers; they became healers, comforters and advocates. Through their lived experiences, they expressed compassion and commitment, despite facing immense physical and psychological challenges. This process illustrates how the embodiment of the Nightingale spirit acted as a guiding force, enabling nurses to maintain their dedication to patient care even in the most demanding circumstances.

The nurses' experience of caring for COVID-19 patients required them to confront their own vulnerability and mortality, bringing their corporeal existence into sharper focus. The constant use of PPE, social distancing measures and adherence to rigorous hygiene protocols heightened their awareness of their own bodies, underlining the fragility and impermanence of human life. This acute awareness of their lived body, affected by the fear of exposure to the virus, created a greater understanding of their existential condition and highlighted the delicate balance between providing care and protecting themselves.

These findings are in keeping with the study conducted by Robinson and Stinson (2021), in which the theme of human connection emerged as a significant aspect of nursing during the pandemic. Nurses expressed their roles through physical acts of comfort and support, generating deep emotional bonds with patients, even during isolation and suffering. The shared experiences among nurses strengthened feelings of solidarity and mutual support, buttressing a sense of community and empathy within the nursing profession through the acknowledgment of each other's experiences, as well as by celebrating and supporting one another during challenging times.

The emotional toll of witnessing patients die alone highlighted the critical importance of nurses' physical presence in alleviating feelings of loneliness and isolation. Coping strategies that engaged the lived body, such as participating in online activities and connecting with colleagues, further emphasised the significance of human connection in both professional and personal spheres. Essentially, the lived body played a pivotal role in forming how nurses handled their roles, relationships and the transformative impact of their experiences during the pandemic. This underscores that physical presence and human connection were essential elements in sustaining nurses' resilience and well-being throughout the challenges of COVID-19 care.

6.2.1.2 The Psychological Embodiment of Fear and Anxiety

The nurses' lived body was profoundly affected by intense fear and anxiety during the pandemic. Previous studies have shown that nurses caring for patients with novel infectious diseases such as severe acute respiratory syndrome, Middle East respiratory syndrome coronavirus (MERS-CoV), Ebola or H1N1 (Swine Flu), have experienced a range of psychological challenges, including loneliness, anxiety, fear, fatigue, weakness, stress,

alienation, frustration, fragility, threat and sleep disorders (Khalid et al., 2016; Kim, 2018; Liu et al., 2019).

As nurses were constantly exposed to COVID-19 patients, their physical responses, such as an increased heart rate, muscle tension and adrenaline rushes, indicated their psychological states. This embodiment of fear is in line with Watson (1924) theory, who suggests that fear can be learned through the association of a neutral stimulus (the act of nursing) with an aversive stimulus (the threat of COVID-19) (Bierlich & Kracen, 2020; Gray, 1987). This associative process resulted in the development of compulsive behaviours, such as incessantly washing hands and clothes to prevent infection, which became part of their lived bodily experience (Liang et al., 2021).

Additionally, the fear of potentially transmitting the virus to family members caused many nurses to physically distance themselves from loved ones, limiting contact for extended periods (Alrasheeday et al., 2023). This self-imposed isolation intensified their sense of loneliness and altered their perception of themselves, not only as caregivers to their patients but also as protectors of their families. The constant vigilance required to avoid infection transformed their bodily existence, making them hyper-aware of every action, space and interaction. This experience blended the concepts of lived body, lived time and lived space, profoundly affecting how nurses handled their roles during the pandemic.

Nurses' extensive medical knowledge and awareness of infection risks heightened their worry and fear compared to the general public (Liang et al., 2021; Schroeder et al., 2020). Their familiarity with worst-case scenarios, transmission modes and potential complications often increased anxiety. Continuous exposure to information through clinical practice and frequent updates from health authorities led to information overload, resulting

in heightened stress and, at times, unnecessary or exaggerated fears. The responsibility of protecting patients, colleagues and family members further compounded this emotional burden, intensifying feelings of guilt and isolation. This hyper-awareness, essential in clinical care, became emotionally exhausting, contributing to mental strain and altering nurses' perceptions of their roles and well-being.

6.2.1.3 Confronting Uncertainty and Redefining Their Existence

In the early stages of the COVID-19 pandemic, nurses confronted significant uncertainty regarding their ability to protect themselves and provide effective care. This unprecedented situation triggered feelings of fear, anxiety and confusion, which became acutely embedded in their lived experiences. The unpredictable nature of the pandemic disrupted their routines and sense of safety, affecting both their physical and psychological well-being. However, this challenging period also encouraged continuous vigilance and enhanced nurses' skills and abilities, enabling them to cope with the demanding phases of the pandemic with resilience and adaptability.

The experience of constantly adapting to new protocols, equipment and safety measures required nurses to embody a state of readiness and resilience. This adaptability demonstrates how the lived body serves as a place for meaning-making, where nurses redefined their roles and responsibilities in the face of the uncertainty. As they contended these challenges, they not only adjusted their physical actions but also cultivated a deeper sense of purpose and resilience, incorporating these experiences into their sense of self.

Nurses confronted their doubt and redefined their existence during the COVID-19 pandemic (Sun et al., 2020). Initially, they experienced intense fear and anxiety when entering negative pressure wards, but as they faced the challenges posed by the novel virus,

they progressively managed their fears and adapted to their roles. This process gave rise to a stronger sense of professional responsibility and pride in their work. Many nurses engaged in self-reflection and developed a greater appreciation for life and their contributions to healthcare. In essence, their experiences during the crisis allowed them to redefine their purpose and identity within the healthcare system, demonstrating how confronting uncertainty can trigger positive experiences and personal growth.

6.2.1.4 Journey from Limitation to Growth

The concept of the lived body also in accordance with Maslow (1954) theory of deficiency needs and growth needs, which are fundamental for human survival and motivation. During the COVID-19 pandemic, nurses experienced unmet physiological and safety needs, including sleep deprivation, inadequate nourishment, emotional exhaustion, as well as the constant risk of infection. These unmet needs manifested physically through extreme fatigue and heightened stress levels.

Love and human connection are fundamental to well-being, encouraging a sense of purpose and fulfilment. Nurses in this study expressed a profound sense of calling, believing they were chosen by God to serve, save lives and care for others. Their commitment to sharing, caring and showing love to humankind is consistent with findings documented by Tamayo et al. (2024). However, the prolonged state of vulnerability and isolation challenged their ability to fulfil these needs. Many experienced alienation, as physical distancing from loved ones, emotional strain from the fear of virus transmission, and stigma associated with frontline work induced a profound disconnection.

In spite of these challenges, nurses transformed their flaws into opportunities for personal and professional growth. The hardships they endured promoted resilience, empathy

and a strengthened professional identity, illustrating a transition from a limitation to growth. This transformation is consistent with Ventegodt et al. (2004) "first-class" perspective, which views adversity not as a barrier but as a catalyst for self-actualisation and the realisation of human potential. Through their lived experiences, nurses demonstrated remarkable adaptability, turning physical and emotional struggles into sources of strength and development. Their lived bodies became places of transformation, strengthening their capacity to not only endure adversity but to emerge stronger, more compassionate, and deeply connected to their professional mission.

6.2.1.5 Fusion of Horizons Demonstrating Psychological Experiences

The fusion of horizons for nurses during the pandemic is evident in how their past experiences, present challenges and future aspirations combined to create a holistic understanding of their existence. The past experiences of dealing with infectious diseases prepared them with the foundational knowledge that guided their actions; nevertheless, the unprecedented nature of COVID-19 required them to adapt and redefine their approaches. This blending of past expertise with current demands allowed them to address the physical and psychological toll of the pandemic more effectively.

The present experience of constantly wearing PPE, facing uncertainty and witnessing suffering led to an acute awareness of their lived body, where every action, decision and movement was influenced by the fear of infection and the desire to provide compassionate care. These experiences became a vessel for personal growth, determining how nurses viewed their future roles, sense of purpose and identity as healthcare providers.

By embodying the Nightingale spirit, confronting fear and anxiety, and adapting to the challenges of the pandemic, nurses engaged in the process of meaning-making that

transformed their lived bodies into resilient places, empathy and professional fulfilment. This ongoing journey reveals the dynamic and transformative nature of the search for meaning, as personal experiences, challenges and reflections contributed to their existential journey.

In conclusion, the psychological experiences of nurses during pandemic in Sarawak, when viewed through the lens of the lived body and the fusion of horizons, convey how their physical and emotional experiences were intensely interconnected. The pandemic brought their corporeal existence into sharper focus, forcing them to confront their vulnerability, adapt to uncertainty, and embody resilience and compassion. As nurses dealt with the challenges of the pandemic, their lived bodies became an indication of their journey, integrating past experiences, present challenges and future aspirations, to contribute to a more profound understanding of their role as nurses and their place in the world. This holistic integration underlines the profound impact of the pandemic on their psychological and physical experiences, providing positive information into the embodiment of caregiving in the face of unprecedented adversity.

6.2.2 Objective 2: To Identify the Social Experiences of Nurses During the Pandemic in Sarawak

The social experiences of nurses during the pandemic in Sarawak can be profoundly understood through the integration of the three existential structures: lived time, lived space and lived other within the framework of fusion of horizons. This integration illustrates how nurses' perceptions of time, space and relationships were dynamically altered and interconnected, determining their overall experiences during the pandemic.

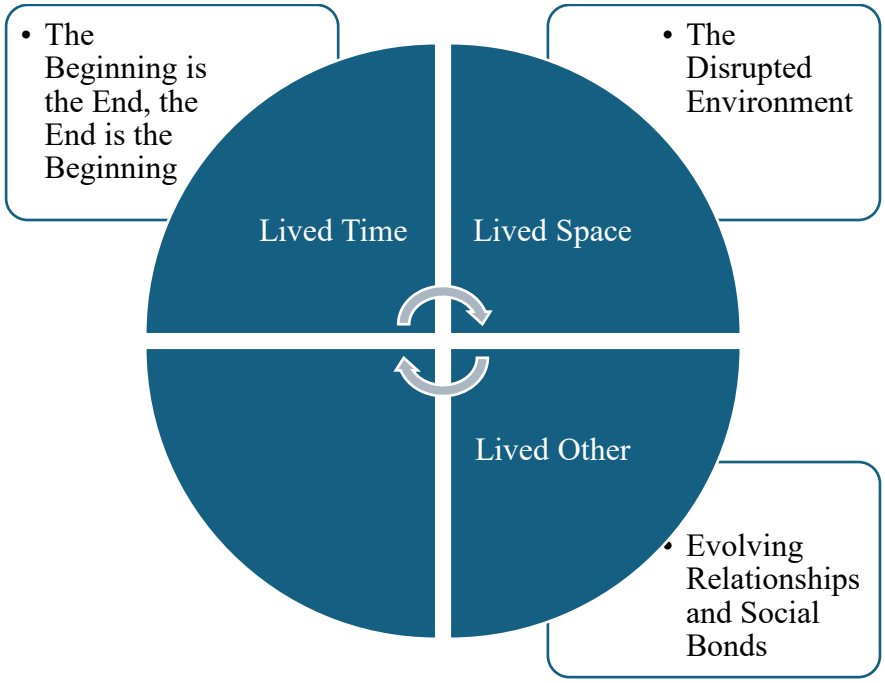


Figure 6.3: The Social Experiences of Nurses During the Pandemic in Sarawak through the Integration of Lived Time, Lived Space and Lived Other

6.2.2.1 Lived Time: “The Beginning is the End, the End is the Beginning”

The COVID-19 pandemic fundamentally altered nurses' sense of time, moving beyond the conventional clock-based measurement to a more subjective, experiential understanding of temporality. The phrase "The beginning is the end, the end is the beginning" encapsulates the cyclical nature of the pandemic experience, where past, present and future merged into a continuous flow.

i. Altered Perception of Time

Nurses experienced a profound distortion of time during the pandemic, influenced by prolonged shifts, heightened stress and emotional upheaval. This altered perception, commonly described as "time dragging" (Zakay & Fleisig, 2011), was marked by the endless demands of patient care and the constant fear of infection. The intensity of their work brought

about an erosion of their work-life boundaries, causing days to run into one another and disrupting their usual temporal framework.

The study by Jang et al. (2022) supports this phenomenon, revealing that nurses expressed a strong desire to return to normalcy and engage in everyday social activities, which felt increasingly distant on account of the ongoing uncertainty in terms of the pandemic. This longing for a return to regular life during the stress and challenges of caring for COVID-19 patients most probably contributed to a distorted perception of time, making the duration of the crisis feel prolonged and disrupting their usual life rhythms. The emotional toll of isolation and the yearning for routine highlight how the pandemic substantially affected nurses' sense of time and daily experiences.

As nurses dealt with the pandemic, their past experiences significantly influenced their responses to present challenges, while their anticipation of future outcomes guided their actions. Drawing on previous training and knowledge, they were able to manage the crisis effectively, even as they adapted to the unpredictable demands of COVID-19. This dynamic interplay created a fusion of horizons, where the past provided invaluable guidance, the present demanded resilience, whilst the future remained filled with uncertainty and hope for recovery. This process aligns closely with Heidegger's concept of temporality and Gadamer's hermeneutic philosophy, which emphasise how past, present and future experiences influence understanding and meaning (Gadamer & Linge, 1977; Heidegger, 1962).

In this study, nurses gained a deeper appreciation for life and relationships, finding joy and personal growth through shared experiences after overcoming the challenges of the pandemic (see Chapter 4.2, Theme 1, Sub-theme 4: Resilience and Meaning-Making through

the Body). As the pandemic receded, they entered a phase of introspection, allowing them to process and reflect on their experiences. This period of reflection enabled them to find meaning and purpose in the challenges they had encountered, potentially leading to post-traumatic growth.

The fusion of lived time facilitated this transformative journey where nurses re-evaluated their professional identity and aspirations, incorporating their past experiences with future goals. Nurses engaged in self-reflection while coping with the challenges of caring for patients with COVID-19 (Sun et al., 2020). This self-reflection assisted them to acknowledge their strengths, appreciate the support they received and reassess their professional identity and values. Many participants expressed feelings of gratitude and a renewed sense of purpose, indicating that the experiences prompted them to reflect on their roles as caregivers and the significance of their contributions during the pandemic.

Nurses reflected on how their experiences during the pandemic influenced their self-perception as healthcare professionals. Some nurses found inspiration and a renewed sense of solidarity with colleagues, while others experienced stress and a loss of self-confidence (Thrysoee et al., 2022). These reflections highlight the profound impact of the pandemic on nurses' professional identity, encouraging both growth and challenges in their sense of self and purpose.

6.2.2.2 Lived Space: The Disrupted Environment

The concept of lived space explains how the physical and social environments of nurses were dramatically altered during the pandemic, influencing their sense of place and belonging. The pandemic significantly eroded the boundaries between personal and professional spaces for nurses. Homes, once places of relaxation, were transformed into

extensions of their work environment, while hospitals became locations of heightened anxiety and stress. Quarantine measures further intensified this disruption, as nurses experienced prolonged periods of isolation, separated from their families and communities.

The challenging and demanding situations faced by nurses during the pandemic, including high levels of stress, exhaustion and emotional strain while providing care for COVID-19 patients, were also evident in studies performed by Lee and Lee (2020). The studies described how nurses were “pushed onto the battlefield without any preparation”, confronting an "invisible enemy," pointing out the immense psychological and physical burdens they endured during this crisis.

The fear of infection during the pandemic created stigmatisation, resulting in social isolation for many nurses within their communities. Often perceived as potential carriers of the virus, nurses faced discrimination and distancing from others, an experience supported by studies conducted by others (Demir & Şahin, 2022; Heydarikhayat et al., 2022; Liang et al., 2021; Sadati et al., 2021). Nurses felt stigmatised because of their profession, particularly when caring for COVID-19 patients or even those suspected of having the virus.

This stigma manifested in various forms, including social exclusion and negative perceptions from the public. For example, one nurse, Umaira (P.8), reported that when she took her daughter to a private healthcare centre for treatment, her daughter was denied care after the staff discovered that Umaira worked as a nurse in an infectious ward, despite her assurance that she always wore full PPE when nursing patients (see Chapter 4.2, Theme 2, Sub-theme 2, Stigmatisation and Altered Social Perception). This experience triggered profound feelings of isolation and shame. Additionally, nurses frequently reported instances

of discrimination, where individuals actively avoided or shunned them, further reinforcing the stigma associated with their profession during the pandemic.

This stigmatisation altered nurses' lived space, making them feel marginalised and excluded, which, in turn, affected their sense of belonging and professional identity (Alrasheeday et al., 2023). These experiences confirmed the profound impact of the pandemic on nurses' social interactions and well-being, as they managed both the physical and emotional demands of their important roles.

6.2.2.3 Lived Other: Evolving Relationships and Social Bonds

The pandemic also significantly impacted nurses' relationships, both with their patients and colleagues, as well as with their families and communities, exhibiting the lived other component.

i. Strengthening of Professional Bonds

In this study, shared experiences amongst nurses cultivated a profound sense of solidarity and mutual support as they collectively dealt with the challenges presented by the pandemic (see Chapter 4.2, Theme 4, Sub-theme 2, Building Multi-dimensional Camaraderie). This camaraderie provided essential emotional strength, enabling nurses to cope with the immense pressures of patient care. The sense of unity and shared purpose within their professional environment was further strengthened through a fusion of horizons, where nurses drew on their collective experience to develop resilience.

Solidarity and mutual support were intricately intertwined, each reinforcing the other in equal measure. Solidarity offered a sense of belonging and collective strength, while mutual support provided the practical and emotional assistance required to endure the hardships of frontline work. Neither could exist meaningfully without the other; there was

no greater weight placed on solidarity than on mutual support, nor vice versa. Instead, the balanced relationship between the two became a cornerstone of nurses' resilience, allowing them to withstand adversity together and promote a shared sense of purpose surrounded by the uncertainty of the pandemic.

The nursing profession grew stronger during the pandemic, with nurses experiencing increased professional satisfaction, a heightened sense of solidarity and an superior reputation (Muz & Erdoğan Yüce, 2021). These findings highlighted their resilience and steadfast dedication to their work. In the same way, nurses working under challenging conditions experienced a strong sense of team cohesion and collective strength (Sun et al., 2020). The support from colleagues, alongside the encouragement and camaraderie within their teams, played a crucial role in helping nurses to manage the stress and emotional challenges of caring for COVID-19 patients.

Together, these studies point out the essential role of solidarity, mutual support and shared experiences in empowering nurses to address the complexities of the pandemic. This collective strength not only enabled them to cope with the unprecedented challenges but also enhanced their professional satisfaction, creating a sense of unity, whilst reinforcing their commitment to patient care and each other.

ii. Disconnection and Reconnection with Family

Family support was highly valued by nurses during the COVID-19 pandemic, which is in line with findings from previous studies (H. Cai et al., 2020; Zhang et al., 2020). However, concerns as regards virus transmission often strained their familial connections. Many nurses made the difficult decision to limit contact with their families, leading to profound feelings of loneliness and isolation. While professional relationships among

colleagues were strengthened during this period, personal connections were maintained primarily through technology. Video calls and virtual interactions became essential tools to reconnect with loved ones, extending emotional support despite physical separation. This finding is consistent with Nipin et al. (2021), who highlighted the critical role of technology in preserving familial bonds during crises. Additionally, structured interventions, such as scheduled video calls or individual therapy during shifts, were encouraged to support nurses' well-being (Ali et al., 2020).

In this study, nurses relied on technology as a vital means of maintaining connections with their loved ones (see Chapter 4.2, Theme 3, Sub-theme 3: Cultivating and Sustaining Affinity in a Restricted Environment). Video calls and messaging apps created a virtual space that provided intimacy and comfort, assisting nurses to share experiences and receive emotional support despite being physically apart. Digital entertainment, for example movies and comedy series, also functioned as a coping mechanism, affording moments of relaxation and emotional escape from work-related stress (Nipin et al., 2021).

This adaptation underlines the dynamic nature of lived space, as nurses creatively used technology to sustain social connections and cope with the challenges of isolation. The integration of digital communication not only bridged the physical distance but also became a breakthrough channel for preserving relationships and fostering emotional resilience. The urge to remain connected, both for survival and emotional well-being, highlighted the inherent human need for social interaction, even when confined to virtual spaces.

However, this adaptation was not without limitations. While technology provided temporary relief and connection, it often fell short of fulfilling the deep-seated need for physical presence and human touch. The constant reliance on digital communication, though

necessary, sometimes heightened feelings of loneliness and emotional fatigue, as virtual interactions could not fully replace the warmth and immediacy of face-to-face relationships. Nevertheless, nurses' ability to harness technology in this context illustrates their remarkable resilience and adaptability as they navigated and redefined their lived spaces amidst unprecedented challenges.

Nurses' social experiences during the pandemic were characterized by their evolving narratives, as they sought to make sense of their roles and relationships. According to McAdams' Narrative Coherence Theory (NCT), individuals construct narratives to understand and find meaning in their lives (McAdams, 2006). Nurses' stories during the pandemic were marked by shared experiences, resilience and empathy, which promoted a sense of continuity and coherence in their professional and personal identities. This narrative process represents the synthesis of lived other, where nurses combined their interpersonal relationships with their broader sense of self.

iii. Fusion of Horizons Integrating Social Experience

Fusion of horizons for nurses during the pandemic represents the connection between lived time, lived space and lived other, creating a comprehensive understanding of their social experiences.

Nurses' sense of lived time influenced their social interactions, as past experiences affected how they responded to the existing caregiving challenges and their hopes for the future guided their aspirations. The pandemic drove them to confront uncertainty and adapt to changing circumstances, leading to a more profound appreciation of time and the significance of relationships.

The disruption of lived space obliged nurses to find new ways to connect with others, both professionally and personally. By adapting to virtual spaces, they maintained their social bonds and nurtured relationships, even with the constraints imposed by physical distancing and isolation. This adaptation reflects the dynamic integration of lived space, where nurses transformed their environments to sustain human connections.

The experiences of nurses during the pandemic were apparent by changing relationships with colleagues, patients and family members. These experiences influenced their sense of identity and belonging, drawing attention to the significance of lived other. As they shared stories of resilience, compassion and growth, they developed a deeper understanding of their roles as caregivers and the importance of their relationships in shaping their journey.

The social experiences of nurses caring for COVID-19 patients in Sarawak can be understood through the integration of lived time, lived space and lived other, within the fusion of horizons framework. The altered perception of time, disruption of physical and social spaces, and changing relationships collectively formed their experiences during the pandemic. This fusion of horizons underlines how nurses past experiences, current challenges, and future aspirations combined to create a holistic understanding of their roles, relationships and identities, providing greater awareness of the complexities of their social experiences amidst the COVID-19 pandemic.

6.2.3 Objective 3: To Understand the Repercussions on the Lives of Nurses During the Pandemic in Sarawak

The experiences of nurses during the pandemic in Sarawak can be comprehensively understood through the integration of lived time, lived space and lived other, as these

existential structures influenced the profound impact of the pandemic on their lives. Fusion of horizons allows an investigation of how these components connected, influencing their professional identities, relationships and general sense of being.

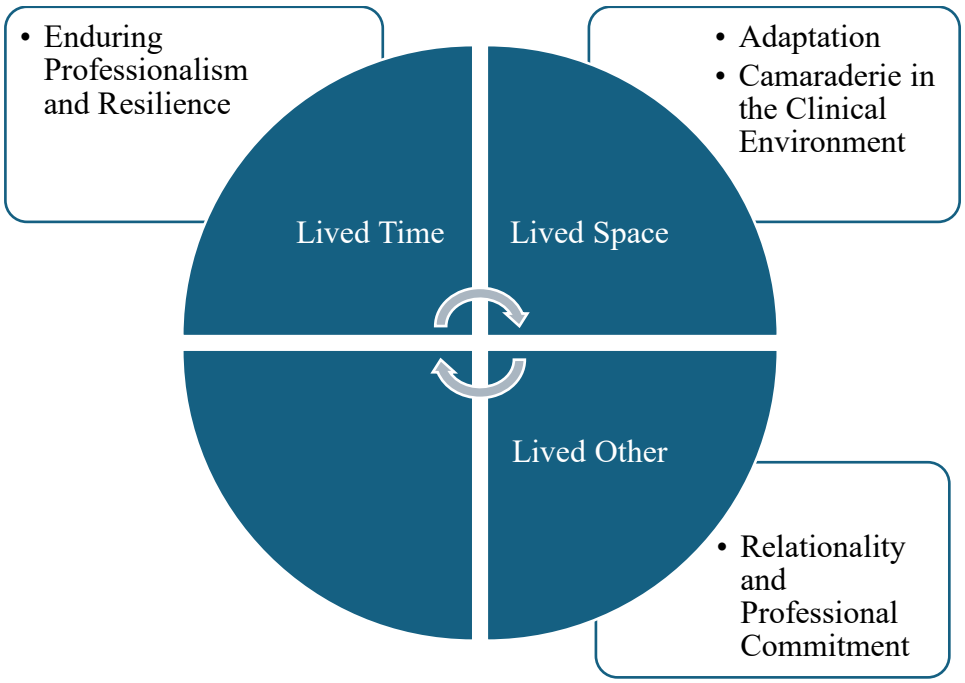


Figure 6.4: The Repercussions on Nurses' Lives in Sarawak During the Pandemic through the Integration of Lived Time, Lived Space and Lived Other

6.2.3.1 Lived Space: Adaptation and Camaraderie in the Clinical Environment

The spatiality of nurses' experiences during the pandemic had a vital role in influencing their sense of belonging, safety and identity. The concept of lived space reveals how nurses handled their environments, adapting to both the physical and emotional changes as they cared for COVID-19 patients.

i. Redefining Home and Workspaces

In terms of nurses, the concept of home underwent a profound transformation during the pandemic. Traditionally, home represented a space where they were surrounded by

family, feeling loved, secure and supported (Mallett, 2004). However, because of the transmissibility of the COVID-19 virus, many nurses were required to relocate to dormitories or hostels to protect their loved ones. As noted by Muz and Erdoğan Yüce (2021), this experience of separation from family and community, challenged their sense of belonging and emotional well-being. These temporary living spaces became additional homes, where nurses forged strong bonds with colleagues, sharing moments of both laughter and tears. This adaptation created a sense of belonging and camaraderie, allowing them to create a new "home" amongst the uncertainty of the pandemic.

a. Changes in the Clinical Space

The clinical environment, once familiar and routine, was profoundly reshaped by the pandemic. The implementation of strict protocols, the constant use of PPE, along with changes in attire shifted the dynamics of the workspace, transforming it into a place of both anxiety and solidarity. Nurses practiced exceptional caution and maintained heightened vigilance in response to the epidemic, continually adapting their practices based on changing information and policies (Liang et al., 2021). The shift from traditional white uniforms to scrubs and PPE not only signified the heightened risk and urgency but also promoted a sense of unity and shared purpose among nurses.

This phenomenon is in agreement with the findings obtained by Segev (2022), who examined civilian nurses deployed to Israeli battlefields in three wars between 1967 and 1982. In those demanding environments, nurses experienced moral distress and role blurring as they were required to adapt quickly to rapidly changing circumstances and assume responsibilities beyond their usual scope of practice. Similarly, the pandemic's spatial changes, while challenging, obligated nurses to adapt by developing flexible coping

strategies, acquiring new clinical skills and embracing roles that extended beyond their conventional duties.

Their ability to adapt in such demanding and unpredictable conditions indicates a high level of professional competence, psychological resilience and emotional intelligence. It also implies their commitment to patient care despite the personal risks and ambiguity. This adaptability suggests that nurses possess not only the technical expertise required for their profession but also the capacity for critical thinking, rapid decision-making and emotional strength in crises. Furthermore, the long-term impact of these experiences may include increased confidence in their abilities, a strong sense of professional identity and a renewed understanding of their role within healthcare systems during times of crisis.

b. Camaraderie and Shared Experiences

The phrase "*susah senang bersama*" (together in sickness and in good times) symbolises the profound sense of solidarity that emerged amongst nurses in this study. This sentiment denotes not just a vow of mutual support but also a validation of their shared experiences and collective resilience. It is in line with the findings of Thrysoee et al. (2022), where nurses similarly expressed that they were “in the same boat”, verifying the common challenges they confronted during the pandemic.

This sense of unity encouraged the development of a collective identity, as nurses perceived themselves as a cohesive team confronting a common enemy—COVID-19. Their solidarity acted as both recognition and appreciation of each other's sacrifices, hard work and emotional struggles. It validated their efforts, making them feel seen, valued and supported within their professional community, basically strengthening their morale and increasing their ability to cope with the immense pressures of the pandemic.

The clinical environment, as their shared lived space, transformed into a supportive setting where nurses offered each other emotional strength and comfort, supporting workplace relationships. This camaraderie significantly alleviated feelings of isolation, stress and burnout, stressing the importance of shared experiences in strengthening their professional roles as caregivers.

6.2.3.2 Lived Time: Enduring Professionalism and Resilience

The concept of lived time reveals how nurses' experiences during the pandemic were not confined to a linear timeline but were instead altered by their perceptions of past, present and future. As their social experiences were disrupted, the feature of lived time became prominent, influencing their lives as a whole.

i. Temporal Disruption and Uncertainty

The pandemic significantly blurred the boundaries of time for nurses, as extended work hours, quarantine measures and constant vigilance disrupted their sense of routine (see Chapter 4.2, Theme 1, Sub-theme 3: Physical and Mental Drain causing Workplace Burnout). Their perception of time became distorted, with shifts feeling seemingly endless, whilst the separation from family members contributed to a sense of timeless isolation. This altered experience emphasised the cyclical nature of their duties, where the start and end of each day often felt indistinguishable. Marey-Sarwan et al. (2022) draw a parallel between nurses' experiences during the COVID-19 pandemic and those of a period of war, as nurses were thrust into an unprecedented crisis beyond their control.

ii. Commitment to Duty and Professional Identity

Nurses exhibited an enduring sense of duty and professionalism, effortlessly integrating their past training with the demands of the present to manage the crisis (see

Chapter 4.2, Theme 5, Sub-theme 1: Embodying a Sense of Duty and Care Over Time). This commitment was not bound to conventional clock time but was deeply rooted in their dedication to patient care. This finding aligns with the study conducted by Schroeder et al. (2020), which highlighted that nurses not only embraced their roles during the pandemic as a professional obligation but also felt a deep connection to their patients and colleagues, further strengthening their commitment to frontline care delivery. Drawing from their past experiences, nurses adapted to the shifting landscape and projected their potentiality-for-being into the future, determining their identities as compassionate and resilient caregivers.

Nurses also significantly in reflection and experienced post-traumatic growth (see Chapter 4.2, Theme 5, Sub-theme 3: Practising Self-Stewardship and Well-Being). They processed their experiences and established meaning in the challenges they met, echoing the findings of Thrysoee et al. (2022). This reflective phase, represented by introspection, allowed them to reconcile their past struggles with their present achievements and future aspirations. This process represents the fusion of horizons, where their lived time combined with their developing sense of self, resulting in post-traumatic growth and a more profound appreciation of their roles as nurses.

Self-reflection during the COVID-19 pandemic occurred as a fundamental process for nurses, letting them to assess the impact of their experiences on their professional identities and emotional well-being. Many nurses reevaluated their self-perception, experiencing both pride and vulnerability in their roles while acknowledging the emotional toll of their work. This introspection produced shifts in behaviour and attitudes, prompting a reassessment of priorities in both their personal and professional lives (Alrasheeday et al., 2023). Principally, self-reflection permitted a forward-looking perspective, with nurses

expressing hope for improved working conditions and mental health support, which contributed to their resilience in handling the challenges of the pandemic.

6.2.3.3 Lived Other: Relationality and Professional Commitment

The relational aspect of nurses' experiences or the lived other, exhibits how their relationships with patients, colleagues, superiors and family members were affected and modified during the pandemic.

i. Hierarchies, Stereotypes and the Cultural Struggle for Nursing Autonomy

Throughout the COVID-19 pandemic, nurses in Malaysia confronted countless challenges created by entrenched hierarchical structures and persistent societal stereotypes. These dynamics significantly influenced staffing decisions, the distribution of work and the broader experience of professional autonomy.

In particular, single nurses were often ordered to participate in frontline care based on assumptions about their personal responsibilities. One participant, Teresa (P.4), observed:

> *"... the first to be involved in caring for COVID-19 patients is mostly the nurse who is single. The superior will choose single people first."*

This practice reflects prevailing sociocultural norms in Malaysia, where women who constitute the majority of the nursing workforce are expected to contend with both professional duties and familial caregiving roles (Charney et al., 2015). Unmarried people were frequently perceived as more available to perform pandemic-related duties, given the assumption that they carried fewer domestic obligations (Tong et al., 2021). Likewise, the single nurses were always chosen because they were deemed to have fever commitments and they did not have the choice to refuse. It could also be argued that on occasions single

nurses actually put themselves forward to be on the frontline as they did not have families and because of altruism; selflessness, self-sacrifice, compassion, kindness, etc. These perceptions, in conjunction with the top-down decision-making common in hierarchical institutions, underlines the need for future pandemic preparedness protocols to consider equity, inclusivity and sociocultural sensitivities in workforce deployment.

Teresa's account also reveals how nurses were constrained by rigid hierarchies and expected to comply with instructions without objection. She shared:

> *"…We need to follow the instructions from the boss, even if we want to be disobedient, we can't. We are subordinates."*

This statement illustrates the enduring stereotype of nurses as subordinates; a perception historically rooted in the "handmaiden" image, where nurses are regarded as assistants to doctors rather than autonomous professionals. This stereotype is particularly pronounced in patriarchal and collectivist cultures, where gendered expectations and professional hierarchies meet to underpin the image of nursing as a subordinate, female-dominated profession (Garcia & Qureshi, 2022).

Malaysia's healthcare system operates within a high Power Distance culture (Hofstede, 2011), where hierarchical relationships are strongly upheld and authority figures such as doctors and nurse managers are rarely questioned. These values are sustained by societal and cultural expectations that emphasise respect for authority and structured roles (Shariff et al., 2010). In these particular settings, decision-making is often centralised, leaving junior staff with a limited voice in clinical discussions. Nurses are expected to comply with orders, even when asked to perform tasks beyond their usual responsibilities, a

situation that exacerbates feelings of powerlessness and professional stagnation (Summers et al., 2014).

The psychological impact of this hierarchical structure is substantial. Nurses may resist additional responsibilities not due to unwillingness, but as a self-preservation mechanism. The physical and emotional burden of pandemic caregiving, compounded by limited recognition and constrained agency, repeatedly leads to emotional exhaustion. The repetitive, task-oriented nature of their roles may further magnify feelings of disempowerment, diminishing their sense of professional worth and autonomy.

These structural dynamics are particularly salient in Sarawak's multicultural context, where the complex relationship between ethnic, religious, and cultural values affects workplace interactions. For example, Islamic principles emphasise leadership grounded in moral integrity, accountability and respect for authority (Haq, 2020). In practice, this may translate into organisational environments where questioning superiors is culturally discouraged, and deference to hierarchy is the norm (Etty Harniza et al., 2020). Consequently, junior nurses may feel hesitant to voice concerns or share alternative perspectives, even when their input could augment patient care.

Addressing these challenges requires the cultivation of psychologically safe workplaces that promote open communication, inclusive leadership and shared decision-making. Particularly in multicultural and hierarchical systems such as Malaysia's, healthcare managers must actively dismantle harmful stereotypes and encourage environments that empower nurses to contribute implicitly to clinical decisions. Improving professional autonomy not only improves staff morale but also strengthens the quality and safety of care delivery.

ii. Building Professional Relationships

As nurses from various wards converged to work in the isolation units during the pandemic, they initially experienced a sense of discomfort due to unfamiliarity. However, this quickly progressed into a sense of solidarity as they collaborated to provide care for patients affected by a novel infectious disease. The expressions "*susah senang bersama*" (together in sickness and in good times) and "in the same boat" encapsulate this shared experience, demonstrating the deep sense of unity and resilience they developed as they experienced the challenges of the pandemic together.

The experience of working side by side stimulated teamwork and collaboration among nurses and other healthcare professionals. Irrespective of the challenges posed by the hierarchical healthcare system, nurses valued their relationships with colleagues, finding vital support and solidarity in these connections. This camaraderie not only helped them deal with the highly-stressful environment but also established mutual trust and respect. By respecting each other's contributions, nurses enhanced their professional relationships, raising them to a level where confidence in one another became necessary. This mutual dependence strengthened their ability to cope with the emotional and physical demands of the pandemic, stressing the key role of teamwork in rising above adversity.

iii. Maintaining Connections through Technology

Nurses in this study, similar to those in previous research (Kang et al., 2018; Sun et al., 2020), discovered significant support from their social environment and families during the COVID-19 pandemic. They coped with the outbreak by expressing their emotions through sharing sessions with peers, engaging in virtual communication with family, and using music and singing as outlets.

The concept of connectivism emerged as a vital aspect of the "lived other," where nurses depended on technology to maintain relationships with family and friends. Video calls, messaging apps and social media became essential tools to sustain connections and provide emotional support regardless of the physical distancing measures. This technological adaptation not only enabled nurses to preserve a sense of relationality but also lessened feelings of isolation during the pandemic.

Technology has become more than just an option to stay in touch; it is now an essential part of maintaining relationships. The expectation from family members to remain connected through digital means has become the norm, making technology a valued and indispensable tool as regards communication. For nurses, this shift stressed the importance of human connection, revealing how the integration of technology into their daily lives allowed them to nurture their relationships and receive emotional support during challenging circumstances.

6.2.3.4 Fusion of Horizons Demonstrating the Repercussion on Nurses' Lives

Fusion of horizons encapsulates how lived time, lived space and lived other come together to mould the comprehensive experiences of nurses during the COVID-19 pandemic, indicating the profound repercussions on their personal and professional lives.

Nurses' experiences were marked by the complex connection between temporal disruptions, spatial adaptations, and evolving relationships. Their perception of time was altered by long, demanding shifts, extended periods of isolation, besides blurring of boundaries between work and personal life. Simultaneously, they adapted to new physical environments, such as unfamiliar isolation wards, stringent protocols and living away from their families to minimise the risk of transmission. Alongside these challenges, relationships

with colleagues strengthened by way of shared experiences, while connections with family were maintained through technology notwithstanding the physical separation.

This integration of existential structures triggered a profound transformation in nurses' lives, stimulating resilience, empathy, and a deeper sense of purpose. The lived space of clinical settings, the lived time marked by uncertainty and endurance, as well as the lived other exhibited in their changing relationships collectively impacted their professional identity and commitment to caregiving.

The repercussions of caring for COVID-19 patients continue to influence nurses, leaving an indelible mark on their sense of self and purpose. Fusion of horizons permitted nurses to incorporate the lessons learned from the pandemic into their future aspirations, whether through advancing their careers, improving patient care, or redefining relationships with family and colleagues.

The experiences of nurses in Sarawak during the pandemic can be understood through the integration of lived time, lived space and lived other within the fusion of horizons. Their adaptation to physical spaces, disruption of temporal perceptions and the evolution of relationships mutually shaped their professional identities and sense of being. Exploring these interconnected existential structures affords a better understanding of the challenges, growth and resilience that defined nurses' lives during the pandemic, accentuating their enduring commitment to care, compassion and professionalism in conjunction with unprecedented adversity.

6.3 Incorporating Hermeneutics into The Findings: The World of the Nurse

As discussed in Section 3.1.3, Justification for Using Interpretive Research, the hermeneutic framework employed in this study is influenced by Heidegger (1962), Gadamer and Linge (1977), in addition to Van Manen (1990) to examine human experiences within the lifeworld. These philosophical perspectives provide a foundation to identify the lived experiences of nurses during the COVID-19 pandemic in Sarawak.

Heidegger's hermeneutic phenomenology is fundamentally centred on the concept of Being (Dasein), which represents human existence (Van Manen, 1990). This study, as an ontological investigation, endeavours to answer the following question: "What are the psychosocial lived experiences of nurses during the COVID-19 pandemic in Sarawak?" Heidegger's notion of Being-in-the-world (Dasein) is particularly relevant, as it acknowledges that individuals exist, act, and engage within the context of their personal, cultural and professional realities. In this study, the terms Dasein, Being and human beings will be used interchangeably to denote this sense of existence.

Van Manen (1990) expands on Heidegger's Being-in-the-world, emphasising that human beings are always embedded in a world formed by relationships, beliefs and cultural backgrounds. Nurses, in particular, experience their professional and personal worlds as connected areas that influence their actions, emotions and decisions. To truly comprehend their narratives, it is essential to interpret their experiences holistically, making sure that their voices are neither decontextualised nor trivialised. The essence of this research lies in allowing nurses to articulate their stories in their own words while maintaining the integrity of their lived meanings.

Expanding upon Heidegger's foundation, Van Manen (1990) introduced the concept of lifeworld existentials, extending the idea of Being-in-the-world to describe the fundamental structures of human existence. He identifies four key existentials: lived body, lived time, lived space, and lived other, that provide a structured framework to interpret the findings obtained by this study, presenting a comprehensive standpoint on nurses' psychosocial expereriences. Compared to Heidegger's broader existential approach, Van Manen's framework presents a more tangible and systematic guide as regards analysing lived experiences.

Gadamer's hermeneutics further enriches this interpretive framework by pointing out that understanding and interpretation are intrinsically connected (Annells, 1996). He speculates that one's present understanding is shaped by past experiences, and the future is continuously influenced by both past and present contexts (Spence, 2001b). This changing process of understanding, known as the fusion of horizons, signifies the ability to integrate new information via openness to different viewpoints (Gadamer, 2004). This approach features the dynamic and developing nature of interpretation, permitting a beneficial understanding as lived experiences are continuously re-evaluated against prior knowledge.

Reflecting on these philosophical perspectives, I posed the question: "What is a nurse's world?" As a profession, nursing is fundamentally about caring, nurturing and engaging in complex interactions with patients, colleagues and the healthcare system. Nurses' experiences are formed by their commitment to patient care, the challenges related to medical procedures, teamwork, and their role as advocates and educators. Within this context, their Dasein is defined by their responsibility to care for others, manage the

complexities concerned with health care environments, and manage the psychosocial demands of their profession.

In relation to this study, my engagement with the nurses' narratives represents an ongoing fusion of horizons between my pre-existing understanding and the changing interpretations formed through their stories. As I listened to and considered their experiences, I continuously questioned and considered the meanings embedded in their narratives. This interpretive process allowed me to remain open to uncovering new data, deepening the understanding of nurses' lived experiences within their Being-in-the-world.

Hence, Van Manen's existential concepts were chosen as the primary analytical framework, as they provide a structured and comprehensive approach to interpreting the findings, suggesting greater clarity compared to Heidegger's broader existential framework.

6.3.1 Lived Body (Corporeality): The Fragility and Fortitude of Being

Van Manen (1990) describes the lived body as the phenomenological reality that individuals are always bodily in the world, engaging with their environment through physical presence. This existential dimension acknowledges that the body is not merely a biological entity but a lived experience that shapes and is shaped by one's interactions, perceptions and emotions.

Regarding nurses, the lived body became a central facet of their experience during the COVID-19 pandemic. Previously, their bodies functioned as instruments of care—competent, composed, and attuned to routine clinical tasks. Movement was purposeful, grounded in familiarity and professional expertise. However, the onset of the pandemic dramatically altered this embodiment. The nurse's body became vulnerable, encased in

layers of PPE that restricted mobility and comfort. Prolonged use of masks, gloves and gowns caused skin to breakdown, pressure sores and persistent discomfort. The relentless physical demands; the long hours, extreme patient loads and continuous high-stress conditions, resulted in chronic fatigue, musculoskeletal pain and physical exhaustion.

In addition to these corporeal burdens, psychological distress was also inscribed on the body. Exposure to suffering and death, fear of contagion and prolonged social isolation triggered somatic manifestations, for instance headaches, sleep disturbances and irritability. Studies by Galehdar et al. (2020) and Rathnayake et al. (2021) reveal how emotional strain, burnout and secondary fatigue translated into both mental and physical symptoms. Touch, once a medium of healing and human connection was transformed into a calculated risk, further complicating the embodied experience of caregiving.

Post-pandemic, the nurse's relationship with the body remains marked by the traces of this ordeal. Recovery involves not only physical healing but also emotional recalibration. Greater attention is now given to self-care, rest and personal boundaries, as nurses become progressively aware of their bodily limits and the need for sustained resilience. While some may regain equilibrium, others may continue to experience long-term physical and psychological consequences, representing the enduring impact of their lived corporeal experiences.

The temporality of the lived body is also integral to this existential dimension. The past, fashioned by clinical knowledge and procedural familiarity, formed a stable foundation for practice. The present, during the height of the pandemic, demanded immediate bodily responsiveness during the chaos and uncertainty. The future is now visualised through the

lens of preparedness, bodily awareness and a renewed commitment to sustaining the self, alongside caring for others.

Thus, the lived body of the nurse during the pandemic became a position of vulnerability, endurance and transformation. It remains a powerful locus through which the complexities of caregiving, suffering and healing are embodied and made meaningful.

6.3.2 Lived Time (Temporality): The Disorientation and Reclamation of Temporality

Van Manen (1990) describes lived time as the subjective experience of time, how individuals perceive, interpret and make meaning of time based on their circumstances, emotions and existential realities. Unlike objective, clock-based time, lived time is fluid and exceptionally personal; moments of joy may feel fleeting, while periods of suffering may appear interminable. This existential temporality becomes particularly significant during moments of crisis, where the sense of time is often distorted.

Heidegger similarly views temporality as central to human existence, asserting that Being is fundamentally temporal. Human beings are historically situated; rooted in a past that informs their present and projected toward future possibilities that impact their identity and purpose. As Polt (1999) articulates, “We are rooted in a past and thrust into a future. We inherit a past tradition that we share with others, and we pursue future possibilities that define us as individuals. As we do so, the world opens up for us, and beings get understood.” This temporal structure emphasizes how Being is always experienced in relation to time, and how meaning arises when past experiences and future aspirations converge in the present.

The COVID-19 pandemic fundamentally disrupted nurses’ experience of lived time. Their pre-pandemic temporal orientation, structured around predictable shifts, routines and

care plans, collapsed into a continuous, disoriented present. The introduction of extended 12-hour shifts, patients who require close monitoring and rapidly changing protocols distorted their perception of time. Days blurred together, with minimal distinction between professional and personal life. Time was no longer experienced in a linear progression but as an exhausting cycle of relentless demands, doubt and emotional fatigue.

Nurses found themselves “thrown” from a familiar past into a chaotic present, where the future became both unknowable and anxiety-provoking. The temporality of the pandemic was discernible by way of urgency, loss and existential suspension, where planning was futile and each moment demanded immediate presence. Yet within this temporal disorder, moments of profound engagement surfaced, where the act of caring itself provided fleeting meaning and purpose during the chaos.

This reconfiguration of lived time also altered nurses’ developing professional identities. The pandemic became a defining life event, prompting reflection on career aspirations, personal values and long-term goals. Various nurses reconsidered their roles within the healthcare system, seeking career paths that offered greater work-life balance or a reduced emotional burden. Others developed a renewed sense of vocation, emerging from the crisis with a stronger commitment to patient care.

Although the acute crisis has passed, the imprint of that altered temporality remains. Nurses now reflect on time not merely as a schedule but as a horizon of meaning. The experience of being fully absorbed in the present during the pandemic has generated a greater appreciation for balance, intentionality and future preparedness. Accordingly, their temporal orientation has been reshaped—where the past holds lessons, the present demands presence, and the future invites cautious hope and reimagining.

The lived time of nurses during the COVID-19 pandemic reveals the profound ways in which temporal disruption influences human understanding, professional transformation and existential resilience. It explains how temporality is not only a backdrop to human action but an integral component of meaning-making in times of crisis.

6.3.3 Lived Space (Spatiality): From Healing Grounds to Zones of Risk

The existential concept of lived space emphasises that space is not merely a physical or geographical entity but a dynamic and relational dimension of human existence. According to Van Manen (1990), lived space describes to how individuals subjectively experience and engage with their environment, where space can evoke feelings of comfort, anxiety, security or isolation, depending on its meaning in a given context.

Heidegger, in Being and Time, expands on this notion by asserting that spatiality is not defined by measurable distance but by the meaningful engagement of Dasein—the human being—with its world. His concept of "ready-to-hand" objects illustrates that spaces and tools are not neutral but embedded in everyday practices, controlling how individuals interact with and make sense of their environments.

In terms of nurses, lived space encompasses more than the physical locations of hospitals, homes or hostels; it is a network of places that reveal and shape their Being-in-the-world (Van Manen, 1990). Prior to the COVID-19 pandemic, the hospital was experienced as a familiar space for caregiving; a structured and predictable environment where nurses cultivated clinical competence, teamwork and emotional connection. Equally, the home functioned as a sanctuary for rest, identity and family life, providing a clear boundary between professional and personal roles.

The onset of the pandemic, however, profoundly disrupted these spatial experiences. The hospital environment, particularly the Infectious Disease (ID) ward, was transformed into a space characterised by crisis, uncertainty and heightened alertness. Infection control protocols, the ubiquitous presence of PPE, along with social distancing measures restructured clinical routines and restricted human contact. Makeshift treatment zones and reconfigured layouts further contributed to disorientation, turning once-familiar spaces into environments of stress and alienation. The ward, once associated with healing and teamwork, became a space of vigilance and emotional strain, fundamentally altering how nurses perceived their work environment.

Simultaneously, the home, typically a space of comfort and belonging, also lost its protective quality. To reduce the risk of transmitting the virus, many nurses chose or were required to isolate themselves from their families. For some, this meant living apart; for others, it comprised coping with extreme hygiene practices and emotional distance within the household. The blurring of work-life boundaries transformed the home into an extension of the clinical space, marked by hyper-vigilance, anxiety and emotional fatigue. Instead of offering reprieve, the home became a place of constant tension and responsibility.

Lived space also embraces social and cultural dimensions. As Polt (1999) depicts, the “they-space” refers to environments shaped by collective norms and societal perceptions. During the pandemic, many nurses experienced stigma due to their association with infectious disease care. This public fear and misunderstanding extended into their communities, where some nurses encountered discrimination, avoidance and exclusion. These distressing experiences altered their sense of belonging and made previously welcoming spaces feel foreign and uninviting.

The COVID-19 pandemic therefore redefined nurses' lived spaces on multiple levels, specifically physically, emotionally and socially. The hospital, once structured and personal, became fragmented and isolating. The home, once restorative, became another source of stress. Social spaces, once familiar, became hostile. These spatial shifts underline the fluidity of lived space and how it shapes and is shaped by the existential experiences of those who inhabit it.

As the crisis abates, nurses are beginning the process of reclaiming and reimagining these spaces. This involves not only returning to familiar environments but transforming them—integrating lessons learned, prioritising safety and well-being, and restoring human connection. The task ahead lies in restoring a sense of groundedness in space and recovering meaning in the environments that frame nurses' personal and professional lives.

6.3.4 Lived Other (Relationality): Disrupted Relationality and Emergent Solidarity

The existential dimension of lived other denotes to the relational aspects of human existence—how individuals experience and understand themselves through their interactions with others. Van Manen (1990) emphasises that human beings are inherently relational, and that personal and professional connections fundamentally influence identity, emotional life and the meaning of one's experiences.

During the COVID-19 pandemic, this relational dimension became particularly salient for nurses, as their interactions with colleagues, patients and family members were profoundly reshaped by the crisis. The experience of being-with-others, once established in face-to-face connection and interpersonal care, was disrupted by the demands of infection control, emotional strain and evolving professional roles.

For many nurses, relationships with colleagues became a vital source of support and resilience. Extended 12-hour shifts, shared accommodation, quarantine protocols and high patient volumes resulted in stronger team dynamics. Within these constraints, nurses forged strong bonds with one another, frequently referring to their colleagues as an "extended family." The collective experience of enduring hardship together underpinned a profound sense of solidarity, portrayed by the phrase "*susah senang bersama*" (together in hardship and ease), which became a sustaining force throughout the pandemic.

At the same time, the high-pressure environment tested the limits of professional relationships. The relentless pace of work, fear of infection and ethical challenges led to emotional exhaustion, interpersonal conflict and occasional failures in terms of teamwork. While camaraderie strengthened some relationships, others were strained under the weight of fatigue, moral distress and organisational pressures, revealing both the resilience and vulnerability inherent in personal care during a crisis.

The nurse-patient relationship also underwent significant transformation. Infection control measures including the use of PPE, physical distancing and isolation protocols, created physical and psychological barriers that impeded emotional connection. The absence of touch, facial expressions and unrestricted interaction undermined the intimate and empathetic nature of nursing care. Nurses struggled to provide reassurance and presence through layers of protective equipment, often feeling that their ability to significantly connect with patients was diminished.

Moreover, nurses assumed the role of emotional surrogates for families who were barred from visiting their loved ones. They were tasked with delivering distressing news, offering comfort to dying patients and bearing witness to profound human suffering in the

absence of familial presence. This dual responsibility, providing clinical care while absorbing emotional burdens, intensified the psychological toll of the pandemic and reshaped the relational expectations placed upon nurses.

The personal challenges confronted by nurses cannot be examined in isolation from other existential dimensions. Lived time shaped relationality through temporal disorientation, extended shifts, unrelenting urgency and an uncertain future, all of which strained interpersonal engagement. Simultaneously, lived space transformed familiar environments into places of risk and alienation, further complicating how nurses related to others. Hospitals became zones of containment and vigilance, while homes, once associated with rest and connection, became places of hyper-vigilance or isolation. These overlapping dimensions intensified feelings of disconnection while also giving rise to new forms of solidarity.

In the post-pandemic context, nurses continue to deal with the aftereffects of these personal disruptions. While many are actively working to rebuild strained personal relationships, they also carry forward the sense of camaraderie and collective resilience established during the crisis. The pandemic illuminated the centrality of lived other in nursing, revealing how connection, empathy and mutual support are not merely emotional expressions but essential for professional identity and psychological well-being.

The pandemic exposed both the fragility and the strength of human connection. It challenged traditional forms of relationality while prompting new understandings of what it means to be present for others in times of crisis. As nurses evaluate their experiences, the enduring impact of these personal transformations continues to affect how they relate to their work, their communities and themselves.

6.3.5 A Horizon of Transformation

The onion diagram (see Figure 6.5) symbolically illustrates the layered and interconnected nature of Van Manen's four existential dimensions: lived body, lived time, lived space and lived other, as they unfold within the lived experiences of nurses during the COVID-19 pandemic. Each existential dimension, while distinct, connects to form a holistic understanding of nurses' being-in-the-world, exhibiting a complex and evolving professional and personal landscape manipulated by crisis.

At the core lies the lived body (corporeality), representing the embodiment of the physical and emotional toll borne by nurses. The experience of caregiving was demonstrated by fear, anxiety and exhaustion, made tangible through the physical discomfort of prolonged PPE use, extended shifts and psychosomatic symptoms such as fatigue and irritability. The body became both a place of vulnerability and resilience, as nurses managed their roles under constant threat of infection and psychological strain.

Encircling this is lived time (temporality), which presents the profound temporal disruption experienced by nurses. The pandemic fractured conventional routines, disintegrating the boundaries between professional and personal time. Nurses lived in an extended present, dominated by urgency and uncertainty, where the future felt suspended and the past seemed distant. Nonetheless, within this temporal chaos, nurses demonstrated remarkable adaptability, drawing strength from their clinical experience and projecting hope toward a reimagined future.

The next layer, lived space (spatiality), signifies the transformation of healthcare environments. Spaces once associated with healing and collaboration were reconfigured into high-risk zones governed by strict infection protocols. Isolation wards, restructured layouts

and the ubiquitous presence of PPE altered spatial dynamics, challenging nurses to preserve human connections within restricted and frequently alienating physical boundaries. Simultaneously, the home—traditionally a place of rest, became a place of vigilance or isolation, further blurring spatial distinctions between care and self.

The outermost layer, lived other (relationality), highlights the re-evaluation of interpersonal relationships. Nurses' connections with patients, colleagues and family members were noticeably affected by the pandemic. While physical barriers and social stigma hindered traditional relational engagement, shared hardship stimulated a renewed sense of solidarity and camaraderie among healthcare teams. Nurses also assumed new emotional roles as intermediaries between patients and their families, intensifying the personal demands of their profession.

Through the lens of Van Manen's existentials, the world of nursing emerges not as a static profession but as a dynamic existential journey impacted by disruption, resilience and transformation. Heidegger's concept of Dasein is particularly resonant in this context, as nurses were not simply passive responders to crisis but beings thrown into an altered world, seeking meaning in the course of uncertainty. The fusion of horizons between philosophical comprehension and lived reality reveals that, although the pandemic shattered familiar structures, it also created space for growth, authenticity and renewed purpose.

This phenomenological interpretation explains the transformative potential embedded in suffering and care, offering a better understanding of how nurses continue to reconstruct their identities, relationships and professional worlds in the aftermath of crisis.

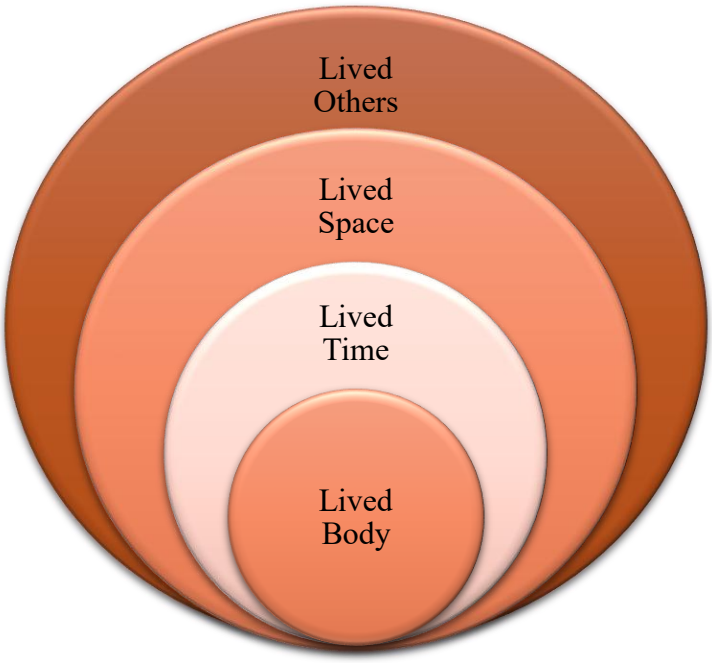


Figure 6.5: Fusion of Horizon Incorporating Nurses' Psychosocial Lived Experiences During COVID-19

6.4 Implication

The occurrence of COVID-19 impacted nurses and community life. The implications for nursing practice, health policies and future research are required, emphasising the importance of supporting and understanding the needs of healthcare workers in challenging circumstances. Following the release of the research findings, the following implications are made.

6.4.1 Nursing Practice

The COVID-19 pandemic posed unprecedented challenges for nurses, including increased workloads, heightened stress and anxiety, and a sense of social disconnection. As highlighted by Chemali et al. (2022) and LoGiudice and Bartos (2021), understanding these challenges is crucial to identify gaps within the healthcare system and increase preparedness

for future public health emergencies. Addressing these gaps can facilitate the development of evidence-best-strategies and best practice for more effective crises management.

The findings of this study accentuate the important need to comprehend the multifaceted challenges nurses faced during the pandemic while emphasising the importance of safeguarding their well-being and professional satisfaction. A comprehensive, proactive approach that includes recognition of nurses' contributions, workplace safety, resilience training, mental health support, leadership development, environmental improvements, equitable compensation and robust pandemic preparedness is imperative. These measures are fundamental to developing a resilient, motivated nursing workforce capable of meeting the evolving demands of contemporary healthcare.

6.4.1.1 Better Recognition of Nurses' Contributions

Nurses have a fundamental role to play in regards to delivering high-quality patient care, particularly during public health emergencies. Notwithstanding their critical contributions, nursing efforts are often undervalued within healthcare systems globally. To address this disparity, healthcare institutions should implement structured recognition programmes, promote clear career progression pathways, and provide access to specialisation training. These initiatives not only support professional growth but also instil a sense of pride and purpose amongst nurses. Additionally, exploiting public platforms to raise awareness can further increase the visibility and societal status of the nursing profession.

The COVID-19 pandemic pointed out the indispensable role of nurses. In addition to providing direct patient care, many assumed additional responsibilities on account of staff shortages and stringent infection prevention protocols (Nelson et al., 2023). Delegating non-

specialised tasks such as cleaning and meal delivery to support staff would allow nurses to focus on their core clinical responsibilities, improving resource allocation and make healthcare more effective.

Documenting nurses' experiences during the pandemic is equally vital. These narratives would be instrumental in professional acknowledgment, inform future crisis preparedness and support knowledge transfer. In Malaysia, former Health Minister Khairy Jamaluddin publicly commended nurses' dedication during the pandemic and advocated for greater professional recognition (Dawn, 2022). In doing so, he boosted morale and strengthened nurses' sense of identity.

Promoting advanced education, particularly through master's and doctoral programmes, presents a significant avenue to develop the nursing profession. Globally, many countries have adopted the bachelor's degree as the minimum qualification for pre-registration nursing education. In contrast, Malaysia offers two basic pathways: the Diploma and the Bachelor of Nursing programmes. While diploma holders constitute the majority of the nursing workforce, the bachelor's degree programme was only introduced in 2003. Post-registration specialisation in Malaysia is pursued through Post Basic (six-month) or Advanced Diploma (twelve-month) courses, predominantly offered by the Ministry of Health and selected private institutions (Mohd Ali et al., 2024).

Specialisation and post-basic training play a crucial role in boosting clinical competency and supporting career progression. According to Benner (1984) model clinical competence develops progressively from novice to expert by way of accumulated experience and education. The Malaysian Ministry of Health encourages all nurses to complete at least one post-basic course to strengthen their clinical skills (Balang & Fradelos, 2021). In

response to changing healthcare demands, private colleges have also introduced new post-basic training designed to provide nurses with specialised knowledge, technical proficiency and the appropriate professional attitudes. Three out of ten nurses interviewed in this study had completed specialised training in midwifery, intensive care, and infection control respectively, bring attention to the need to promote post-basic education, specifically among nurses working in high-risk areas such as infectious disease wards.

As of August 31, 2023, Malaysia had 114,922 registered nurses, 78,118 in the public sector and 36,804 in the private sector (Lajiun, 2016). This represents a significant decline from approximately 193,000 registered nurses in 2016. At that time, only 10–20% held a nursing degree, and an even smaller proportion possessed advanced qualifications (Hana, 2023). In 2012, 90% of registered nurses held diplomas, while only 10% had earned degrees (Lim, 2012). These figures highlight the urgent need to increase educational opportunities and promote academic progress among nurses, so as to strengthen the capabilities and professionalism of the nursing workforce.

In Malaysia, ongoing attempts to update the professionalism of nursing focus on developing higher education, promoting specialisms and increasing clinical autonomy. Although the profession has undergone considerable development since the 1950s, it continues to strive toward meeting international standards (Balang & Fradelos, 2021). According to Sarawak General Hospital Director, Dr. Ngian Hie Ung, achieving full professional status requires nurses to possess the autonomy to make independent clinical decisions grounded in expertise (Natasha, 2022). This affirms the view that true professional recognition extends beyond academic credentials or job designations. It entails empowering nurses to exercise sound clinical judgment, make complex patient care decisions and assume

accountability for their practice. Autonomy is a hallmark of advanced nursing roles in many countries and is fundamental to establishing nursing as an equal and respected profession within multidisciplinary healthcare teams.

Public awareness of the diverse roles of nurses can be bolstered through targeted social media campaigns. These platforms operate as powerful tools to educate the public regarding the responsibilities nurses hold, including patient care, infection control, and health promotion (Sensor et al., 2021). Improving society's understanding of the contribution nurses make will help reform public perceptions, garner support for healthcare reform and strengthen nurses' influence on policy-making. Sharing evidence-based content and personal stories can also attract new talent, foster community support and advocate for improved compensation, career development and working conditions.

Acknowledging nurses' contributions through structured programmes, public advocacy and opportunities for professional development is essential to sustain a motivated and competent workforce. When nurses feel valued, their professional identity is strengthened, leading to increased job satisfaction, higher retention rates, and greater commitment to delivering better quality care. Essentially, these efforts enhance workforce stability and raise the standard of patient care throughout healthcare systems.

6.4.1.2 Enhanced Training in Resilience and Crisis Management

Public health emergencies have stressed the urgent need for comprehensive training in infection control, resource allocation and crisis management (Chau et al., 2021; Demir & Şahin, 2022; Zhou et al., 2021). As such, resilience and crisis management have become essential components of modern nursing education, furnishing nurses with the competencies they require to respond effectively during health crises. Integrating lessons learned from past

emergencies particularly the COVID-19 pandemic into nursing curricula can significantly strengthen the preparedness and adaptability of nursing professionals.

For instance, Dehghani et al. (2022) implemented a disaster nursing competency programme in South Korea, which focused on the knowledge, skills and attitudes essential for disaster response. The programme demonstrated significant improvements in participants' disaster knowledge, triage abilities and general preparedness. Similarly, in Saudi Arabia, nurses encounter numerous challenges throughout each phase of disaster nursing, including the limited development of the specialism and a lack of education, preparedness, research and clinical expertise (Al Harthi et al., 2021).

In Malaysia, incorporating a specialised course within the infectious disease unit is recommended to strengthen nurses' competencies in managing pandemic-related challenges. A valuable model is delivered by the University of the West Indies School of Nursing, a PAHO/WHO Collaborating Centre which developed a four-week training course during the COVID-19 pandemic to prepare nurses with critical care skills (PAHO, 2021). This blended learning programme combined virtual sessions with face-to-face clinical training and included modules on COVID-19 clinical care, the fundamentals of critical care, respiratory and renal management, infection control, plus a practicum in intensive care. Adopting a similar model in Malaysia would boost nurses' clinical preparation and resilience in future infectious disease outbreaks.

Additionally, simulation-based learning, interdisciplinary teamwork exercises and practical training encourage confidence and competence in managing complex healthcare challenges (Demir & Şahin, 2022). Hands-on practice in the use of PPE, infection control protocols and biohazard handling is paramount as regards workplace safety (Colgan et al.,

2019; Delaney, 2018). Continuous training in the use of PPE, nasopharyngeal swabbing, symptom recognition and specialised infection prevention measures strengthens preparedness in crisis situations (Tashkandi et al., 2021). For staff who fail PPE fit-testing, supplementary training in the use of Powered Air Purifying Respirators (PAPR) is essential to guarantee appropriate respiratory protection.

Equally important is the integration of psychological resilience training. Stress management workshops, mindfulness practices and simulation-based pandemic drills help nurses develop the mental strength needed to cope with high-pressure situations (Rathnayake et al., 2021; Zhou et al., 2021). Incorporating self-care strategies such as meditation, yoga and cognitive-behavioural techniques into training programmes can mitigate stress and prevent burnout (Kim, 2018; Shanafelt et al., 2020).

These holistic initiatives not only support nurses' mental and emotional health but also contribute to improved patient outcomes, reduced absenteeism, and a more sustainable and resilient healthcare workforce. Strengthening resilience and crisis management training is therefore vital in developing a competent, adaptable nursing workforce prepared to handle future health emergencies. A proactive, well-structured educational approach promotes individual and collective resilience, assuring the continuity and effectiveness of healthcare services during times of crisis.

6.4.1.3 Safer Work Environment

A safe work environment is essential to safeguard nurses' physical and psychological well-being, particularly during public health crises such as pandemics (Rutherford et al., 2019). During these times, nurses are regularly confronted with increased workloads, rapid changes in clinical protocols and the challenges of adapting to a drastically altered "new

normal" (Cook, 2020). These demands are further intensified by staff shortages, inadequate PPE, unfamiliar care settings and limited organisational support, all of which contribute to increased stress levels and compromised job satisfaction (Maben & Bridges, 2020).

The COVID-19 pandemic confirms the urgent need for comprehensive and sustained safety measures within healthcare systems. These include the consistent supply of high-quality PPE, ongoing infection control training and ergonomic workplace designs. These measures are vital to reduce workplace hazards, enhancing clinical performance and establishing patient safety (De Vera & Nero, 2020). However, prolonged use of PPE introduced additional challenges, including excessive sweating, fatigue, skin irritations and respiratory discomfort (Kabunga & Okalo, 2021). These issues draw attention to the need for innovation in PPE design to achieve a balance between effective protection and user comfort.

Maintaining optimal nurse-patient ratios is also critical to ensure a safe and effective work environment. As of 2024, Malaysia's nurse-to-patient ratio stands at 1:279 (Jayakumar, 2024), far below recommended standards. High patient loads are associated with fatigue, increased risk of clinical errors and reduced job satisfaction, factors that ultimately compromise the quality of care. Strategic workforce planning, evidence-based staffing models and flexible planning policies are essential to meet varying patient acuity levels. Moreover, reducing 12-hour shifts to 8-hour rotations can help ameliorate nurse fatigue while maintaining adequate staffing (Shwe et al., 2021).

A holistic approach guaranteeing a safe and effective working environment also encompasses competitive remuneration, fair salaries and equitable opportunities for career development (Soh et al., 2023). In Malaysia, diploma-qualified nurses in Grade U29 earn a

starting salary of RM1,797 per month, whereas bachelor's degree holders are eligible for Grade U41 with a salary of RM2,426. However, the limited availability of U41 positions forces many degree holders to remain in lower-paying roles (Public Service, 2023). This inaction in relation to salary structures has contributed to workforce attrition and the migration of skilled nurses to higher-paying countries. For instance, newly graduated Malaysian nurses in Singapore earn approximately SGD3,000 monthly, compared to only about SGD670 in Malaysia (Augustin, 2017). Addressing wage disparities is crucial to improve job satisfaction, retain talent, and guarantee the sustainability of the workforce (Catton, 2018).

In response to the pandemic, the Malaysian government introduced a RM600 monthly risk allowance for nurses in direct contact with COVID-19 patients. This financial incentive was widely regarded as a significant recognition of the risks undertaken and helped ease financial burdens (Guldbrandsson & Bremberg, 2020). Financial support of this nature acts not only as a form of appreciation but also as a motivating factor that boosts staff morale and willingness to work in high-risk settings.

Work-life balance is an additional critical component of a safe work environment. Strategies such as limiting work beyond designated hours, offering flexible schedules, and implementing stress management programmes help reduce burnout (Menschner & Maul, 2016; Ross et al., 2017). Nurse leaders can further support these efforts by modelling healthy behaviours, promoting peer support and implementing initiatives such as regular, organised meetings and wellness check-ins.

Psychological safety in the workplace is a key component of a supportive and healthy working environment. It is imperative that nurses feel empowered to express concerns, share

ideas and propose improvements without fear of reprisal or negative consequences. However, findings from this study suggest that their well-being is not always guaranteed. For instance, Malik (P5) expressed hesitation in disclosing genuine problems to a manager, citing fears of stigma and judgment from colleagues. This indicates a persistent perception among staff that revealing mental health struggles may negatively impact their professional standing. These findings are consistent with those of Maben et al. (2022), who reported that nurses repeatedly experienced difficulties in acknowledging the extent of their struggles. Many delayed seeking support until it became absolutely necessary, frequently resorting to anonymous channels to do so.

Effective leadership is fundamental to establishing and sustaining a psychologically safe and supportive work environment. Transparent leadership practices, regular feedback and interprofessional collaboration are key strategies that encourage trust and promote a culture of openness (Rushton & Pappas, 2020). This sort of environment encourages teamwork and knowledge-sharing, which not only bolsters staff engagement but also supports nurses' roles in clinical decision-making (Lacerenza et al., 2018; Rosen et al., 2018). Nurse managers play a key role in forming this culture by promoting adaptability via intellectual stimulation, individualised support and open communication (Andreasson et al., 2016).

A positive and supportive work environment significantly impacts nurse retention, job satisfaction and morale (Morsiani et al., 2017). Effective supervision, typified by strong communication and emotional intelligence, improves both team dynamics and patient care outcomes (Boamah et al., 2018). Continuous professional development—through training workshops, mentorship and assistance with tuition for further education strengthens nurses’

clinical competence, augments their professional identity and assists to workforce resilience (Mohd Ali et al., 2024).

Inherently, creating a safer work environment demands an integrated approach that addresses physical, psychological and professional aspects of nursing practice. Investment in safety measures, equitable remuneration, adequate staffing and ongoing development opportunities increases nurse's well-being, reduces turnover and improves the quality of care delivered across healthcare systems.

6.4.1.4 Empowering Nurses in Leadership Roles

The COVID-19 pandemic provided nurses with an essential opportunity to demonstrate their leadership skills. It also functioned as a crucial lesson, emphasising the need for nurses to be well-prepared with leadership skills for future healthcare challenges.

Healthcare systems should actively include nurses in leadership, planning and decision-making processes, as their clinical expertise provides beneficial information to improve the delivery of care and workforce management (Mlambo et al., 2021). Empowering nurses with leadership responsibilities enhances professional autonomy, strengthens decision-making processes and aids improved patient care outcomes. To achieve this, healthcare institutions must implement structured leadership development programmes that furnish nurses with the skills necessary to assume supervisory and management roles. These courses should include training in critical areas such as decision-making, communication, conflict resolution and strategic problem-solving to prepare nurses for the complexities of modern healthcare environments.

Incorporating nurses into policy development and decision-making forums determines that healthcare protocols and practices are informed by the practical knowledge

gained from frontline experiences. Nurses' individual perspectives are conducive to more pragmatic and effective policies, improving the delivery of care. Likewise, encouraging interdisciplinary cooperation among nurses, physicians and other healthcare professionals can further improve communication, encourage teamwork and boost patient outcomes (Jordan et al., 2022). Collaborative decision-making not only improves healthcare practices but also underlines the importance of nurses' contributions to the effectiveness of systems in general.

Promoting nurses' active participation in evidence-based practice and shared decision-making processes enables their confidence and professional autonomy to increase (Rahmah et al., 2021). Effective empowerment strategies should provide nurses with access to essential resources, continuous learning opportunities, in addition to leadership training courses. Workshops focused on critical thinking, stress management and leadership competencies are essential to assist nurses to cope with the dynamic challenges associated with healthcare settings. Additionally, mentoring programmes that pair less experienced nurses with experienced nurse managers can provide practical guidance and promote long-term professional growth (Boamah & Tremblay, 2018).

In the Malaysian healthcare context, nursing teams operate as interdependent units with complementary skills, which work in partnership to achieve shared goals (Azizan et al., 2017). These teams comprise members with different levels of expertise and responsibilities, working collectively to improve patient outcomes. Leadership within these teams is typically undertaken by senior nurses, commonly referred to as “Sisters” or supervisors who demonstrate effective communication, knowledge-sharing, and supportive leadership (Afsar & Masood, 2018).

Nurse supervisors play a key role in planning, organising, directing and controlling nursing services within healthcare institutions (Aydogdu, 2023). Their responsibilities require the application of technical, human and conceptual skills to ensure effective unit management. However, in their daily routines, nurse supervisors typically encounter challenges related to leadership styles, ineffective communication, and conflicts with multidisciplinary team members, patients or their families (Ferreira et al., 2019). Considering these challenges, effective nurse leaders coordinate a cohesive and positive work environment by empowering team members to take ownership of their roles and contribute to the delivery of quality patient care.

Supporting nurses to accept leadership roles requires more than professional training; it demands the establishment of supportive institutional structures that value and incorporate nurses' voices in decision-making processes. Healthcare institutions should implement formal mechanisms for nurse representation in policy development, strategic planning and healthcare governance. This includes involving nurses in hospital-wide and governmental healthcare committees such as health coordination committees and task forces for specific initiatives, as well as appointing them to leadership positions at national and regional levels to make certain that nursing perspectives influence protocols and strategies (National Academies of Sciences et al., 2021). This would improve coordination, avoid the duplication of support and provide an opportunity for nurse leaders to understand the directives issued by the local partners.

This sort of involvement is crucial in guaranteeing that nurses' perceptions are incorporated into the development of policies that directly affect patient care and the well-being of staff. Nurse leaders should also be included in provincial coordination meetings and

key planning discussions, particularly during health crises and outbreaks (Nkowane et al., 2021). Prompt and active engagement allows nurses to make a worthwhile contribution to the identification of needs, formulation of response strategies, along with the implementation of nursing-related initiatives.

Promoting nurse leadership requires a comprehensive, strategic approach that encompasses targeted training, active participation in policy-making, psychological support and access to developmental resources. By developing a culture that values leadership and professional autonomy, healthcare institutions can increase workforce morale, boost the delivery of care and prepare nurses to effectively address future healthcare challenges.

6.4.1.5 Prioritising Nurses' Mental Health

The mental well-being of nurses is a critical determinant regarding clinical performance, sound decision-making and the overall quality of patient care. Prolonged exposure to demanding environments, particularly during public health crises such as the COVID-19 pandemic, places nurses at significant risk of psychological distress, including burnout, anxiety, and depression. These psychological burdens not only undermine the quality of care provided but also contribute to increased staff turnover, reduced job satisfaction, and weakened workforce resilience.

In this study, nurses reported experiencing ‘secondary fatigue’, profound psychological distress stemming from behaviours or the failure to act, in ways that contradict their moral or ethical values. This was manifested through feelings of despair, helplessness, hopelessness and guilt, particularly in situations depicted by resource scarcity. These findings are in keeping with the work of Griffin et al. (2024), who also identified similar emotional responses among healthcare professionals during crises. It is therefore imperative

to address and regulate the effects of early, secondary fatigue before they lead to long-term psychological harm and further compromise the healthcare workforce.

Chirico et al. (2021) proposed a two-pronged psychological intervention framework for healthcare workers. This included making certain they are given with adequate training, information and PPE; and second, strengthening their emotional coping skills to manage anxiety and uncertainty. Similarly, Zhao et al. (2021) emphasised the importance of managers being approachable, peer support and teamwork in boosting nurses' psychological resilience during the pandemic.

The pandemic brought to light the urgent need for accessible and comprehensive mental health support specifically created to tackle with the extraordinary pressures nurses experience. During the pandemic, many were overwhelmed by prolonged stress, emotional fatigue, and chronic understaffing. To deal with these challenges, healthcare institutions must implement structured psychological support systems. Effective interventions include mental health hotlines, on-site and virtual counselling services, peer support groups and regular debriefing sessions (Demir & Şahin, 2022; Liu et al., 2020). These mechanisms provide nurses with safe channels to process experiences, manage stress and develop emotional resilience (Kim, 2018).

Peer networks and mentorship programmes further reduce isolation, promote professional connections and support team cohesion (Kusumaningsih et al., 2019). Regular debriefings held weekly or monthly, offer confidential opportunities for reflection, while informal practices such as post-shift huddles, shared breaks and handovers aid ongoing peer engagement and support (Cole-King & Dykes, 2020).

To further strengthen individual coping strategies, nurses can be encouraged to adopt evidence-based stress-reduction techniques. The FACE COVID mnemonic provides a practical framework: Focus on what is within your control, Acknowledge thoughts and feelings, Come back into your body, and Engage in the present activity (Harris, 2020). Additional practices such as meditation, mindfulness, yoga and cognitive-behavioural strategies also boost emotional regulation and stress resilience (Cole-King & Dykes, 2020).

Endowing nurses with the ability to recognise and manage psychological distress within themselves and others increases both individual and collective well-being. Similarly, structured reflective activities such as journaling and guided group discussions provide significant opportunities for emotional processing and resilience-building (Van Manen, 2017).

Nurse leaders play a fundamental role in creating work environments that offer psychological support. Key leadership competencies include effective communication, interprofessional collaboration, appropriate staffing and the acknowledgement of staff contributions (Sihvola et al., 2022). Transparent, empathetic leadership has been proven to heighten staff well-being and develop organisational resilience. Nurse managers, in particular, must be adept at identifying mental health concerns and implementing appropriate interventions to alleviate the effects of prolonged stress and trauma (Cole et al., 2020; Hu et al., 2022).

Establishing a workplace culture that normalises mental health discussions is essential to reduce stigma and promote emotional well-being (Duncan, 2020). Leaders who keenly engage in mental health initiatives and demonstrate empathy exhibit supportive behaviour, empowering staff to seek help without fear of being judged. Leadership

development programmes focused on emotional intelligence, communication and conflict resolution are vital to prepare nurse leaders to proactively meet the mental health needs of their teams. A culture founded on empathy, respect and emotional well-being strengthens organisational trust and cohesion (Markey et al., 2021).

Promoting a work-life balance is also fundamental in regards to mental health support. Institutions should implement flexible scheduling, guarantee adequate rest periods, and offer wellness initiatives such as physical activity programmes and stress-reduction workshops. These measures are associated with greater job satisfaction, reduced burnout, improved retention and better patient care outcomes (Georgousopoulou et al., 2024).

Safeguarding nurses' mental health requires a comprehensive approach. This comprises accessible psychological support services, a stigma-free and empathetic workplace culture, emotionally intelligent leadership, the integration of mental health into education and training, together with institutional support for a work-life balance. Through these endeavours, healthcare institutions can safeguard the well-being of their nurses, reduce the turnover rate attributed burnout, resignations etc, and maintain the quality of patient care.

6.4.1.6 Extending Support Beyond the Workplace

Nurses' ability to fulfil their professional responsibilities is sunstantially influenced by external factors such as family obligations, logistical challenges and the need for a balanced personal life. Healthcare institutions must acknowledge this and implement comprehensive support systems that extend beyond the workplace to address these broader needs.

As discussed previously, nurse leaders play a central role in developing psychologically supportive environments. Important leadership competencies include

effective communication, interprofessional collaboration, appropriate staffing and the recognition of staff contributions (Sihvola et al., 2022). Furthermore, transparent and empathetic leadership promotes staff well-being and bolsters organisational resilience. Open communication, particularly during changes or crises, helps build trust and clarity within the workforce.

To support nurses holistically, managers should promote the development of positive psychological traits and encourage effective coping strategies. Key initiatives include providing regular rest days, rotating complex care assignments, simplifying access to professional mental health services and guaranteeing that managers are available for frontline staff (Shahrour & Dardas, 2020).

Flexible work arrangements are increasingly identified as vital in promoting work-life balance for nursing professionals (Shanker, 2022). Options such as flexi-time, self-scheduling and accessible childcare services empower nurses to align their responsibilities at work with personal and caregiving needs. Flexi-time allows staff to adjust their start and end times within set parameters, affording greater autonomy. Equally, self-scheduling enables nurses to select shifts that best suit their individual circumstances, increasing both control and job satisfaction.

Childcare support complements these strategies by addressing the practical needs of working parents (Shanker, 2022). On-site crèche facilities or nearby day nurseries ensure that children receive reliable care during working hours. These measures reduce stress and burnout while improving staff retention by accommodating diverse family responsibilities. In doing so, healthcare organisations are in favour of a more inclusive and resilient workforce, better equipped to maintain high standards of care.

Beyond formal institutional policies, peer support groups and community networks play a fundamental role in providing emotional support to nurses (Demir & Şahin, 2022; Liu et al., 2020). Social media platforms, in particular, have emerged as valuable spaces where nurses feel empowered to share their experiences with colleagues who have endured similar challenges. These networks afford a sense of solidarity, allowing individuals to exchange advice, consider shared struggles and access practical resources in a psychologically safe environment. Likewise, peer-led programmes encourage mutual understanding, collective resilience and a culture of emotional support that strengthens the general well-being of nursing professionals. Given the observed reticence among nurses to disclose personal difficulties to managers, there is a pressing need for short-term support mechanisms to exist independently of employers. Establishing autonomous support systems free from managerial referrals may encourage help-seeking behaviour and guarantee more equitable access to appropriate psychological support (Maben et al., 2022).

Supporting nurses' mental health and well-being requires a holistic, multi-pronged approach that tackles both workplace and external pressures. By providing accessible psychological services, promoting a work-life balance and offering family and logistical support, healthcare institutions can augment nurses' quality of life, improve job satisfaction, and assure sustained excellence in patient care. These initiatives prompt the development of a motivated, resilient nursing workforce capable of meeting current and future healthcare demands.

6.4.2 Policy and Preparedness

Effective policy and preparedness strategies are essential to safeguard the mental well-being of nurses and other healthcare professionals, particularly during public health

emergencies. Monitoring and reporting mental health concerns, for instance anxiety, depression, self-harm and suicide are imperative to enable appropriate interventions (Holmes et al., 2020). A comprehensive approach should address psychological coping mechanisms, physiological needs, for example sleep and nutrition, and structural factors, such as workload, shift patterns and timetabling, all of which impact general well-being.

During the COVID-19 pandemic, nurses were often required to work 12-hour shifts, which triggered physical exhaustion and emotional fatigue. Evidence suggests that reducing these extended shifts to 8-hour rotations can ameliorate fatigue and make care more effective (Morley et al., 2020; Shanafelt et al., 2020). In addition, healthcare institutions should implement transparent policies regarding special leave for high-risk nurses with underlying health conditions, as well as protocols to manage staff who test positive for COVID-19 or exhibit symptoms, support a sustainable workforce.

To create long-term psychological resilience among nurses, mental health support must be rooted in national nursing and workforce development policies. This includes normalising access to psychological services as part of routine occupational health, mandating regular mental health screenings particularly in high-stress units such as ICUs, emergency departments and infectious disease wards, in addition to offering flexible schedules or rotational breaks to reduce prolonged exposure to stress (National Academies of Sciences et al., 2021). Furthermore, incorporating mental health and resilience training into nursing education can prepare future professionals with essential coping strategies and self-care tools from the very beginning of their careers.

Strengthening healthcare infrastructure by means of policy reform is equally vital. Under the 12th Malaysia Plan, the government prioritises interdisciplinary teamwork to

improve the quality, safety and productivity of healthcare services. Aligned with this, Malaysia's National Mental Health Strategic Plan 2020–2025 emphasises the need to develop mental health preparedness and emergency response (MOH, 2020). Key initiatives supervised by the Ministry of Health (MOH) include the establishment of a national Psychosocial Support Helpline, Psychological First Aid (PFA) sessions, pre- and post-deployment mental health monitoring cards, along with the increased placement of counsellors in district-level clinics. Public awareness campaigns such as "Let's Talk Minda Sihat" aim to destigmatise mental health, while targeted training for first responders assists the management of suicidal behaviours.

To safeguard the mental well-being of nurses and other healthcare workers located at quarantine centres during the COVID-19 pandemic, the Ministry of Women, Family and Community Development launched the 24/7 Talian Kasih helpline (15999) (Ting et al., 2022). A total of 528 counsellors from the Malaysian Board of Counsellors and the Welfare Department were mobilised to provide psychological support for nurses experiencing emotional distress. In addition, psychological first aid (PFA) and suicide prevention training were conducted to give nurses the basic self-help strategies and skills they require to support their peers (Ting et al., 2022).

Nurses assigned to care for patients infected with COVID-19 received pre-deployment briefings to strengthen mental preparedness, given their higher risk of psychological strain. Secondary and tertiary prevention strategies included mental health screening using tools such as the DASS-21 and the Copenhagen Burnout Inventory to detect signs of distress or burnout. These screenings were followed up with individual phone counselling sessions and participation in physical support groups (Ting et al., 2022).

Demonstration videos with multilingual subtitles were also developed as visual aids to help nurses practise psychological coping strategies, including deep breathing exercises, grounding techniques, and good sleep hygiene (Ting et al., 2022). Additionally, psychiatric departments throughout each division in Sarawak established a dedicated Telegram group to disseminate essential updates, contact information for local health authorities, motivational quotes and mental health resources. This platform delivered interprofessional collaboration and connected nurses from various regions, enabling them to share resources, experiences, and emotional support while strengthening team solidarity.

Non-governmental organisations played a crucial role in supplementing these efforts. Befrienders Kuching, a volunteer-run non-profit organisation, continued to provide emotional support through phone and email for nurses experiencing psychological distress or in need of someone to talk to. The organisation compiled a directory of available psychological and counselling services from both government and non-government agencies, which was shared via social media platforms. This initiative provided much-needed support for nurses experiencing emotions such as sadness, anger, loneliness and helplessness. Furthermore, a microsite called Safe Haven was developed to complement the support directory, offering nurses a variety of stress-relieving activities such as arts and crafts, fitness routines, self-care resources and motivational content (Natasha, 2020).

Inter-agency cooperation further strengthened national preparedness through coordinated mental health promotion strategies targeting frontline nursing staff (MOH, 2020). Both digital and in-person interventions including QR code-accessible resources and helplines such as Befrienders assured timely access to mental health support. Nurse supervisors were also encouraged to remain alert for signs of burnout and psychological

distress among their team members, adopting proactive and responsive leadership approaches to promote emotional well-being and resilience.

A key policy recommendation is to revise the Nurses Act 1950 (last amended in 2006) and the Code of Professional Conduct for Nurses (1988) to establish a regulatory framework that more accurately replicates the changing role of the nursing profession particularly in terms of clinical autonomy, professional identity and how nursing has developed over time. Legislative reform should aim to strengthen nurses' decision-making authority, particularly during public health emergencies, where appropriate and independent clinical judgments are essential for effective patient care (Anisah et al., 2017). Increasing nurses' autonomy not only improves care outcomes but also promotes professional accountability, job satisfaction and relationships. In addition, the revised Act should include provisions for mandatory access to psychosocial support services, acknowledging the significant emotional and psychological burden borne by nurses during crises such as the COVID-19 pandemic. Recognising and institutionalising mental health support as part of professional rights would represent a critical step toward safeguarding nurses' well-being and maintaining a resilient healthcare workforce.

Strengthening the Malaysian Nurses Association (MNA) is also paramount to advance the nursing profession (Sowtali, 2019). As the nation's sole professional nursing body, MNA plays a vital role in advocating for nurses' welfare, promoting professional development, influencing policy and establishing competitive salaries and a work-life balance. By supporting workforce planning and leadership training, the MNA can contribute significantly to improved nurse retention and the development of a resilient healthcare workforce.

To maintain psychological well-being and the stability of the workforce, healthcare policies must include provisions for peer support, professional counselling and structured debriefing sessions (Z. Cai et al., 2020). The COVID-19 pandemic also accelerated the adoption of innovations such as telehealth, while highlighting the need for clear and efficient communication channels among healthcare professionals (Tashkandi et al., 2021).

Mandatory crisis preparedness training including simulation-based exercises in infection control, triage and disaster response should be integrated into ongoing professional development courses (Lababidi et al., 2021). Similarly, increasing opportunities for advanced education, such as post-basic certification and graduate-level training, will further professionalise nursing and improve the standard of care (Balang & Fradelos, 2021).

Strategic communication is another critical component of preparedness. Exploiting mass media and digital platforms to share nurses' personal experiences can encourage public empathy and highlight their vital contributions (Sensor et al., 2021). These storytelling initiatives not only transform societal perceptions of nursing but also influence health policy by generating public advocacy for workforce support and improvements in healthcare systems. Media-driven campaigns can also prompt policymakers to allocate resources more effectively and aid the rapid dissemination of accurate information during emergencies, supporting public trust and compliance.

A robust policy and preparedness framework requires a multifaceted approach encompassing mental health support, legislative reform, leadership development, strategic communication and continuous professional education. These coordinated attempts will strengthen the resilience, effectiveness and sustainability of the nursing workforce,

enhancing the ability of healthcare system's to respond to current and future public health challenges.

6.4.3 Future Research

The psychosocial experiences of nurses during the COVID-19 pandemic have provided useful data with significant implications for future research in nursing, public health and social sciences. This information can act as a foundation to guide research on pandemics and other large-scale health emergencies, basically contributing to more effective preparedness and response strategies.

Future research could focus on the development and evaluation of mental health interventions specifically adapted for nurses (Pountney et al., 2023). Focusing on issues such as stress, burnout, anxiety and depression experienced during crises is essential to safeguard nurses' well-being. Investigating resilience-building strategies and identifying effective coping mechanisms will be critical in enhancing nurses' capacity to adapt to future health emergencies.

Moreover, it is crucial to explore the long-term psychological effects of the pandemic on nurses, including the potential development of post-traumatic stress (Marcomini et al., 2021). Understanding these long-term impacts can help identify current support needs and inform the establishment of interventions designed to promote psychological recovery and resilience. This research will assure that nurses are more capable of managing the emotional demands of their profession in the face of future crises.

Adopting a longitudinal research approach is particularly important in this context, as it provides a systematic method to monitor psychological outcomes over time. A

longitudinal study enables researchers to observe patterns, identify causal relationships and analyse long-term outcomes rather than being dependent on a single point of observation. Monitoring the changing mental health status of nurses' post-pandemic through this type of study can generate valuable information into the factors that are conducive to sustained well-being or persistent distress (Pountney et al., 2023). Understanding these dynamics is essential to develop targeted, evidence-based support systems to address both the immediate and delayed psychological impacts. This long-term perspective principally nurtures a more resilient and better-prepared nursing workforce, which can manage the demands of future health crises.

6.5 Limitations

I began my first interview on 16th July 2021 during Phase 2 of the National Recovery Plan. The nurse manager instructed me to wear PPE, for instance a face shield and face mask during the interview as a precautionary method. Whilst wearing the face shield and face mask, I found it incredible difficult to observe the non-verbal response of the participant. But I had to follow order to protect both myself and the safety of the nurses. However, as there was a surge of the Delta variant in Kuching, I was forced to withhold the data collection until the new COVID-19 cases declined. Access to nurses was controlled because of hospital restrictions or safety protocols, which impacted me as a researcher and as a nurse.

Studying qualitative data from interviews can be time-consuming and complex owing to the subtle nature of human language. This includes accurately interpreting and presenting emotionally charged content without misrepresenting the participants' experiences. I had to carefully consider the context, tone and word choice used by the participants, while guaranteeing the anonymity and confidentiality of the participants.

As in most interpretive phenomenological studies, the study sample was kept small and purposefully selected against a set of predetermined criteria. This was carried out with the aim of validating that the collected data is beneficial and extensive so that the psychosocial experience of the nurses caring for COVID-19 patients could be clearly demonstrated. The small study sample of 10 nurses was too small to generalise to the wider population. However, generalisation is not the intention of this study, but rather it is aimed at explaining the inter-subjective psychosocial experience of a small group of nurses caring for COVID-19 patients in Sarawak, Malaysia.

It must be acknowledged that the translation is neither absolute nor finite, as interpretations are always influenced by one's pre-understanding. Heidegger (1962) asserted that people approach any given situation with preconceived viewpoints, interpreting experiences in light of prior knowledge and the context in which they find themselves. This suggests that qualitative research is inherently subjective and not definitive, as understanding is continuously situated within the hermeneutic circle. The pandemic was a dynamic situation, with rapidly changing experiences, making it challenging to obtain a complete representation of nurses' experiences at a specific point in time.

6.6 Conclusion

This Heideggerian hermeneutic phenomenological study has clarified the psychosocial lived experiences of nurses who cared for COVID-19 patients in Sarawak. Grounded in Martin Heidegger’s philosophical framework, the study adopted an epistemological stance that views individuals as self-interpreting beings who are meaningfully engaged with their world. In this context, language is not merely a tool for communication but a fundamental medium through which meaning is disclosed, interpreted

and shared. It acts as a vehicle to express lived experiences, creating space for reflection and interpretation by both the participants and the researcher. Moreover, it revealed the deeper structures of meaning embedded in human experience.

Data was collected through in-depth conversational interviews with ten purposively selected nurses and examined thematically. Five major themes emerged from the data, denoting the core structures of the nurses' psychosocial experiences: navigating the emotional and physical landscape of COVID-19 nursing care, experiencing social disconnection and isolation, adapting to workplace challenges, strengthening camaraderie in the healthcare environment, and upholding commitment and professionalism. These findings were further interpreted through the lens of Heidegger's four existential structures: lived body, lived time, lived space and lived other have provided a holistic understanding of the nurses' Being-in-the-world during the pandemic.

The Being of nurses is intricately woven into a temporal and personal web, wherein their past, present and future are interconnected. Nurses were "thrown" into a radically altered world as the pandemic disrupted their familiar routines, reshaped their professional identities and challenged their understanding of care. The healthcare world comprising the home, community and institutional systems, was no longer stable or predictable but transformed into a space filled with risk, urgency and emotional burden.

Before the pandemic, nurses experienced a world grounded in routine and meaningful engagement, where their caregiving roles were characterised by emotional presence, technical competence and supportive relationships. The onset of the pandemic shattered this world, threatening them with an existential crisis denoted by fear, isolation and secondary fatigue. Their lived time became disjointed, with disrupted shift cycles and

uncertain futures. Their lived space was redefined by isolation wards, PPE and restricted physical interaction, distancing them from both patients and colleagues. Regardless of these disruptions, nurses symbolised resilience and care, maintaining their roles by means of solidarity and professional dedication, signifying not only professional fortitude but also the moral strength that underpins the essence of nursing in times of crisis.

In the post-pandemic context, nurses continue to consider their transformed world. The crisis prompted a heightened awareness of mental health, self-care and professional meaning. The relationships forged during the pandemic, among colleagues, patients and within the self, have evolved into enduring sources of strength. This transformation illustrates the continued process of becoming, as nurses reinterpret their lived experiences and incorporate them into a transformed understanding of care.

It must be acknowledged that interpretation is an ongoing, evolving process, neither absolute nor final, as meaning continually emerges through reflection, context and the dynamic relationship between the interpreter and the interpreted. As Heidegger asserted, individuals approach any situation with pre-understandings that impact their interpretation of experience. Within this hermeneutic circle, understanding is continuously influenced by prior knowledge, contextual factors and the researcher's positionality. In this light, qualitative research is inherently interpretive and situated. The COVID-19 pandemic, as a dynamic and evolving phenomenon, further reinforces this difficulty. Nurses' experiences unfolded within a fluid context exhibited by shifting risks, changing protocols and fluctuating emotional landscapes, making it difficult to acquire meaning as fixed or universal. Significantly, this study offers a situated and temporal understanding of Being within a moment of crisis.

Viewed from the philosophical perspective of Dasein, the nurses' journey from pre-pandemic normalcy through crisis to post-pandemic reflection reveals not only the magnitude of disruption but also the depth of human adaptability and growth. This study contributes substantially to the understanding of the psychosocial experiences of frontline nurses in crisis settings, highlighting the need for institutional support systems that are attuned to the existential dimensions of care. While the COVID-19 pandemic was conspicuous for its extraordinary challenges, it also acted as a severe test, which in many cases, resulted in personal growth, affording powerful awareness of the processes of meaning-making, moral endurance and the enduring humanity at the heart of nursing.

6.6.1 My reflection

This study was motivated by a significant concern for the emotional, psychological and professional challenges encountered by nurses during the COVID-19 pandemic, predominantly in underrepresented regions such as Sarawak. As a nurse educator and researcher, I was compelled to explore how nurses made sense of their experiences while coping with an unprecedented health crisis that profoundly disrupted their personal and professional worlds.

Throughout the course of this study, I have come to appreciate the depth that phenomenology and hermeneutics provide in terms of understanding lived experiences. These philosophical and methodological traditions provide a foundation to uncover the structures of meaning that affect human existence. Heidegger’s hermeneutic phenomenology, particularly the concept of the hermeneutic circle, emphasizes that interpretation is never complete or objective but always formed by pre-understandings, cultural context and the dynamic relationship between the interpreter and the interpreted.

Understanding, therefore, is not a finite endpoint but an evolving process of meaning-making grounded in the temporality of human experience.

This study affords a distinctive contribution by applying Van Manen's four existential dimensions: lived body, lived time, lived space and lived other to explain the lived experiences of nurses within the culturally rich and diverse context of Sarawak. These existential structures permit a multidimensional examination of human experience, found in specific spatial, temporal and relational experiences. Sarawak's multicultural backdrop, with its diverse ethnicities, indigenous traditions and strong communal values, provides a fascinating setting to examine how nurses handle and make sense of crisis. This study therefore interprets experience as situated and evolving, with meaning formed by the fluid interactions of time, space, embodiment and relationships.

The COVID-19 pandemic, emerging a century after the Spanish flu, represents a decisive moment in the history of global health. Similar to previous pandemics, specifically the Asian flu (1957–1958) and the Hong Kong flu (1968–1969), COVID-19 profoundly impacted healthcare systems and redefined professional roles. For many nurses, this crisis became a life-changing event, reshaping their aspirations, identities and future paths within the nursing profession.

The interpretive process in this study acknowledges the distinction and interaction between participant and researcher. While participants live and express their experiences, the researcher engages in an interpretive dialogue with their narratives. This co-constructed process fosters new information that is both situated and significant, created by Sarawak's distinctive sociocultural landscape and the temporal unfolding of the pandemic. Although distinct, the perceptions of the participants and the researcher combine through reflection,

generating layered interpretations that illuminate the complexity of human experience in times of unprecedented crisis.

While the findings produced by this study may not be directly transferable across all cultural contexts, they nonetheless reveal experiences that are liable to resonate with nurses globally, particularly those who have been subjected to similar crises. I believe that articulating the psychosocial lived experiences of nurses can act as a powerful catalyst to influence more compassionate and responsive healthcare policies. This knowledge can boost awareness of the existential dimensions of nursing care, inform the development of targeted mental health support systems and strengthen the resilience of healthcare institutions. By giving voice to the often-overlooked experiences of frontline nurses, this study describes the importance of acknowledging the human aspects of caregiving and underlines the transformative potential of reflection, understanding and meaning-making amid uncertainty and adversity.

6.7 Summary

This chapter has presented a comprehensive discussion of the research findings in relation to the study's objectives. It has also provided recommendations concerning nursing practice, policy development and preparedness, as well as suggestions for future research. The chapter concluded by outlining the limitations of the study.

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APPENDICES

Appendix A: Ethical Approval from Faculty

Fakulti Perubatan dan Sains Kesihatan
Faculty of Medicine and Health Sciences

UNIMAS/NC-21.02/03-02 Jld.5 (92)

27 Julai 2021

Chen Ai Ling
Fakulti Perubatan dan Sains Kesihatan
Universiti Malaysia Sarawak
94300 Kota Samarahan
Sarawak

Puan,

Kelulusan Etika Untuk Penyelidikan:
Ethical Approval for Research:
- Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A Qualitative Study
NO. RUJUKAN ETIKA: FME/21/81
ETHICS REF. NO.: FME/21/81

Dengan segala hormatnya perkara di atas dirujuk.
The above matter is referred.

Sukacita dimaklumkan bahawa etika untuk penyelidikan seperti di atas telah **DILULUSKAN**. Penyelidik-penyelidik yang terlibat adalah seperti dibawah:
*Faculty Medical Ethics Committee, University Malaysia Sarawak (UNIMAS) has provided ethical **APPROVAL** for this study. The investigators involved in this study are:*

1. Chen Ai Ling (Penyelidik Utama/*Principal Investigator*)
   Universiti Malaysia Sarawak
2. Dr. Rekaya anak Vincent Balang (Penyelidik Utama/*Principal Investigator*)
   Universiti Kebangsaan Malaysia
3. Prof. Madya Dr. Manfred Mortell
   Universiti Malaysia Sarawak

Segala rekod dan data subjek adalah SULIT dan hanya digunakan untuk tujuan penyelidikan dan semua isu serta prosedur mengenai kerahsiaan data mesti dipatuhi. Kebenaran daripada Ketua Pusat Tanggungjawab di mana kawasan kajian yang terlibat mesti diperolehi terlebih dahulu sebelum penyelidikan dimulakan.
All records and data are to be kept strictly CONFIDENTIAL and can only be used for the purpose of this study. All precautions are to be taken to maintain data confidentiality. Permission from all relevant heads of departments/ units where the study will be carried out must be obtained prior to the study.

Untuk makluman, kelulusan ini adalah sah untuk tempoh bermula dari **Julai 2021** sehingga **Julai 2023** sahaja. Sebarang urusan surat-menyurat berkaitan dengan penyelidikan ini haruslah dinyatakan nombor rujukan kelulusan etika bagi melancarkan proses yang berkaitan.
*Please note that the approval is valid from **July 2021** until **July 2023**. The reference number for this letter must be stated in all correspondence related to this study to facilitate the process.*

Sekian, terima kasih.
Thank you with regards and well wishes.

Yang benar,
Regards,



Profesor Dr Lela Hj Su'ut
Pengerusi
Chairperson
Jawatankuasa Etika Perubatan
Medical Ethics Committee
Fakulti Perubatan dan Sains Kesihatan
Faculty of Medicine and Health Sciences
UNIMAS

Appendix B: Ethical Approval from Institution

Ver 3.0 September 2014 *NMRR/FORM/IAHODIA*

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT AND ORGANISATIONAL / INSTITUTIONAL APPROVAL
PERSETUJUAN PENYELIDIK DAN KEBENARAN KETUA JABATAN DAN PENGARAH ORGANISASI/INSTITUSI

This document is intended for online submission for formal research registration. It is issued as the Investigator's Agreement to participate in the research as well as the investigator's **Head of Department and Director's Approval.** Please upload this document in the required section in NMRR upon completion.
**Note: This form is NOT to be used for obtaining permission to conduct the research at the named / selected study site(s).

*Dokumen ini adalah untuk penghantaran 'online' mengikut prosedur rasmi pendaftaran penyelidikan. Borang ini dikeluarkan sebagai pengakuan penyelidik untuk menjalankan penyelidikan dan persetujuan serta kebenaran daripada **Ketua Jabatan dan Pengarah masing-masing**. Sila lengkapkan borang ini dan memuat naik ke dalam sistem NMRR di seksyen yang telah ditetapkan.*
***Nota : Borang ini BUKAN digunakan untuk tujuan mendapatkan keizinan untuk menjalankan penyelidikan di lokasi kajian yang dipilih.*

Research Title *[Tajuk Penyelidikan]*	Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A qualitative study		
Research ID *[Nombor Pendaftaran]*	58279	**Protocol Number (if available)** *[Nombor Protokol (jika ada)]*	

INVESTIGATOR'S AGREEMENT *[PERSETUJUAN PENYELIDIK]*

I have understood the above mentioned proposed research and I agree to participate as an investigator and being responsible to conduct the research.

Saya faham atas cadangan penyelidikan di atas dan bersetuju untuk mengambil bahagian serta bertanggungjawab untuk melaksanakan penyelidikan tersebut.

Name *[Nama]*	Chen Al Ling
IC number *[Nombor K/P]*	831017135444
Institute *[Institusi]*	UNIVERSITY MALAYSIA SARAWAK (UNIMAS)
Signature and Official stamp *[Tandatangan dan Cop Rasmi]*	CHEN AI LING Jururawat/U41 No. [illegible] FPSK, UNIMAS
Date *[Tarikh]* 3/2/2021	

HEAD OF DEPARTMENT AGREEMENT *[PERSETUJUAN KETUA JABATAN]*

I agree to allow the above named investigator to conduct the above titled research.

Saya bersetuju dan membenarkan pegawai seperti bernama di atas untuk menjadi penyelidik di dalam projek penyelidikan tersebut di atas.

Name of Head : *[Nama Ketua Jabatan]*	DR. REKAYA VINCENT BALANG
Signature and Official stamp *[Tandatangan dan Cop Rasmi]*	Dr Rekaya Vincent Balang Senior Lecturer DoN, FMHS UNIMAS
Date *[Tarikh]* 3/2/2021	

ORGANISATIONAL / INSTITUTIONAL APPROVAL *[KEBENARAN ORGANISASI / INSTITUSI]*

I acknowledge and approve the named officer to conduct the above titled research.

Saya mengesahkan dan mengambil maklum penglibatan pegawai ini di dalam penyelidikan tersebut.

Name of Director *[Nama Pengarah]*	
Signature and Official stamp *[Tandatangan dan Cop Rasmi]*	DR. NGIAN HIE UNG PENGARAH HOSPITAL HOSPITAL UMUM SARAWAK PAKAR PERUBATAN KESIHATAN AWAM NO. PPP: 32504, NO. NSR: 127655
Date *[Tarikh]*	3 Feb 2021

This is computer generated, Borang ini adalah cetakan komputer. [58279/14239/100342]

Appendix C: Ethical Approval from National Institute of Health (NIH)

JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN
(*Medical Research & Ethics Committee*)
KEMENTERIAN KESIHATAN MALAYSIA
d/a Kompleks Institut Kesihatan Negara
Blok A, No 1, Jalan Setia Murni U13/52,
Seksyen U13, Bandar Setia Alam,
40170 Shah Alam, Selangor.
Tel: 03-3362 8888/8205

Ref : KKM/NIHSEC/ P21-283 (4)
Date: **25-Feb-2021**

Chen Ai Ling
UNIVERSITY MALAYSIA SARAWAK (UNIMAS)

Dear Sir / Mdm,

ETHICS INITIAL APPROVAL: NMRR-21-127-58279 (IIR)
Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A qualitative study

This letter is made in reference to the above matter.

2. The Medical Research and Ethics Committee (MREC), Ministry of Health Malaysia (MOH) has provided ethical approval for this study. Please take note that all records and data are to be kept strictly **CONFIDENTIAL** and can only be used for the purpose of this study. All precautions are to be taken to maintain data confidentiality. Permission from the District Health Officer / Hospital Administrator / Hospital Director and all relevant heads of departments / units where the study will be carried out must be obtained prior to the study. You are required to follow and comply with their decision and all other relevant regulations, including the Access to Biological and Benefit Sharing Act 2017.

3. The investigators and study sites involved in this study are:

   HOSPITAL UMUM SARAWAK
   Chen Ai Ling (Penyelidik Utama)

4. The following study documents have been received and reviewed with reference to the above study:

Documents received and reviewed with reference to the above study:

1. Study Protocol_Version 3, dated 23-Feb-2021
2. Information Sheet & Informed Consent Form_English_Version 3, dated 23-Feb-2021
3. Information Sheet & Informed Consent Form_Malay_Version 3, dated 23-Feb-2021
4. Interview Guide_Version 1, dated 03-Feb-2021
5. Investigator's documents : Declaration of Conflict of Interest (COI), IA-HOD-IA, and CV:
   a) Chen Ai Ling (Penyelidik Utama)

Appendix D: Interview Guide

Study Title: The Psychosocial Lived Experiences of Nurses Caring For Patients With COVID-19 in Sarawak: A Qualitative Study

Opening

My name is Chen Ai Ling, I am a PhD candidate at UNIMAS. My research study is titled: "Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A qualitative study". I would like to ask you some questions about your experience of working during the COVID-19 pandemic in Sarawak. The face-to-face interview should take between 45 to 60 minutes. I will explain the rationale for the interview and the methodology and purpose of my data collection. Then, if you agree to participate in this face-to-face interview, I would like you to read and sign the informed consent before we start the session.

1. **Please tell me** about your career working as a nurse in Sarawak.

2. What do you know about the COVID-19 pandemic when it first affected Sarawak in January 2020?

Probe:

- Did you care for any patients affected with the COVID-19 virus?
- How were you involved in caring for patients affected with the COVID-19 virus?
- Have you had any education-based training in the management of patients affected with the COVID-19 virus?
- Did you feel this education-based training prepared you to meet the challenge when caring for a patient with the COVID-19 virus?
- Can you describe how you felt when you were caring for patients affected with the COVID-19 virus?

3. **Can you describe your workplace experience during the COVID-19 pandemic in Sarawak.**

Probe:

- What concerns, if any, did you have about providing patient care during the COVID-19 pandemic?
- What effect, if any, do you think the COVID-19 pandemic had on your work environment?
- Can you describe a typical day in the patient care environment during the COVID-19 pandemic in the context of 2020 and 2022?
- Can you recall and describe any unique situations or experiences that you encountered when you were caring for patients who were affected by the COVID-19 virus?

4. **Please describe your feelings and thoughts about the COVID-19 patients that you cared for during the pandemic.**

Probe:

- What coping strategies did you employ as a nurse during the COVID-19 pandemic?
- What concerns did you have as a healthcare provider during the COVID-19 pandemic?

- What was your motivation to continue working during the COVID-19 pandemic?
- How have your feelings changed in respect of the COVID-19 pandemic in the context of 2020 and 2022?
- What are the significant differences, if any, which have changed since your involvement in the care of COVID-19 patients?

5. Can you describe the social experiences you encountered as you cared for patients affected with the COVID-19 virus?

Probe:

- Can you explain whether your family and community time was affected during the COVID-19 pandemic?
- How did the COVID-19 pandemic effect your family members when they knew that you were required to care for patients with the disease?
- How did the COVID-19 pandemic affect your relationship with coworkers in your daily work environment?
- What effect do you think the COVID-19 pandemic had on your work environment?
- How is your relationship with 1) your spouse 2) children 3) parents 4) siblings 5) relatives 6) friends of friends 7) coworkers?

6. When you reflect on your experiences during the COVID-19 pandemic, what did you learn from your encounters?

Probe:

- What life experiences did you discover from your encounters during the COVID-19 pandemic?
- What source of support did you receive during the COVID-19 pandemic?
- Was the support provided during the COVID-19 pandemic adequate? Yes or no. Why?
- Would the support be adequate if there was another pandemic? Yes or no. Why?
- If not, what kind of support would be required?
- How do you feel that support resources (both material and human) were managed during the COVID-19 pandemic?

Closing

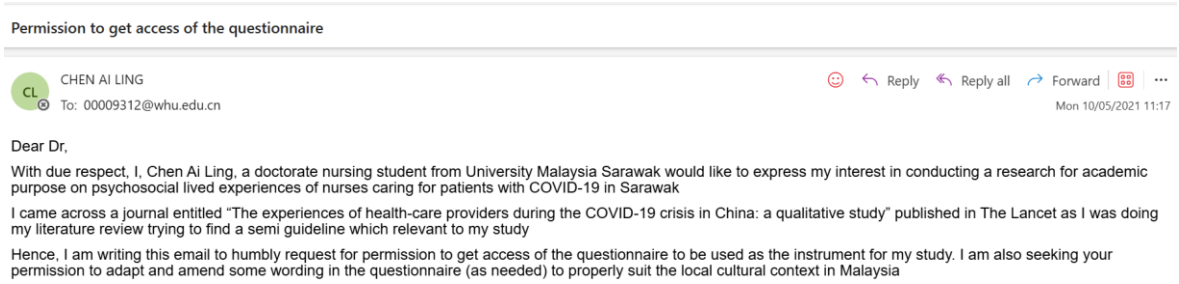
First and foremost, I want to express my sincere gratitude for your participation in the interview. Your presence has contributed significantly to revealing information about the pandemic in Sarawak, Malaysia. I truly appreciate your support and value your thoughts and insights as I reflect on your lived experiences during the COVID-19 pandemic.

Before we conclude this interview, let me briefly summarise our session. You mentioned…… Is there anything else you would like to add or think might be useful for this research project? Thank you very much again for your participation. If you have any questions, please contact me.

- End of Questions -

Adapted from Lam & Hung, 2013; Liu et al., 2020

Appendix E: Permission to Adapt Questions



Permission to get access of the questionnaire

CL CHEN AI LING

To: 00009312@whu.edu.cn

Reply Reply all Forward

Mon 10/05/2021 11:17

Dear Dr,

With due respect, I, Chen Ai Ling, a doctorate nursing student from University Malaysia Sarawak would like to express my interest in conducting a research for academic purpose on psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak

I came across a journal entitled "The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study" published in The Lancet as I was doing my literature review trying to find a semi guideline which relevant to my study

Hence, I am writing this email to humbly request for permission to get access of the questionnaire to be used as the instrument for my study. I am also seeking your permission to adapt and amend some wording in the questionnaire (as needed) to properly suit the local cultural context in Malaysia

Appendix F: Patient Information Sheet

PATIENT INFORMATION SHEET

TITLE OF STUDY
Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A qualitative study

PRINCIPAL INVESTIGATOR
Chen Ai Ling (19010127), UNIMAS PhD of Nursing Student

SUPERVISORS
Assoc Prof Dr. Rekaya Vincent Balang, Senior Lecturer, Faculty of Medicine and Health Sciences UNIMAS

INSTITUTION ADDRESS
Department of Nursing, Faculty of Medicine and Health Sciences, University Malaysia Sarawak, 94300, Kota Samarahan, Sarawak

NAME OF SPONSOR
No external funding

INTRODUCTION
It is important that you understand why the research is being conducted and what it will involve. Please take your time to read through and consider this information carefully before you decide if you are willing to participate. Ask the researcher if anything is unclear or if you would like more information. After you are satisfied that you understand this study, and that you wish to participate, you must sign this informed consent form.

This study has been approved by the Medical Research and Ethics Committee, Ministry of Health Malaysia.

THE NATURE AND PURPOSE OF THE STUDY
The purpose of this study is to explore the lived experiences of nurses working during COVID-19 pandemic in Sarawak. This research is necessary to improve the psychosocial experience of nurses during a pandemic.

STUDY DESCRIPTION
You understand that you are being asked to take part in nursing research that will require your consent and cooperation to be interviewed by the researcher. The researcher will need your permission to audio-record the interview. The interview may take approximately 30 to 60 minutes and consists of questions related to your experiences during the pandemic.

RISKS OF STUDY PARTICIPATION
Participation in this study will not affect you, and the risk is minimal. You are free to decline to answer any of the questions that you feel uncomfortable with.

POSSIBLE BENEFITS OF STUDY PARTICIPATION
The possible benefit of this study is for a better understanding of the lived experience of nurses working during the COVID-19 pandemic in Sarawak. Information obtained from this study will help to achieve the research objective and to generate more research regarding the psychosocial experience in the future.

WITHDRAWAL FROM STUDY
You have the right to withdraw at any time without any discrimination if any of the questions causes you any distress.

VOLUNTARY PARTICIPATION
Your participation in this study is voluntary. You do not have to be in this study if you do not want to. You may also refuse to answer any questions you do not want to answer. If you volunteer to be in this study, you may withdraw from it at any time. If you withdraw, any data collected from you up to your withdrawal will still be used for the study. Your refusal to participate or withdrawal will not affect any medical or health benefits to which you are otherwise entitled.

I understand that any relevant findings from the research may be used in academic publications. I will receive a signed and dated copy of this subject information/informed consent form.

CONFIDENTIALITY
All data obtained from this study are confidential and personal data will not be identified.

Appendix G: Informed Consent Form

Informed Consent Form to Participate In This Study

(Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A qualitative study)

I have read, or have read to me, in language understandable to me, the above information. The content and meaning of this information has been fully explained to me.

I have had the time and opportunity to ask any questions that I have about the study and this form, and all my questions have been answered. I voluntarily consent and offer to take part in this study. By signing this consent form, I certify that all information I have given, including my medical history, is true and correct to the best of my knowledge.

I understand that my participation is voluntary and I can withdraw from the study at any time without giving a reason and that this will in no way affect my future treatment. I am not participating in any other research study at this time. I understand the risks and benefits, and I freely give my informed consent to participate under the conditions stated. I understand that I must follow the study doctor's (investigator's) instructions related to my participation in the study.

I understand that relevant findings from the research may be used in academic publications.

I will receive a copy of this subject information/informed consent form signed and dated to bring home.

_____ _____

Printed name of subject IC. No.

_____ _____

Signature of subject Date

_____

Thumbprint of subject (if applicable)

_____	_____
Printed name of witness	IC. No.
_____	_____
Signature of witness	Date
_____	_____
Printed name of legally authorized representative (if applicable)	IC. No.
_____	_____
Signature of legally authorised representative	Date

Relationship to the subject: _____

(The investigator, or person designated by the investigator to conduct the informed consent process, must sign and date the form at the same time as the subject.)

_____	_____
Printed name of person explaining consent	IC. No.
_____	_____
Signature of person explaining consent	Date

Appendix H: Examples of Coding

Meaning unit	Condensed meaning	Code	Sub-categories	Categories	Theme
"… I'm afraid that I won't be able to spend time with my family. //… I'm most worried that I might get infected by COVID-19. //… I'm afraid. I'm afraid to die. Plus, I don't have any vaccines either."	Fear of infection, death and not spending time with family.	Fear and anxiety	Emotional struggles, worry about infection, fear of death, lack of vaccines	Navigating the emotional landscape	Navigating with the Emotional and Physical Landscape of COVID-19 Nursing Care
"… I regretted choosing nursing as a profession. //… the main reason I stay is that this is our work, a source of sustenance, right? It means that if I don't work, I won't be able to pay for things or be paid a salary. I have my own commitments with a car, a house, and then I have to help the family as well."	Regret over career choice but need to work for financial reasons	Regret and need	Career regret, financial obligations, commitment to family	Hope and meaning making	
"… When we were inside the patient's room, we had to resist hunger, drinking, urination and defecation. Hmm, it was sad that time. //… like me, I commute from home daily. It's sad that I can't go back." (Amanda, P.3)	Physical discomfort and sadness due to demands of the job	Physical discomfort and sadness	Resisting basic needs, commuting, stress, sadness	Workplace stress and burnout	

"… we are really tired working for 12 hours. There was one time they worked up to 7 days. //… Maybe some are okay with seven days, but once you have already worked the sixth or seventh day, they give up, exhausted. The 12 hours for seven days shift lasted for one week. Those who work during the day may be okay, they don't feel "huyung hayang". Those who work at night "mabuk". //… After that, 12 hours for three days shift implemented. There aren't enough staff so a deployed nurse was recruited to help.	Exhaustion from long shifts and staffing issues	Exhaustion and staffing issues	Long shifts, staff shortage, day vs. night shift differences, extreme fatigue	Workplace stress and burnout	
"… I think the stronger I am, the stronger it is to hold my heart. Before this, little things made me cry, stress made me cry. However, after dealing with COVID-19 patients for a long time, I feel that I am more confident than before as we are used to dealing with stress. It means that I can control the feeling of missing my family."	Increased emotional strength and confidence from dealing with stress, leading to better control of emotions, including missing family	Emotional strength, increased confidence, stress adaptation, emotional control	Emotional resilience: emotional strength, increased confidence stress management: adapting to stress, emotional	Personal growth and resilience adapting to stressful environments	

Source: Author's work

Appendix I: Example of Reflective Notes

Reflective Notes – Post Interview (P.4)

Date: 23/10/21

Time of Writing: 9 PM

This morning, I visited the Infectious Disease (ID) ward at 8 AM as scheduled to interview Participant No. 4, Miss T. The interview lasted for approximately 1 hour and 15 minutes.

Miss T was exceptionally cheerful and friendly, often laughing and joking throughout our conversation. Her warm demeanour created an engaging atmosphere, making the interview flow naturally. As a former nurse in the same hospital, I had encountered her several times before, which encouraged an excellent rapport during the session. However, I remained mindful of my position as both an insider and outsider position to ensure objectivity and reduce bias in interpreting her experiences.

Background and Experience

Miss T is an experienced nurse with 12 years' experience in infectious disease nursing. She is married with three children and is currently expecting. Despite the physical and emotional demands of her role, she maintains an optimistic and resilient outlook, embodying the spirit of dedication in nursing.

After completing her Diploma in Nursing in 2009, Miss T began her career on the Medical Isolation Ward. When the ward was relocated and renamed the Infectious Disease Ward, she continued working there, gaining extensive experience in managing infectious diseases such as Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Swine Flu (H1N1), Middle East Respiratory Syndrome Coronavirus (MERS-CoV).

Her vast expertise in infection control made her an essential member of the team during the COVID-19 pandemic, where she played a critical role in managing patient care and mentoring junior nurses.

Leadership and Team Dynamics

As the eldest of three siblings, Miss T naturally assumes a leadership role both in her family and at work. She is a senior nurse on shift, often acting as a key reference point for her colleagues. During the interview, we were interrupted several times by junior nurses seeking her guidance, highlighting her role as a mentor and decision-maker in the ward.

She is particularly strict regarding safety protocols, especially in ensuring the correct wearing and removal of PPE. She does not hesitate to correct junior nurses if they overlook critical infection control measures, reinforcing the importance of discipline and accountability in high-risk environments.

Nonetheless, beneath her assertiveness, Miss T exhibits a nurturing, motherly personality that extends to both colleagues and patients. One poignant moment she disclosed was when a colleague broke down in tears during a handover shift, overwhelmed by the stress of working on the COVID-19 ward. Rather than dismissing the emotions, Miss T allowed the

colleague to cry, offering comfort before gently asking what had happened. This demonstrated her emotional intelligence and ability to support her team, qualities that are essential in high-pressure environments.

Her leadership was also evident in how she helped reassure a doctor who was visibly nervous while treating a COVID-19 patient. By offering encouragement and emotional support, she helped calm the situation, making certain that the team remained focused and confident in their roles. This incident underlines the importance of teamwork, psychological safety and mutual support among healthcare workers in crisis settings.

Adapting to the COVID-19 Pandemic

Traditionally, nurses wear white uniforms to maintain a professional and neat appearance. However, during the COVID-19 pandemic, nurses in isolation wards changed to wearing scrubs, as they were required to shower after each patient encounter to prevent cross-contamination.

Miss T reflected on how nurses had to constantly adapt to evolving protocols, working conditions, and infection control measures. She likened their role to that of soldiers in wartime, alluding to how frontline nurses not only cared for the sick but also defended public health by preventing further spread of the virus.

Key Takeaways

1. Resilience & Positivity – Despite the immense challenges of working in an infectious disease ward, Miss T maintains a cheerful and optimistic outlook, creating a supportive and uplifting work environment.
2. Leadership & Accountability – She upholds strict adherence to infection control measures while also providing emotional support to colleagues, reinforcing team morale and discipline.
3. Professional Adaptability – The pandemic required nurses to modify their attire, routines and mindsets, demonstrating their commitment to patient safety and infection prevention.
4. Nurses as Silent Warriors – The war analogy emphasises the dedication and sacrifices of healthcare workers on the frontline. Their role extends beyond patient care—it is a fight against an invisible enemy, requiring strength, adaptability and unwavering commitment.

This interview reaffirmed that nursing is more than just a profession: it is a calling, a duty and an act of service to humanity. Miss T's reflections act as a powerful reminder of the courage, selflessness and unwavering spirit that define the nursing profession, particularly in times of crisis.

Appendix J: Validation of the Research Question Guidelines

University Malaysia Sarawak (UNIMAS)

Validation of Research Questions Guideline

Study Title: Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A qualitative study

Below are the questions included in the interview guide for the study. Please evaluate each item for acceptability by placing a check mark (√) in the appropriate column. Additionally, space is provided for any comments or suggestions. Your feedback is highly appreciated.

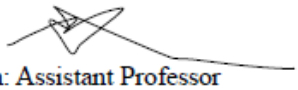
Questions	Acceptable	Not acceptable	For revision	Comments/Suggestions
Opening	√		√	Comments made in RED the text and deleted in BLUE
Section 1	√		√	Comments made in RED the text and deleted in BLUE
Section 2	√		√	Comments made in RED the text and deleted in BLUE
Section 3	√		√	Comments made in RED the text and deleted in BLUE
Section 4	√		√	Comments made in RED the text and deleted in BLUE
Section 5	√		√	Comments made in RED the text and deleted in BLUE
Section 6	√		√	Comments made in RED the text and deleted in BLUE
Closing	√		√	Comments made in RED the text and deleted in BLUE

Other Comments and Suggestions (if any):

There are numerous international studies which address this research topic in healthcare, however it is an important study which will certainly benefit the evidence-based nursing literature in Sarawak and Malaysia. Nevertheless, it should be noted that there is no current global COVID-19 pandemic, despite spikes and variant mutations of the COVID virus in different countries. The focus of this research study is to determine the psychosocial lived experiences of nurses in Sarawak Malaysia during the pandemic from 2020 to possibly 2024. Therefore, that should be the focus of the study, not what could be or what is happening in isolated pockets of Sarawak. There is no pandemic, despite a potential threat in the future. Well done and I wish you success in your data collection and findings.

Validator's Details

Name: Dr Manfred MORTELL

Signature: 

Designation: Assistant Professor

Institution: University of the Bahamas, Nassau, Bahamas

Appendix K: Member Checking with Study Participants

University Malaysia Sarawak (UNIMAS)

Verification of Interview Transcript

Study Title: Psychosocial lived experiences of nurses caring for patients with COVID-19 in Sarawak: A qualitative study

Instructions:

Please review the attached transcript of your interview and indicate whether it is accurate. If there are any corrections, additions, or comments you would like to make, please note them in the appropriate section.

Verification:

Section	Corrections, additions, or comments	Acceptable	Not acceptable
	I have reviewed the transcript and can confirm that it accurately reflects my responses and experiences as shared during the interview. **Please ensure that all details are kept anonymous in the final report.**	√	

Certification:

I, **Nurul Nawafil bt Zulkifli**, hereby certify that the attached transcript accurately reflects the content of the interview conducted on **7/12/21 @ 8am** with **Chen Ai Ling**. I have carefully reviewed the transcript and confirm that it is a true and complete record of our conversation. No material changes or omissions have been made to the transcript without my prior written consent.



Participant Signature: _____

Date: **07.12.2022**

Appendix L: Example of Participant Transcript

Date: 23/10/21 @ 8am (P.4)
Venue: Disclosed
Interviewer: Chen Ai Ling
Duration: 1 hour 15 minutes

Interviewer: Okay.. Selamat pagi Puan

Respondent: Ya selamat pagi

Interviewer: Nama saya Chen Ai Ling, ahhh saya akan melakukan apa penyelidikan bertajuk "Pengalaman hidup psikososial jururawat lah yang merawat pesakit COVID-19 di Sarawak.

Respondent: Ehm ehm

Interviewer: Jadi, saya akan mengemukakan beberapa soalan mengenai pengalaman Puan bekerja semasa pandemic di Sarawak lah.

Respondent: Ehm ehm

Interviewer: Jadi, temu bual ini akan berlangsung dalam ahh 30 hingga 45 minit mengikut macam mana la kita nanti ahh.. Jadi Puan telah sign ahh borang persetujuan, kita akan memulakan sesi kita hari ini ya Puan.

Respondent: Ehm ehm

Interviewer: So bolehkan Puan ahh berkongsi dengan saya mengenai diri Puan dan keluarga? Dan latar belakang Puan la serba sedikit.

Respondent: Okay nama saya [redacted]. So bekerja di err ID wad tok dah almost 12 tahun lebih dah. So dah berkeluarga, so ada ahh anak 3 orang coming soon semua 4 hehehe (ketawa)

Interviewer: Best..

Respondent: So errr sekarang ni dah bertugas memang dekat ID wad saja la. Dari since Medical Isolation lama, so terus pindah bawah masih lagi lah. Errr kerja dekat ID wad sehingga sekarang gitu..

Interviewer: Ermm dari.. apa.. maksudnya dari first posting ka Puan terus pergi sitok ka
Respondent: Ahh ahh.. Mula-mula dari Medical Iso la.. kan Medical Iso terus jaga H1N1

Interviewer: Tahun bila ya

Respondent: Tahun 2009

Interviewer: Oooo 2009

Respondent: Ahh ahh.. Terus pastu masuk Medical Iso, setahun lepas tu pindah dekat bawah tok terus jaga ID.

Interviewer: Ooo..

Respondent: Sampai sekarang la

Interviewer: Kenak kitak boleh terpilih pergi sitok? Kitak empun yang maok ka camne?

Respondent: Nya memang wad ya upgrade, wad ya dolok kan dekat atas.

Interviewer: Ahh ahh

Respondent: So kat atas kan ada 4 bilik jak

Interviewer: Ehm

Respondent: So sik cukup. Kan masa ya memang ada juga ahh H1N1 masa tu, so ahh dia orang upgrade. Pada masa yang sama ID wad tok memang dah upgrade juga, so dia orang pindah la. Straight away pindah kat bawah masa tu

Interviewer: Ohhh

Respondent: Dah lepas H1N1 so sambung la jaga infectious yang lain-lain la

Interviewer: Oooo

Respondent: Semua pindah kat bawah

Interviewer: Oooo.. Ahh berapa.. adakah Puan sudah mempunyai post basic ka

Respondent: Belum

Interviewer: Belum, okay.. Ahh Puan apa ada berapa orang adik-beradik
Respondent: Adik-beradik ada 3, so saya sulong, laki nombor 2, yang bongsu tu perempuan. 3 jak la

Interviewer: Oooo okay.. jadi ahh.. okay. Sekarang ini Puan sebagaimana yang kita tahu

Respondent: Ehm ehm

Interviewer: Pandemik COVID-19 di Malaysia dia start pada ahh dia datang ke Sarawak ni bermula pada Januari 2020.

Respondent: Ehm ehm

Interviewer: Jadi pada masa itu apa yang Puan faham mengenai COVID-19 masa itu

Respondent: So mula first daripada ahh dapat mesej daripada bos (Dr Chua) masa tu dia orang suruh prepare wad, kita orang ingat lagi la 27 haribulan. Ermm
Interviewer: Januari?

Respondent: Januari ataupun Februari antara dua la.. Sebab mula-mula kes ya kan dekat China dekat Wuhan

Interviewer: Ehm ehm

Respondent: So dia orang cuma ingatkan itu takkan sampai la. Tapi oleh kerana pada masa tu cun juga tahun baru cina, so memang akan ada macam tourist la dia orang akan keluar masuk.

Interviewer: Ya ya

Respondent: Memang belum lagi di isytihar pandemic so memang kita orang dah prepare siap-siap la cuma tak tahu macam mana ahh dia punya contagious tu la

Interviewer: Ehm ehm

Respondent: Seteruk mana kan so kita orang semua just prepare apa yang perlu la. So maksudnya prepare bilik patient

Interviewer: Ehm ehm

Respondent: And then buat dia punya apa tu partition-partition yang perlu

Interviewer: Ohh

Respondent: Ahh and then after that kita orang tunggu lah arahan daripada bos nak kena buat apa, siapa yang masuk dulu.

Interviewer: Ehm
Respondent: And then kita orang limit la, cuma masa tu ada 2 orang staf jak boleh masuk. Sama dengan doctor sorang, 3 orang je yang boleh masuk la.

Interviewer: Kalau ada patient la

Respondent: Ahh ada patient. Seorang runner, seorang incharge, seorang MO

Interviewer: Oooo

Respondent: Yang lain tak boleh masuk. Even though kita nak suruh cleaner pun tak boleh.

Interviewer: Oooo

Respondent: Memang very limit la masa tu, kita orang pun tak tahu tak dapat imagine lagi macam mana rupa dia punya err contagious kan samada through airborne ka ermm contact ka, so memang tak tahu lagi la

Interviewer: Ehm.. jadi macam mana ahh Puan boleh terlibat dalam merawat pesakit COVID-19?

Respondent: Dah hehehe (ketawa). Kalau part merawat tu memang kita orang take turn la kita orang pun tak tahu kan, so memang kita orang terpaksa juga by hook by crook pun mesti masuk. Memang dia orang, tapi yang first masuk tu ahh yang mostly (terkk) yang single la. Dia orang suruh yang single dulu.

Interviewer: Ohh

Respondent: Sebab masa tu masih ada baby, umur baru setahun lebih kot, masih breastfeeding.

Interviewer: Oooo.. Puan la masa tu

Respondent: Ahh ahh.. So kita orang priority untuk yang junior-junior dulu la dia orang dulu masuk. Ermm tapi second batch kita orang masuk (ketawa)

Interviewer: Ehm

Respondent: Tak dapat dielak la sebenarnya.

Interviewer: First batch ya maksudnya nya ikut masa ka

Respondent: Ahh ahh.. nya.. dia by group, dia ada group. Dia group yang first tu ada 2 orang la, staff nurse 2 orang, MO seorang. So dia orang kerja untuk 12 jam, and then next shift tu pun sama juga. Kita orang second, second daripada group yang after 12 jam tu.

Interviewer: Oooo… tapi yang second group ya masih 12 jam?

Respondent: Masih juga sampai la kita orang cukup staff. Sebab masa tu memang tak cukup staff, so dia orang terpaksa ambil dari luar la

Interviewer: Ohh

Respondent: Daripada wad-wad luar, daripada eye, maternity, ada lagi la a few wad macam ortho ambik sorang sorang kan sebab memang tak cukup

Interviewer: Ehm

Respondent: Supaya cukupkan (ketawa). Sebab masa tu memang susah la sebab terpaksa jaga bawah atas. Ermm dia punya macam terkk cara kerja first dulu tu memang kita orang terlalu strict, maksudnya kalau you masuk you tak boleh keluar. Once you masuk you mesti manage everything

Interviewer: Ehm ehm

Respondent: Bawa sekali masuk, even you nak buang sampah you kena sendiri buang

Interviewer: Ehm ehm

Respondent: And then kena buat sendiri nobody will help you.

Interviewer: Oooo
Respondent: Masuk dalam kena one go la maksudnya termasuk your doctor sekali. You kena prepare betul-betul la, time you in time you out.

Interviewer: Biasanya macam ya.. pukul berapa masuk dan pukul berapa keluar lah?

Respondent: Selalu ermm depend la sebenarnya.. sebab kita orang ikut doctor, doctor round. Macam masa dia ikut round la dalam kol 9 pagi ka 10 pagi. Sebab masa tu kita orang cuma limit masuk sekali jak se-shift. Se-shift sekali jak masuk.

Interviewer: 12 jam la

Respondent: Ahh ahh tapi kalau 12 jam tu depend la kalau patient okay. Sebab masa awal-awal tu patient semua okay, sik ada masalah gilak macam sik ada banyak problem la.

Interviewer: Oooo

Respondent: Kebanyakan nya stable bab balik-balik kan memang orang yang ahh agik healthy la (ketawa)

Interviewer: Yang closed contact ajak la masa ya

Respondent: Yess.. Sebab sidak nya kebanyakan yang masuk ya mula-mula ya PUI, nya bukan yang positif gik. Yang start positif yang bulan 3 yang group tabligh ya

Interviewer: Oooo.. Adakah Puan ada menjalani latihan ka untuk merawat pesakit COVID-19?

Respondent: Ermm cuma kita orang buat training la.. training untuk PPE demo dan cara bungkus-bungkus specimen semua la. And then apa yang perlu/sik perlu buat memang ada guideline la, ikut SOP yang diberi oleh infection control. Sidak nya yang akan guide la step by step nya. That why pada mula-mula memang agak macam ganjil la rasa macam “eh nak buka tok ka nak buka ya ka”, memang sik betul bah. And then that why

Interviewer: Pakai PPE

Respondent: Ahh Pakai PPE la macam nak buka neh dolok, kan benda gik baru. So nya sik macam previous macam MERCOV ka H1N1 ka Influenza then benda ya simple jak. Cam tok kita orang macam nak buka something ya pun macam rasa was-was. Nak buka glove

dulu, buka faceshield dulu ka apa ka, macam takut la gik mula-mula dolok. Takut la everybody ada rasa takut ya, kinek tok ok la.

Interviewer: Kinek tok ok la.. Jadi, adakah Puan rasa latihan itu mencukupi?

Respondent: Ermm mula-mula cam agak rasa sik berapa faham la mula-mula sebab kita pun sik tahu apa yang perlu apa yang sik perlu. Macam sidak nya ada penambahbaikan dari masa ke semasa macam perlu pakai double layer ka apa ka, glove sampai 3 layer tapi susah la, even though nak ambil darah patient pun sakit.
Interviewer: Ya, sik dapat feel nya

Respondent: Ahhh kita sik dapat feel apa-apa pun, terpaksa la nampak sik nampak blind poke kadang-kadang. Tapi patient ok la, gik awal-awal ya memang patient ok juga. Kak ya sidak nya buat penambahbaikan la, glove cukup so double layer jak. Cam dolok lebih 3 4 layer dipakei hahaha (ketawa) sebab sidak doctor yang first batch ya, dolok ya mostly sidak memang takut la. Takut kena jangkit kan bab kita pun sik tahu camni nya empun cara jangkitan

Interviewer: Belum buat kajian lagi kan

Respondent: Ahh mula-mula dolok la, tapi kinek tok ok la, sik seteruk yang first ya la

Interviewer: Jadi, bagaimana Puan melihat keterlibatan Puan dalam merawat pesakit pada masa itu?

Respondent: Ermm camni ooo

Interviewer: Camne kitak empun, sejauh mana kitak terlibat dalam merawat pesakit masa ya?

Respondent: Cara merawat pesakit kan.. Ermm camne nak madah oo..

Interviewer: Sik hal padah jak apa yang bermain di fikiran, cara kitak faham

Respondent: Camni contohnya

Interviewer: Boleh bagi contoh la.. Camni kitak terlibat.. melihat kitak empun penglibatan la dalam merawat pesakit COVID-19

Respondent: Penglibatan la.. sejauh mana.. Sebenarnya bagi kami orang nurses tok, nya memang terlibat secara langsung la orang madah, memang 100% perlu berada dengan patient sama dengan doctor sekali la. Macam kamek orang without doctor pun sik dapat juga nak buat apa-apa kan. Nya memang akan ada sentiasa perlu ada la sebenarnya. Sebab ada certain-certain patient tok nya sik faham apa dipadah doctor, even though nak dengar pun susah. Kan kita kadang-kadang dah full PPE semua, dak nya sik faham.

Interviewer: Mok cakap kuat la kedak orang tua nak

Respondent: Ada yang language barrier la, kadang-kadang sidak nya yang dari rural area ya memang sik faham la. Macam yang first admit dolok mostly sidak nya dari China, yang datang dari China.

Interviewer: Oooo

Respondent: Memang nasib juga masa ya banyak doctor dari Cina juak tek kata orang madah. So sama la. So mun dah sorang India sorang dari China memang alu habis ceta memang sik faham langsung la. Terpaksa la sorang jadi translator dari luar

Interviewer: Ooo..

Respondent: Sebab ada doctor duduk luar untuk clerking, so sidak nya akan jadi translator sebab susah. Mula-mula memang mostly datang dari China memang susah sikit la.

Interviewer: Ehmm

Respondent: Cun juga balik daripada Chinese new year masa ya memang susah mula-mula, struggle juga la. Kinek tok ok sikit la, doctor dah faham doctor da banyak juga. Mun dolok cuma sorang jak MO, yang masuk sorang, yang dekat luar sorang. So mun cun-cun kena 2 orang ya bukan Chinese habis la (laugh), nunggu sorang gik translator datang nolong. Kadang-kadang ya just pakei jak la bahasa isyarat (makan) cam ya jak la. Susah la.. part ya jak la susah cam kita tok (terkk) language jak la.

Interviewer: Ya

Respondent: Mun nya orang local atleast nya faham la kan.

Interviewer: Ehmm

Respondent: Perlu ada kerjasama jak la antara dua mun macam kita dengan doctor nurses ka. Mun sik ada sefahaman susah sikit la. Nya perlu ada sebenarnya, sentiasa ada sampai kinek tok la nya perlu. Macam biasa la apa-apa pun tempat kerja nak mun dak nya sik sama pun, sik sepalak kata orang susah..

Interviewer: Ehmm ehmm betul..

Respondent: Termasuk dengan bos-bos pun sama. Tapi okay la atleast bos ID tok semua understanding kata orang

Interviewer: Yaka

Respondent: Ehmm okay

Interviewer: Okay, so kita akan masuk ke pengalaman di tempat kerja Puan ahh.. so bolehkah Puan menggambarkan satu hari biasa di wad pengasingan tok, apa yang kitak buat dengan patient ahh waktu kita mula-mula COVID-19 dulu ya yang kerja 12 jam ya contohnya dari shift pukul 7 pagi sampai 7 malam? Camne kitak start the day?

Respondent: Ok.. biasanya la for first kali dolok waktu first batch ya tek.. so biasanya 7 pagi akan handover dolok la

Interviewer: Okay

Respondent: Handover everything dolok and then sidak doctor specialist akan round la. Sidak nya akan nanga through sorang-sorang so after that kamek orang akan catat balik la apa yang plan-plan, kan mesti manage la kita punya time. And then prepare early la ubat nya terus, kita sik dapat nak macam face to face dengan patient bagikan. Memang semua perlu letak dalam plastic kecik-kecik, label siap-siap, ermm what time what time patient akan makan ubat tok la, then terangkan sigek-sigek la dengan dak nya. So selalu nya dalam kamek orang selalu mun breakfast pagi akan masuk dekat pintu depan jak, nya ada 2 pintu kan, so sebab kita takut patient pun lapar. Bab kamek orang before patient admit di sia, and then kamek orang perlu prepare everything la dalam bilik ya such as air ka, cracker ka, mun ada dak mee cup ka apa semua just prepare.

Interviewer: Oooo

Respondent: Sebab patient pagi kamek orang memang akan siap masuk dolok la awal. Errr pasya dalam kol 10 kol 11 baru kamek orang start masuk (Interruption 14:43 until 14:54)

Interviewer: Prepare siap-siap pasya

Respondent: Pasya tek prepare ubat la. Tapi dalam masa yang sama nanga la juak ada plan terbaru sik daripada doctor la, perlu ambil spesimen sik. Sebab part ya memang doctor akan buat la, so kamek akan tanya dengan doctor. So if nya madah perlu blood tok then kita orang terus prepare tube semua la.

Interviewer: Ehmm

Respondent: At the same time memang prepare awal-awal siap-siap tulis lengkap-lengkap terus letak dalam plastic. Plastic ya mun dolok, specimen nya ada 3 layer plastic, yang 3 layer plastic ya 2 igek layer bawa dalam, 1 layer simpan kat luar.

Interviewer: Oooo

Respondent: So seorang akan bungkus specimen dekat luar la. So kita akan prepare siap-siap tulis nama takut salah nak sebab patient tok biasalah mun nya dah banyak nama habis salah.

Interviewer: Ya.. satu M dua M

Respondent: Ahhh yala tek.. Pasya dalam kol 10 kol 11 dah start prepare la barang macam makanan patient.

Interviewer: Okay.. masa ya belum masuk gik la

Respondent: Belum, mek orang belum masuk gik sebab dah hantar jak breakfast siap-siap kat luar pintu tek nak, sidak akan collect sendiri la. Dah prepare segala ubat pasya tek diet nya la, siap-siap bawa yang plastic kuning ya kena prepare awal-awal setiap pintu.

Interviewer: Mok tukar kan

Respondent: Ahh sebab sampah memang akan banyak sebab kita masuk se-shift sekali jak, so kita akan tie semua mesti bawa, jangan salah sikit pun.

Interviewer: Ooo

Respondent: So kita kan ada 2 orang jak staff nurse

Interviewer: Ehmm

Respondent: Sorang incharge memang akan masuk dalam, sorang runner akan kat luar jak la. So nya akan ambil la apa-apa barang yang kita lupa. Masuk setiap bilik ya akan ambil vital signs, ahh ya la vital signs, ambil blood ka

Interviewer: Ehmm

Respondent: If perlu sample ambil awal la. Doctor ambil sample kita akan pass through kawan kita dekat runner dekat luar la. So runner akan packing then nya akan pass gik dengan orang kat luar, so nya ada banyak step la. Pasya selesai agak patient vital signs semua

Interviewer: Bagi ubat..

Respondent: Kalau dah perlu ubat then kita orang akan terang sigek-sigek la siap tanda dolok la untuk yang tengahari, untuk yang petang, ahh macam ya jak la. Kak ya ermm kemas patient tidy up nya empun bed semua mun perlu mun patient ok la. Selalu nya ok la patient stable mula-mula dolok,

Interviewer: Ehmmm

Respondent: Baru kita kemas last sekali after dah doffing semua baru buang sampah. Letak gik plastic kuning baru, sampah gik keluar perlu second layer seorang gik tukang sambut kat luar. Doctor masa ya memang sama jadi cleaner juga la (ketawa).

Interviewer: Oooo sama la

Respondent: Sama la mek orang, kerjasama la sorang tied sigek, kan nya ada 2 igek tong sampah kan.

Interviewer: Satu yang hitam ya

Respondent: Kuning jak dua-dua

Interviewer: Oooo kuning jak

Respondent: Sik ada tong sampah hitam

Interviewer: Oooo

Respondent: Sebab nya kan semua untuk

Interviewer: Yang infectious

Respondent: Ahh yes.. so memang akan terang dengan patient betul-betul la. Suruh sidak buang jak semua sampah takut dak nya kan was-was kadang-kadang nak buang sampah dalam ya. Cam ya jak la selalu and then doffing semua, pergi bilik sebelah pasang gik baru, macam ya la donning balit.

Interviewer: Ehmm

Respondent: Dolok la.. Stail dolok mesti buka semua mula-mula sekali terpaksa pasang gik yang baru macam banyak step la banyak step. Then kinek tok ok la just outer layer jak sik macam first dolok. First dolok memang susah la kita kena buka gik everything

Interviewer: Shoe cover semua

Respondent: Dolok every room ada step nya empun. Bilik patient sigek step, dekat empty room sigek step, dekat luar sigek step. Camya memang wasting juak la sebenarnya, mungkin dolok sik banyak patient kan.

Interviewer: Ya.. ataupun dolok kita sik tahu gik how dangerous bah nak

Respondent: Yes.. Yes..

Interviewer: Kita precaution la

Respondent: Sik tau nya airborne ka contact ka apa semua nak so memang lekak ya dah settle semua patient dah settle baru keluar, mandi, kak mandi ya baru sambung buat report. So biasanya lepas kami orang akan keluar dalam pukul 1 kul 2 cam ya bah. Masuk kita pun dalam pukul 10 11 nak, akan berjam la kat dalam ya sebab settle sigek-sigek kan bukan sorang patient, dah selesai semua tek baru buat report. Buat report pun bukan sikit, buat report tok la, chart tok la, lagipun sik kan banyak orang

Interviewer: Ehmm

Respondent: Dalam memang sik akan ada JM masuk, sik akan ada PPK masuk, sik akan ada cleaner masuk. Masa mula-mula ya you semua la buat, nasib la tangan rupa lipas kudung dalam ya. Tapi kepak nang kepak la, berasa bah badan kita kepak. Balit-balit kerja pun terus tidur.

Interviewer: Oooo

Respondent: Dolok kan kamek orang tidur di Anjung Kasih kan. Dah pukul 7 tukar shift orang next shift ya sama juga la cam ya, malam pun sama juga. Mun bila perlu jak jarang la kami masuk sampei 2 3 kali la.

Interviewer: Ooo

Respondent: Selalu sidak doctor akan limit kan sekali jak se-shift masuk.

Interviewer: Sebab mok jimat PPE ka? Cukup ka PPE masa ya

Respondent: Nya akan madah cam tok la, selalu akan suruh kita less contact dengan patient

Interviewer: Oooo

Respondent: Kan kita sik tau kan macam ni keadaan nya dolok-dolok. Errr.. memang perlu minimal jak la kata orang. Kita dengan patient pun mun dapat jarak, nya sik akan suruh dekat gilak la, ambil specimen semua. Dolok nya memang takes times sikit la sebab dolok mula-mula kan kita sik tahu nak, apa yang perlu.

Interviewer: Ya

Respondent: Kita pun sik tahu camni cara exactly ambil sample even though nasal ka oral ka pun sik tauk camni. Dolok pun orang main-main jak sambil-sambil (ketawa). Kann.. Kita sik tauk exactly rupanya bah and then bok sidaknya tukar slowly tukar la.

Interviewer: Ehmm

Respondent: Kinek tok ok sikit la cepat sikit ambil, dolok memang take time. Belum gik patient termuntah-muntah gik

Interviewer: Patient sik cooperate la

Respondent: Ahh cam ya la. Rasa nak muntah la, kita gik prepare tisu la so sidaknya nak ya dolok buang segala nok dalam mulut.

Interviewer: Ada yang nervous gik

Respondent: Ahh belum hahaha (ketawa). Biasa cam ya la salunya, ya untuk beberapa bulan pertama, lepas ya dah masuk staff dah rami. Kami orang dah ambik staf dari luar kan, ya ada ok sikit la.

Interviewer: Ooo

Respondent: Tapi still juga kerja 12 jam. Ada one time ya

Interviewer: Berapa lama kerja 12 jam ya? Berapa bulan ka camne

Respondent: Berbulan la mek orang dolok.

Interviewer: 2 bulan lebih la

Respondent: Berbulan.. sik ingat sampei kan nya ada satu tahap nya dah reda kejap kan, nya ada reda kejap kak ya nya nait balit.

Interviewer: Ahh haa

Respondent: Masa ya dah reda ya

Interviewer: Kitak orang turun ke syif biasa?

Respondent: Ahhh ke shift biasa sebab masa ya ada ok sikit la, da dapat manage sikit kan.

Interviewer: Ehmm

Respondent: Dah ok dah turun pergi shift biasa kak ya kamek orang macam kepak bah sebenarnya 12 jam sebenarnya. Kepak sigek kan ada one time ya sidak sampai 7 hari

Interviewer: Uiii

Respondent: 12 jam untuk 7 hari. Masuk hari ke.. Mungkin orang kerja siang mungkin sik ada apa-apa la. Ahh yang kerja siang mungkin ok la kan, sik la rasa huyung hayang, yang kerja malam ya mabuk (ketawa).

Interviewer: Adoii.. kenak nya molah 7 hari? Bukan kah salah di sisi kan “labour”, akta labour tek nak kita sik boleh macam.. kiranya dalam satu minggu y akita mesti ada off sehari nak?

Respondent: Ermm ehmm.. Masa ya kamek sik ingat la. Sebab masa ya kamek cun anak kamek nang kena chicken pox, cun kamek sik dapat kerja la 7 hari ya tapi kawan kamek orang lain ya ada kerja sampei 7 hari.

Interviewer: Memang sik cukup staf la

Respondent: Memang sik cukup staf la juga sigek, patient tiba-tiba cam banyak pula prosedur nya. Jadi memang sidak nya tambahan masa ya kamek orang kan sik boleh bertembung di antara group

Interviewer: Ehmm

Respondent: Takut contact kan.

Interviewer: Ada team-team la

Respondent: Ahh nya ada 4 team masa ya A,B, nya ada team A,B. Team A tok ada yang pagi petang, nya ada 2 igek group gik. Jadi team A sik boleh bertembung dengan team B takut kelak incase ada yang positif nak, at least ada yang safe la dekat team B tok.

Interviewer: Aok

Respondent: So macam ya dolok la. So mungkin masa ya mungkin ada yang ok dengan 7 hari ya tapi da masuk hari ke 6 ke 7 memang sidak surrender la kepak.. one week jak sidak nya survive la untuk yang 7 days ya.

Interviewer: Ehmm

Respondent: Tapi lepas ya pun macam sik cukup staf so terpaksa tarik gik dak nya kerja.

Interviewer: Ehmm

Respondent: Cam memang sik cukup masa la, masa mula-mula ya memang nang packed la kata orang, memang struggle juga sebenarnya nak menghabiskan off pun macam sik ada masa.

Interviewer: Mun nya dah kerja 7 hari, 7 hari off?

Respondent: Aok kalau diikutkan tapi dolok sampei sidak nya ada yang off cuma 3 hari jak 4 hari jak then terpaksa turun kerja balit cover bab sik cukup orang nak. Cam ya la..

Interviewer: Kesian ehh

Respondent: Memang teruk la mula-mula dolok, kan macam agik terumbang-ambing kata orang nak.

Interviewer: Ya

Respondent: Kita gik nak carik pa sebenarnya perlu apa yang sik perlu.

Interviewer: Sebab benda ya baru nak
Respondent: Ahhh

Interviewer: Kita belum pandei manage la kiranya nak

Respondent: Nasib juak la yang geng daripada luar ya sidak ya sporting la sebenarnya, very supportive juak la geng ya even sidak nya dari wad biasa nak. Sidak nya sik pernah gik

Interviewer: Ya

Respondent: Tapi slowly sidak nya learn la tapi ok la sidak nya. Kinek tok pun banyak yang pergi PKRC kamek nanga

Interviewer: Ehmm

Respondent: Sidak dihantar ke PKRC area-area dekat la mana yang cover-cover ya.

Interviewer: KSKB juak nak

Respondent: Ehmm banyak-banyak-banyak. Geng-geng yang dah masuk sitok kira sidak dah expert la sebenarnya benda-benda macam ya. Benda baru bah

Interviewer: Yala.. Jadi adakah terdapat situasi atau pengalaman yang memberi impak ka kepada Puan semasa merawat pesakit COVID-19 masa dolok la first wave? Kita discuss more to first wave la masa nya first dolok la

Respondent: Ahh ahh..

Interviewer: Ada apa-apa situasi pengalaman yang memberi impak la

Respondent: Ermm yala burnout jak la. Kawan la banyak sidak yang sensitive sikit la part ya. Kesian la kesian macam sidak yang kerja 12 jam ya, 2 orang jak. Just imagine 2 orang jak staff dengan patient yang banyak, prosedur nya gik. Cam nya mesti ikut protocol bah, kita kan ikut protocol sop semua kan.

Interviewer: Aok

Respondent: And then ne gik dengan orang luar yang macam-macam la, ne gik dengan bos-bos semua call semua push kita nak buat. Even doctor pun kesian la, sampai nangis-nangis la sidak nya. Terpaksa kita lawan nangis sidak nya so that kita pun sik nangis sekali. Cam ya la maksudnya. Kesian la kesian dengan sidak nya sebab sidak nya sampei bertangisan la molah report ya. Kepak bah.. kepak sebenarnya mula-mula kesian la nanga geng-geng.

Interviewer: Yang doctor sitok Houseman la yang ada pergi sitok nak

Respondent: MO jak masa ya

Interviewer: MO jak

Respondent: Memang sik ada houseman

Interviewer: Oooo

Respondent: Mula-mula MO seorang jak
Interviewer: Oooo

Respondent: Sorang jak MO

Interviewer: Cover 12 jam la nya

Respondent: 12 jam for 7 days, MO 12 jam 7 days memang lama sidaknya masa ya. Nya rotation sidak lambat. Tapi masa lekak ya tek sidak nya tambah gik MO, sorang clerk di luar, clerking semua calling-calling semua sidak ada seorang la, ya seorang ya memang masuk dalam. Tapi kesian la memang cepat burnout la sidak nya. Semua macam ya, dah sik tauk gik kan sik dapat berfikir kadang-kadang. Kesian la tanga kawan-kawan, kita pun faham

situasi ya nak. Mun kita sama-sama bertangisan di sia habis ceta (ketawa), terpaksa la kita tek cover jak la diri tedah.. nama gik biak-biak nak

Interviewer: Ehmm ehmm

Respondent: Macam sidak gik muda-muda tok macam sidak pressure bah benda-benda cam ya. Memang banyak la

Interviewer: Dah la sidak nya jauh dari family nak

Respondent: Ahh.. Kan masa ya kamek orang sik boleh balit, memang semua stay dekat sitok ajak. Balik pun balit di AK jak, anjung kasih jak.

Interviewer: Ehmm

Respondent: Ulang-alik cam ya jak la. Sik boleh pulang rumah selagi result patient yang ko jaga tek negative selagi ya ko sik boleh pulang. And then kamek orang akan sentiasa called up wad la nanya apa result patient so that kamek orang boleh pulang.

Interviewer: Ooo

Respondent: Even though kita dah habis kuarantin cam 3 hari kitak jaga nak 3 hari kita off, hari pertama hari kedua hari ketiga, selagi sik ada result keluar kita sik boleh pulang.

Interviewer: Hmmm

Respondent: Kadang-kadang pulang sekejap jak sehari jak tek kerja balit, cam sik cukup la. Masa sik cukup, cam kepak nang kepak la, stress ya memang sik tauk level nya level

Interviewer: Macam kitak pulang ke anjung kasih nak lepas habis syif nak.. Ermm camne kitak habiskan masa kitak di hostel la nak

Respondent: Selalu cam kamek orang sik ada la sebab kebanyakan dah kepak.. nyawa dah kepak lelah, tidur jak la, tido makan tido. Ya jak la kerja (ketawa) sik ada kerja lain, kita nak gi sine sine pun sik boleh. Kita nak keluar gi sine even though pergi Kozi kan masa ya Kozi dah buka juak nak, pun sik boleh. Memang di sia jak la. Mun ada famili yang dekat-dekat senang la hantar barang makan semua, yang jauh-jauh ya tek eh.. nasib ya la masa ya ada juak la orang donate barang makan nak. Tapi yang paling sedih nya tek bila kena part makanan daripada kitchen la.

Interviewer: Nya berik supply untuk kitak orang juak ka

Respondent: Ahhh.. tapi nang sedih la makanan kitchen ya. Adohhh ehh.. mana yang ok ok, cuba kitak nanga banyak gia. Dah kita kepak lapar jak gik, nasi arum bulak sesudu dua sudu jak dalam ya adohh..

Interviewer: Adohhh haii

Respondent: Cam ya jak mek orang nanga. Kamek orang puas la komplen la dengan kitchen la daripada entah apa-apa lauk nya. Ya ku madah ada nemu yang mantak ka

Interviewer: Cuba nya molah aiii..

Respondent: Teruk.. serius teruk. Masa ya kamek orang nang sakit hati dengan kitchen. Bagus mek orang empun masak mek orang madah, sampei berangkut rice cooker kamek orang pergi kat tempat kuarantin ya. Sik ada choice bah terpaksa makan maggi la

Interviewer: Yala

Respondent: Camne la ya jak la cara nya.

Interviewer: Kesian nya..

Respondent: Teruk la makanan daripada kitchen teruk.. memang serius teruk, kan kontena biasa kita yang putih ya, nya main letak-letak jak lauk kat atas ya. Mun nya makanan ya datang awal, imagine jak kitak kamek orang habis shift dah sejuk dah makanan ya. Kita nak makan pun sik lalu.

Interviewer: Kadang kan nya masak awal takut nya dah basi bah

Respondent: Ahhh.. yala

Interviewer: Kamek sik taok la basi ka sik la tapi bau nya lain la

Respondent: Pernah nasi basi, nasi mentah pernah. Kamek orang pernah jumpa gik yang memang belum masak dak lauk nya macam dak ayam pa semua yak an. Pa boleh buat la, mun dah terpaksa makan makanan dalam tin jak. Nasib jak ada makanan dalam tin diberi orang kadang-kadang, sidak nya donate la apa nak. Ya jak la, nasi masak dik pun. Mun nunggu makanan kitchen lalu la kita tok.

Interviewer: Lalu keracunan kita tok. lain ceta gik

Respondent: Yala tek.. Nang banyak isu la makanan kitchen masa ya nang teruk. Kamek orang lejuk komplen. Every time kamek orang komplen nak, nya ada lah polah pembaharuan konon nya tek tapi simpan dalam plastic la. Kan benda ya bekum dalam plastic nak, kita nak bawa balik tempat tidur kunun nak makan dah basi dah.
Interviewer: Yala betul

Respondent: Salu jumpa la cam ya kes cam ya dolok sampei la... Atleast la nya pakei compartment senang sikit la, yang ber partition kata orang ya nak, sik nya bercampur sama dirik dalam kontena kecik ya. Dicampur semua dalam ya. Yarabi frust rasa nak makan, ni kita kempang nak makan (ketawa).

Interviewer: Adohh haii

Respondent: Tapi nang teruk la first wave memang pelik-pelik jak.. daripada makanan, daripada staf ahh memang susah la. Sigek pun pressure

Interviewer: Staf macam ne? Ada yang share dengan kitak ka macam sidak nya stress ka apa ka? Kawan-kawan la I mean, rakan sekerja

Respondent: Ermm memang camya la kamek orang sebab sik ada orang lain kan tempat bercerita even dengan doctor pun sidak nya tauk bah.

Interviewer: Ehmm

Respondent: First dolok kan Dr Toni yang jaga kan, so kamek orang akan madah la sama dirik dengan sidak nya so sidak nya pun faham. Ya la tek sampei kadang-kadang nya beli dak apa nama benda ya tek ka.. dak bird nest semua ya pakei berik untuk staff.

Interviewer: Oooo untuk boost

Respondent: Nya memang beli la nak pelik-pelik cam ya

Interviewer: Untuk awet muda

Respondent: Ahhh gitu.. Kak ya tek berik nya vitamin prescribe nya mesti makan sampai makan booster dose ya sampei 10 biji, kebas lidah nak makan banyak ya haha (ketawa).

Interviewer: Oooo

Respondent: Tapi nya memang ok la sebab nya takut kita stress kan

Interviewer: Aok

Respondent: So nya akan sentiasa tanya la kamek orang apa yang perlu. Macam dekat AK dolok kan orang derma air sejuk jak, nya suruh orang pasang water heater la setiap bilik ya so that mandi ok sikit la. Aat least ada la

Interviewer: Peruntukan dari siapa ya? Nya empun ka bukan la

Respondent: Ada yang kamek orang mintak dari sidak pengarah la, ada kadang-kadang orang sponsor. Banyak la yang orang sponsor juak sebenarnya,

Interviewer: Bagus la syukur

Respondent: Yala tek nasib la masa ya tek memang banyak orang donate yang macam cooler la, kipas la, banyak la mula-mula dolok.

Interviewer: Ooo bagus oo

Respondent: Kan masa first wave dolok semua kamek orang buat kat depan ya, sik ada booth kat belakang nun.

Interviewer: Sik ada apa?

Respondent: Sik ada booth yang Medical 5 ya.. Untuk diswab ya

Interviewer: Oooo

Respondent: Masa ya staf yang kat luar sidak nya akan jadi orang tukang swabbing luar ya, ambik la sample-sample

Interviewer: Busy la

Respondent: Serius busy sik cukup orang. Kitak la terpaksa buat tok la, runner terpaksa nolong sorang sitok la. Memang banyak-banyak kerja la, sik cukup orang sebenarnya. Everything depend dengan kamek orang so orang lain sik pandei sik berani.

Interviewer: Yala..

Respondent: Orang pun sik berani agak kamek orang masa ya so memang stress ya bertimbun-timbun la sebenarnya. Dengan orang luar sik berani agak kita even though famili pun takut. Cam kawan-kawan kamek orang kan mana yang dari luar ya kan, sidak yang cover-cover ya

Interviewer: Ahh hahh

Respondent: Sidak nya sampei famili pun sik berani agak sidak nya sebab yala.. takut tek nak. Sidak nya pun terus down la cam ya tapi mek orang kita support la kawan-kawan. Kesian la nanga mana yang famili nya takut la (ketawa). Ada..ada geng-geng dari luar la, geng-geng sidak yang cover-cover ya, yang deployed ya kan, banyak la sebenarnya.

Interviewer: Ehmm

Respondent: Tapi kebanyakan yang single la sidak nya hantar, sidak ambik yang masih single la, jarang nya ambik yang berkeluarga especially yang ada baby ya susah sikit la. Cam kamek ahh, bagi kamek empun la kamek stress sebab masa ya anak kamek masih breastfeed.

Interviewer: Oooo

Respondent: Jadi kesian la kesian dengan baby sebab kita kat sitok kan, baby di rumah. Nasib jak nya bukan jenis fully breastfeed la tapi..

Interviewer: Nya ada cari kitak la

Respondent: Ada la kadang terpaksa video call jak la, cam kita dengan kawan-kawan tok. Cam geng-geng lain sik dapat jumpa famili la, sik dapat jumpa mak bapa la, ya dah biasa kan tapi mula-mula semua orang memang struggle la maok cari cara menenangkan diri ya memang macam-macam la (ketawa).

Interviewer: Contohnya untuk kitak macam ne caranya

Respondent: Yala terpaksa la video call jak, cam yala kita tok buat la apa-apa ibadah kata orang alu beribadah jak doa jak la benda cam ya. So support memang supportive juak la kawan-kawan

Interviewer: Dengan kawan-kawan juak la share experience

Respondent: Nasib baik la kawan-kawan memang semua jenis sporting la. Sama-sama la bertangisan mun semua bertangisan dalam ya. Orang sik kan tauk apa kita rasa nak so kita dalam tok jak la yang tauk apa yang kita rasa sampei doctor pun paham la (almost teary). Doctor pun dak nya macam dua kali lima juak sebenarnmya (ketawa).. sama-sama stress, kadang-kadang doctor pun dah macam.. ada seorang MO dolok yang first batch la,

Interviewer: Ehmm
Respondent: Nya sampei marah-marah sik tentu pasal sebab nya pun da sik tahu gik. Nya sik dapat berfikir lagi bah

Interviewer: Shake head

Respondent: Nya empun da marah-marah jak end up tek terpaksa la nya mengaku kira nya tek.. ahh tiba-tiba marah sorry la nasib la katanya.

Interviewer: Stress la nya tek ooo..

Respondent: Nya stress sebenarnya, nya terpaksa kerja 7 hari 7 hari kedak ya berturut-turut bah. Sik ada orang tukar pa semua, jadi sidak nya kepak sigek, memang badan pun dah..

Interviewer: Emm emm

Respondent: Nanga muka pun dah tauk dah muka sidak muka letih bah. Kesian la nanga sidak nya.

Interviewer: Kenak bos nya sik nak ya consider la oo..
Respondent: Yala..

Interviewer: Kesian bah

Respondent: Dolok kan memang sik banyak MO yang berani dolok,

Interviewer: Pergi sitok la oo

Respondent: Ahh macam ada yang dihantar pun terpaksa (ketawa). Banyak lah paksa rela sebenarnya sidak nya sebab kebanyakan doctor yang cover sitok dolok nya bukan dari medical side ajak bah.
Interviewer: Ehmm

Respondent: Ada yang dari skin

Interviewer: Oooo

Respondent: Ada yang dari..

Interviewer: Yang deployed juak la

Respondent: Ahh yes.. banyak sidak nya deployed jugak. Kebanyakan yang deployed ya ok la, faham juak la sidak-sidak ya, cuma yala sidaknya.. lambat la lambat la.. nak nunggu sidak nya macam..

Interviewer: Sidaknya sik familiar bah nak?

Respondent: Ahh.. nunggu sidaknya catch up sigek-sigek pun lambat. Tapi ok la sidaknya..

Interviewer: Ehmm

Respondent: Lama-lama pun okay juak sidaknya.. ambik masa juak untuk belajar bah

Interviewer: Aok betul

Respondent: Tapi atleast masing-masing dah pernah dengan medical so sidak nya faham la

Interviewer: Yala.. yala.. Jadi ada pengalaman yang manis kah yang Puan lalui semasa menjaga pesakit COVID-19 tok?

Respondent: Ermmm..

Interviewer: Apa-apa lah pengalaman yang kitak ingat yang rasa manis lah

Respondent: Mun jaga COVID-19 masa first wave dolok la errr.. yala jumpa patient yang lucu-lucu cam biak.

Interviewer: Ooo

Respondent: Kan sidak nya dolok kan banyak yang paed masuk sitok, nya sekali dengan mak nya, nasib la jumpa nak comel-comel ya. Tapi ya la tek nya nasib jenis yang sik penakut la cam kita pun ok juga la, cam baby.. mang banyak juak camya sekali dengan mak kan. Ahh rinduk juak sebenarnya nanga.

Interviewer: Kitak ngenang anak kitak cam ya bah

Respondent: Ahhh yala tek.. Tapi kesian la nanga sidak nya terpaksa diambik swab semua. Tapi yala.. ya jak la kesian sebenarnya. Tapi kebanyakan nya mun kena geng yang sporting ya, best la.

Interviewer: Ehmm

Respondent: Mun macam geng yang (cherkk) cam sik best cam orang padah sik ikot palak kita, arrr mun nya tek sepalak jak orang madah tek best la memang best la sebenarnya.

Interviewer: Sama kerja la

Respondent: Ahhh enjoy la even though kita stress pun kita rasa enjoy. Cam yala..

Interviewer: Ehmm

Respondent: Cam geng yang mun nya embak palak dirik pun nya sik cun dengan orang ya yang sakit na, susah nak kerja dengan orang yang sik sepalak tok.

Interviewer: Ehmm

Respondent: Tapi kamek orang so far ok la,
Interviewer: Ok la..

Respondent: Dak nya.. kita tok support each other kan

Interviewer: Ya

Respondent: Macam “kitak sik dapat tok, sik ada hal kelak ku ganti ko”. Macam ya la sidak nya, cam yala sidak nya

Interviewer: Ehmm

Respondent: Cam sidaknya mok gilir-gilir juak bah even though nya as a runner ka dekat luar tok. Selalunya yang deployed masa ya, dak nya jarang incharge

Interviewer: Ehmm

Respondent: Sebab takut sidak nya sik familiar kadang-kadang patient on ventilator semua nak

Interviewer: Aok

Respondent: Sidak nya sik pernah jaga.
Interviewer: Ya

Respondent: Tapi kamek orang akan ajar la, sidak nya akan belajar.. slowly belajar bab ada kadang-kadang sidak nya sik pernah manage ventilator

Interviewer: Aok betul-betul yala

Respondent: Sebab sidaknya bukan dari pa orang madah tek..

Interviewer: Medical ataupun ICU setting lah

Respondent: Ahh yess.. ahh ahh tapi sidak nya pandei lah.. pandei belajar lah, slow-slow kata orang nak.

Interviewer: Ehmm
Respondent: And then sidak nya pun da expert la, pandei juak la part-part cam ya, cara management. Untung la kena yang group-group deployed yang supportive kata orang, very cheerful (ketawa) best sebenarnya sidak nya. Nasib juga kena yang memang sporting la kata orang

Interviewer: Yala

Respondent: Ok la sidak nya.. (ketawa) lucu sebenarnya sidak nya sebab sidaknya kan first time nak cam semua nervous tapi oleh kerana kita tek "eh sik ada hal, cuba lok tok tok tok".

Interviewer: Aok

Respondent: So sidak nya willing la kata orang nak belajar lah nak, sidak nya pun memang excited waima sidak takut-takut tapi sidak nya ok la group-group ya.

Interviewer: Ehmm

Respondent: Tapi sidak nya semua macam "ok la kelak kamek dengan kitak tok tok tok semua". So sidak cam ada la inisiatif dirik empun kan nak nolong kita nak tapi sidak nya faham la sebenarnya. Nang benda ya pun cam.. Nya tauk kita kepak nak so nya akan take turn tukar la

Interviewer: Ehmm

Respondent: Even though nya tauk nya nombor nya tok tok nak, tapi sidak nya selalu jadi runner geng ya. Tapi sidak nya runner pun sidak nya cakah la kata orang madah lah.. memang rajin la.. rajin.. nasib nemu geng deployed yang rajin kata orang.

Interviewer: Yala

Respondent: Mun nemu yang nyampah malas-malas ya aduhh.. stress (ketawa).

Interviewer: Mungkin sebab sidak nya masih muda satu

Respondent: Ermm sigek lah.. Kebanyakannya.. (Ermm) kebanyakan sidak nya okay lah, memang okay.. memang sangat bagus group-group yang deployed ya. Mungkin dak nya dah dipilih oleh bos-bos sidak nya bah, memang very.. nak orang yang selected ya tek antara orang-orang yang terpilih lah..

Interviewer: The chosen one
Respondent: Yess.. Sebab kebanyakan nya ya ermm sidak matron sister yang akan pilih sidak nya.

Interviewer: Ooo

Respondent: Ahh cam geng-geng yang dari ortho ya memang.. kan sidak matron kamek orang sitok dolok ada cover ortho. So nya tauk la a few staff yang nya boleh

Interviewer: Pinjam kan la

Respondent: Ahh.. So sidak nya memang akan cari lah staff yang memang berkaliber kata orang madah (ketawa)

Interviewer: Okay.. yala

Respondent: Yang masih muda-muda, masih bertenaga kata orang nak, so memang sidak nya akan cari la. Nya akan ambil setiap wad tok, eye sorang, maternity sorang kah, wad ni ka.. ahh RTU ada juak, yang bukan orang madah mother-mother wad nya la, sidak ambik dari wad kecik-kecik la.

Interviewer: Ooo

Respondent: So far ok la sidak nya geng-geng ya dari PSY, dari ortho, surgical pun ada, gynae pun ada. Tapi banyak la..banyak dari wad-wad biasa ok lah sidak nya.. bagus-bagus..

Interviewer: Bagus oo..

Respondent: Bagus (ketawa)

Interviewer: Ada pengalaman buruk ka yang anda lalui masa jaga pesakit COVID?

Respondent: Ermm.. Yang buruk hrmm.. buruk camni oo

Interviewer: Ermm apa-apa pengalaman yang buruk dari segi staff ka patient ka apa-apa persekitaran ka

Respondent: Ahh mun setakat tok la sik lah kata nya buruk la cuma (terkk) yala.. mungkin kita tok embak dirik kata orang nak.. macam stress sendiri ka ataupun, ya jak sebenarnya la. Mun gik dalam kerja sik juak banyak gilak pengalaman buruk la sebenarnya, cuma nya more to macam pengalaman pahit-pahit yang light-light jak (ketawa).

Interviewer: Okay.. contoh apa pengalaman yang light-light ya

Respondent: Macam yala kata orang tek.. Stress tempat kerja, yang macam sik cukup barang.. ya yang paling main problem memang sik cukup barang.

Interviewer: PPE kah?

Respondent: Bukan PPE tauk sik.. nya macam barang untuk patient cam kita nak biar patient

Interviewer: Barang makan ka?

Respondent: Aok dalam ya 12 jam sik ada apa-apa, nya pun sik ada embak apa-apa juga.. sehelai sepinggang. Kitak nak bagi nya makan ka apa cam kita atleast kita ada sediakan barang lain bah.

Interviewer: Ya

Respondent: Yala.. Masa mula-mula yang memang agak sukar la kata orang madah sebab..

Interviewer: Sebab belum ada orang sumbang la

Respondent: Yaa.. kita just prepare nya mesti ada mineral cukup dalam bilik ya. Benda ya yang susah la kadang-kadang barang sik ada.. terpaksa la kita tunggu apa kata orang tek.. orang derma. Cam ya jak la

Interviewer: Kita pun cam sik kita mampu nak berik dengan semua nak

Respondent: Ahhh yess..

Interviewer: Sebab kan patient banyak..

Respondent: Sebab masa ya memang orang nak embak barang ke dalam ya sik ada. Cam kita kan 2 orang jak nak, sik kan la kita nak embak semua ke dalam. Cam barang ya mesti di prepare waktu patient sik ada dalam bilik ya.

Interviewer: Aok

Respondent: Kita just prepare semua

Interviewer: Sebelum nya admit la

Respondent: Ahh yess.. Everytime bilik ya kosong kita kena prepare. So cam ya jak la.. Selalunya yang lain sik ada gilak problem, selalunya masalah equipment masa ya memang ada juak la. Cam barang-barang untuk check patient, kan dolok kamek orang terpaksa pakei yang portable empun

Interviewer: Ehmm ehmm

Respondent: BP set semua ya ahh sebab masa ya mula-mula ya kita sik boleh kongsi dengan patient lain.

Interviewer: Yes yes

Respondent: Dah la monitor masa ya tek bermasalah juak.. macam ada banyak masalah lah especially yang first floor masa ya. Kan monitor ada yang maok, ada yang sik maok. Kan barang dah rosak juak berapa tahun dah.. lebih 10 tahun dah building tok kata orang.. barang nya dah pun lama.

Interviewer: Ya

Respondent: So memang ambil masa la kata orang kena prepare sigek-sigek yang portable ya, dolok sik boleh kongsi kata orang madah, so kamek orang terpaksa la wipe everytime kat pakei memang ambik masa lah. Ambik masa untuk wipe la.. ya jak sebenarnya Kamboh.. kamboh benda-benda macam ya.

Interviewer: Ehmm

Respondent: Kita terpaksa nak weight patient lah sebab sidak nya kan perlu body weight untuk tauk ubat nya kan, berapa dos berapa dos. Cam ya jak lah.. Kamboh kedirik jak lah sebenarnya. Memang macam ya jak lah masalah, sika da masalah lain lah. Masalah besar-besar sik juak la besar gilak la masalah nya (ketawa kuat) lucu..

Interviewer: Sebab kitak happy nak

Respondent: Aokk.. jenis yang hahaha jak (ketawa kuat).. mun kena dengan orang jenis yang stres mesti nya akan cepat stress sebenarnya. Tapi ada jak geng-geng yang kaki stress kat sitok tapi yala mun kita dah ekot nya juak stress kita pun stress juak alu pening palak kita.

Interviewer: Yala kita mesti able to support nya lah kan..

Respondent: Yala tek

Interviewer: Kita yang okay tok support nya

Respondent: That why la kamek orang macam ya jak, if nya bertangisan kat sebelah ya, biarnya nangis sia sampei nya habis nya pandei berhenti bah (ketawa)..

Interviewer: Biar nya luahkan lah nak

Respondent: Ahh.. Kamek orang selalu macam ya even though kita tengah kitak nak take over pun nya nangis-nangis tulis report nak.. diam jak kitak. Tunggu nya habis nangis lok baru kita tanya nya (ketawa).. sik dapat kadang-kadang sidak nya macam ya lah tengah molah report bertangisan

Interviewer: Adohhh

Respondent: Teruk sidak nya ya. Nangis-nangis madah stress la, staff sik cukup la, boleh sik tambah staff, “ehh sama jak kito tok” kamek madah dengan nya. Sik perlu ko nak nangis, mek orang tok lagi lah ada anak di rumah nak dijaga nak dipikir

Interviewer: Aok..

Respondent: Kitak orang single ok la

Interviewer: Aok betul

Respondent: Cam sik ada benda lain nak difikir kan. Cuma stress, kita tok sama jak kerja.. cam ya jak la, and then end up sidak nya diam jak la (ketawa). Nya sik dapat nak kelakar lebih bah, sidak nya stress nya cam.. ada yang sik dapat manage stress la kesian juak la nanga sidak nya cam gik budak-budak nak.

Interviewer: Masih mudak nak.. darah muda tek lain

Respondent: Aok lain juak upanya.. Kita tok cam "okay lah stress neh nak molah nak, dah stress stress lah" (ketawa). Dah busy busy la, kita biasa jumpa kan.. benda-benda busy cam ya so sik ada gago gik sebenarnya. Buat bodoh jak la (ketawa)

Interviewer: Ermmm.. Okay so sekarang kita pergi ke bahagian psikologi gik ah..

Respondent: Ahh ahh

Interviewer: So bagaimana anda meletakkan diri anda sebagai seorang jururawat masa pandemik ya? Bagaimana

Respondent: Hrmmm camne oo.. eh camni oo aku gik tanya camni

Interviewer: Camne kitak meletakkan diri kitak macam tadi kitak ada madah kita memang bekerja dengan doctor lah nak?

Respondent: Ahh ahh

Interviewer: Jadi kitak rasa penting sik watak kitak dalam menjaga pesakit masa pandemic tok?

Respondent: Hrmm.. memang penting la. Ya jak la penting nya tek.. Sebenarnya mun sik ada nurses pun memang sik dapat juak doctor nak polah apa-apa

Interviewer: Ehmm

Respondent: Especially part ahh bahagian nursing care la

Interviewer: Yess

Respondent: Especially nursing care patient kan.. memang sidak nya pun akan cari nurse la untuk buat semua even dilution ka.. untuk yang medication ka.. sidak ya just prescribe jak tapi yang berik nya kita. So without kita tek memang macam sidak nya separuh lah (half way) jak. Sidak nya mungkin pandei beri ubat ya tapi ada certain-certain ya sidak akan gago bercari la apa semua la. "Oh kak sine tok tok tok". Jadi sidak nya macam pun sik familiar

Interviewer: Ya lah

Respondent: Even though nya dah lama sitok pun ada benda yang nya sik tauk. Mok ermm apa orang madah mok nak bagi
Interviewer: Sebab dilution macam kita yang lebih tauk bah kan..

Respondent: Ahh yes kita lebih tahu kan.. apa cara beri nya even though yang simple-simple IV pun kadang dak nya pun sik tauk camni. Just bagi bolus jak kata dak nya padahal sik boleh jak pun, jadi cam ya la. Kita betulkan apa yang sidak nya salah la sebenarnya. Selalu macam ya give and take jak la dengan doctor, mostly sidak nya bagus la dak nya rajin tanya sigek lahh. MO yang cover-cover kat sitok, bagus la dak nya.

Interviewer: Bagus lah.. Jadi macam ne perasaan kitak masa kitak apa pada hari pertama lah kitak disuruh kerja menjaga pesakit COVID-19 masa first wave dolok?

Respondent: Ermm

Interviewer: Camne perasaan kitak masa ya?

Respondent: Of course nervous (ketawa), nervous.. takut kata orang madah, ermm excited at the same time kata orang sebab kita sik pernah kan.. sik pernah jumpa and then kita pun sik tauk macam ni situation bila kita dah masuk bilik patient nak, apa yang akan jadi kata orang. So memang..

Interviewer: Takut sebab apa..

Respondent: Takut sebab kita sik tauk nya seteruk ni nya empun ahh effect nya dengan kita, sebab kita sik tauk camni kita nak doffing ka kelak ka, salah ka, adakah kita akan embak penyakit dengan kawan-kawan, dengan pulang rumah ka kata orang nak,

Interviewer: Ehmm
Respondent: So benda yang selalu doctor ka sister ka matron ka akan madah.. buat betul-betul PPE ya buat betul-betul.. Ya the first thing sidak nya akan sebut la sebab bila kita salah PPE then semua orang akan kena.

Interviewer: Ehmm

Respondent: Bab masa ya first wave ya memang pa orang madah stress ya berlipat kali ganda la kata orang sebab everybody akan ahh blame you mun you salah buat. Cam you jangan gelabah la,

Interviewer: Ehmm

Respondent: Tapi kamek orang selalu first wave ya kamek orang akan guide MO. Sebab MO yang akan lebih nervous gik daripada nurses. Nurses mungkin okay la biasa, dak nya dah biasa PPE nak

Interviewer: Yala

Respondent: Tapi MO memang nya akan 2 kali ganda lebih nervous gik. Ada one time ya kamek pernah masuk dengan seorang doctor tok.. and then patient ya daripada Wuhan. Patient ya memang exactly balit dari Wuhan, so nya dah travel pergi ke Sibu and then nya ngantar dirik la pergi SGH

Interviewer: Ooo Okay

Respondent: Sebab ahh nya baruk dapat tauk kes ya tek ahh dah start berlaku, tapi nya sik tahu pun benda ya sebenarnya dah lama.

Interviewer: Kenak nya sik dari Sibu jak oo

Respondent: Endak ku tauk nya balit kuching.. Sebab masa ya kan memang Kuching jak centre nya

Interviewer: Ooo

Respondent: Masa ya lom ada gik tempat lain bah. Nya pergi Kapit, patient nak pergi ke Kapit. Nya macam entah la macam ermm kan kinek tok banyak yang company-company daripada nak ya.

Interviewer: Ahh ahh
Respondent: Nya tek kerja company tek, nya sik tauk yang nya daripada Wuhan tek kira macam nya high risk la.

Interviewer: Nya dah exposed lah..

Respondent: Ahh.. Sebab nya tek masa ya history ya tek nya makan dekat tempat yang sik jauh tempat dari benda yang first case ya detected kat Wuhan ya.

Interviewer: Oooo

Respondent: So MO yang nak attend nya tek memang extra nervous la. Nya sik tauk gik nak macam ni sampei nya mengelabah (ketawa), kamek terpaksa tenangkan nya la doctor ya madah "relak doctor" kamek madah dengan nya "mun kitak nervous kamek tok pun nervous juak". Macam mana ni macam mana ni? Nya macam nya dah sik tauk gik dah hilang arah dah nya. Kesian nanga nya tauk sik, sampei nya atur mask ya pun dah berpuluh kali nya ator.

Interviewer: Ehmm

Respondent: Sik la kamek madah dengan nya.. "Just you jaga betul-betul la, jangan cakap banyak sangat" ku madah dengan nya (ketawa). Doctor ya pun dah nervous, nang muka nya dah nang beliang nyawa nya bah. Jaik hati juak nanga doctor ya padahal kamek dua jak dalam bilik ya. Sama juak kita dua masuk ku madah dengan nya. Relak la doctor, kita terpaksa calm sidak nya lah. Mun sik sidak nya pun dah macam.. tangan pun dah bergegar megang dak swab pakei ngambik neh gaya kita tok (ketawa). "Relak doctor relak" ku padah dengan nya, nya pun dah

Interviewer: Aduhh kesian nya..

Respondent: Setengah nyawa dah. Nya terlalu takut bah sebenarnya.

Interviewer: Aok

Respondent: Kesian juak la nanga nya la and then patient ya ok jak.. very cooperative even though nya dari China tapi nya faham la sikit-sikit la kata orang madah tek pakei ya tek orang madah tek bahasa isyarat jak. Okay la patient okay. Masa mula-mula memang patient cooperative la cuma ada few jak yang sik faham sebab language barrier.

Interviewer: Language barrier la

Respondent: Ahh ahh tapi mostly sidak nya nang balit dari China la banyak. First wave memang semua dari China. Hampir half la, lebih dari half la semua daripada China. Lucu MO ya (ketawa)

Interviewer: Okay.. so apa yang perkara yang bermain di fikiran Puan masa kitak jaga patient masa disuruh bekerja jaga patient pandemic first wave?

Respondent: Ermm
Interviewer: Apa perkara pertama yang bermain di kepala kitak?

Respondent: Yala kita takut kita berjangkit jak. Kita takut kita jangkit daripada benda ya.
Interviewer: Ehmm

Respondent: Ya jak la benda yang paling kita takut. Everybody akan rasa benda yang sama sebab kita pun akan rasa macam alu paranoid bah..

Interviewer: Ya betul..

Respondent: Memang of course kita akan rasa paranoid sebab takut kelak even kita rasa nak flu sikit pun kita rasa macam “ehh aku ok ka aku ok ka”. Ya kamek orang semua kan dolok sampei memang bercheck temperature every time masuk wad.

Interviewer: Ahh hah

Respondent: Check temperature la check tok check ya la semua benda nak di check. Makei kab dolok kan nya sik strict macam kinek tok pakei face shield semua kan

Interviewer: Ehmm

Respondent: Sebab dolok kan orang madah sik ada nya masuk through mata lah kata orang madah. Dolok makei face mask jak cukup kata orang madah so, ahh first wave ya sik la kata nya terlalu strict sama staff as long as kira healthy la sebenarnya. Tapi ya lah.. lama-lama kan oleh kerana dah banyak staff yang kena so benda ya alu jadi dua kali ganda gik.

Interviewer: Protection gik la oo

Respondent: Ahh yes.. macam-macam tapi ya lah orang akan fikir ya jak la sebenarnya.. Kita takut kita berjangkit dari patient jak, takut ada geng-geng yang ambik sambal lewa bah PPE tok.

Interviewer: Aok..

Respondent: Ada nya macam “ala.. eh sik dah la sik ada pa-pa bah ya”, cam ya bah. Cam sidak nya cam sik ikut step betul-betul nak. Memang lah macam kamek, kamek pernah lah kerja dengan junior seorang tok. Nya jenis yang camni kata orang.. ambik simple jak bah cam

Interviewer: Ambik sambal lewa jak

Respondent: Ahh ambik sambal lewa jak, “ehh ok tok kak”. “Ehh sik ada” (serius). Nang kita marah lah (ketawa), kita tok jenis orang yang memang mulut cerobeh kata orang. Memang automatic mulut ku ya sik kira.. biar keluar dari bilit patient alu terus kena anok, tedah nanga nya tapi ok la.

Interviewer: Benda ya untuk keselamatan kita semua

Respondent: Yess.. Kita sik maok nya kena ngan orang lain bah, kita keluar pun bukan kita jak di luar tok. Orang lain pun ada kan..

Interviewer: Yala.. then nya makin banyak spread agik kelak kan

Respondent: Ahhh yess yess
Interviewer: Ya kita takut bah

Respondent: Nasib juak tek ya la orang madah.. Atleast nya learn something la kata orang madah. Kita terpaksa la tegur. Mun kita sik tegur nak, dak nya gik baru jugak. So okay la sidak nya, kinek tok dah expert la orang madah dah di hujung jari dah (ketawa).

Interviewer: So apa yang membuat Puan terus bekerja semasa krisis tok?

Respondent: Yala dah memang tempat kerja orang madah nak, so terpaksa kerja juak la. Sik dapat dielak.

Interviewer: Terpaksa kerja la.. Terpaksa la

Respondent: Yes.. Mostly sebab terpaksa lah banyakkan bila kita tanya dengan siapa-siapa pun. Mun kitak dah masuk dalam tok, kitak sik akan dapat keluar gik kecuali kitak mintak pindah la. Tapi memang yala bekerja dengan terpaksa ya jak la. Sik ada orang suka kerja kawasan-kawasan yang berisiko kata orang nak..

Interviewer: Berbahaya

Respondent: Tapi what to do, by hook by crook pun mesti juak masuk nak terpaksa juak masuk nak. Dah benda ya dah jadi satu amanah nak untuk kita nak so terpaksa juak la.

Interviewer: Ya betul

Respondent: Kita tok ikut jak arahan (giggling), kitak nak bangkang pun sik dapat (giggling)

Interviewer: Ya betul.. sebab kita orang bawahan jak nak

Respondent: Iya tok benar-benar..
Interviewer: Lepas ya sebagai seorang isteri dengan ibu dengan anak
Respondent: Ahh ahh

Interviewer: apa cabaran yang Puan hadapi semasa bekerja time pandemik tok la

Respondent: Ermm.. Cam kamek, cam kamek sendiri la, cam first daripada first wave dolok sampei kinek tok errr kita perlu jaga diri jak la. Kita sik tauk kita tok berjangkit ka sik ka daripada kawan-kawan nak. Even though kita balik rumah pun kita rasa cam paranoid, kita mesti mandi extra gik. And then bila sampei rumah tengok gik takut gik kita tok apa-apa benda sebab yala mun macam before balit ka apa mandi gik extra sampai 3 kali 4 kali mandi. Kinek tok ok la, cam dolok cam dolok se-shift ya kitak boleh mandi sampai 5 sampei 6 kali sebab kena mandi 2 kali ehh 2 kali lah kat belakang, mandi gik kat belakang nun. Setiap kali kitak keluar terpaksa mandi gik 2 kali 2 kali cam ya la.

Interviewer: Ehmm

Respondent: Kinek tok ok la mandi sekali jak pun, dah kira longgar la. Cuma yala kita takut jak la sebenarnya kita tok berjangkit dengan keluarga di rumah la. Ya jak la.. takut jak... Sebenarnya mun kena dengan orang tua lagi la kita kesian, anak gik kecik. Kan masa ya belum ada vaksin gik nak
Interviewer: Aok

Respondent: Memang takut la. Pi kinek tok ok la.. sik ada lah, dak nya pun faham.

Interviewer: Parents kitak la?

Respondent: Ermm parents kamek, dak husband, anak-anak pun faham la.

Interviewer: Ooooo

Respondent: Dak nya cam sidak nya tauk kamek kerja nak, so sidak nya sik akan banyak la.. jenis yang understanding juak la anak-anak tok sebenarnya. Dak nya sik encarik bah

Interviewer: Ehmm

Respondent: Atleast pun sidak nya ada call, sidak nya faham. Nasib bukan jenis yang mencari la kata orang even though yang baby ya sidak nya okay la masa ya. Tapi kinek tok dah okay lah. Dolok kan nya masih usia setahun lebih macam umur ya gik orang madah tek mencari bah kata orang

Interviewer: Aok ya lah.. gik mok main semua oo

Respondent: Ehmm ehmm okay la.. Nasib la sidak nya bukan jenis yang terlalu mencari sampei bertangisan ka apa ka.. sik ada. At least kinek tok kan dah zaman moden tek nak.. dapat video call (ketawa), ok la sik lah macam dolok-dolok bertelefon hello hello jak.

Interviewer: Aok betul

Respondent: Nampak la muka tek nak

Interviewer: Aok atleast happy la anak-anak

Respondent: Ahh ahh

Interviewer: So ada apa.. macam perasaan psikologi kitak ada berubah sik sebelum dengan semasa pandemik tok? Sebelum pandemic maksudnya sebelum kita dapat COVID-19 tok nak, sebelum COVID-19 dengan yang lepas kita dah dapat COVID-19 tok, adakah perasaan kitak berubah ka?

Respondent: Ermm.. berubah… ada la kot sebenarnya macam factor-faktor pergaulan jak la sigek

Interviewer: Ehmm

Respondent: Kita takut bah, kita takut bila kita nak bergaul dengan ahli keluarga, kita nak embak penyakit pulang ke rumah. (Interruption at 57:03 until 57:38). Sineh kita tek?

Interviewer: Perasaan kitak ada berubah sik tek?

Respondent: Ermm
Interviewer: Kitak madah ada tadi sikit-sikit

Respondent: Ada.. ada lah sebenarnya tek.. before tok kan kita macam

Interviewer: Pergaulan padah kitak tek nak

R: Macam part-part pergaulan ya okay jak sebenarnya. Kita dengan confident nya tek nak kita boleh bergaul dengan siapa-siapa

Interviewer: Sik perlu pakai mask

Respondent: Ahh kira free la oo.. So kinek tok bagi kamek la cam kita ada tersekat sikit la kata orang madah even though kitak, mun kitak rasa especially bila part tempat kerja kita ada orang yang positif ka apa.

Interviewer: Ya

Respondent: Jadi kita pun cam takut-takut tauk sik.. even dengan anak dirik empun dengan husband ka, dengan mak bapa di rumah pun kita jadi takut. Kita mok terpaksa isolate diri kita sendiri dolok. Check dolok la..

Interviewer: Ehmm

Respondent: Macam kinek tok senang sikit la dah ada macam kit ya nak

Interviewer: RTK nak?

Respondent: So senang sikit la nak ngecheck. Mun dolok macam (bunyi cherkk) orang madah memang lebih kepada paranoid sebenarnya lah, kita tok errr mikir takut kita jangkit dengan orang tua ka kita tok waima kita sik ada penyakit tek nak..

Interviewer: Ya

Respondent: Takut jak la kita embak penyakit dengan orang ka.

Interviewer: Ehmm ehmm

Respondent: Ya jak la sebenarnya.. Sik juak kata terlalu terkongkong oleh pandemic tok kata orang madah tapi

Interviewer: Kita perlu jaga-jaga la kan cam ya

Respondent: Part ya kita akan lebih berjaga-jaga daripada dolok. Dolok mungkin sebab kita bebas senang sikit la kita nak keluar, kinek tok nak pergi mana-mana pun cam was-was tauk sik (giggling). Cam kita nak pergi sine-sine cam “boleh ka ooo” “sik teruk ka tempat ya” “cam okay ka”, kita gik mencari tempat yang sik crowded.

Interviewer: Aok betul

Respondent: Kita sik berani juak bah nak expose diri waima kita tek cam nanga tempat ya okay jak kata orang madah sik ada apa-apa tapi kita tek, sik akan terfikir cam ya memang kita akn fikir lain bab mungkin sigek kita tok kerja dalam medical kata orang madah.

Interviewer: Aok betul

Respondent: Jadi mindset kita lebih kepada benda-benda cam ya nak. Mun orang awam mungkin nya ok jak kot janji aku sihat katanya (ketawa).

Interviewer: Yala betul.. Jadi arrgh ada perbezaan apa perbezaan yang ketara, yang berubah sejak kitak terlibat dalam memberi rawatan kepada pesakit? Ada ka?

Respondent: Yang ketara..

Interviewer: Dari segi psikologi kitak ada sik
Respondent: Ermm

Interviewer: Yang berubah la ada sik? Anything yang berubah

Respondent: Cam macam kinek tok

Interviewer: Emosi kitak ka

Respondent: Ermm so far okay la sik la banyak gilak berubah sebenarnya sebab sebelum tok pun kita pernah jumpa yang ermm camni kata orang madah tek.. cam penyakit-penyakit cam tok nak macam MERCOV H1N1 sebelum tok.

Interviewer: Ehmm
Respondent: Tapi impak nya tek lebih kepada yang COVID tok sebenarnya. Yang dolok ya mungkin agik okay

Interviewer: Sebab nya sik banyak juak kan

Respondent: Ahhh sik banyak and nya cepat habis, and then nya terus dapat ada ubat lah kata orang madah. Cam tok sidak nya kena step by step kata orang madah tukar tok sikit, ubat pun belum.. belum ada gik yang specific untuk sakit ya kan.

Interviewer: Ya.. betul
Respondent: Ya macam ya jak la, yang lain ya sik banyak gilak, sik ada lah beza sebenarnya, mungkin bagi budak-budak baru mungkin sidak nya akan rasa benda ya lain la. Cam kamek orang yang pernah yang sebelum tok attend-attend patient-patient sebelum tok mungkin dah biasa..

Interviewer: Dah biasa..

Respondent: Jadi cam ada la sikit-sikit jak la macam cara-cara manage nya ajak.

Interviewer: Ehmm

Respondent: Macam ubat nya agak complicated sikit la sebenarnya. Cam ubat nya pun selalu bertukar-tukar. Cam ubat tok nya mesti ada dengan ubat cair darah la.. cam ubat especially untuk yang obesity la. Kan kinek tok banyak nya kebanyakan nya kan patient obes yang selalu kena, and then yang elderly age, so nya empun management ya berubah-ubah la. Selalu ku nanga cam ya jak la kebanyakan nya.

Interviewer: Okay.. kita akan beralih kepada part **social** pulak oo..

Respondent: Ahh ahh
Interviewer: So adakah Puan mempunyai masa yang cukup untuk diri sendiri dan orang di sekeliling anda sepanjang pandemic tok la sepanjang COVID tok?

Respondent: Ermmm.. masa..

Interviewer: Ehmm ehmm me time ka cam ya

Respondent: Me time rasanya memang sik ada lah kot (ketawa). Family time jak la tapi cam yala kita tok always sik cukup staff ya jak la masalah nya. Staff yang sik cukup, cam kamek

orang sitok pun macam bila dah ermm start-start patient dah rami tok memang staff sik cukup lah.. Kadang-kadang sigek shiff ya cuma ada 3 orang 4 orang padahal tek ventilator sampei 2-3 igek. Belum gik yang lain kan, yang memang patient yang critical ill semua so kesian lah nanga kawan-kawan. Masa tok pun kamek sik masuk dalam sebab mek sik ada, sik dibenarkan kata orang nak. Tapi kesian la nanga situation sidak nya cam ya lah. Selalu staff la yang sik cukup, ya jak la problem nya la.

Interviewer: Ehmm

Respondent: Macam benda lain ya so far okay memang akan ada la.. sik ada la me time kita, kitak terpaksa ganti geng la turun kerja, cover tok la sebab tok terpaksa Q

Interviewer: Kuarantin kan

Respondent: Ahh cam ya lah.. Mun dah sorang dua orang kuarantin ya, habis la cerita nya, memang sik akan banyak staff kerja.

Interviewer: Ehmm

Respondent: Kitak terpaksa owing la kitak empun off. Kedak ya la sebenarnya. Memang jarang la, macam ya la sebab memang masa kitak banyak terbuang kedak ya jak la. Even though ko ambik HR pun, terpaksa la tarik HR ko tek

Interviewer: Ehmm

Respondent: Terpaksa ganti lok geng kerja petang kah kerja pagi ka cam ya

Interviewer: Pasya owing gik la

Respondent: Yes owing gik owing gik. Bersambung-sambung la owing nya (ketawa). Salu cam ya lah

Interviewer: Ehmm.. Lepas ya camne perasaan kitak empun ahli keluarga apabila sidak nya tahu kitak kena bekerja time pandemic tok?

Respondent: Hrmmm.. sigek sidak takut sebenarnya la, macam my husband lah takut nya sebenarnya. Macam kita tok situasi kerja bah. Mun dolok mungkin okay la cam dolok kan kita jaga yang infectious biasa jak nak.

Interviewer: Ehmm

Respondent: Nya bukan yang boleh membawa kematian yang drastic kata orang nak

Interviewer: Ya betul

Respondent: Cam tok nya kita pun sik tauk camni sebenarnya benda ya boleh berjangkit and then kita tauk benda ya memang yang memang orang madah (bunyi cherkk) infectious pun barang and then orang semua tauk benda ya boleh membawa kematian. So memang.. kesian

nanga husband la sebenarnya. Nya memang worried la dengan kita even parents kita pun macam ya juak.

Interviewer: Ehmm

Respondent: So macam kamek just chill jak la, cam anggap jak la benda ya dah kerja nak. Kita nak (giggling) elak pun sik dapat. Nasib juak nya jenis yang understanding la, cam sidak nya di rumah paham la situasi kita. Cam kamek mun pulang rumah memang ahh mak kamek kan duduk dengan kamek nak, nya akan madah dengan anak-anak jangan dolok agak sampei mak mandi. Ahh cam ya
Interviewer: Ehmm

Respondent: Sidak nya pun paham la. Anak-anak pun dah tauk dah cam sidak nya pun tauk kamek kerja-kerja tempat camtok, so sidak nya memang akan paham la "mandi dolok la" "apa la". Ahh "kerja COVID la" "jaga COVID la" dak nya tauk paham la

Interviewer: Ehmm.. Husband, kitak madah tadi husband kitak worried tapi nya masih benarkan kitak kerja la?

Respondent: Ahh boleh lah.. nya ya lah.. dah nama kerja nak, kita sik dapat elak bah. Even sidak nya nasib la nya jenis orang yang paham kata orang madah so nya jaga (take care) budak-budak. So cam ya jak lah. Nasib juak nya ada pakei jaga budak tek nak so anything happen orang madah cam kita tek bersangka baik jak lah

Interviewer: Aok..

Respondent: Ehh tiberr (interruption phone call 1:04:56 until 1:05:00). Okay teruskan

Interviewer: Okay.. Ermm apa tok tek macam ni hubungan kitak dengan doktor dan rakan sekerja semasa bekerja merawat pesakit COVID tok? Hubungan kitak dengan doctor ker dengan kawan-kawan lah
R: Okay la.. semua okay

Interviewer: Sik ada masalah la?
Respondent: Sik ada masalah.. So far ok la, yang pastinya kamek orang semua memang jenis yang teamwork la kata orang madah. Setakat tok semua ada teamwork la

Interviewer: Ehmm

Respondent: Even though ada la certain MO yang baru ya mungkin sidak nya sik pernah lagi alami situasi macam tok. Dak nya sik faham sebenarnya, tapi once kita dah ajar dak nya so sidak nya pun okay la. Mula-mula memang sidak nya stress, banyak jak sebenarnya MO-Mo lah especially. Mungkin nurses tok sik ada masalah gilak.

Interviewer: Sik ada lah hoh..

Respondent: MO yang baru datang and then attend benda kedak ya, nya sik pernah so agak cultural shock la bagi sidak nya sebenarnya. Terpaksa ber-PPE semua so sidak nya macam

stress juak la. Tapi yala kita mesti ajar sidak nya slow-slow, yala dak nya pun belajar juak sebenarnya.

Interviewer: Okay.. jadi ahh tok tek.. okay tok part last lah hoh.

Respondent: Ahh

Interviewer: So apakah pelajaran dalam hidup yang anda pelajari daripada pengalaman menjaga pesakit tok?

Respondent: (interruption at 1:06:18 until 1:06:25)

Interviewer: Apa apa pelajaran ataupun perubahan dalam hidup yang kitak belajar daripada pengalaman menjaga pesakit tok? Adakah?

Respondent: Ermm.. bagi kamek lah.. ermm dalam situasi kinek tok, sigek jak la kamek selalu pesan untuk yang udah berkeluarga la. Kita just make sure kita sentiasa hati-hati lah. Ya jak lah sebenarnya even though sama dirik pun make sure pergi sine-sine kinek tok pun, mesti salu pesan kawan-kawan ka ahli keluarga pakai mask. Jaga dirik empun

Interviewer: Jaga SOP

Respondent: Yes.. mesti bekalkan apa yang patut lah. Hand sanitizer jaik-jaik pun lam keta mesti pakei. Even my husband pun kamek rasa nya lebih lagi berSOP daripada kamek (giggling).

Interviewer: Ehmm ya la

Respondent: Nya jenis yang sentiasa berhand-rub la empun orang dalam kereta even kita pun kadang-kadang lupa bah. Tapi nya faham nak, even anak-anak pun kita ajar. So benda ya kita learn something new la kata orang madah nak, as a new norm kata orang.

Interviewer: Ehmm Ehmm

Respondent: Memang okay la okay.. cam bagi kamek kita

Interviewer: Kita adapt la..

Respondent: Ahh ahh..

Interviewer: Adapt dengan hidup new norm

Respondent: Yess.. yang baru tok kata orang nak. Even though nak pergi sine-sine pun macam kita nak embak budak-budak pun cam kita susah hati nak embak ke sine-sine. Kita tengok la nanga tempat ya okay sik baru kita embak. Ah cam ya jak lah

Interviewer: Ehmm..

Respondent: Sik juak sebarang gik kinek tok, susah bah sik berani juak nak embak gi sine-sine. Even mall pun macam ehh dua tiga mok pegi mall.

Interviewer: Yala

Respondent: Embak jak la pergi yang open space la macam open-open space cam ya nak. Tengok juak la.. kinek tok kan sik macam marik, kita kan main redah jak pergi.. “wohh rami orang best nya pergi sia”. Kinek tok mun dapat pergi tempat sunyi best agik

Interviewer: Aok betul.. so apa sumber sokongan yang anda terima semasa merawat pesakit COVID tok

Respondent: Errmmm contohnya camne ooo

Interviewer: Sumber sokongan.. apa-apa la sumber sokongan kitak daripada siapa? Sumber kitak..

Respondent: Maksud kitak sumber sokongan?

Interviewer: Ehmm.. yang kitak terima sepanjang kitak bekerja merawat pesakit tok nak, dari sine kitak dapat sokongan-sokongan tok? Daripada orang ka

Respondent: Ermmmm..

Interviewer: Daripada orang ka daripada apa-apa ka?

Respondent: Sumber sokongan…

Interviewer: Siapa yang kuat support kitak camya?

Respondent: Oooo semestinya la kita sesama tempat kerja tok jak la macam dak sister, matron, doktor and then ada juak group support yang dari yang ahh yang kaunseling unit ya

Interviewer: Oooo ada lah..

Respondent: Sidak nya memang ada la, nya akan mesej kita. First dolok memang sidak nya akan tanya one by one. Dia akan tanya “you ok ka sik ka”

Interviewer: Oooo

Respondent: If anything sidak nya akan call. Dolok kamek orang ada sigek group yang tok under sidak yang sidak nok tok la.. sidak ya apa tek kaunseling.. sidak nya akan nanga takut kita down bah. Cam dolok kan memang banyak orang. Tapi setakat tok ID so far sik ada problem benda ya, so sidak nya memang senang la. Senang manage kamek orang bab kamek orang sik ada banyak group yang stress.

Interviewer: Oooo

Respondent: Stress kamek orang manageable empun stress lah.. Stress kira ok la, ada la certain-certain wad yang memang sidak nya banyak refer. Refer untuk kaunseling semua nak, sidak dah sik tahan gik.

Interviewer: Nang stress giler la

Respondent: Aok ah.. So far mek orang okay la

Interviewer: Oooo.. Adakah anda rasa sokongan yang ada tok sekarang memadai ka? Ya atau tidak?

Respondent: Ya

Interviewer: Kenapa? Tidak pun mengapa?

Respondent: Cam okay la. Ya macam ahh sokongan yang ada tok pun memang dah memadai kata orang madah. Unless la mun macam kita tek dah burnout dah sik terkabei kata orang madah, terlalu banyak gilak pressure.
Interviewer: Ehmm

Respondent: Mula dolok memang la sebab kita terpaksa gik jaga PKRC semua

Interviewer: Ehmm

Respondent: Cam kinek tok dah reda sikit. Cam orang dah banyak kuarantin kat rumah so mungkin ok la kot. Sik la nampak gilak stress nya di sia. Dolok kan mun dapat sik pernah lah balit on time kata orang madah, jaik-jaik pun 12 tengah malam balit mun orang kerja petang.

Interviewer: (Bunyi cherk cherk cherk)

Respondent: Mun kerja petang balik nya petang kol 3 kol 4 kol 5 sebab ya lah nak jaga palak patient berapa orang

Interviewer: Census nya la

Respondent: Ahhh census ya sampei 500 palak mok dijaga. Ya jak la stress benda macam ya la.

Interviewer: Ehmm

Respondent: Tapi okay la kinek tok kan dah kira manageable sikit tek nak, dah banyak orang kuarantin di rumah. So okay la sik ada seteruk yang first-first dolok. Dolok nang angol ehhh

Interviewer: Okay.. so anda rasa sumber macam benda dan manusia dalam sitok ooo cukup ka?
Respondent: Ermm

Interviewer: Macam tadi kitak madah ahh staf sik cukup

Respondent: Ehmm memang staff sik cukup, equipment pun sama sebenarnya. Cam monitor-monitor

Interviewer: Ehmmm

Respondent: Macam kan banyak monitor kamek orang tek ada problem lah.. Kita memang everyday la orang di ID lah.. ada jak benda maok di komplen, monitor rosak la, telefon rosak la, benda tok rosak la, ya rosak la. Cukup lah.. everyday lah ada komplen. Nang ID wad tok nang glamor la apa-apa komplen. Biar lah..

Interviewer: Okay.. tok soalan last ahh.

Respondent: Ehmm

Interviewer: So dimana kah anda rasa anda berada dalam masa 5 tahun ke hadapan?

Respondent: Hrmmm).. belum tauk gik la tapi kinek tok masih lah di ID wad tok. Ada lah perancangan nya kita maok transfer out tek nak

Interviewer: Transfer lah

Respondent: Nak menukar angin kata orang madah tapi sik taok gik la camni, berjaya atau tidak (ketawa) terpaksa tunggu la hahaha (ketawa)..

Interviewer: Belum ada nampak gik lah..

Respondent: Ahhh belum nampak lagi lah cahaya nya di situ la. Ada lah bunyi-bunyi maok juak la plan mok keluar nak.. Lejuk dah nyawa kata orang madah, dah 12 tahun kat sitok, masuk tahun depan dah 13 tahun dah aduhh.. boring..

Interviewer: KUP dah

Respondent: Ehmm gitu.. alu cam tok cam tok palak. Janji jangan suruh jadi sister jak lah pening ehh.. yarabi.. nanga sister dah stress dah molah kerja ya. Kita yang jadi orang bawahan tok pun dah pening, dek-dek gik orang atasan.

Interviewer: Ya betul

Respondent: Dak nya pun lagi banyak.. ya la macam doctor, “ahh mana sister ahh”.

Interviewer: Sikit-sikit sister dicari kan

Respondent: Yala... sik da nya cari orang lain. Mek orang sitok lagi lah aduhh... jadi mother board tok. Mun wad tok tutup rasa sik dapat ke sine-sine orang, semua orang cari ID ward cari barang. Kamek orang kan stokis.

Interviewer: Ehmm ehmm

Respondent: Hahahah (ketawa besar).

Interviewer: Center nya di sitok nak camya..

Respondent: Ahh.. Yala mek orang madah, mun mek orang tutup.. wad lain okay lah gik dapat tutup. Dah close contact dengan siapa-siapa dak nya alu tutup wad kan

Interviewer: Aok

Respondent: Mun kamek orang tok tutup camni ceta, hujung-hujung nak nangis orang bercari barang lah, ngantar dak casenote lah.

Interviewer: Mok tanya apa nak oo
Respondent: Ahh.. Kan semua dak nya akan hantar sitok, casenotes semua memang kamek orang terpaksa buat gik sigek-sigek. Hantar gik distribute gik despatch-despatch despatch.

Interviewer: Oooo

Respondent: Ehh banyak kerja la sebenarnya. Ya jak la sebenarnya, kerja macam ya, kerja entah sik berfaedah kerja ya. Boring ada jak haha (ketawa).. kita gik terpaksa tulis casenote daripada luar PKRC ya datang ya kumpul timbun-timbun timbun tulis.

Interviewer: Ehmm

Respondent: Mun ada masa senang la, mun sik ada masa ni.. terpaksa orang next shift gik polah. Cam ya jak lah sebenarnya lah.. Kamboh..kamboh angin kata orang madah eh. Kamboh hantam benda-benda buruk kedak ya.

Interviewer: Paperwork lah ya

Respondent: Ahh ahh ya.. Kinek tok kebanyakan nya paperwork la, ni gik patient gik.. ya sigek ceta. Orang incharge ya neh dapat nak nolong kita, kita sorang la kat dibah ya bertungkus-lumus. Yang office hour ya senang lah macam dak kak cil kak amoi ada nak, ok sikit la.

Interviewer: Oooo

Respondent: Bok kinek tok la ada sukarelawan yang sorang ya tek. Tedah.. nya lah kinek tok. Nya kan daripada PKRC pergi kat kamek orang sitok, nya ikot sister yang dari PKRC juak bah ariya. So nya la kinek tok tukang tulis, nasib ada nya. Untung juak la tapi baru jak kinek-kinek tok lah ada. Cuba dari awal nya ada kan bagus gik oo
Interviewer: Aok sik sakit palak ooo

Respondent: Benar..

Interviewer: Aok okay.. so tok kita habis interview kita lah haritok ahh

Respondent: Boleh-boleh

Interviewer: Okay, any last words ka kitak mok merumuskan pengalaman kitak kerja di wad tok ka?

Respondent: Pengalaman lah.. pengalaman yang berharga sebenarnya sigek la. Yang pengalaman yang memberi kita ilmu kata orang nak, tapi ya la sigek nya ada pahit nya empun, nya ada manis nya empun. So terpaksa la kita telan semuanya, jadikan nya sebagai satu pelajaran kata orang madah, atleast kita ada benda untuk kita cerita in future tek nak. Ya sebenarnya lah.

Appendix M: Timeline of The Study

Proposed schedule	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
Literature Review	√	√	√	√	√	√	√
Submit Literature Review		√					
Submit Draft Proposal		√					
Submit Final Proposal			√				
Application for Ethical Clearance			√				
Data collection			√	√			
Data analysis				√	√	√	
Manuscript writing				√		√	√
Thesis writing					√	√	√
Corrected thesis submission							√
Meeting with supervisor	√	√	√	√	√	√	√

Appendix N: List of Publications

Oral presentation

JCHS International Conference 2022 Post COVID Healthcare, Medical Research & Education, 29-31 March 2022

Proceeding

Chen, A.L., Rekaya, V.B. (2022). Psychosocial Live Experience of Nurses Caring For COVID-19 Patients: A Systematic Review. *Journal of Clinical and Health Sciences*, 7(2)(Supplementary), S48

Journal

Accepted manuscript

Chen, A.L., Rekaya, V.B. (2025). Exploring the Nurses Experiences During Unprecedented Crisis: A Heideggerian Perspectives. Malaysian Journal of Medicine & Health Sciences