Turkish Online Journal of Qualitative Inquiry (TOJQI)
Volume 12, Issue5, May , 3531- 3538

Research Article

Analytical Study On Role Of Nursing Officers In Curing Covid Pandemic

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Abstract

Health practitioners were obviously at the centre of worldwide anti-pandemic mobilization, which were designed and/or improvised to provide specialist attention for COVID-19 19 patients in the separate medical networks or campus hospitals. The pandemic is spreading, thus decreasing the elevated probability of infection and damaging effects for society and the need for particular care for patients with disease. In reaction to the COVID-19 crisis, this integration assessment discusses the problems with nurses. The crucial deficiency of caregivers, beds and health care materials, including personal protective devices, and psychological shifts and perceptions of infections among nurses are the key problems confronting nurses in this scenario. These unexpected conditions have led us, as health practitioners, to consider, take timely decisions. The greatest obstacle now is to heal and provide for the individuals associated with COVID 19. We as nurses represent humanity.

Keywords: Pandemic, Health, Mobilization, Infection, Society, Nurses, COVID-19

Introduction

This era of COVID 19 also introduced several fresh and unexpected obstacles to the management of the population's health needs. This paper describes the obstacles direct care nursing managers face to preserve and raise the morals of their workforce and update existing infection management procedures and workflows throughout the initial COVID-19 epidemic phase. This reflection builds on the administration of an isolation unit in one of the main tertiary hospitals in Singapore. Morality is an attitude of trust that indicates an individual and/or a community being ready to accomplish tasks assigned to it by defining and responsive to group objectives. There is a common challenge in the treatment of a modern, unpredictable infection of psychoemotional tension experienced by health care personnel. The emotional well-being of health care personnel is important because it impacts the moral of the entire staff. A research showed that improved social bonding moderated challenging conditions in order for the workers to enhance their emotional well-being. The deputy head of the nursing divisions responsible for the isolation wards showed that, through having regular meetings with the nursing administrators, the topic of COVID-19 patients has been established and handled. Therefore there was a spirit of friendship, improving the values of the party.

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For any nation, healthcare providers are essential services. However, healthcare workers taking charge of patients during extreme acute respirative syndrome (SARS) and in Middle East (MERS) outbreaks have been under extraordinary stress due to a high risk of illnesses, shame, under-statement and confusion, and co-operation. Their health and welfare are essential not just for ongoing and healthy medical care, but also for prevention of any outbreaks. To our knowledge, no qualitative study has been conducted on the perspectives of these providers. In order to serve them adequately, perspectives into their perceptions must be obtained. We needed to guarantee that the expertise of those first line health care workers who had no experience of viral viruses were not wasted when quarantined at home and were not in a position to offer frontline care at the height of a coronavirus epidemic. Therefore, in the early stages of the epidemic we decided to explore the perspectives of these doctors and nurers who take charge of COVID-19.

In battling Covid-19, nurses worldwide are at the frontline. They operate 24 hours a day to provide continuous treatment for chronically diseased people, all of which use fans and need particularly nuanced care. However, they're not super heroes. The World Health Organisation has recognised the primary role of nurses in the care and control of Covid-19 incidents. In cooperation with the International Council of Nurses and with the help of policymakers and donors, this United Nations organization released the study on the Condition of the World nursing 2020 on 7 April 2010. The paper underlines the problems and the value of the global health care workforce. Pflege staff are at the frontline of the case management of Covid-19 and face significant obstacles in order to change their working environments and to understand the value of personal protection. This awareness must be converted into policies which help professionals fighting the virus and jeopardizing the pandemic.

Nursing Care for Patients with COVID-19

The Johns Hopkins University & Medicine Coronavirus Resource Center 2020 has hit its limits, with over 27 million COVID19 confirmed cases, and 890,000 deaths globally as from beginning of September. The US is still recovering from a slow rise in deaths following 190,000 deaths in September (Johns Hopkins University & Medicine Coronavirus Resource Center, 2020). The need for treatment has never been so great and the effects have never been so serious. In situations of confusion, nurses operate every day. In reality nurses have long known, irrespective of their professional particulars or functional climate, that the possibility that they are a nurse remains. They will also be prone to workplace risks like needle cuts and back and muscle strains, blood and body fluid touch sprinkles, verbal and natural misuse, and fumes with toxic chemicals and disinfectants in their day-to-day job environments. Patients of HIV, Ebola, measles, Staphylococcus aureus (MRSA), and other respiratory diseases have also been treated with personal protective gear. And they have achieved this by honoring their professional and ethical commitment and by evaluation of what they considered to be a "acceptable risk" for the general good of the patient, and by supporting, and preserving, the integrity and worth of all patient caregivers. However, the advent of this coronavirus and its extremely infectious existence have broken conventional procedures. The shortage of sufficient personal protection equipment and the lack of institutional preparedness for the number of COVID-19 patients in healthcare systems has made first-aid nurses vulnerable to constant feelings of remorse and distress both physically and emotionally. While patients are also considered as susceptible by sickness or other underlying conditions, nurses are often sensitive to numerous stressors, illnesses and diseases. Stress is compounded in clinical practice if statements and voices of medical clinicians are diminished

(Hurst, 2008). "Risk factors which affect health, Danis and Patrick argue, so broadly that, at some point in life or in certain special circumstances, any member of the population can be vulnerable" (2002, 311). It is actually not there, which nurses believed to cover them. The photos, recordings, and tears of grief and emotional angst on several nursing caregivers, who are struggling to deal with the stresses of an unbelievable circumstance, have shocked and outraged spectators throughout the United States. Caregivers themselves are sick and potentially are now dead from the illness hundreds of them (The Staffs of Kaiser Health News and The Guardian, 2020). At least 156,000 US healthcare staff have been contaminated with COVID-19 by the beginning of September and the Centers for Disease Control and Prevention (2020) accept this as being overlooked.

The nurses work long hours with patients with COVID-19, wearing masks that bleed their skin and strain from the heat of whatever devices they are able to shield themselves and their patients. They are forced to move to another unit to cover the scarcity, stay alone with dying patients and have a fear of going around the doors of the hospital to start a transition. In reality, an early survey conducted by Indian Nurses, in April, showing that over 87 percent of health care professionals are very or very afraid of being working, 58 percent are very worried about their personal protection and 55 percent are extremely concerned about the care of COVID-19 patients or suspects of the virus (American Nurses Association, 2020a, 2020b). Few nurses wanted to abandon their work for this issue and others, but several others persisted. Most nurses work tirelessly to overcome these difficulties and are determined to strive to treat and reduce the misery of patients through limitations, adversity and eventual death. All classes - those who have decided to quit and those that have chosen to go - experience circumstances that can contribute to moral distress where ethically acceptable steps are not taken due to internal or external restrictions (Ulrich & Grady, 2018). Furthermore, there is a fear of reprisal, whenever nurses share their complaints. How do we start building faith in a framework which questioned fundamental values on how to "good," how to safeguard the frontlines of the pandemic patients, communities, nurses and other clinicians, and how to care for patients in need of limited resources?

Literature Review

The community of Melissa L. Desroches (2020) is extremely at risk for poor outcomes of COVID-19. Desroches (2020). COVID-19-specific threats of higher co-orbidity of individuals with DD compound significant health inequalities. DD nurses are well-prepared to care for the interests of DD patients during the COVID-19 pandemic through their experience in caring for people with DD and recognizing the core values of infection prevention. Evaluating the problems for caregivers with DDs during the COVID-19 pandemic, and the effects of DDs on individuals. From April 6e20, 2020, we analyzed 556 DD nurses. The 35-point mixed-method survey questioned nurses to assess the extent to which the treatment concerns of DD staff are treated. In the treatment community and globally, we evaluated the answers centered on COVID-19 current. One open-ended query posed problems which we examined using manifest content review and not included in the survey. In order to ensure the critical care requirements of people with DD are addressed, and to reduce the undue load on this disadvantaged group in COVID-19, DD nurses can be active in public health preparation and policy creation.

Registered caregivers are a significant working force worldwide. Connie M. Ulrich (2020) Every day in clinical practice, they use their experience and abilities to defend, support and speak on

behalf of the individuals and families they care about. This paper examines the bodily, mental and moral pressures corrupted by the novel coronavirus in their daily practice. We recognize the pressures put on nurses by sudden patient spikes and insufficient personal security equipment and other vital services in hospital settings, which threaten nurses' willingness to satisfy their professional and ethical obligations. We also express our thoughts about how to help nurses and others, and how to cure patients and organisations as we advance. Finally, we conclude that substantive systemic structures and frameworks need to be reformed in future to provide reliable services in the face of more catastrophic humanitarian and public health crises.

Nabeel F. Allobaney (2020) provides an overview of reported literature in nursing in the last six months surrounding the COVID-19 pandemic. The COVID-19 based papers released between 1 Jan 2020 and 15 June 2020 were searched on the Google Scholar online database. The outcome indicates that nurses quickly reacted to the COVID-19 pandemic, primarily by a quantitative method and a vast volume of publishing papers. In partnership with other disciplines, particularly physicians, nurses worked to enrich the research findings. Nonetheless, there is a restriction to the financing of nursing studies. The key problems of the nurses during the COVID-19 pandemic include stress and psychological causes.

Research Methodology

Via telephone interviews we did a quantitative analysis. The competence of physicians and nurses without an infectious disease expertise in delivering medical treatment during COV ID- 19 was represented in depth in an observational phenomenological method. Phenomenology study focuses on the description of social events in a society. Purposeful and snowball sampling recruited the members. Qualified doctors or nurses from their original units were hired for direct care or management of COVID-19 patients. The sample size was calculated by the saturation of results, i.e. no new problems emerging out of the interactions of participants. One of the two interviewees already heard of five participants and snowball survey approached the others. The variety in the expertise acquired from caring for COVID19 patients was known to involve differences in years of job experience, amount of support days and the jobs hospital. Participants were clarified the research aims and the cooperative essence of the study and prior to the telephone interview oral informed consent was received. Privacy has been ensured by the usage and exclusion of identity details from transcripts of titles instead of names (eg, doctors P1, P2, etc. and nurse, N1, N2, etc.). Both audio and transcripts have been stored on a secure password device. We have adopted the quality research criteria in this analysis.

Data Analysis

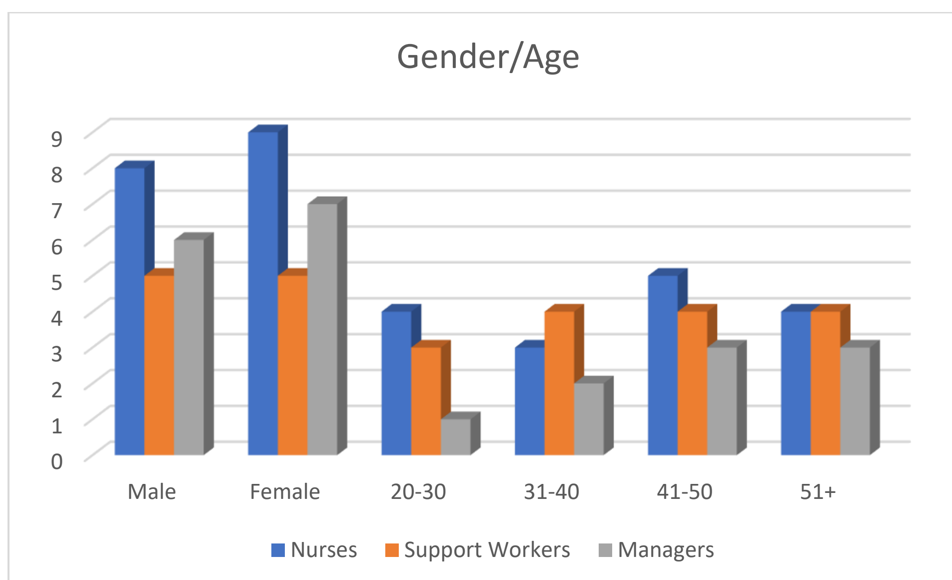
Forty in-depth one-to-one, half-structured interviews with support staff and managers is conducted with HSCFWs. The members of the study came from care centers and care centers. More than thirty groups, 20 of which were accepted to engage in the analysis were contacted. For information on the profile see Table 1. The aim of this study was to investigate the challenges that HSCFWs face during COVID-19.

Table 1. Profile of research participants

Occupation	Male	Female	20-30	31-40	41-50	51+

Nurses	8	9	4	3	5	4
Support Workers	5	5	3	4	4	4
Managers	6	7	1	2	3	3
Total	19	21	8	9	12	11

Fig 1.1: Research Respondents



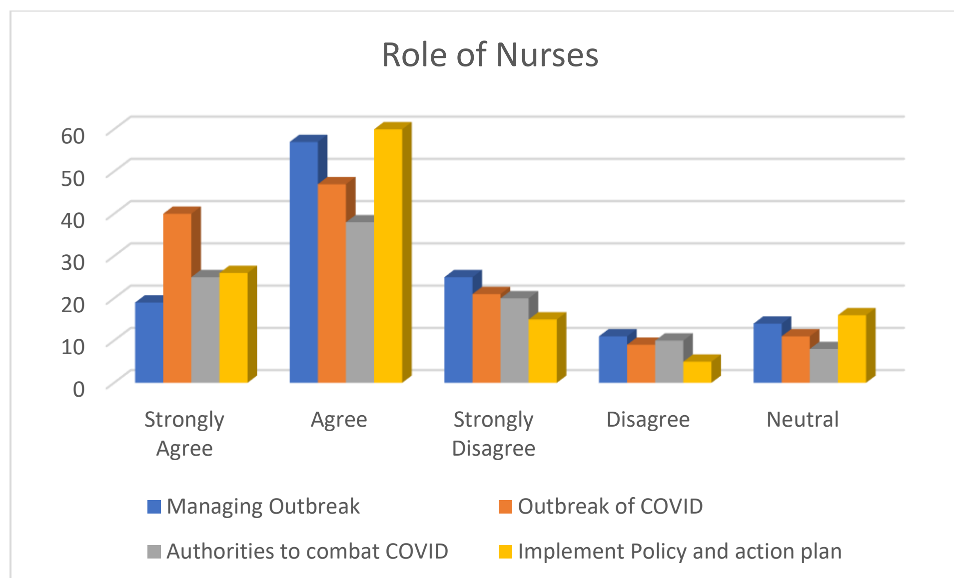
This research included a total of 80 nurses in varying roles. The survey consisted 61.71% of women's nursing (n=128%) and the remaining 28.29% of the male nurses. 45 (35.15), 32 (25) infection center nurses led by 28 (21.87) in the ambulance unit and 23 (21.87) nurses in the general unit is the Intensive Care Facilities (17.96). The bulk, 78 (60.9%), accepted that an epidemic should be dealt with by the agency. Three of them (27.3%) disagreed. Three-fourths (67.96) of the Nurses 80 thought it was strongly taken by the government, while 30 (23.43) were just against the hysteria. The decision by health organizations is approved and determined promptly by 50% of the study. More than 3/4 (69.5%) of the sample accepted that in the decision-making phase the organisations are integrating themselves with all the industries, although less than 1/4 did not accept. Most nurses (66.4%) have expressed the clear application of policy and procedures..

Table 2. Nurses perception about healthcare resources

Items	Strongly Agree	Agree	Strongly Disagree	Disagree	Neutral
Managing Outbreak	19	57	25	11	14
Outbreak of COVID	40	47	21	9	11
Authorities to combat COVID	25	38	20	10	8

Implement Policy and action plan	26	60	15	5	16

Fig 2: Nurses views about Healthcare



The nurses expressed mixed emotions such as altruism, humanitarian approach, togetherness besides the mental battle, they are willing to serve the community. The ancient history of a pandemic outbreak and authenticating nurses' real value; however, one participant expressed, "extreme level of mental depression because we happen to travel this pandemic work journey with the bitter and sad sense of mixed experiences." Another nurse stated that we are the challenging warriors to protect and save our people; also, we tend to embrace them as our family members; however, we are more likely to develop mental burnout". Apart from patients, many nurses died having been battled with the severity and its associated comorbid illness. "Losing family members, friends, and patients' community enhanced confusion and caused health workers to undergo devastating situations".

Health care professionals' challenges have enormous turmoil where the critical concerns of workload and personal protective equipment mitigate the nurses' actual and potential burnout syndrome. Mounting studies discuss that corona viruses spread by contact and droplet infections and airborne diseases. Nevertheless, researchers also discussed determining factors of hospital employees' comprehensive healthcare issues, healthcare professionals' welfare, and supportive measures to diagnose and implement preventive strategies.

Conclusion

Clinical and science landscape research nurses are now omnipresent colleagues. For various factors such as "shielding" and more, many nurses have migrated into scientific study, whereas some nurses have briefly went into clinical positions. What is interesting about this rapid increase of science knowledge is how research staff and their physicians reacted to this dramatic

emergency. The scientific concerns are constantly being considered by doctors, health problems are being researched, plans are being planned, applications for research are being pursued, funding for research concepts and more is to be learned. In addition to vaccine production, protection and health trials and more, modern study nurses excel in their clinical positions and lead to a coordinated research initiative involving some "50 different COVID-19 treatments". We never again hope that nurses will begin to be afflicted by compulsory workshop instruction, which will expose "the secrets and strategies" of resilience and adaptability in the work setting to some proto-adult management consultants.

Many procedures would shift in the future of research workers after COVID-19. For instance, where feasible, several additional cancer patients are studied remotely, as domestic surveillance technology already demonstrate 'feasibility, acceptance and usability. There would be even less clinics in hospitals, more patients in their own homes and in group environments – much what many people call about for for years. Testing workers would have to build workable solutions, remote and interactive, to "face to face" approaches to patients for research and digital tests. It is often important that these mechanisms gain support, ethical and other permissions to become "the new rule." Modern and interactive infrastructure has also been reluctant to implement NHS, often with good cause, in the UK and other national healthcare system. However, the COVID-19 crisis has demonstrated that new and emerging technology will boost and open up scientific and therapeutic processes so long as "the previous unjustifiable barriers of regulation can be removed". Present frontier working practices and innovative forms of working across fields, programs or other frontiers, like public and private hospitals are required for research personnel. Research staff may capitalize.

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