Lived Experiences of the Patients Hospitalized with COVID-19: A Phenomenological Study in a Province of Northwest Iran

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Abstract: Abstract: COVID-19 is a serious infectious disease whose rapid and widespread spread urged the World Health Organization to declare it a global public health emergency. Understanding the experience of people infected and quarantined with COVID-19 is very important in maximizing disease control and minimizing the negative effects on patients, their families, and social networks. This study explored the experiences of patients with COVID-19 during care and quarantine in northwest Iran. A purposive sample of 11 patients with COVID-19 was recruited. Data were collected from the beginning of March to the beginning of June 2020, using semi-structured interviews and these were analyzed according to van Manen's phenomenological method. Interviews were audiotaped, transcribed verbatim and analyzed using thematic analysis.

Ultimately, four themes, Characteristics of the experience, Response to traumatic experience, Deprivation, and Confusion, and containing 19 sub-themes, emerged. After understanding the findings of this research, nurses working in the wards of patients with COVID-19 can better consider the importance of assessing and analyzing the challenges and experiences of patients during periods of illness and quarantine. Findings also enhance the identification and organization of training needs during such a pandemic and the design of nursing programs to respond to them.

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Introduction

The novel coronavirus 2019 was considered a serious infectious disease whose rapid and widespread urged the World Health Organization (WHO) to designate it as a global public health emergency.[1, 2] After the start of the outbreak of COVID-19 pandemic in December 2019 from China, the first cases in Iran were officially announced on February 19, 2020 in Qom city.[3] Although the clinical symptoms of COVID-19 are nonspecific,[4] studies in most countries show that its common symptoms include fever, cough, myalgia fatigue,[5,6]

and shortness of breath[7,8] with acute respiratory syndrome, acute heart damage, acute kidney damage and death occurring in severe cases.[9,10]

On the other hand, confirmed or suspected COVID-19 inpatients may also experience fear of the consequences of the potentially lethal virus, and quarantined people may experience boredom, loneliness, and anger.[11] Moreover, symptoms such as fever, cough and hypoxia, and the side effects of treatment (such as insomnia caused by corticosteroids) can exacerbate anxiety and mental distress.[12]

Literature Review

COVID-19 spread rapidly in the world, and as of 22 January 2021, globally there were 96,267,473 confirmed cases of COVID-19 and 2,082,745 deaths. The total number of confirmed cases in Iran from 3rd January - 21 January 2021 was 1,348,316 with 57,057 deaths.[13] However, experts in many countries believe the infection and death rates are much higher because of undetected cases and unexplained deaths. A study in Iran indicated that anxiety is higher among residents in those provinces that have a high prevalence of infection and also among people who have at least a family member, relative, or a friend with COVID-19 and that women and young people are significantly more anxious about the disease. Furthermore, the severity of anxiety symptoms is very high in approximately 10% of cases.[14]

Since the pandemic, many emergency measures have been taken to reduce the transmission of the illness from person to person, for example, providing public services and facilities with disinfectants to promote good hand hygiene. Many countries have taken important steps to prevent and control the disease, including screening travellers to control the further spread of the virus.[15] One of the recommendations of the WHO is to quarantine people infected and or suspected with the disease.[1]

Quarantine is often an unpleasant experience for patients. Being separated from loved ones, loss of freedom, uncertainty about the illness, and boredom can cause significant psychological effects.[17] On the other hand, the current pandemic is greatly associated with psychological complications and its unknown nature and the lack of a specific vaccine or medication also exaggerate people's anxiety.[18] These issues along with other contributors such as quarantine can lead to serious psychological problems such as post-traumatic stress disorder, anxiety, depression, panic, and behavioral disorders. The risk factors of these are exacerbated by being away from the family, loneliness, misinformation on social media, and economic insecurity.[18]

The incidence of COVID-19 and its very concerning results in Iran, at the same time as the highest unilateral US sanctions against the country, has created many obstacles in the country's health system, for example, severe penalties for non-US companies conducting business with Iran. The quick pace of the outbreak and the harmful effects of sanctions have caused reduced access to life-saving medicines and equipment. These have added to the health sector's pre-existing needs for other complex health conditions.[19] This is despite Iran's health system having a very resilient and health system, one of the best in the Eastern Mediterranean region.[20] As a result, all aspects of prevention, diagnosis, and subsequently, treatment has been directly and indirectly disrupted, and the country is in trouble in dealing with the crisis.[19] This situation undoubtedly has had a negative impact on the level of psychological problems among the Iranian people.

In several studies, participants reported that others had behaved differently with them after quarantine (e.g. avoiding meeting or spending time with them, behaving toward them in a suspicious manner, and making critical remarks about them).[21,22] This has led to a particular sense of stigma among people during the quarantine period.[17,18]

A qualitative study on the experiences of Ebola survivors reported that participants being isolated from their families, their worries about their well-being, and sometimes being disrespected by medical staff were stressful to them.[23] In another study, participants stated that they were upset by the way the corpses of people with COVID-19 were treated after death.[24] Qualitative research provides an opportunity for an in-depth evaluation of mental experiences by taking into account a wide range of subjects. Qualitative studies on other infectious diseases have provided precious insights for conducting clinical trials and improving health policies.[25]

Given the importance of the issue, as nurses and health professionals we need to be aware of various dimensions, challenges, and concerns about COVID-19 and increase our efforts to contain the disease. Since one of these dimensions is understanding the experiences of patients with this disease, it was decided to conduct a qualitative study with a phenomenological approach to provide a deeper understanding of the patients' experiences. Data will help inform practice.

Study Aim

To explore the experiences of patients with COVID-19 during care and quarantine in northwest Iran.

Methods

Design: This phenomenological study used van Manen's methodology since this scholar chronicles interpretive phenomenological method as the incorporation of interpretation and description, and believing these entities cannot be separated. In this study, the phenomenon experienced by patients with COVID-19 about the disease course and quarantine period was gathered through in-depth interviews.

Participants and Setting: Participants were recruited from adults with COVID-19 at a hospital in Qazvin, Iran. This hospital is a specialized center for infectious diseases and has served as a referral hospital for patients with this disease in northwestern Iran since the beginning of the outbreak of COVID-19 in the country. The researchers were nurses working in units of patients with COVID-19. We used purposive sampling to recruit and interview 11 patients (six females and five males) with COVID-19. The first researcher introduced himself and explained the study to prospective participants. Sampling was undertaken to gain a diversity of sample characteristics such as gender, religion and age. Participants were enrolled in the study if they met the inclusion criteria of having COVID-19 and being mentally stable, assessed by the history given in the patient's hospital record and also asking questions of them; able to express their experiences of illness and quarantine; and willing to take part in the study.

Ethical considerations: This study was approved by the research committee of Qazvin University of Medical Sciences after obtaining the approval of the Ethics Committee (ethics code: IR.QUMS.REC. 1399.072). The hospital research unit also approved the study. Before data collection, and after explanations given by the researchers, informed consent was obtained from all participants. Participant anonymity and confidentiality were ensured; we did not capture names and addresses. Participants were assured that all of their interviews and subsequent data would be confidentially stored on the researcher's personal computer.

Data collection: The first author collected data between March - June 2020 through semi-structured interviews until no more new description of the phenomenon was found. Individual, face-to-face interviews were conducted in Persian after having established rapport with participants, in a doctors' office where they felt safe and comfortable and privacy was assured. To reach a comprehensive understanding of the phenomenon, interviews began with a general question: "Please share your experiences with COVID-19" to encourage participants to talk about their experience. This was supplemented with the question: "What is your

experience with COVID-19 disease?" and followed with probes, such as "Can you give an example?" and "Can you explain further?" Each interview was audio-recorded and the average duration of the interviews in one to two sessions was 40 minutes. Field notes were used during interviews to record participants' behavior, such as non-verbal communication, facial expression, and eye contact.[26]

Data analysis: After each interview with patients, the findings were transcribed immediately and then checked several times to increase their accuracy and comprehension. From this point, the transcribed data were the primary source for describing the experiences of COVID-19 disease and quarantine in this study. The transcriptions were then translated into English by a bilingual person, with full observance of grammatical, writing, and literary tips. Finally, the transcripts were edited by two native translators. The data analyzed using van Manen's phenomenological method. He introduced the following six steps in his approach to hermeneutic phenomenology:[27]

1) Paying attention to the nature of the lived experience: The first step is to understand the nature of lived experience.

2) Discovering a particular experience as lived: in this step the researcher studies an experience exactly as it lived and not as conceptualized.

3) Reflection on basic themes that define the characteristics of this event: Three approaches, comprehensive, selective, and line-by-line, are then used to clarify and explore the thematic aspects of the phenomenon: precise and selective approaches were also used to separate presentive sentences.

At first, each interview transcript was read several times and as researchers, we asked ourselves "Which statements are essential for describing the phenomenon or experience?" Then we identified and underlined phrases and those similar to the participants' words (descriptive) or their meanings and interpretations (interpretive) were written down. The main themes and sub-categories were obtained by merging and categorizing the thematic sentences.

4) Describing the phenomenon using the art of writing and rewriting: Here we wrote explanations about the participants' statements by establishing and maintaining a strong, conscious relationship with the phenomenon. The main research questions were reviewed throughout the data analysis, and then we extracted the themes about them.

6) Balancing the research context considering the sections and the whole: Using a selective and detailed approach, we then defined the concepts of the COVID-19 disease and quarantine. For thematic analysis, inductions and deductions were frequently used according to the research question.

During the coding process, each interview was initially read several times and we asked ourselves "Which statements were necessary for describing the phenomenon or experience?" Then, the statements were identified and underlined and those similar to the patients' words (descriptive) or their meanings and interpretations (interpretive) were written down. At all steps of data analysis, the researchers reviewed the main principles of the research and tried to extract the themes according to it. Finally, the thematic sentences were merged and categorized and the major themes and sub-categories were obtained.

Trustworthiness: The accuracy of the qualitative findings was determined by assessing the criteria of credibility, dependability, confirmability, and transferability.[26] To assess the credibility of the study, the findings were presented to the participants and they expressed their views on the coordination of the findings with their experiences to the researchers. Excerpts from the transcripts of the interviews were analyzed separately by them. In this study, an attempt has been made to help ensure the conformability of this research by preserving the documents related to the study. Dependability was assessed by participants and peer analysis. For transferability, the researcher tried to provide accurate and complete explanations of the research process and the samples had the maximum variety.

Findings

Participants' characteristics: The participants were 11 patients with COVID-19 (6 women and 5 men). Their mean age was 55.7 years (**Table 1**). All of these patients were hospitalized for 4-8 days, and after that, due to the increasing prevalence of the disease, we needed to empty beds in the hospital, so the patients were discharged after partial recovery with the advice to follow health tips given by the health team.

In continuous data analysis, 419 initial codes were extracted which were reduced to 172 codes considering their overlaps after being merged. The analysis of the interviews, in response to the main research question, revealed 4 main themes, 19 categories, and 76 sub-categories. Two of the main themes related to the course of the disease were Characteristics of the experience and Response to traumatic experience (**Table 2**) The other two main themes related to the quarantine period included Deprivation and Confusion (**Table 3**)

Table 1: Demographic characteristics of the participants

Participants	Age	Ethnicity	Level of Education	Gender	Marital status
1	27	Turkish	Academic	Male	Single
2	66	Tat	Primary school	Female	Married
3	40	Persian	Never been to school	Female	Married
4	72	Persian	Primary school	Male	Married
5	63	Gilaki	Primary school	Female	Married
6	70	Persian	Never been to school	Female	Married
7	54	Turkish	Junior secondary	Female	Married
8	33	Turkish	Secondary school graduate	Female	Married
9	34	Turkish	Primary school	Male	Married
10	37	Gilaki	Academic	Male	Married
11	54	Persian	Secondary school graduate	Male	Married

Table 2. Themes and categories of COVID-19 disease

Themes	Categories	Sub-categories
1. Characteristics of experience	1. Physical symptoms	Extraordinary pain
		Contusion
		Torturous suffocation
		Severe hypoxia
		Anorexia
	2. Psychological reactions	Reaching the end of the line
		Grief
		Insomnia
		Restlessness
		The presence of an invisible enemy in the body
		Despair
		Anger
	3. Penetration into existence	Reservoir
		Pervasive influence

Table 2. Themes and categories of COVID-19 disease (Cont.)

Themes	Categories	Sub-categories
2. Response to traumatic experience	1. Fear	Fear of a painful death
		Fear of infection
		Disgust and hatred
		Economic insecurity
		Fear of having an unknown disease
		Fear of being killed by the medical staff
	2. Failure	Failure to end well
		Death of dreams
		Waiting for death
		Suicidal ideas
	3. Support	The sympathy of friends
		Relatives′ vowing
	4. Rejection	Being ignored
		Lack of face-to-face support from family and colleagues
		Lack of support from doctors and nurses
		Lack of community support
	5. Denial	Denial of diagnosis
		Denial of quarantine
		Fight against emotional turmoil
		Insistence on doing previous activities
	6. Stigma	Feeling shame
		Social isolation
		Hiding the disease from the family and society
		Dissatisfaction with pity
	7. Feeling guilty	Blaming oneself
		Blaming those around you
		Blaming social media
		Blaming authorities
		Blaming strangers
	8. Remorse	Recommendation to boost physical strength
		Sharing experiences
		Advising those around you to take the disease seriously
	9. Growth	rebirth
		Survival, a gift from God
		Starting a new life
		discovering oneself
		Being satisfied with destiny
		Strengthened faith
		Success in a divine experiment
		gratitude

Table 3. Themes and categories of the quarantine themes

Themes	Categories	Sub-categories
1. Deprivation	Elimination of normal routine	Disruption of job and social activities
		Disruption of marital and family relationships
		Inability to perform daily activities
	Loneliness	Slow-passing time
		Being stuck at home
		Meeting with others being prohibited
	Disruption of religious beliefs	Pilgrimage to holy places being forbidden
		Closed religious ceremonies
		Changed funeral customs
		Decreased beliefs in traditional medicine
	Restriction	Emotional
		Social
2. Confusion	Preferring recovery center	Sacrifice to prevent harm to others
		Staying hidden from others
		Fear of scandal in the neighborhood
	Ignorance of the principles of segregation	Lack of adequate knowledge
		Inadequate attention by health authorities
		Lack of acceptance of the need to avoid public toilets
	Uncertainty	Lack of confidence in the treatment team
		Doubts about the usefulness of quarantine and the efficiency of Covid-19 preventive measures
		Doubts about successful recovery

Theme 1: The characteristics of the experience

This theme included the definition of the experience of having COVID-19 and the explanations of phenomena of *physical symptoms*, *psychological reactions*, and *penetration into the patient's existence*. Physical symptoms included profoundness of experiences as *extraordinary pain*, *confusion*, *torturous suffocation*, *cellular hypoxia*, and *anorexia*, for example:

> *Shortness of breath made me feel suffocated and although my doctor discharged me today, I still cannot breathe deeply because my lungs are burning.* (P1)

Psychological reactions included *reaching the end of the line*, *grief*, *insomnia*, *restlessness*, *the presence of an invisible enemy in the body*, *despair*, and *rage*. Most of the participants reported that in addition to physical symptoms, they also suffered from mental and psychological problems. Some were in anguish comparing the hospital to the front line of an unequal war against an invisible enemy.

The main category of *"penetration into the patient's existence"* included "source" and "pervasive influence." Each participant imagined the coronavirus as penetrating a part of their body and causing pain and discomfort to an organ, for example:

> *"Coronavirus is like a curtain drawn on my right lung."* (P7)

> *"It seems that the virus is squeezing my throat and trying to suffocate me."* (P9)

Theme 2: Response to traumatic experience

This theme related to participants' descriptions of COVID-19 being a traumatic experience, *fear*, *failure*, *support*, *rejection*, *denial*, *stigma*, *feeling guilty*, *remorse*,

and *growth.* Fear involved self-threats to their holistic well-being and this involved *fear of a painful death, fear of infection, disgust and hatred, economic insecurity, fear of having an unknown disease,* and *fear of being killed by the medical staff.*

> *"I was afraid that I might be killed by the medical staff when I was hospitalized and thought the reason was that my disease was contagious and that I might transmit it to them."* (P3)

It was clear that the participants did not have a good self-image and lacked positivity, as they sensed *failure which involved failure to have a good end, not fulfilling one's dreams, waiting for death,* and *suicidal ideas.* One explained:

> *"At the height of my illness, I wanted to find a way to kill myself. I could no longer bear the growing suffering"* (P1)

Failure to have a good end was graphically portrayed by two participants:

> *"I saw that a patient's corpse on the bed beside mine was placed without washing in a black nylon bag and the medical staff poured some materials on it and took it away."* (P5)

> *"I am a Quran teacher. How could I consent to such a death? I wanted my corpse to be bathed before burial. I just wished that I could have a good end."* (P5)

The feelings of rejection were categorized into *being ignored, lack of face-to-face support from family and colleagues, lack of support from doctors and nurses,* and *lack of community support.* This feeling of rejection was intertwined with a sense of isolation as experienced by Participant 6:

> *"I complained about the absence of nurses and the fact that they came to my bed only in emergencies. I thought the reason was that the medical staff feared me and the contagiousness of the disease and that they were negligent."*

Denial also emerged as a complex psychological issue, and involved denial of diagnosis, *denial of quarantine, fight against emotional turmoil,* and *insistence on doing one's previous activities.* One participant said:

> *"I did not believe that I had the corona disease even after hearing the doctor's diagnosis and I thought that it was a pulmonary problem or I had caught a cold."* (P3)

Existential *shame, social isolation, hiding the disease from the family and society,* and *dissatisfaction with pity* were extracted from the *stigma* category.

> *"I did not want to tell anyone that I was infected with coronavirus even my children. If the neighbors found out that someone had contracted the coronavirus, that would be a scandal and no one would talk to him/her anymore. I would tell them that I had a lung infection. Even if health services asked me, I would not say that anyone in our house had been infected with coronavirus."* (P7)

Theme 2 also involved more positive viewpoints emerging from the threat of COVID-19, such as *rebirth, survival as a gift from God, starting a new life, discovering oneself, being satisfied with destiny, strengthened faith, success in a divine experiment,* and *gratitude.* In this regard, a participant admitted:

> *"I was struggling with death. I saw death with my own eyes. My dreams died. So far, I had not thought that I would be so sick. However, I say now that health is the greatest blessing. This disease was a warning for me to appreciate my health. I have just found myself and a new world has begun for me."* (P9)

Regarding the participants' experience with the concept of quarantine, the two main themes of *Deprivation* and *Confusion* were developed.

Theme 1: Deprivation

The quarantine experiences of the participants resulted in a sense of *deprivation* which had major effects that seemed to profoundly affect them. Such

deprivation manifested in the *loss of the normal routine of life, loneliness, disruption of religious beliefs and practices,* and *restriction.*

The *loss of the normal routine of life* was explicated into the phenomena of *disruption of job and social activities, disruption of marital and family relationships,* and *inability to perform daily activities.* A participant was concerned about their livelihood:

> *"I am worried about my job because I have not worked for 2-3 weeks and I am worried about my cheques and paying rent. After discharge, I cannot work for a while because of being quarantined."* (P1)

Disruption of religious beliefs and practices was explained by one participant as:

"We had seen earthquakes, floods, and wars, but we had not seen the doors of the mosques closed ... we had not seen the doors of the shrines closed ... who thought that such days would come? I was even afraid of kissing the seal." (P2) (A seal is an object made of soil that Muslims place their heads on it when they worship God, and it symbolizes Earth).

Theme 2: Confusion

Confusion was the second main theme relating to quarantine and involved the phenomena of *preferring the recovery center, ignoring the principles of social distancing* and *segregation, and uncertainty.* Some participants preferred to stay in the recovery centre for a period of quarantine. In doing so, they sacrificed being with their loved ones to prevent harm and so as not to offend anyone, and another reason was that they hid the corona from others. If they stayed in quarantine at home they may have made others aware of the disease and felt ashamed of it.

> *"In order to pass the quarantine period, it is better for me to go to a recovery center so that I can spare my loved ones and prevent harm to anyone. Another reason is that I do not want others to be informed of my illness. Quarantine at home may alert the neighbors and make me notorious."* (P7)

Ignoring the principles of social distancing and segregation. Unawareness of the principles of separation causes some participants to insist on carrying out their activities as before. The lack of amenities such as ambiguities in the characteristics of a separate health service and a separate exit corridor from the family also eliminated the need to comply with the new principles and quarantine.

> *"I have to knock on my door and the door is open to hear the voices of others and children playing, I think the toilet and bathroom should be separate from the others and go from one door to another. Toilet, but I do not have such facilities; It takes me fourteen days to get well, but I might pass it on to someone. Do you think it is better to go to a convalescent home? "* (P8)

Discussion

From the participants' points of view, COVID-19 was a disease associated with physical symptoms and psychological, social and economic consequences. Their existential well-being was shaken by the experiences of physical symptoms such as pain, myalgia, anorexia, shortness of breath, and hypoxia. These were consistent with the results of the other studies that reported that the main symptoms of COVID-19 were fever, cough, fatigue, headache, anorexia, hemoptysis, and dyspnea.[7,8] Further, the participants' psychological reactions to the disease were described as grief, despair, rage, restlessness, impatience, and subsequently insomnia which prevented them from engaging in any activity. It was evident that through the description of these reactions the participants were undergoing physical and psychological turmoil that adversely affected their well-being and existence.

The participants' responses to the traumatic experience of COVID-19 were also investigated. They expressed these responses in the forms of fear, economic

insecurity, failure, rejection, denial, stigma, guilt, remorse, and ultimately the valuable concept of growth. Thus, having COVID-19 affected not only a person's physical and psychological aspects but also the socio-economic aspect. Fawaz et al. found that people undertaking quarantine because of COVID-19 exposure experienced stigma regarding potential infection and feared both contracting and spreading the virus.[28] In a study examining the psychological effects of quarantine, some have reported some negative psychological issues such as post-traumatic stress symptoms, confusion, and anger. Stressors also included long-term quarantine, fear of the illness, despair, boredom, insufficient information, financial problems, and stigma.[17]

Analysis of data showed that, without exception, there was a fear of death among all our participants, which led to despair and such concepts as failure to have a good end, not fulfilling one's dreams, and suicidal ideas. This is consistent with another study which found that people who had to undergo COVID-19 quarantine were five times more likely to think about self-harm and/or suicide compared to those who were not quarantined.[29] Analysis of Indian media reports of COVID-19-related suicides explained that multiple suicide deaths had a direct correlation with quarantine or the social pressure to quarantine.[30]

Additionally, the participants blamed others, social media, officials, and strangers as culprits who were somehow responsible for their infection. Nevertheless, in the end, most of the participants reached a kind of maturity and mental growth which gave them the sense of starting a new life, gratitude, strengthened faith, and satisfaction with destiny. These results were consistent with the findings of another qualitative study during the Ebola epidemic that found that within the patients' descriptions of the disease, surviving from an epidemic was perceived as a gift from God.[23]

We found that the deprivation of the patients of their normal routines in life during the quarantine disrupted their jobs and social activities as well as their marital and family relationships. Thus, their socio-economic circumstances were affected by this disease. These results are consistent with another study during an epidemic of other infectious diseases such as Ebola that determined that keeping the disease a secret, being deprived of the normal routine of life, and reduced social and physical contacts with others often led to boredom, frustration, and feeling isolated which were agonizing for the patients.[21,31] Practical ways to reduce the unintended outcomes of isolation include providing sufficient space to walk around, allowing people to engage in more activities, and environments having large windows to enable the participants to connect to outside their room.[32] Additionally, we found that loneliness, the slow passing of time, disruption of religious beliefs and practices, and emotional and social restrictions also deprived the patients of the normal routine of life. These results were consistent with the findings of a study in which most patients with Ebola reported that they faced non-acceptance from the community and even their friends, and they thus experienced a sense of rejection and stigma.[33]

Factors such as inadequate knowledge about COVID-19 and ignoring health advice, on the one hand, and lack of confidence in the treatment team, doubts about the usefulness of being isolated, and uncertainty about recovery, on the other, caused insecurity and confusion in the patients during their quarantine. Researchers have reported that patients under quarantine explained their fears were mostly due to concerns over their health and the possibility of infecting others.[34] They also stated that the inadequate information shared by health authorities was a stressor.[35]

Limitations

In this study, the patients' unfavorable physical condition and shortness of breath prevented them from conducting long interviews, which was controlled by dividing the interview into several parts.

Conclusion and Implications for Nursing Practice

According to the findings, it was found that many patients experienced profound and various mental and psychological changes during this period, and also suffered from socio-economic effects. Loneliness, fear, or financial worries are aspects of COVID-19 quarantine that may cause greater risks for poor mental health. Awareness of patients' experiences helps the care team provide the necessary care and training to increase the quality of services to these patients with the necessary knowledge. The results of this study emphasize the importance of training the healthcare team to determine the impact of physical, psychological and socio-economic problems in patients with COVID-19 and the need to investigate and discover the requirements for quality in healthcare for them. Findings also indicate the critical need for patients to have psychological support and counseling with psychologists. Other measures include giving as much attention as possible to people during the quarantine period and giving important and effective sensory stimuli. We recognise that this is often difficult in situations of staff working to capacity or being short-staffed during a pandemic.

One of the issues that caused psychological harm to patients and their families is stigma related to COVID-19. Nurses are obliged to explain to the patient and the family that this disease is like other viral diseases and to emphasise with the patient and the family measures to try to reduce the psychological effect caused by this disease. In addition, community education efforts by the government are important too, such as media information to try to reduce stigma and inform the population about the nature of COVID-19 and how people can better protect themselves from infection – there is far too much misinformation in many countries, especially spread by social media and ill-informed people.

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ประสบการณ์ของผู้ป่วยโควิด 19 ที่รับไว้รักษาในโรงพยาบาล: การศึกษาโดยใช้ปรากฏการณ์ในโรงพยาบาลแห่งหนึ่งทางตะวันตกเฉียงเหนือของอิหร่าน

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บทคัดย่อ: โควิด 19 เป็นโรคติดต่อร้ายแรงที่แพร่กระจายอย่างรวดเร็วไปทั่วโลก จนองค์กรอนามัยโลกต้องประกาศภาวะฉุกเฉิน ทางด้านสาธารณสุขของโลก ความเข้าใจในประสบการณ์ของผู้ติดเชื้อและถูกกักกันมีความสำคัญในการควบคุมโรค และผลกระทบต่อผู้ป่วยที่ติดเชื้อ ครอบครัว และเครือข่ายทางสังคม การศึกษานี้ได้สำรวจประสบการณ์ของผู้ป่วยติดเชื้อโควิด 19 ในระหว่างได้รับการดูแลและกักตัว ในทางตะวันตกเฉียงเหนือของอิหร่าน โดยเลือกผู้ป่วยที่ติดเชื้อโดยวิธีเจาะจง 11 คน เก็บข้อมูลระหว่างเดือนมีนาคม – มิถุนายน 2563 โดยใช้การสัมภาษณ์กึ่งมีโครงสร้าง และวิเคราะห์ข้อมูลโดยวิธี van Manen's phenomenological ข้อมูลจากการสัมภาษณ์ได้บันทึกเทปไว้ ถอดเทปแต่ละคำและวิเคราะห์โดยใช้แก่นสาระ

ผลการวิเคราะห์สามารถสกัดได้ 4 แก่นสาระ คือ คุณลักษณะของประสบการณ์ การตอบสนองต่อประสบการณ์ที่สะเทือนใจ ความรู้สึกแปลกแยก และสับสน และพบ 19 แก่นสาระย่อย ผลการวิจัยนี้ช่วยให้พยาบาลสามารถใช้ในการประเมินและวิเคราะห์ประสบการณ์เหล่านี้ในระหว่างที่ผู้ป่วยถูกกักกันอยู่ในโรงพยาบาล และผลการวิจัยยังเป็นแนวทางในการจัดโปรแกรมการฝึกอบรมพยาบาลและเจ้าหน้าที่ที่เกี่ยวข้อง

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คำสำคัญ : โควิด 19 ประสบการณ์ การพยาบาล โรคระบาด ปรากฏการณ์วิทยา การศึกษาเชิงคุณภาพ

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