Original article

Nursing staff experiences in caring for COVID-19 patients in the Salvadoran public health system

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Experiencias del personal de enfermería en la atención a pacientes con COVID-19 en el sistema público salvadoreño

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Abstract
Introduction. The COVID-19 pandemic imposed unprecedented conditions on nursing staff, characterized by high workloads, increased exposure to occupational risks, a significant impact on emotional health, and substantial changes in family and social dynamics. In El Salvador, nursing staff, both in hospital and community settings, provided care in contexts marked by uncertainty, resource constraints, and social stigma. **Objective.** Understand the lived experiences of nursing professionals while caring for patients with COVID-19 in Ministry of Health of El Salvador facilities in El Salvador, exploring the meanings they attributed to their professional practice, emotions, and social relationships during the pandemic. **Methodology.** A qualitative study with a descriptive phenomenological approach, based on 20 semi-structured interviews analyzed using Colaizzi's method. Three main categories emerged from the analysis: professional practice, emotional experiences and coping strategies, and social and family implications. **Results.** The pandemic redefined the professional identity of nursing staff, strengthening dimensions such as resilience, spirituality, and solidarity. Likewise, tensions arising from the care burden and the impact on personal life were identified. **Conclusion.** The results showed that nursing professionals experiences during the COVID-19 pandemic were characterized by a tension between vulnerability and resilience, highlighting the need for institutional psychosocial support policies for nursing professionals.

Keywords
Nursing, COVID-19, Attention.

Resumen
Introducción. La pandemia de COVID-19 impuso condiciones sin precedentes al personal de enfermería, caracterizadas por una elevada sobrecarga laboral, mayor exposición a riesgos ocupacionales, impacto significativo en la salud emocional y cambios sustanciales en las dinámicas familiares y sociales. En El Salvador, el personal de enfermería, tanto en el ámbito hospitalario como comunitario, brindó atención en contextos caracterizados por incertidumbre, limitaciones de recursos y estigmatización social. **Objetivo.** Comprender las experiencias vividas por profesionales de enfermería durante la atención a pacientes con COVID-19 en establecimientos del Ministerio de Salud de El Salvador, explorando los significados atribuidos a su práctica profesional, emociones y relaciones sociales durante la pandemia. **Metodología.** Estudio cualitativo con enfoque fenomenológico descriptivo, basado en 20 entrevistas semiestructuradas, analizadas mediante el método de Colaizzi. Del análisis emergieron tres categorías principales: práctica profesional, experiencias emocionales y estrategias de afrontamiento, e implicaciones sociales y familiares. **Resultados.** La pandemia redefinió la identidad profesional del personal de enfermería, fortaleciendo dimensiones como la resiliencia, espiritualidad y solidaridad. Asimismo, se identificaron tensiones derivadas de la carga asistencial y del impacto en la vida personal. **Conclusión.** Los resultados muestran que las experiencias del personal de enfermería durante la pandemia de COVID-19 estuvieron marcadas por la tensión entre la vulnerabilidad y la resiliencia destacando la necesidad de aplicar políticas institucionales de apoyo psicosocial al personal involucrado.

Palabras clave
Enfermería, COVID-19, Atención.

Introduction

The SARS-CoV-2 pandemic, or COVID-19 disease, represented one of the greatest public health challenges of the 21st century, triggering a global crisis that reshaped the clinical, social, and emotional structures of health care systems. Since the World Health Organization (WHO) declared it a public health emergency of international concern on January 30, 2020, health services have faced an unprecedented overload, accompanied by scientific uncertainty and a shortage of human resources.[1,2]

In this context, nursing staff became the first line of response, taking on essential roles in the detection, treatment, education, and emotional support of patients with COVID-19. According to Sinh D *et al.* and Shen X *et al.*, prolonged exposure to risk, physical fatigue, and psychological stress led to high levels of stress, anxiety, and emotional exhaustion among nursing professionals.[3,4]

The evidence highlights that, in addition to the clinical impact, the pandemic profoundly altered the family and social dynamics of healthcare workers, increasing isolation and stigma.[5,6] Yasin *et al.* demonstrated that COVID-19 caused an abrupt change in nursing staff's work routines, which made it difficult to make appropriate decisions *in situ*ations that go beyond direct patient care and involve professional and organizational dimensions, leading to experiences of moral suffering.[7] In El Salvador, the Ministry of Health (Minsal) implemented an early containment strategy by establishing quarantine centers, repurposing hospitals, and hiring staff for COVID-19 units. These measures, although necessary, placed nursing professionals in highly demanding settings, with constant exposure to infection and limited material and emotional resources.[8]

In El Salvador, there is little scientific literature addressing nursing experiences from a qualitative and humanistic perspective. To understand the lived experiences of nursing professionals while caring for patients with COVID-19 in Ministry of Health facilities in El Salvador, exploring the meanings they attributed to their professional practice, emotions, and social relationships during the pandemic.

Methodology

Study design

A qualitative study with a descriptive phenomenological approach was conducted to understand the experiences of nursing professionals in caring for COVID-19 patients at Minsal facilities. This approach allowed for an exploration of the meaning of these experiences from the participants' perspective, applying the principles of phenomenological reduction: suspension of prior judgments, identification of units of meaning, organization into thematic categories, and description of the phenomenon.

The study was conducted within the Minsal network: health centers, departmental hospitals, and specialized hospitals.

This structure enabled the collection of experiences in both community and hospital settings. The study period ran from March 2020 to March 2021, and participants with the participation of registered nurses and nursing technicians. The inclusion criteria were: nursing staff who provided direct care to patients with COVID-19, held a permanent position within the, and a voluntarily agreed to participate in the research study by providing informed consent. Intentional sampling with maximum variation was used to ensure representation accross levels of care and professional categories.

The final sample consisted of 20 participants (12 registered nurses and eight nursing technicians), selected for their direct experience in caring for patients with COVID-19. The sample size was justified by the heterogeneity of professional profiles and levels of care described above, which allowed for capturing a diversity of perspectives and ensuring the interpretive richness of the data.

Department heads identified nursing staff who met the inclusion criteria. Additionally, physical spaces within the institutions were arranged for conducting the interviews, ensuring adequate privacy, a quiet environment, and minimal distractions, in order to optimize the quality of the information collected.

The exclusion criteria included professionals on medical leave, those who had less than six months of experience providing care during the pandemic, or declined to participate in audio-recorded interviews. Participation was voluntary, and no financial or material incentives were offered, ensuring transparency and ethical conduct throughout the process.

Data collection techniques and instruments

The instrument used was validated by nursing staff who are experts in qualitative research, ensuring its relevance and clarity. In-depth interviews were conducted using a semi-structured guide designed to explore the personal, professional, and emotional experiences of the nursing staff. The guide included five items with open-ended questions on performance, emotions, institutional support, family relationships, and lessons learned. The interviews were conducted in person, recorded with participants' consent, and supplemented with field notes to document nonverbal observations and contextual reflections. Although a single guide was used, its application was flexible and adapted to each participant's roles and settings based on their level of care, whether in a hospital or community setting.

Data analysis

Data analysis was conducted according to the stages of Colaizzi's phenomenological method.[9] Specifically, five researchers independently performed the initial coding, reading and familiarizing themselves with the complete transcripts. Subsequently, consensus meetings were held to resolve discrepancies, with the participation of a sixth researcher in cases of disagreement. The process included three coding cycles: open coding (extraction of units of meaning), axial coding (grouping into categories and subcategories), and selective coding (thematic integration). The analysis was conducted manually, using office software solely to support organization and systematization, without resorting to specialized software due to its unavailability at the time the research was conducted.

Methodological rigor was ensured by applying the criteria of credibility, transferability, dependability, and confirmability.9 For the latter criterion, the researchers maintained a reflective journal that allowed them to identify potential influences from their professional experience, control for biases, and maintain interpretive objectivity. Theoretical saturation was reached after the fifteenth interview, when the narratives began to repeat thematic patterns without generating new categories. The final decision regarding saturation was reached by consensus among the researchers, taking into account the density of the data, the internal coherence of the themes, and the sufficiency of information to describe the essential structure of the phenomenon experienced.

Validation with participants was conducted by providing a narrative summary of the preliminary findings to five interviewees, who reviewed the interpretation of the meanings attributed to their narratives. This process allowed to corroborate the accuracy of the emerging categories. During the review, the participants expressed agreement with the interpretation presented; therefore, no modifications to the wording of the themes were necessary. This feedback strategy helped strengthen the credibility and confirmability of the analysis, in line with the criteria for methodological rigor proposed by Lincoln and Guba.[10]

Ethical considerations

The research protocol was approved by the Ethics Committee of the National Institute of Health of El Salvador. Informed consent was obtained from all participants, ensuring data confidentiality and anonymity.

Results

Participant Characteristics. The sample consisted of 20 nursing professionals: 12 registered nurses and eight nursing technicians distributed across the three levels of care within the Ministry of Health. The characteristics of this population are presented in Table 1.

As a result of the analytical process and the application of the stages proposed by Colaizzi,[9] three central themes and nine subthemes emerged, which structure the presentation of the results and reflect the experiences of nursing professionals while caring for patients with COVID-19 (Table 2).

Table 1. Characteristics of participants from the three levels of care within Minsal

Variable	Indicators	Frequency	%
Sex	Female	16	80
	Male	4	20
Age in years	34–38	10	50
	39–43	4	20
	44–48	6	30
Level of care	First level	7	35
	Second level	8	40
	Third level	5	25
Professional category	BS in Nursering	12	60
	Technicians	8	40
Years of experience	2–7 years	4	20
	8–15 years	10	50
	16–22 years	6	30
Marital status	Married	11	55
	Single	6	30
	Separated	3	15

Source: own compilation.

As shown in Table 3, the categories are accompanied by both predefined and emergent representative codes. The process of theoretical saturation is also described, and it was achieved by observing repetition and redundancy of meanings starting with interview number fifteen.

Professional practice during the pandemic

Adapting to an unknown disease

The participants described the onset of the pandemic as a time of uncertainty and professional disorientation. "At first it was worrisome because I wondered… What am I going to do? Maybe I won't be able to… We tried to follow the protocols, even though the situation was out of control. Our role shifted from preventive care to a completely different kind of care in the containment centers. It was a unique experience." "As nurses, we all started out feeling afraid when the pandemic began, but little by little we realized that we are essential to this healthcare system."

At the hospital level, the physical strain was greater due to the sustained increase in patients and the implementation of strict biosafety measures. During the initial phase of the pandemic from 2020 to 2021, there were shifts that lasted up to 24 continuous hours. Likewise, the use of Level three personal protective equipment (PPE) involved lengthy processes for donning and doffing; at the beginning of the health emergency, these procedures could take approximately 30 minutes due to staff inexperience and the need to strictly adhere to safety protocols. "It took us almost half an hour to put on the protective suit, but we didn't notice the time passing, and we'd work until 5:00 p.m. without drinking water, eating, or using the restroom since we'd started at 7:00 a.m." "We kept working until the end of our shift. When we arrived at six in the morning, we were already extremely exhausted, but we were satisfied that during our shift we did the best we could."

Teamwork and redefining roles

Collaborative work emerged as an essential coping strategy. The camaraderie among colleagues allowed to maintain continuity of care and compensate for the lack of resources. "When a patient's condition deteriorated and we had to immediately switch them to mechanical ventilation, the area supervisors provided support because we couldn't neglect the other patients." At the primary care level, nurses took on health education and community support tasks, while in hospitals the focus was on patient care.

Authorities responded quickly. Containment centers were set up, using hotels and other facilities to shelter and enforce quarantine for people entering the country.

Table 2. Themes and subthemes emerging from the phenomenological analysis of nursing staff experiences while caring for patients with COVID-19

Central Theme	Subthemes	Representative quotes
Professional practice during the pandemic	Adapting to an unknown disease	"It was a disease we didn't know... that scared me"
	Teamwork and professional solidarity	"We organized ourselves into teams... we all worked in harmony"
	The Transformation of the nursing role	"Our role shifted from preventive care to a different kind of care"
Emotions and personal coping	Fear and vulnerability	"My biggest fear was becoming a patient"
	Spirituality and faith as coping mechanisms	"Many of my colleagues prayed alongside a patient"
	Professional satisfaction and pride	"We realized that we are essential to this system"
Social and family implications	Isolation and broken ties	"We realized that we are essential to this system"
	Stigma and social discrimination	"People didn't want to come near us because they thought we had the virus"
	Resilience and collective learning	"We learned to draw on our strength to keep caring for her"

Table 3. Categorization of the phenomenological analysis of nursing staff experiences while caring for patients with COVID-19

Central theme	Subtheme	Initial codes	Emerging themes	Signs of saturation
Professional practice	Dealing with Initial Uncertainty	Unfamiliar protocols, fear of infection	Inexperience, improvisation	Code repetition starting in interview 12; saturation in interview 15
	Teamwork	Cooperation, support among colleagues	Camaraderie, spontaneous	Thematic stability across interviews 10–15
	Role reconfiguration	New responsibilities	Work overload, adaptation	Recurrence of meanings starting in interview 14
Emotions and coping	Fear and vulnerability	Stress, fear getting sick	Existential anxiety, sense of duty	Saturation after interview 16
	Spirituality	Faith, hope	Spiritual strength	Recurrence across interviews 8–17
	Professional	Gratitude from patients	Reaffirmed calling	Saturation from Interview 12
Social implications	Family isolation	Distancing	Personal sacrifice	Recurrence starting in interview 9
	Social stigma	Community rejection	Stigmatization of staff	Thematic stability across interviews 7–16
	Collective resilience	Learning	Professional cohesion	Saturation starting in interview 15

During the initial phase of the COVID-19 pandemic, El Salvador implemented a series of public health measures aimed at containing the spread of the virus, including the creation of containment centers for the preventive isolation of people suspected of having the virus or with a history of exposure. The Ministry of Health issued technical guidelines to regulate care at these centers and in hospitals: "Every day, many people arrived in minibuses, and we had to help them settle in, unload their luggage, take them to their rooms, and guide them through the quarantine process. Our role changed, but it was for the better, because that was exactly what we were there for."

Patient care and the family–patient bond

Despite the restrictions, staff maintained communication between patients and their families through phone and video calls. These took place daily or as dictated by the patient's clinical condition, coordinated primarily by nursing and social work staff, who ensured the confidentiality of the information:

"We made video calls with the families and could see the improvement in some patients."

Feelings and emotions of the nursing staff

Fear, anxiety, and vulnerability

The fear of infection and of losing one's life was a recurring feeling, especially during the first months of the pandemic. This fear intensified as colleagues fell ill or passed away. "I thought I wouldn't make it; I was afraid of getting sick and dying."

"From inside, I could hear the funeral music they played for our deceased colleagues, and hearing it left me with that feeling because suddenly they were gone."

Fear coexisted with a sense of duty and commitment, reflecting the tension between personal risk and professional calling. "As a healthcare worker, it was difficult, but at the same time I thought, I'm giving it my all."

Emotional impact and proximity to death

Experiences of being close to death frequently generated a range of emotions. Participants expressed fear, sadness, helplessness, and psychological exhaustion. "Seeing patients die every half hour, every 35 minutes, was difficult"; "Some colleagues

I could observe were worried; I was too; some were broken"; "I felt stressed for all the patients…and seeing so many deceased patients, I often felt helpless."

Personal coping strategies included prayer, reflection, and seeking support from colleagues. Spirituality emerged as a practice used by some participants, though this does not imply a prescriptive judgment:

"I always entrusted myself to God, asking Him to help me endure wearing the suit and to keep me safe"; "As a facility, we came together in prayer every day; this became a routine"

Satisfaction and sense of accomplishment

Despite their exhaustion, the nurses expressed satisfaction at seeing their patients recover. This feeling reinforced their professional commitment.

"When we saw them being discharged and thanking us, it was all worth it."

Social and personal implications

Family Isolation and Self-Care

Family isolation was a recurring experience among participants, who described the need to limit contact with their loved ones as a strategy to reduce the risk of infection. In most cases, this measure was managed on a personal level. "I slept alone, ate alone, everything separate from my children. It was painful, but necessary." "At home, there were designated decontamination areas, water, soap, and bleach; the baths had hot water."

Some participants reported becoming infected despite these precautions, which

heightened their anxiety and sense of vulnerability. "I was admitted to a regional hospital for 11 days; I was diagnosed with COVID-19."

Stigma and Discrimination

Various testimonies revealed experiences of social rejection and stigmatization toward nursing staff, who were perceived by some community members as potential "carriers of the virus." These reactions occurred in a sociocultural context marked by collective fear of contagion and the circulation of limited or inaccurate information during the health emergency. "In my neighborhood, they wouldn't even sell me tortillas because they knew I worked at the hospital."

"Once, a motorcycle taxi driver refused to give me a ride; he told me I was a risk, that I was going to infect everyone."

These experiences of discrimination affected the participants' self-esteem and generated feelings of injustice; however, they also helped strengthen solidarity and cohesion among colleagues. The findings suggest the need to promote institutional and community strategies aimed at reducing stigma toward healthcare workers through public information and campaigns, health education, and policies of recognition and social protection during health emergencies.

Social Support and Resilience

Support from colleagues, family members, and patients was essential for coping with the emotional burden. Expressions of gratitude strengthened professional identity and a sense of purpose. "They gave us letters, messages… that reminded us we were doing something important." "Working with colleagues was very rewarding; we learned the value of camaraderie and empathy. This crisis helped us come together and show greater solidarity."

Phenomenological synthesis

The analysis made it possible to identify the essential structure of the phenomenon experienced, expressed in three interrelated dimensions: a) professional: adaptation to change, teamwork, and reaffirmation of one's role; b) emotional: the coexistence of fear, sadness, faith, and satisfaction; c) social: isolation, stigma, and a strengthened sense of belonging. Taken together, the narratives reflect a process of collective resilience, in which ethical commitment and spirituality served as pillars for coping with uncertainty and loss.

Discussion

This study provided insight into the experiences of Salvadoran nursing staff while caring for COVID-19 patients in Ministry of Health facilities. From a phenomenological perspective, the narratives reveal the coexistence of professional, emotional, and social dimensions, which together constitute the essential structure of the phenomenon: a practice of care marked by uncertainty, vulnerability, and resilience.

The pandemic disrupted established routines across the different levels of care within the Ministry of Health and challenged traditional competencies. The need to confront an unknown disease generated initial uncertainty but also fostered rapid adaptation through collaborative learning

and teamwork. This finding aligns with Latin American studies highlighting the development of new clinical competencies and solidarity among colleagues as coping mechanisms.[5,11]

Likewise, the redefinition of the nursing role emerged as a transformative experience: shifting from preventive care to intensive and emotional care. Research in similar contexts confirms that functional flexibility was key to maintaining the quality of care during a crisis.[4,12] In El Salvador, nursing practices across different levels of care highlighted the ability to reorganize service delivery, assume nontraditional responsibilities, and maintain patient care under extreme conditions, reflecting a resilient professional practice.

Similarly, studies in Latin America have documented that nursing staff faced significant constraints during the pandemic, characterized by resource shortages, work overload, and the need to take on additional duties, which forced them to improvise care strategies and reorganize care.[13,14,15] Furthermore, in other contexts across the region, training and the strengthening of competencies, especially in critical care, have been highlighted as a key strategy for adapting to the emerging demand for care.[16,17]

Fear of infection and the proximity to death were common experiences. This fear coexisted with a strong sense of moral responsibility, a phenomenon also described by studies in Spain and Brazil,[18,19] where ethical commitment served as a driving force for continuing to work. In this study, support among colleagues and spirituality were fundamental strategies for emotional coping, which aligns with recent literature on spirituality as a coping resource during public health emergencies.[19,20,21]

Faith, prayer, and support among colleagues helped transform suffering into meaning and moral support. These findings are consistent with those reported by Alvarado and Pagan,[22] who identify spirituality as an essential coping resource for the emotional well-being of healthcare workers during the pandemic. Similarly, another study highlights the importance of social support and group cohesion as protective factors against work-related stress.[23]

The satisfaction expressed upon observing patients' recovery revealed a positive emotional component associated with the notion of the meaning of care.

This finding complements the views of those who suggest that positive emotions such as gratitude and professional pride can mitigate the effects of work-related stress in high-demand contexts.[24]

Family isolation and the adoption of disinfection protocols at home created tensions in nurses' personal lives. These experiences correspond to those described in Spain and Argentina,[2,24,25] where physical distancing led to feelings of loneliness and guilt over the risk of infecting family members. On the other hand, discrimination and social stigma manifested to varying degrees, following established patterns.26 However, this study showed that such experiences triggered mutual support within the nursing profession, reaffirming the professional identity of nurses as a supportive and ethically committed group. These studies reaffirm the statements made by PAHO and the International Council of Nurses:[2,27] the sustainability of the health care system depends on the well-being and protection of its workforce.

It is recommended that the phenomenology of care be incorporated as a tool for health education, as it allows for an understanding of experiences beyond the technical, integrating the human dimension of suffering and hope.

It is suggested that future research expand its scope to include different institutional levels and regions of the country, incorporate comparative analyses between the public and private sectors, and delve deeper into the psychological and spiritual dimensions of care in crisis contexts.

Limitations

Among the study's limitations, although data saturation was achieved, the sample size and institutional selection may limit the generalizability of the findings. Likewise, we acknowledge the possible influence of the researcher's dual role as a nurse on data interpretation and the risk of social desirability bias in the responses. To mitigate these effects, reflexivity strategies were implemented, including the use of a reflective journal and the systematic documentation of methodological decisions.

Conclusion

The results show that nursing staff's experiences during the COVID-19 pandemic were marked by the tension between vulnerability and resilience. Conditions of work overload, biological risk, and initial disorganization fostered feelings of fear and uncertainty, but also spurred adaptation, leadership, and cooperation.

On an emotional level, spirituality, faith, and support among colleagues served as coping strategies that provided meaning and strength in the face of suffering. The

social implications were reflected in isolation and stigma, although they also gave rise to processes of cohesion, learning, and a reaffirmation of professional commitment. From a descriptive phenomenological perspective, these experiences reveal the essential structure of the lived phenomenon, defined by ethics, solidarity, and the transcendence of care. The study provides evidence of the professional resilience of Salvadoran nursing staff and highlights the need to strengthen institutional policies and to create psychosocial support programs, crisis management training, and public recognition of the work of nursing staff.

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