

CHAPTER 1

INTRODUCTION

1.1 Background

At the beginning of 2020, the world was shocked by the presence of a new virus, namely a new type of coronavirus (SARS-CoV-2), the disease is called Coronavirus disease 2019 (COVID-19). This virus was first reported to have originated from Wuhan, China by the end of December 2019. On February 12, 2020, WHO named the disease Coronavirus 2019 (COVID-19) which is the seventh type known in man. SARS-CoV-2 is classified in the betaCoronavirus genus (PDPI, 2020).

Coronaviruses are defined as family viruses that are transmitted between humans and animals (zoonosis) and can cause mild to severe symptoms. As happened in the past, there are two types of coronaviruses that have been identified to cause pathological effects in humans, these include Severe Acute Respiratory Syndrome (SARS-CoV) and Middle East Respiratory Syndrome (MERS-CoV) (Moudy & Syakurah, 2020). Symptoms and signs of the impact of the COVID-19 disease include signs of problems related to shortness of breath, fever, and cough. The incubation phase of the COVID-19 disease lasts for five to six days, and the longest incubation phase is 14 days. In severe cases of COVID-19, this can lead to kidney failure, acute respiratory syndrome, pneumonia, and even death. The symptoms and signs are the onset of fever, there is also difficulty breathing, and the X-ray also shows an extensive pneumonia infiltrate in the lungs. (Kemenkes, 2020). COVID-19 spreads from

person to person through the mouth, nose and eyes. Transmission can attack all ages ranging from infants, children, adults, the elderly, pregnant and lactating women. When first infected with COVID-19, a person's mental attitude can be in the form of fear, anxiety, and panic (Kemenkes, 2020).

World COVID-19 data as of October 26, 2021, there were 243,857,028 confirmed cases of COVID-19, including 4,953,246 deaths, reported. Meanwhile, in Indonesia from January 3, 2020 to October 26, 2021, there have been 4,241,090 confirmed cases of COVID-19 with 143,270 deaths reported (WHO, 2021). East Java Province contributed to the number of confirmed COVID-19 deaths as of November 26, 2021, as many as 397,885 people and the death rate of 29,601 people (East Java Provincial Government, 2021). In Banyuwangi Regency, as many as 13,653 people were confirmed to have COVID-19 and 1698 people were reported to have died (Banyuwangikab, 2021). As the front line in dealing with the COVID-19 pandemic, nurses are one of the professions that are at very high risk of contracting COVID-19. The International Council of Nurses (ICN) stated that as many as 90,000 health workers have been infected with COVID-19 and more than 260 nurses have died (ICN, 2021). On February 11, 2020, more than 3,000 health workers in China were suspected of being infected with SARS-CoV-2. Among them, 1,716 cases were confirmed and 5 died (China Disease Control Report, 2020). The Indonesian National Nurses Association (PPNI) stated that as of October 15, 2020, nationally 2479 nurses were infected with COVID-19, 188 nurses were suspected of having COVID-19, 639 had close contacts, 68 probable, 1633 were confirmed to be COVID-19 and declared cured, and many 101 nurse dies of

COVID-19. The death rate of health workers due to infection with the COVID-19 virus in Indonesia is the highest among countries in Southeast Asia (Pusparisa, 2020). Meanwhile, the results of a study of 4679 doctors and 348 hospital nurses during the COVID-19 pandemic showed 15.9% psychological distress, 16.0% anxiety symptoms and 34.6% depression symptoms (Liu Z et al, 2020) . The results of research from Cheng et al (2020) stated that as many as 13 respondents experienced anxiety disorders due to a lack of personal protective equipment that had not been fulfilled when taking action against patients. Research by Lai et al (2020) states that health workers have a risk of psychological disorders when treating COVID-19 patients, the results of the study show that 44.6% have symptoms of anxiety caused by feeling depressed. The results of the study stated that COVID-19 caused a psychosocial impact of anxiety on nurses, namely 154 respondents (34.00%) experienced mild anxiety, 16 respondents (3.53%) experienced moderate anxiety and 2 respondents (0.44%) experienced severe anxiety. (Cui S, et al, 2020). Another study of 85 nurses during the COVID-19 pandemic showed the mean anxiety score was 6.02 ± 2.6 and their anxiety score about family infection was 6.87 ± 2.8 (Nemati M et al, 2020). The results of a preliminary study conducted on October 24, 2021 on 5 nurses using the interview method at the Blambangan Hospital, Banyuwangi, 4 people stated that they had confirmed COVID-19. When they found out they were very shock, worried that it would get worse, they were also afraid of infecting their family members, and they felt burdened with the stigma of friends and the surrounding community. Meanwhile the other one person said he had never confirmed COVID-19.

Nursing personnel are one of the health care workers who interact with patients the most often compared to other components of health workers (Romadhoni & Widowati, 2017). Nurses have a very important role because nurses are always in a touch and interact with patients for approximately 24 hours being beside the patient (Wong et al, 2009). Medical personnel such as nurses are in the top position in the types of work that are most often exposed to diseases and infections such as the risk of facing an exposure to COVID-19 (Tiasari R, 2020). The high risk was according to (Ehrlich, McKenney, & Elkbuli, 2020) is caused by the length of interaction with patients and the large number of patients causing an increase in the number of viruses around them, these factors are exacerbated by the lack of the personal protective equipment (PPE) and lack of knowledge related to the use of the PPE.

The increasing number of patients makes nurses experience tremendous pressure, because of the increase in work every day (Sihombing & Septimar, 2020). This is in a line with the results of research which state that the medical team, especially nurses, are the main ones in the fight against COVID-19 (Chen et al, 2020). During the COVID-19 pandemic nurses sacrificed themselves to actively participate in services against the pandemic. Facing this situation results in higher stress levels experienced by nurses, so they are at the risk of experiencing a burnout (Sun et al, 2020). As stated (Huang & Zhao, 2020) in their research that apart from having a physical impact, COVID-19 can also cause serious effects on a person's mental health. The fear of the contracting COVID-19 is a trigger for psychological problems, anxiety and depression that is very detrimental to health workers and have an adverse effect on the quality

of care. They must overcome the anxiety so that they can treat patients according to the established care process (Wang et al., 2020).

The phenomena of anxiety, depression, workload, and worrying about being infected patients make nurses not optimal in providing holistic nursing care to COVID-19 patients. Anxiety and fear are actually common reactions to disease stress. Feelings of loss of control, guilt and frustration also play a role in the reaction of individuals affected by a disease. Adequate treatment of COVID-19 patients is necessary for healing and reducing the spread of the disease. In this case, nurses in particular have an important role in the readiness to handle COVID-19 patients (Li T, 2020). One way to improve the quality of nursing services is supported by the development of nursing theories, namely by applying the Caring theory by Swanson. Caring is central to nursing practice because caring is a dynamic approach, in which nurses work to increase their care for clients. The key to the quality of nursing care services is the care, empathy and concern of nurses (Muhlisin & Ichsan, 2008). Nurses in the COVID-19 special care room must pay more attention to the patient's condition which is dangerous and life-threatening. In this condition, caring nurses are needed to provide care to patients because patients need total care (Mersi et al, 2021). Caring is a human behavior that leads to physical, emotional, social, spiritual and moral care (Hunter, 2006). The experience of nurses can be seen in aspects of knowledge, motivation, and psychological conditions. Efforts to reduce the distribution and role of nurses in providing nursing care. These aspects can be influenced by the caring behavior of nurses such as the center of attention on people, respect for self-esteem and humanity, presence, empathy,

nurse motivation to be able to care more for clients and be able to take actions according to client needs (Dwidiyanti, 2015). The impact of caring for clients is to increase trusting relationships, increase physical healing, security, a lot of energy, lower treatment costs, and create a more comfortable feeling (Watson, 2012).

In general, discussions related to nursing care for COVID-19 patients are still in the form of quantitative research that focuses more on disease prevalence (Hui, et al., 2020), clinical characteristics, diagnosis, and treatment (Huang et al, 2020). Therefore, researchers is interested in exploring the experience of nurses in providing holistic nursing care to COVID-19 patients at the Blambangan Hospital, Banyuwangi.

1.2 Problem Formulation

Based on the previous description, the problem formulation of this research is How the Experience of Nurses in Providing Holistic Nursing Care for COVID-19 Patients at Blambangan Hospital, Banyuwangi ?

1.3 The Objective of Study

Based on the above problem formulation, the objectives to be achieved in this research are:

1.3.1 General Aim

To explore the Experience of Nurses in Providing Holistic Nursing Care for COVID-19 Patients at Blambangan Hospital, Banyuwangi

1.3.2 Specific Aims

1. To explore the experiences of nurses regarding the impact on health while treating COVID-19 patients at Blambangan Hospital, Banyuwangi.
2. To explore the experiences of nurses related to the difficulties experienced when treating COVID-19 patients at Blambangan Hospital, Banyuwangi.
3. To explore the experiences of nurses regarding the support needed by nurses when treating COVID-19 patients at Blambangan Hospital, Banyuwangi.
4. To explore the experience of nurses in providing nursing care in biological, psychological, social, spiritual aspects to COVID-19 patients at Blambangan Hospital, Banyuwangi.

1.4 Expected Result

Based on the research objectives to be achieved, the expected results of this research are:

1.4.1 Theoretical

Contribute to the field of health, improve and develop knowledge, especially in the field of nursing. Get information about The Experience of Nurses in Providing Holistic Nursing Care for COVID-19 Patients at Blambangan Hospital Banyuwangi and can be input for other researchers.

1.4.2 Practical

1. Researcher

The benefits achieved by researchers the process of qualitative nursing research, especially in the field of medical surgical nursing with the topic of nurses' experiences in providing nursing care to COVID-19 patients.

2. Next Researcher

The results of this study are expected to be a reference for further research using different research methods and involving more participants.

3. Educational Establishments

The results of this study are expected to be used as research examples for other researchers who study further in the field of medical-surgical nursing with the topic of nurses' experiences in providing nursing care to COVID-19 patients.

4. Nurses

Become a literature for health workers, especially nurses in Banyuwangi Regency about the experience of nurses in providing holistic nursing care to COVID-19 patients and become a motivation for nurses to be more sincere in caring for patients in hospitals.

CHAPTER 2

LITERATURE REVIEW

2.1 Overview of COVID-19

2.1.1 History of COVID-19

COVID-19 is the fifth most recorded pandemic since the 1918 influenza pandemic. COVID-19 was first reported in Wuhan, China, and has since spread around the world. The coronavirus that causes Covid19 has been officially named Severe Acute Respiratory Syndrome Coronavirus 2 (SARSCoV2) by the International Commission on Virus Taxonomy (ICTV) based on phylogenetic and taxonomic analysis. SARSCoV2 is thought to be the outbreak of the coronavirus in animals and has since been adapted and transmitted from person to person. Due to its high infectivity, the virus spreads rapidly and continues to multiply in the population (WHO, 2021).

Other reports show transmission to travelers Chinese who visited Japan accompanied by other evidence of infection in household contacts outside China of confirmed patients and went to The city of Wuhan to his partner in the United States. Direct transmission between humans (human to human transmission) this gives rise to an extraordinary increase in the number of cases until the end of January 2020 an increase of 2000 confirmed cases in 24 hours. At the end January 2020 WHO declares Global Emergency status for virus cases This Corona and on February 11, 2020, WHO named it as COVID-19.

All human coronaviruses originate from animals as natural hosts. As quoted from (JVI) Bats may be natural hosts of HCoV-229E, SARS-CoV, HCoV-NL63, and MERS-CoV. In addition, HCoV-OC43 and HKU1 may be of rodent origin. Bats are the main natural reservoir of alpha-coronaviruses and beta-coronaviruses. Pets can suffer from disease and act as intermediate hosts causing virus transmission from natural hosts to humans; for example, SARS-CoV and MERS-CoV cross-species barriers such as civets and camels. The SARS-CoV-2 sequence in the early stages of the Covid-19 outbreak had only a 79.6% match with SARS-CoV by comparison of the full genome sequence. However, the SARS-CoV-2 genome was very identical (96.2%) with Bat-CoV RaTG13, which was previously detected in the bat species *Rhinolophus affinis* from Yunnan Province, more than 1500 km from Wuhan (WHO, 2021).

Bats are most likely the reservoir host for SARS-CoV-2. Whether Bat-CoV RaTG13 jumps directly to humans or transmits via an intermediate host to facilitate transmission remains no concrete evidence. That's because no intermediate host samples were obtained by scientists in the initial case of infection at the Huanan Seafood and Wildlife Market in Wuhan, where the sale of wild animals may have been a source of zoonotic infections (WHO, 2021).

2.1.2 Epidemiology of Corona Virus Disease 19 (Covid-19)

It started with the discovery of the first case in Wuhan, China, which reported its first case and then spread to other areas and even all

over the world. Covid-19 cases are likened to a snowball which is increasing in positive numbers from almost all countries, until this article was made there were more than 205 million positive cases with 4.33 million deaths (WHO, 2021). Since the first case in Wuhan, there has been an increase COVID-19 cases in China every day and peaking late January to early February 2020. Initially most reports come from Hubei and the provinces in around, then increased to the provinces others and all of China (Wu Z & McGoogan, 2020). As of January 30, 2020, there have been 7,736 confirmed cases of COVID-19 in China, and 86 other cases were reported from various countries such as Taiwan, Thailand, Vietnam, Malaysia, Nepal, Sri Lanka, Cambodia, Japan, Singapore, Saudi Arabia, South Korea, Philippines, India, Australia, Canada, Finland, France and Germany (WHO, 2020).

The first case of Covid-19 in Indonesia was reported in Depok on March 2, 2020, so far positive cases in Indonesia have reached 3.75 million and 112,000 have died. World COVID-19 data as of October 26, 2021, there were 243,857,028 confirmed cases of COVID-19, including 4,953,246 deaths, reported. Meanwhile, in Indonesia from January 3, 2020 to October 26, 2021, there have been 4,241,090 confirmed cases of COVID-19 with 143,270 deaths reported (WHO, 2021). East Java Province contributed to the number of confirmed COVID-19 deaths as of November 26, 2021, as many as 397,885 people and the death rate of 29,601 people (East Java Provincial Government, 2021). In Banyuwangi

Regency, as many as 13,653 people were confirmed to have COVID-19 and 1,698 people were reported to die (Banyuwangikab, 2021).

2.1.3 Definition of COVID-19

According to WHO (2020), coronavirus disease 2019 (COVID-19) is an infectious disease caused by the newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. The elderly and people who have comorbidities such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to catch COVID-19. Coronavirus disease 2019 (COVID-19) is a disease caused by a novel coronavirus strain. 'CO' is taken from corona, 'VI' virus, and 'D' disease (disease). Previously, the disease was called '2019 novel coronavirus' or '2019-nCoV.' The COVID-19 virus is a new virus related to the same virus family as Severe Acute Respiratory Syndrome (SARS) and several strains of the common cold virus (UNICEF, 2020). According to Sun et al., 2020, COVID-19 is the third known zoonotic coronavirus after SARS and Middle East respiratory syndrome (MERS). According to Gennaro et al., 2020, Corona Virus Disease 2019 (COVID-19) is an RNA virus, with a crown-like appearance under the electron microscope due to the presence of glycoprotein spikes on its envelope.

2.1.4 Variant Classifications of COVID-19

Corona viruses containing the mutated gene are called "SARS-CoV-2 wild-type", while the corona viruses containing the mutated gene

are called "SARS-CoV-2 mutant". The more gene mutations in the coronavirus, the more variants of SARS-CoV-2. The mutation of the corona virus gene has become popular since the discovery of the SARS-CoV-2 variant in the UK, South Africa, Brazil, the United States and other countries.

a. Variant B.1.1.7 (Alpha)

The SARS-CoV-2 variant found in the UK on 18 December 2020 is B.1.1.7 or Variant Under Investigation-2020-month12/variant 01 (VUI-202012/01) (Members et al., 2020). Variant B.1.1.7 has a characteristic mutation in the S gene, later referred to as 20I/501Y.V1 (Rambaut et al, 2020). Recent studies have shown that variant B.1.1.7 is associated with significant changes in the SARS-CoV-2 phenotype (Volz et al, 2021). In addition, variant B.1.1.7 is also referred to as variant of concern 202012/01 (VOC-202012/01) (Washington et al, 2021). It was later discovered that variant B.1.1.7 spread rapidly in several countries, thus it was also more effective at spreading than wild-type SARSCoV-2. (Rambaut et al, 2021). In a retrospective observational study it was shown that variant B.1.1.7 was associated with a 30% increased risk of death (Horby et al., 2021).

b. Variant B.1.351 (Beta)

In addition to the B.1.1.7 variant above, there is also a B.1.351 variant in South Africa. Variant B.1.351 has 8

mutations in the S gene, 3 of which are K417N, E484K and N501Y. Another term for variant B.1.351 is 501Y.V2 (Tegally et al, 2020). It was reported that the B.1.351 variant had a 20 times stronger affinity for ACE-2 than the SARS-CoV-2 variant that was endemic in Wuhan, China (Zhou, 2021).

c. Variant P.1 (Gamma)

It has also been reported that the discovery of variant 20J/501Y.V3 (P.1) of SARS-CoV-2 which has the mutation K417T / E484K / N501Y in Kofu, Japan (Hirotsu, 2021). This variant is identical to the P.1 variant (B.1.1.28) found in Northern Brazil (Faria, 2021).

2.1.5 Pathogenesis of COVID-19

The pathogenesis of SARS-CoV-2 remains largely unknown, but several SARS-CoV-2 viruses have been identified and are not much different from others. In general, this virus infects cells in the respiratory tract that line the alveoli in the human body. These will make each other bind to the receptor and then make their way and enter the cell. The glycoproteins contained in the viral spike envelope will also bind to cellular receptors such as ACE2 in SARS-CoV-2. Inside the cell, this virus will duplicate the genetic material and synthesize the proteins needed, then will form new virions that appear on the cell surface. Similar to SARS-CoV, in SARS-CoV-2 it is known that after the virus enters the cell, the viral RNA genome will also be released into the cell cytoplasm

and translated into 2 polyproteins and structural proteins (Susilo et al., 2020).

Next, the viral genome will begin to replicate. Inside the new viral envelope, glycoproteins will form and enter the Golgi cell or endoplasmic reticulum membrane. This will result in the formation of a nucleocapsid consisting of a nucleocapsid protein and an RNA genome. Virus particles will grow into the endoplasmic reticulum and Golgi cells. In the final stage, vesicles containing viral particles will fuse with the plasma membrane to release new viral components. In SARS-CoV, Spike Protein was reported to be a significant determinant of where the virus enters the host cell. And it is known that SARS-CoV enters the cell beginning with the fusion of the plasma membrane with the viral cell membrane (Susilo et al., 2020).

In this process, the S2' protein plays an important role in the proteolytic cleavage process that mediates the membrane fusion process. In addition to membrane fusion, there is also clathrin-independent and clathrin-dependent endocytosis that mediates the entry of SARS-CoV into host cells. One of the viral and host factors plays a role in SARS-CoV infection. The impact of cytopathic viruses is that they have the ability to overpower the immune response and determine the severity of the infection. Dysregulation of the immune system then functions in tissue damage in SARS-CoV-2 virus infection. Inadequate immune response leads to viral replication and tissue damage. When this immune response is excessive, it can cause tissue damage. The immune response

caused by SARS-CoV-2 is not fully understood, but can be studied from the mechanisms found in MERS-CoV and SARS-CoV.

When this virus enters the cell, the viral antigen will be presented to the Antigen Presentation Cells (APC). This viral antigen presentation is dependent on Major Histocompatibility Complex (MHC) Class 1 molecules. However, MHC class II also contributes. Subsequent antigen presentation stimulates humoral and cellular immune responses mediated by virus-specific B cells and T cells. In this humoral immune response, IgG and IgM are formed in SARS-CoV. Finally, IgM in SAR-CoV is lost by the end of week 12 and IgG persists in the long term.

2.1.6 Transmission of COVID-19

According to Xu et al. (2020) there are several types of spread of COVID-19 including the following.

- a. Droplet. Covid-19 is transmitted primarily through respiratory droplets. When a patient coughs or sneezes, droplets containing the virus may be inhaled by vulnerable individuals.
- b. Direct Contact. It was found that 71.8% of the non-local population had a history of Covid-19 due to contact with individuals from Wuhan. Over 1800 from 2055 (~88%) medical workers with Covid-19 are in Hubei, according to reports from 475 hospital.
- c. Indirect Contact. This happens when droplets containing Covid-19 land on a surface desks, doorknobs, telephones, and other inanimate objects. The virus was transferred from surface to

mucous membranes with a contaminated finger touching the mouth, nose or eyes. Research has estimated that Covid-19 can last up to 5 days at 20°C, 40-50% humidity, and can survive less than 48 hours in dry air, with reduced viability after 2 o'clock.

d. Asymptomatic Transmission. Asymptomatic infections have been reported in at least two cases with history of exposure to potentially pre-symptomatic patients who later diagnosed with Covid-19. The virus used to be transmitted to three family members other healthy. Before symptoms develop, individuals may not be isolated and may be an important source of cellular viruses.

e. Transmission Between Families. Transmission within family clusters is very common. One study reported that 78 to 85% of cases in the large aggregate cohort occur due to intertransmission military in Sichuan and Guangdong, China.

f. Aerosol Transmission. Closed environment with poor ventilation conditions, aerosols can persist in air for 24-48 hours and spread from a few meters to tens of meters. However, there is no strong evidence for aerosol transmission yet. WHO also considers that this route requires further investigation.

g. Ocular Contagion. It has been reported that doctors without eye protection were infected for inspection in Wuhan on January 22, 2020. Further study found that Covid-19 can be detected in tears and conjunctival secretions of Covid-19 patients.

- h. Fecal-oral transmission. First reported in a case of Covid-19 in the US. Next study SARS-CoV-2 was detected in the stools and rectal swabs of Covid-19 patients. Furthermore, 23.3% of Covid-19 Patients remain Covid-19 positive even when viral load is no longer detectable in the respiratory tract. SARS-CoV-2 has also been detected in gastric, duodenal, and rectal epithelium. There is not enough evidence to support vertical transmission due to samples from neonates born positive for Covid-19 from a negative mother. Moreover, no viral load has been detected from the vaginal environment of 35 female patients, indicating a lack of evidence for sexual transmission of Covid-19.

2.1.7 Risk Factor of COVID-19

According to R. Miller (2020) there are several risk factors for Covid-19 including:

- a. Age 65 and Older

Severity and outcome of Covid-19 highly dependent on the age of the patient. Elderly people aged 65 years and over represents 80% of hospitalizations and have a 23-fold greater risk of death than those under 65 years (Mueller et al., 2020).

- b. Living in a Nursing Home or Long-Term Care Facility

This is due to poor maintenance or hygiene and lack of tools for personal protection so that they are easily at risk of Covid-19 (S. M. Shi et al., 2020).

c. Chronic Obstructive Pulmonary Disease (COPD)

In a study evaluating 1,099 patients diagnosed at Covid-19 laboratory in China, COPD was detected in 1.1% of patients. In a meta-analysis evaluating the incidence of this underlying disease in Covid-19 patients who requiring hospitalization, 0.95% of patients were found to have COPD (95%) (Çakır Edis, 2020).

d. Asthma sufferers

The proportion of people with asthma and Covid-19 during the study period was 1.41%, which is much higher than the 0.86% observed in the general population. Even though the data this suggests a higher frequency of Covid-19 in asthmatic patients, manifestations of the disease in this clinical population are less severe, with low hospital admissions. Moreover, this proportion is lower than reported for patients with other chronic diseases (Izquierdo et al., 2020).

e. Serious Cardiovascular Conditions

The increase in cardiovascular comorbidities applies to Covid-19 as well, especially among those with more severe diseases. In 1 cohort of 191 patients from Wuhan, China, comorbidity was found in 48% (67% who did not survived), hypertension in 30% (48% who did not survive), DM (Deabetic Mellitus) in 19% (31% did not survive), and CVD (Cardiovascular Disease) in 8% (13% of did not survive). In the cohort of 138 hospitalized patients with Covid-19, comorbidities

are similar common (46% overall and 72% in patients requiring treatment Intensive Care Unit [ICU]), as well as cardiovascular comorbidities: hypertension in 31% (58% in patients requiring ICU care), CVD in 15% (25% in patients requiring ICU care), and DM in 10% (22% in in patients requiring ICU care) (Clerkin et al., 2020).

f. Receiving Chemotherapy

People receiving chemotherapy with compromised immune systems and complications, after stem cell transplantation has an increased risk of infection (Ahnach & Doghmi, 2020) .

g. History of Bone Marrow or Organ Transplant

During bone marrow transplantation, pulmonary complications are common and related to death. Covid-19 infection can complicate clinical symptoms with a higher risk of respiratory distress and this situation can become more critical depending on comorbid factors such as age, disease cardiovascular, liver, and kidney (Ahnach & Doghmi, 2020).

h. Immune Deficiency

In summary, the clinical impact of Covid-19 on PIDs varies from mild symptoms until death. The proportion of deaths in this series (25%) is greater than in general population with Covid-19 reported in New York City hospitals (10.2%), and are similar to the outcome data reported in kidney transplantation population

(28%). In this single-center experience, those who died from PID-related illness or other pre-existing comorbidities.

i. HIV/AIDS is not well controlled

Symptoms reported with severity of Covid-19 patients with HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immunodeficiency Syndrom) infection. Common symptoms were fever (165 of 223, 74.0%), cough (130 of 223, 58.3%), and dyspnea (68 of 223, 30.5%). Less common are headaches (44 of 223, 19.7%), arthralgia/myalgia (33 of 223, 14.8%), and sore throat (18 out of 223, 8.1%). Each gastrointestinal symptom was reported at 13.0%. Covid-19 was reported as mild to moderate in 141 cases 212 (66.5%), severe in 46 patients (21.7%), and critical in 25 patients (11.8%). The majority of patients (158 of 244, 64.7%) were hospitalized; 16.8% admitted to the intensive care unit (Mirzaei et al., 2020).

j. Smoking History

A total of 16 articles detailing 11322 Covid-19 patients were included that The results of a meta-analysis revealed a relationship between smoking history and 95% of severe Covid-19 cases. In addition, a relationship was found between history of current smoking and severe Covid-19 95%. then 10.7% (978/9067) non-smokers, Covid-19 is severe, while in smokers active, severe Covid-19 occurred in 21.2% (65/305) of cases (Gülşen et al., 2020).

k. Diabetes Mellitus

Patients with diabetes mellitus have a tendency to increase infection viruses and bacteria that affect the respiratory tract. One mechanism responsible for this tendency is the leukocyte syndrome, which is a disorder of leukocyte function from phagocytosis (immune disorders). This matter further emphasizes the possible increased tendency of SARSCoV-2 infection in the diabetic group.

l. Chronic Kidney Disease (CKD)

Chronic kidney disease is associated with a higher risk of infection critical. In a meta-analysis, 20% of patients with kidney disease chronically infected with Covid-19 have severe disease, the risk is 3 times more higher than those without chronic kidney disease (Hassanein et al., 2020).

m. Liver Disease

In addition, according to Susilo et al. (2020) several other risk factors such as type of male sex which is known to be closely related to the prevalence of active smokers who height, people who have close contact, people who live with the patient confirmed to have the Covid-19 virus, have traveled to an area affected by the virus, the same environment but never close contact or distance of 2 meters including low risk, and lastly, health workers are one of the most high risk of infection.

2.1.8 Complication of COVID-19

The most important complication in COVID-19 patients is ARDS, but not only ARDS, but other complications can occur among them (Susilo et al., 2020).

- a. Acute Kidney Disorder
- b. Cardiac Disease
- c. Liver dysfunction & Pneumothorax
- d. Sepsis Shock
- e. Disseminated Intravascular Coagulation (DIC)
- f. Rhabdomyolysis
- g. Pneumomediastinum

According to Ferreira., et al. (2020), reports a typical confirmed case of Covid-19 pneumonia, with hypoxemia that did not require mechanical ventilation, with an initial apparent favorable recovery, this case highlights an uncommon clinical scenario of spontaneous pneumothorax as a late complication of Covid-19 pneumonia. Covid-19 has been associated with several neurological complications. We presented a case of acute myelitis as a neurological complication of Covid-19 infection that was admitted with paraplegia and urinary retention. The patient eventually improved and regained motor functions. In the current pandemic Status; Covid-19 should be considered a differential diagnosis in patients presenting with loss of consciousness, ataxia, convulsions, status epilepticus, encephalitis, myelitis, or neuritis (AlKetbi., et al. 2020). Cases of pulmonary

embolism that we believe were triggered by Covid-19 infection (Akel, T., et al. 2020). In systematic review and meta-analysis evaluated the epidemiology, clinical course, and outcomes of patients suffering from stroke as a complication of Covid-19 (Siow, I. et al. 2021).

According to the KEMENKES RI (2020) complications consist of several types:

- a. Complications Due to Prolonged Use of Invasive Mechanical Ventilation (IMV)
- b. Ventilator-Associated Pneumonia (VAP)
- c. Venous Thromboembolism
- d. Catheter-Related Bloodstream
- e. Ulcer Stress And Gastrointestinal Bleeding
- f. Weakness Due to Treatment in ICU
- g. Other Complications During Patient Care

2.1.9 Prognosis of COVID-19

The prognosis of COVID-19 is influenced by several factors, with the reported mortality rate in severe COVID-19 patients reaching 38% with a median length of ICU stay and up to 7 days of death. This rapid increase in cases could make it difficult for hospitals with high burdens of Covid-19 patients. This will increase the rate of acceleration of mortality in hospital facilities. Another report reported the improvement of existing eosinophils in patients, initially low eosinophils were thought to be a predictor of recovery (Susilo et al., 2020).

Reinfection in recovered patients is controversial. Animal studies reveal that cured monkeys do not get COVID-19, but there have been reports of patients coming back positive for rRT-PCR within 5-13 days after testing negative twice in a row and then being discharged. back from the hospital. This may be due to reinfection or false negative results on rRT-PCR when returning home or being discharged. Other researchers have also reported the detection of COVID-19 in feces in negative patients based on oropharyngeal swabs (Susilo et al., 2020).

2.1.10 Comorbid of COVID-19

According to Kemenkes RI, (2020) COVID-19 is easy to attack patients with comorbidities, including:

- a. Diabetes Mellitus (Type 1 and Type 2 Diabetes Mellitus)
- b. Kidney illness
- c. Glucocorticoid-Associated Diabetes
- d. Geriatric Related Diseases
- e. St Segment Elevation Myocardial Infarction (STEMI)
- f. Non-St-Segment Elevation Myocardial Infarction (NSTEMI)
- g. Hypertension
- h. Chronic Obstructive Pulmonary Disease (COPD)
- i. Autoimmune Related Diseases
- j. Tuberculosis
- k. Another chronic disease that is exacerbated by the disease condition COVID-19.

2.1.11 Incubation Period

According to WHO, the incubation period ranges from 5-6 days and the longest is 14 days. However, according to one of the journal Clinical characteristics of 2019 novel coronavirus infection in China explained that the incubation period of COVID-19 ranges from 0-24 days (Wang et al., 2020).

2.1.12 Characteristics of COVID-19 Symptoms

From the research journal Pullen et al. (2020) of 1,252 participants who completed the screening survey and were included in this analysis, there were 316 participants with confirmed infection, 393 with probable infection, and 543 with probable infection. All participants with confirmed infection in this analysis reported at least 1 symptom at the time of screening. The mean age for the sample population (interquartile range [IQR]) was 45 (35–55) years, with no significant difference between the confirmed, probable, and probable groups. Health workers comprised 37% of those included in this analysis. Among 316 non-hospitalized adults with confirmed SARS-CoV2 infection, 258 (82%) reported cough, 212 (67%) reported fever, and 143 (45%) reported dyspnea, regardless of the time of symptom development. Only 27% of participants with confirmed infection reported having all 3 symptoms of cough, fever, and dyspnea, whereas 53% of participants had fever and cough. When compared without symptom duration, several symptoms showed significant differences between the confirmed and unconfirmed infection groups, including

fever, headache, diarrhea, fatigue, myalgia, and anosmia (all $P < .05$). These symptoms are possible and likely appears very similar. Thus, when viewed without the context of symptom duration, it is difficult to separate possible infection and probable infection from one another. It may also suggest those with confirmed infections have more severe (or multiple) symptoms, leading them to seek treatment and receive exams. To further explore the question of symptom temporality in SARS-CoV-2 infection, we examined the rates of symptoms reported in participants with confirmed infection who completed a screening survey during early ($n = 77$), midinfection ($n = 84$), and late infection ($n = 155$). There was a significant difference in threshold in the prevalence of fatigue at the 3 time points ($P = .011$). No significant differences in the prevalence of remaining symptoms were included in our screening survey across these time points. The median duration of symptoms at screening (IQR) was slightly longer in the confirmed group, at 5 (3-11) days, compared with 2 (1-5) days for probable infection and 3 days (1-7) days for probable infection. . At initial infection, patients with confirmed infection were more likely than those with unconfirmed infection to report fever, headache, fatigue, myalgia, and diarrhea (all $P < .01$).

According to Sukmana & Yuniarti (2020), the most common typical signs and symptoms include:

- a. Fever 38°C (87.9%),
- b. Dry cough (67.7%),
- c. Fatigue (38.1%).

Other mild-to-moderate symptoms include:

- a. Sputum Production (33.4%)
- b. Shortness of Breath (18.6%)
- c. Sore Throat (13.9%)
- d. Headache (13.6%)
- e. Myalgia or Arthralgia (14.8%)
- f. Shivering (11.4%)
- g. Nausea or Vomiting (5.0%)
- h. Nasal Congestion (4.8%)
- i. Diarrhea (3.7%)
- j. Hemoptysis (0.9%)
- k. Conjunctival Congestion (0.8%)
- l. Anosmia, Rash Skin on Fingers and Feet (WHO, 2020)

Severe symptoms:

- a. Shortness of Breath (18.6%)
- b. Breathing Rate More Than 30x/Minute
- c. Hypoxemia
- d. PaO₂/FiO₂ Ratio 50% in 24-48 Hours

Then a new symptom has emerged, namely happy hypoxia, a condition in which the patient has low oxygen saturation (SpO₂ < 90%), but is not experiencing significant respiratory distress and often appears clinically well (Widysanto et al., 2020).

2.2 Overview of Nurse

2.2.1 Definition of Nurse

A nurse is a person who has passed nursing education, both at home and abroad, in accordance with the applicable laws and regulations (Decree of the Minister of Health of the Republic of Indonesia, 2001). According to Wardah, Febrina, Dewi (2017) argues that nurses are workers who work professionally and have the ability, authority and responsibility in carrying out nursing care.

2.2.2 The Role of A Nurse

In carrying out nursing care, nurses have roles and functions as nurses including care providers, as family advocates, disease prevention, education, counseling, collaboration, ethical decision makers and researchers (Hidayat, 2012). The nurse's role can be interpreted as a person's behavior and gestures that are expected by others according to their position in the system, these behaviors and gestures can be influenced by social conditions inside and outside the nursing profession which are constant (Potter & Perry, 2010).

The role of nurses according to Potter & Perry (2010)

- a. Caregivers, nurses help clients to meet their basic needs and get their health back through the healing process by providing nursing care.
- b. Clinical Decision Makers, nurses make decisions before taking nursing actions and develop action plans related to assessment, care delivery, evaluation of outcomes, using the best approach

for patients. Decision making can be done independently, or in collaboration with other health professionals and the client's family.

- c. Case Manager, the nurse has the role of coordinating the activities of team members, managing work time and available resources in the work environment.
- d. Rehabilitators, nurses with all the ability to help clients return to improve their maximum function after experiencing an accident, illness or other event that causes the client to lose ability and cause helplessness.
- e. Convenience, comfort and emotional support provided by nurses while carrying out nursing care as a whole to clients, can have a positive influence in the form of strength to achieve client recovery.
- f. Communicators, nurses serve as communicators that connect clients and families, between nurses and other health workers. The most important factor in meeting the needs of clients, families and communities is the quality of communication.
- g. The instructor, in this case the nurse, explains to the client about the importance of health, gives examples of basic care procedures that the client can use to improve his health status, conducts an independent assessment of whether the client understands the explanation given and evaluates to see progress in the client's learning.

- h. Career roles, nurses have a career and get certain positions, this gives nurses more job opportunities both as a nurse educator, advanced nursing nurse, and health care team.

According to Puspita (2014) the role of nurses in providing comprehensive nursing care as an effort to provide comfort and satisfaction to patients, includes:

- a. Caring, is an attitude of caring, respect, respect for others, which means paying attention and learning about one's preferences and how one thinks and acts.
- b. Sharing means that nurses always share experiences and knowledge or discuss with their patients.
- c. Laughing, meaning that a smile is the main asset for a nurse to increase the patient's sense of comfort.
- d. Crying means that nurses can accept emotional responses from both patients and other nurses as a normal thing when happy or sad.
- e. Touching means that physical and psychological touch is a sympathetic communication that has meaning.
- f. Helping means that nurses are ready to help with nursing care.
- g. Believing in others means that nurses believe that other people have the desire and ability to always improve their health status.
- h. Learning means nurses are always learning and developing themselves and their skills.

- i. Respecting means showing respect and appreciation for others by maintaining patient confidentiality to those who do not have the right to know.
- j. Listening means wanting to hear the patient's complaints.
- k. Feeling means that nurses can accept, feel, and understand the feelings of grief, pleasure, frustration and patient satisfaction.

According to Law of the Republic of Indonesia Number 38 of 2014 explains that the duties and authorities of nurses are as follows:

a. Providing nursing care

Perform nursing assessments holistically, determine nursing diagnoses, plan nursing actions, carry out nursing actions, evaluate the results of nursing actions. Counselors and counselors.

b. Extension and counselor

Carry out a holistic nursing assessment individuals and families as well as at the community group level, conduct community empowerment, carry out advocacy in public health care, establish partnerships in community health care, conduct health education and counseling.

c. Nursing Service Manager

Conduct assessments and determine problems, plan, implement, and evaluate services nursing, case management.

d. Nursing researcher

Conduct research in accordance with standards and ethics, use resources in health care facilities with permission from the leadership, use clients as research subjects in accordance with professional ethics and the provisions of laws and regulations.

e. Executing tasks based on the delegation of authority or

Take appropriate medical action competence over the delegation of the power of delegative authority medical, perform medical actions under the supervision of delegation of mandated authority, providing health services in accordance with government programs.

f. Executing tasks under certain conditions of limitations.

Performing treatment for common ailments in terms of there are no medical personnel, referring patients in accordance with the provisions of the referral system, providing limited pharmaceutical services in the event that there are no pharmaceutical personnel.

2.2.3 Functions of a Nurse

The function of a nurse is a job or activity carried out by nurses according to their role and can change according to existing conditions (Hidayat, 2008). The actions of nurses who are independent without doctor's instructions and carried out based on nursing science are included in the independent function, in this case the nurse is responsible

for the actions and consequences that arise on the client who is her care task, while the nurse's actions are carried out under the supervision and on the instructions of the doctor. The action that should be taken and becomes the doctor's authority is included in the dependent function (Hidayat, 2008). According to Kusnanto (2004), in addition to dependent and independent functions, nurses have an interdependent function, namely nurses carry out activities carried out and relate to other parties or other health workers.

2.3 Overview of Experience

2.3.1 Definition of Experience

Definition of experience is something that has been experienced (lived, felt, borne) according to Alwi Hasan (2002:26). Experience is something that cannot be separated from everyday human life. Experience is also very valuable for every human being, and experience can also be given to anyone to use and be a guide and human learning. Experience can be interpreted as something that has been experienced, lived, or felt, whether it has been a long time or has just happened (Mapp in Saparwati, 2012). Notoatmojo (2010) said that experience is an observation that is a combination of sight, smell, hearing, and past experiences. From some of these opinions, it can be concluded that experience is something that has been experienced, lived, or felt which is then stored in memory (Oktorina et al., 2019).

Definition of experience according to Schmitt (1999:60), experiences are personal events that occurs due to a certain stimulus (for

example, the marketer before or after the purchase of goods or services). Pine II and Gilmore (1999:12), argue that experience is an event that occurs and binds each individual personally. According to Kotler (2005:217) experience is learning that influences change in a person's behavior. The type of experience that appears to create an experience through the five senses such as eyes, ears, skin, tongue and nose (Schmitt in Amir Hamzah, 2007:23).

2.3.2 Factors Affecting of Experience

Everyone has a different experience though see the same object, this is influenced by: knowledge and education of a person, actor, or factor on the part of who have experience, object, or target factors perceived and factors in the situation in which the experience is carried out. Age, education level, socio-economic background, culture, environment physical, work, personality, and life experiences of each individual as well determine the experience. (Notoatmojo, 2012). Everyone's experience of an object can be different because experience has a subjective nature, which is influenced by the content his memory. Whatever enters the senses and is noticed will stored in its memory and will be used as a reference to respond to new things.

According to Sulaiman (2015) the level of knowledge consists of 4 kinds, namely descriptive knowledge, causal knowledge, knowledge normative and essential knowledge. Meanwhile, according to Daryanto in Yuliana (2017), a person's knowledge of objects has intensity different and explains that there are six levels knowledge are as follows:

- a. Knowledge interpreted only as recall. Someone is required to know facts without being able to use them.
- b. Comprehension an object is not just knowing, no can only mention but must be able to interpret correctly about known objects.
- c. Application is defined when people who have understood the object be able to use and apply known principles to another situation.
- d. Analysis is the ability someone to describe and separate, then look for the relationship between the components contained in an object.
- e. Synthesis is the ability to arrange new formulations from existing formulations. Synthesis indicates a person's ability to summarize or put in a logical relationship the components knowledge possessed.
- f. Evaluation, which is a a person's ability to make an assessment of an object certain criteria are based on criteria or norms that apply in the public.

2.4 Holistic Nursing Care

2.4.1 Definition of Holistic Nursing Care

Global health problems currently require holistic nursing because there are various problems experienced by patients, such as increasing antibiotic resistance, microbes, and economic, environmental, and social factors that affect health. Holistic nursing in chronic diseases globally

has not been developed, even though it is urgently needed in services that are in accordance with the problems faced by patients, namely not only physical, but psychosocial and spiritual (Bec-Deva, 2010). Holistic understanding is comprehensive or comprehensive consisting of body to body, mind to mind and spirit to spirit or it can also be said to be bio, psycho, social and cultural (Dossey, 2005). Another understanding of holistic service is seeing patients holistically which consists of physical, psychosocial, spiritual and cultural problems that affect perceptions of illness (Salbiah, 2006). A spiritual process that affects a person comprehensively. Every human being has an experience that includes the body-mind-spirit component. Mind-body-spirit is an important component of the healing process including emotional, physical and mental problems. spiritual and therefore requires a holistic and patient-centered care.

This is a must considering that patients are human beings who have personal values and belief systems that have an impact on attitudes and responses to health services provided (Salbiah, 2006). Holistic is closely related to well-being (Dossey, 2005) which is believed to have an impact on a person's health status. To achieve holistic health and well-being there are five dimensions that must be considered: spiritual is all inseparable and part of the healing process (Smucker, 1998).

- a. Physical dimension: A person's ability to carry out daily activities in general to carry out positive living habits.

- b. Social dimension: doing social activities and being able to interact with other people.
- c. Emotional dimension: expressing emotions and controlling stress.
- d. Intellectual dimension: cognitive ability to learn.
- e. Spiritual dimension: Associated with beliefs in things such as: nature, science, religion or higher powers that help humans achieve life goals. Includes the morals, values, and ethics of a person (Salbiah, 2006).

The holistic approach of nursing includes interventions that focus on the patient's response that heal the whole person and promote balance, therapy, and the art of self-healing is not the essence of holism and wellness. Holistic nurses help patients to take responsibility for their personal health by serving as a health role model that integrates self-care in life and is carried out in daily life. According to the American Holistic Nurses' Association, this will help patients cope with stress and give a lot of energy to help patients by establishing a balance between what is given to themselves and what is given to others (Dwidiyani, 2015).

2.4.2 Difference Between Holistic And Allopathic Model

The allopathic model is very different from the holistic in the focus on problem solving, resulting in differences in the approach to services provided to patients. An explanation of the differences in the Allopathy model which focuses on physical treatment and the holistic model can be seen in the following table.

Holistic Model	Allopathic Model
Looking for patterns and causes	Treating physical symptoms
Integration, with a holistic view of the patient	Specialist
Focus on human values	Focus on efficiency
Caring is a component in healing	Professionals should not involve emotions
Pain and illness are signs of internal conflict	The main interventions are drugs and surgery/surgery
Equipped with noninvasive techniques (psychotechnology, diet and activity)	Equipped with noninvasive techniques (psychotechnology, diet and activity)
Autonomic patient	Patient dependent
Professionals as partners	Authority from professionals

Table 2.1 Difference between Allopathic and Holistic Model (Dossey, 2005)

The holistic approach seems to emphasize the patient's comprehensive attention to human values, which have individual values that have beliefs, feelings and the ability to think and make decisions. Humans consist of biopsychosocial and spiritual, as shown in the image below:

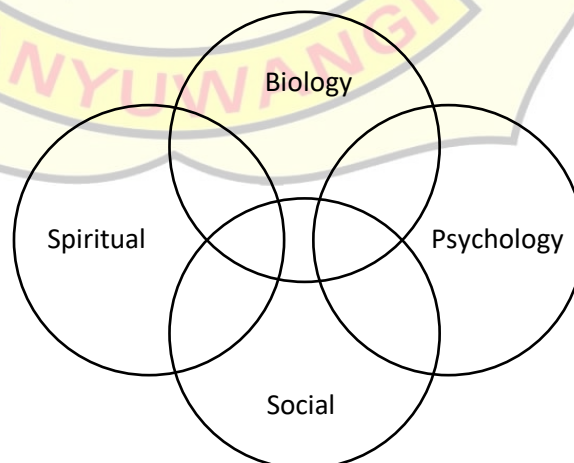


Figure 2.1 Holistic Approach to Individual (Dossey, 2005)

2.5 Caring of Nurses

2.5.1 Definition of Caring

Caring is English, which means to care. According to the Big Indonesian Dictionary (KBBI) caring is an attitude of heeding, ignoring, paying attention to something that happens to other people. Caring is considered a basic concept of the nursing role and provides a framework to guide nursing practice (Calong & Gil, 2018). Caring according to Sapountzi-Krepia et al., (2013) is a concept that is universally recognized within the scope of nursing. Caring in nursing is very important as described by Potter and Perry (2009) which states that caring is the core of good nursing practice, because caring is special and depends on the nurse-client relationship. Caring facilitates the nurse's ability to recognize clients, identify client problems, find and implement solutions. Caring as the core of nursing is also mentioned by Watson (2004) that caring is the essence of nursing and is the focus and central of nursing practice which is based on the values of kindness, concern, love for oneself and others and respect for the patient's spiritual beliefs.

Caring according to Pepin and Cara (2001) is a concept that is formed based on a combination of action and intuition that allows nurses to skillfully read signs that indicate people's health conditions are improving or deteriorating. Caring is considered an act of caring that leads to relief or improvement of symptoms and increased well-being (Anderson et al., 2015). Caring contains 3 things that cannot be separated, namely attention, responsibility, and being done with

sincerity. According to Lavdaniti (2014) caring is a form of love shown to patients, respect for human rights and dignity, support and honesty towards patients and their families. Providing simple care is not just an emotional feeling or simple behavior, because caring is caring to achieve better care.

The purpose of caring is that the behavior of nurses in providing nursing services consists of efforts to protect, enhance and maintain or perpetuate humanity by helping others in the healing process of illness, suffering and their existence helping others to increase knowledge and self-control with a touch of humanity. Caring is an important thing in the nurse-patient relationship, with caring there can be interactions between nurses and patients regarding a health problem to problem solving and potential options that can be used regarding the problem. Caring is the basis for carrying out professional nursing practice to provide satisfaction to patients (Watson, 2004).

2.5.2 Caring Behavior

Caring is a universal phenomenon and can affect the way a person thinks, feels and behaves (Potter & Perry, 2013). Caring behavior (caring act) according to Dwidiyanti (2008) is an action taken in providing support to the individual as a whole. Actions in the form of caring behavior should be taught to each individual starting at the time the individual was born, during the development, growth until the individual dies. This is in line with caring behavior according to Balis (2017) that caring behavior is very important for growth and development to improve

and improve human conditions or ways of life. Caring behavior is the essence of nursing that distinguishes it from other professions and dominates and unites nursing actions.

Nursalam (2004) states that caring behavior is a form of caring, paying attention to others, being person-centered, respecting self-esteem, and humanity, a commitment to prevent deteriorating health status, paying attention and respecting others. Caring in nursing is a transcultural phenomenon in which nurses interact with clients, staff and other groups. Caring behavior aims and functions to build the social structure, views and cultural values of each person which is different from one place to another (Dwidiyanti, 2007).

Nurse caring behavior according to Modic, et al. (2014) is the most important part which is considered as the basic key in providing health care facilities to patients and also an interpersonal process that includes the delivery of health services, building a close trusting relationship between patients and service providers. Caring behaviors of nurses include respecting patients, providing a sense of security and minimizing patient anxiety, good and positive communication, providing knowledge and taking professional actions, and giving attention (Azizi-Fini et al, 2012). Caring skills have nursing values that change nurses from a situation where nurses are considered as just a job to a more respectable profession. Caring skills not only revolve around practicing the art of care, giving compassion to relieve the suffering of patients and

their families, promoting health and dignity but also expanding the actualization of nurses (Dwidiyanti, 2007).

2.5.3 Caring in Nursing Practice

Caring is the result of the culture, values, experiences and relationships between nurses and clients. Experts agree that caring is not a basic method that exists in the world, individuals who have never experienced treatment will find it difficult to practice caring behavior (Potter & Perry, 2009). According to Potter and Perry (2009) the attitude of nurses in nursing practice related to caring is the presence, touch of affection, always listening and understanding the client. According to Gregg & Joan (2014) being with the patient, touching the patient and listening to the patient are the most important things in nursing practice.

a. Presence

Attendance is a meeting between nurses and clients which is a means to get closer and convey the benefits of caring. The presence of nurses includes being physically present, communicating with understanding. Attendance is also something that nurses offer to clients with the intention of providing support, encouragement, calming the client's heart, helping to reduce the client's anxiety and fear due to certain situations, and always being there for the client (Potter & Perry, 2009). This is also in line with Gregg & Joan (2014) that attendance is not only physically present, but presence can also

be realized by using interventions (actions) to patients to overcome patient problems.

b. Touch

Touch is a calming approach, where the nurse can get closer to the client to provide attention and support. Caring touch is a form of non-verbal communication that can affect the comfort and safety of the client, increase the client's self-esteem, and improve orientation about reality. Expression of touch should be task-oriented and can be done by holding the client's hand, giving a back massage, placing the client carefully and participating in the conversation (Potter & Perry, 2009). Watson (1997) in Gregg & Joan (2014) states that touch can convey certainty, comfort and concern that cannot be conveyed in words. Norred (2000) in Gregg & Joan (2014) states that a nurse's caring touch is a valuable therapeutic tool. Touch here is a touch that is more like a connection with the patient's emotions such as feelings and worries.

c. Listen

The nurse must really listen to the conversation with the client. Listening is one of the keys to the nurse-client relationship, because listening to the client's story/complaint will help the client reduce the pressure on his illness. The nurse's service relationship with the client is to build trust, open the topic of conversation, listen and understand what the client is saying.

Nurses who really listen to clients, will know correctly and respond to what really means to the client and his family (Potter & Perry 2009). Listening also includes paying attention to every word spoken, the tone of voice, facial expressions, and body language of the client. This will assist the nurse in obtaining clues to help help the client find ways to find peace.

d. Understanding clients

Understanding the client will help the nurse in responding to what the client's problem is. Understanding the client means the nurse avoids assumptions, focuses on the client, and engages in a caring relationship with the client who provides information and provides clinical judgment. Understanding the client is at the core of the process nurses use in making clinical decisions. Nurses who make accurate clinical decisions with a good understanding context, will improve client health outcomes, clients will get personal care, comfort, support, and recovery (Potter & Perry, 2009).

2.5.4 Factors Affecting Caring Behavior

Caring is an application of the nursing process as a form of performance displayed by a nurse. Gibson, et.al (2006, in Kusnanto (2019) states that there are three factors that influence individual performance including individual, psychological and organizational factors.

a. Individual Factors

These variables are grouped into sub-variables of ability and skill, background and demographics. according to Gibson, et al (2006), ability and skill variables are important factors that can affect the behavior and performance of an individual. Intellectual ability which is an individual's capacity to do various tasks in a mental activity.

b. Psychological factors

These variables include attitude, commitment and motivation variables. This factor is influenced by family, social level, experience, demographic characteristics. A person tends to develop a certain pattern of motivation. Motivation is the strength that a person has that gives birth to intensity and persistence that is carried out with his own abilities. Psychological variables are difficult to measure and complex.

c. Organizational factors

Human resources, leadership, rewards, structure and work are organizational factors that can influence caring behavior (Gibson, 2006). The reward variable will greatly affect the motivation variable, which in the end directly affects the individual's performance.

According to Yulianti (2017) the factors that influence the caring behavior of nurses are:

1. Workload

The very high workload carried out by a nurse is very influential because of the high stress that occurs in nurses so that the motivation of nurses decreases to do caring.

2. Work environment

A comfortable work environment will create comfort in a nurse's job so as to allow nurses to apply caring behavior.

3. Knowledge and training

It has previously been mentioned that caring does not grow by itself as a nurse, but arises based on values and experiences in relationships with other people. Increased knowledge and training provided to a nurse will increase nurses' awareness to carry out caring in accordance with theory.

2.5.5 Caring According to Swanson Theory

At first the caring theory presented by Swanson was applied to postpartum mothers who had miscarriages. Where Swanson involves the family to participate in providing support for a loss that has occurred to the post partum mother. However, over time, Swanson's caring theory was applied to patients who needed nursing care. Swanson's theory is a theory The latest one is called Middle Range Theory. Middle Range Theory is a revolutionary theory from Grand Theory where the theory presented is more concise and easy to apply (Priambodo, 2014).

Caring according to Swanson is a value-added nursing care that upholds commitment and responsibility in its application (Teting, 2018).

In another source, Swanson defines caring as a way of maintaining relationships by respecting others accompanied by a sense of belonging and responsibility (Febriana, 2017).

2.5.6 Swanson Caring Component

Swanson's theory emerged with the research conducted by Swanson under the guidance of Jean Watson. However, this does not mean that Swanson's theory is a copy of Jean Watson's theory, but they agree that Swanson's theory is a theory belonging to Swanson which strengthens Jean Watson's theory (Alligood, 2014). While the Swanson theory, where this theory emerged in 1993, this theory is more concise but contains everything. In Swanson's theory there are 5 components of Caring (Febriana, 2017). The components of caring according to Swanson are:

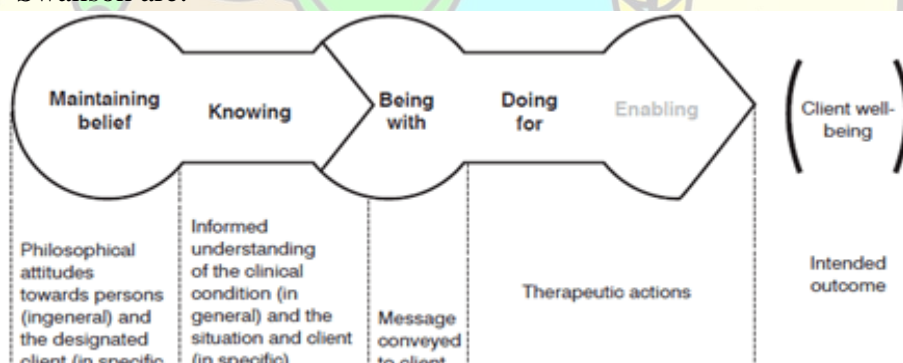


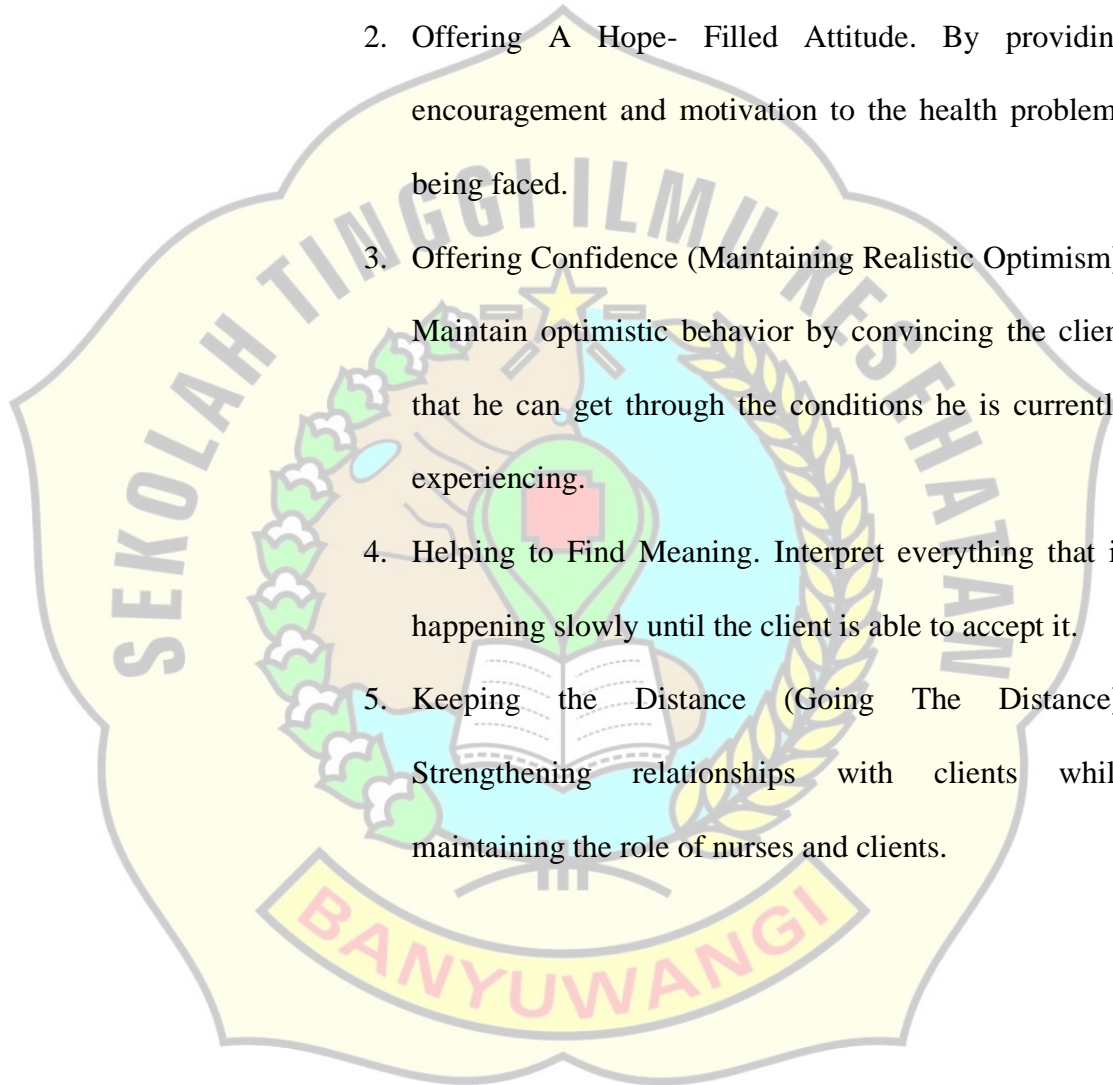
Figure 2.2 Model Structure of Caring (Swanson, 1993)

a. Maintaining Belief

In this component, Swanson fosters trust and confidence in clients so that they can go through the life process and go through a transition period to face the future with confidence, be able to behave optimistically, and take lessons from all the events that have occurred in their lives. The purpose of maintaining this

belief is to help others interpret all the lives that have happened in the past in order to live lives in the future. The sub-dimensions contained in maintaining belief are:

1. Believing In. This is done by listening to all the complaints of the client.
2. Offering A Hope- Filled Attitude. By providing encouragement and motivation to the health problems being faced.
3. Offering Confidence (Maintaining Realistic Optimism). Maintain optimistic behavior by convincing the client that he can get through the conditions he is currently experiencing.
4. Helping to Find Meaning. Interpret everything that is happening slowly until the client is able to accept it.
5. Keeping the Distance (Going The Distance). Strengthening relationships with clients while maintaining the role of nurses and clients.



b. Knowing

Try to understand what the client is going through. In this component in carrying out nursing care more by digging up detailed information, focusing on one nursing goal and uniting perceptions between nurses and clients. The sub-dimensions contained in knowing are:

1. Avoiding Assumptions. Avoiding assumptions between nurse and client and equating perceptions.
2. Overall Assessment. Conduct a holistic assessment based on biological, psychological, sociological, spiritual and cultural aspects.
3. Looking for Hints. Efforts to find in-depth and comprehensive information about the client.
4. Focus On One Person Service. Perform nursing care with a focus on the client.
5. Engaging the self of both, involving yourself as a nurse as a whole and working with clients in carrying out effective nursing care

c. Being With

In this context, nurses are not only present as a whole but also communicate with each other with the aim of sharing what the client feels and providing support and comfort both physically and emotionally. The Being With subdimensions are:

1. Non Burdening. In carrying out nursing care, nurses must uphold the ethics of autonomy where they must not impose their will.
2. Covering Availability. Perform nursing care by helping clients as needed and able to provide facilities to achieve prosperity.
3. Enduring With. Establish a commitment between nurses and clients in an effort to improve the health of clients.
4. Sharing Feelings. Sharing life experiences that can improve the client's health.

d. Doing For

Perform nursing care by providing comfort, always maintaining privacy and meeting client needs as needed. The Doing For subdimensions are:

1. Comforting. Always provide comfort both environmental and physical in carrying out nursing care to clients.
2. Competently Performing. In carrying out nursing care, nurses must be able to demonstrate the skills or skills possessed so that clients believe in the competencies we have.
3. Preserving Dignity. Maintain client's dignity and privacy by not spreading client's problems to others.

4. Anticipating. Ask for prior approval every time you want to take nursing actions.
5. Protection. Provide protection of patient rights during nursing care.

e. Enabling

Providing convenience for clients to go through the transition period by facilitating everything that is needed by the client by providing various information, providing support for what is being faced, and improving the client's healing process so that the client is able to act independently. The subdimensions of Enabling are:

1. Validating. Validate all actions taken to the client.
2. Informing. Provide information related to improving the client's health.
3. Supporting. Provide support to clients to achieve well-being in accordance with their capacity as nurses.
4. Feedback. Giving rewards to clients every time he is able to get through a health problem well.
5. Helping Patient to Focus Generate Alternative. Helping patients to always focus on carrying out their therapy.

2.6 The Experience of Nurses in Providing Holistic Nursing Care For COVID-19 Patients

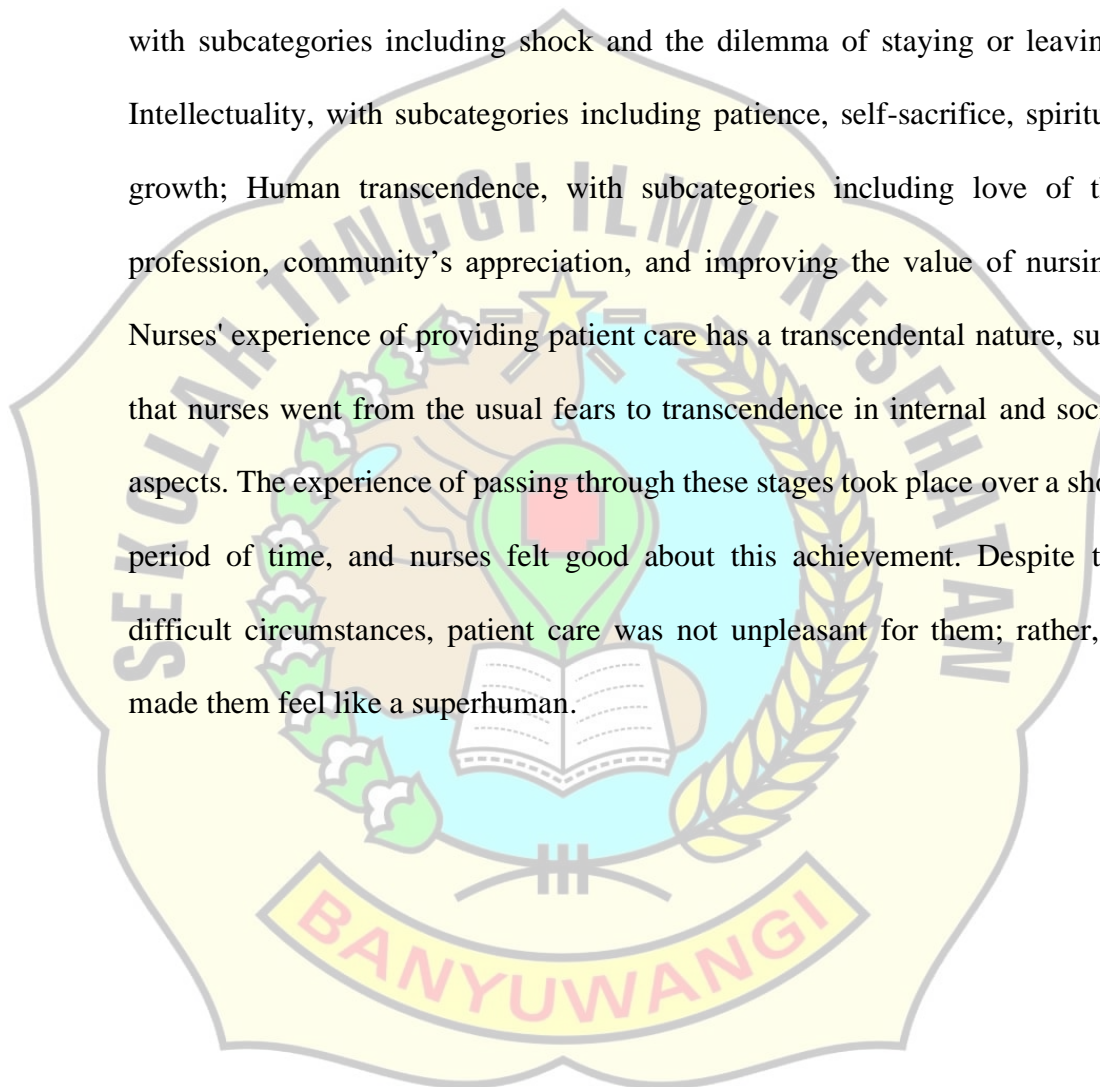
In a research by Kellogg et al., 2021 entitled "Exploring the Experience of Nurses Foreign Patient with COVID-19 in the United States" stated that the

experience of nurses in providing care to COVID-19 patients was summarized into six themes: (1) feeling overwhelmed by the quantity of work (33.1%), (2) patient death (30.5%), (3) helplessness (23.7%), (4) the absence of the patient's family presence and the need for additional support (22.9%), (5) concerns about personal protective equipment (PPE) regarding safety and how PPE can interfere with the nursing role (20.3%), and (6) lack of preparedness to face a pandemic (16.9%). These findings suggest that working directly with COVID-19 patients is a significant psychological stress on nurses. Adequate personal and institutional support for nurses is necessary to prevent and treat mental stress from working under these conditions.

Meanwhile in another study by Sun et al, 2020 with the title "A qualitative study on the psychological experience of caregivers of COVID-19 patients" stated that the psychological experience of nurses caring for COVID-19 patients can be summarized into 4 themes. First, negative emotions present in early stage consisting of fatigue, discomfort, and helplessness was caused by high-intensity work, fear and anxiety, and concern for patients and family members. Second, self-coping styles included psychological and life adjustment, altruistic acts, team support, and rational cognition. Third, we found growth under pressure, which included increased affection and gratefulness, development of professional responsibility, and self-reflection. Finally, we showed that positive emotions occurred simultaneously with negative emotions. During an epidemic outbreak, positive and negative emotions of the front-line nurses interweaved and coexisted. In the early stage, negative emotions were dominant and positive emotions appeared gradually.

Self-coping styles and psychological growth played an important role in maintaining mental health of nurses.

Research conducted by Khanjarian & Hoseini, 2021 entitle “Lived experiences of nurses providing altruistic care to patients with COVID-19” The lived experiences of nurses dealing with COVID-19 included: Disquietude, with subcategories including shock and the dilemma of staying or leaving; Intellectuality, with subcategories including patience, self-sacrifice, spiritual growth; Human transcendence, with subcategories including love of the profession, community’s appreciation, and improving the value of nursing. Nurses' experience of providing patient care has a transcendental nature, such that nurses went from the usual fears to transcendence in internal and social aspects. The experience of passing through these stages took place over a short period of time, and nurses felt good about this achievement. Despite the difficult circumstances, patient care was not unpleasant for them; rather, it made them feel like a superhuman.



2.7 Synthesize Table

Table 2.2 Synthesize of The Experience of Nurses in Providing Holistic Nursing Care COVID-19 Patients

No.	Title/Author	Study Design & Sample	Data Analysis	Variable and Measurement	Result	Conclusion
1	<p>Title : “All of this was awful:” Exploring the experience of nurses caring for patients with COVID-19 in the United States</p> <p>Author: Kellog et al, 2021</p>	<p>This research is part of a more extensive cross-sectional study that examined the nursing experience during the COVID-19 pandemic using mixed methods and convergent data collection</p> <p>N= A total of 229 nurses responded to the overall survey, 118 of which responded to the open-ended question (51.5%).</p>	Data were analyzed using content analysis, which can be used to examine themes in written material	Data were collected through an online survey of nurses, including demographics, screening measures of mental health outcomes, and open-ended questions.	The experience of nurses providing care to patients with COVID-19 was summarized into six themes: (1) feeling overwhelmed with the quantity of work (33.1%), (2) patient death (30.5%), (3) helplessness (23.7%), (4) absence of patient family presence and need for additional support (22.9%), (5) personal protective equipment (PPE) concerns regarding safety and how PPE can impair the nursing role (20.3%), and (6) lack of preparedness for the pandemic (16.9%).	These findings suggest working directly with COVID-19 patients is a significant psychological strain on nurses. Adequate personal and institutional support for nurses is needed to prevent and treat mental distress from working under these conditions.
2	<p>Title: Lived experiences of nurses providing altruistic care to patients</p>	We used Van Manen’s interpretive phenomenology in this study due to	Data were collected through open, in-depth, semi-structured interviews and		The lived experiences of nurses dealing with COVID-19 included: Disquietude, with subcategories including shock and the dilemma of staying or leaving; Intellectuality, with subcategories	The results of the present study showed that the existence of selfsacrificing role-models who protected the country and its

No.	Title/Author	Study Design & Sample	Data Analysis	Variable and Measurement	Result	Conclusion
	with COVID-19 Author: Khanjarian & Hoseini, 2021	the uniqueness of the study subject. N= The present qualitative phenomenological study was conducted in spring 2020 on 12 nurses (8 women and 4 men) selected by purposive sampling	were analyzed using the Glazer technique		including patience, self-sacrifice, spiritual growth; Human transcendence, with subcategories including love of the profession, community's appreciation, and improving the value of nursing.	people helped nurses adapt themselves with the difficult situation and go through humane and professional transcendence while providing services
3	Title : A qualitative study on the psychological experience of caregivers of COVID-19 patients Author: Sun et al, 2020	Our research used the Colaizzi's phenomenological method to qualitatively analyse the psychological experience of nurses caring for patients with COVID-19.	Within 24 hours of each interview, the recording was transcribed and analysed by Colaizzi's phenomenological analysis method		The psychological experience of nurses caring for COVID-19 patients can be summarized into 4 themes. First, negative emotions present in early stage consisting of fatigue, discomfort, and helplessness was caused by high-intensity work, fear and anxiety, and concern for patients and family members. Second, self-coping styles included	During an epidemic outbreak, positive and negative emotions of the front-line nurses interweaved and coexisted. In the early stage, negative emotions were dominant and positive emotions appeared gradually. Self-coping

No.	Title/Author	Study Design & Sample	Data Analysis	Variable and Measurement	Result	Conclusion
		N= 20 nurses who provided care for COVID-19 patients			psychological and life adjustment, altruistic acts, team support, and rational cognition. Third, we found growth under pressure, which included increased affection and gratefulness, development of professional responsibility, and self-reflection. Finally, we showed that positive emotions occurred simultaneously with negative emotions.	styles and psychological growth played an important role in maintaining mental health of nurses.
4	Title: Nurse Caring Experience In Providing Nursing Services Among Covid-19 Patients In The Private Hospital Pekanbaru: A Phenomenological Study	The research design is used descriptive phenomenology N= Participants were 12 participants who were selected by purposive sampling technique.	Furthermore, it is analyzed verbatim and using Colaizzi's approach	The Data be in the form of indepth interviews and field notes	The researcher collected data by using in-depth interview and field notes methods. The results of the interviews in the form of written transcripts were carried out by content analysis. Based on the results of the analysis found six themes, namely: 1) nurse anxiety, 2) support system, 3) professional responsibility, 4) workload, 5) refusal of information by patients and their families, 6) risk of infection. The themes are discussed in detail to interpret the	Based on the results of this study, it can be concluded that the caring experience of nurses in providing nursing services to COVID-19 patients at the hospital. Ibnu Sina Pekanbaru got 6 themes, namely: nurse anxiety, support system, professional responsibility, workload, refusal of information by

No.	Title/Author	Study Design & Sample	Data Analysis	Variable and Measurement	Result	Conclusion
	Author: Ekaputri et al, 2021				caring experience of nurses in providing nursing services.	patients and their families, risk of infection. This emerging theme can serve as a reference for health workers, especially in the managerial field in taking policies regarding health services, especially nursing services by COVID-19 nurses in order to produce good and safe nursing services for both patients and nurses as nursing service providers
5	Title: Nurses' experiences of providing care to patients with COVID-19 in the ICU	A descriptive phenomenological research design was used	The data were transcribed Verbatim and analysed using Colaizzi's	All interviews were conducted by a researcher in April and May 2020. WeChat	An analysis of these significant statements yielded four distinct stages of feelings, thereby revealing the essence of this phenomenon. Worry about being infected and infecting family	The nurses reported distinct experiences of providing care to patients with COVID-19 in ICUs. Interventions, such as

No.	Title/Author	Study Design & Sample	Data Analysis	Variable and Measurement	Result	Conclusion
	<p>in Wuhan: a descriptive phenomenological research</p> <p>Author: Hu et al, 2021</p>	<p>N= A total of 13 nurses were recruited from three ICUs in Wuhan, Hubei, China.</p>	<p>seven-step framework.</p>	<p>was used to collect interview data.</p>	<p>members was present across in all four stages. The themes associated with the four stages were as follows: initial contradictory feelings, quick adaption to the 'new working environment' in the first 1–2weeks in the ICU, desperation after adaption, holding on and survive.</p>	<p>providing information about the disease, simulation training, emotional support and followup care, are needed to help nurses manage patients with COVID-19 and maintain nurses' health.</p>

CHAPTER 3

RESEARCH FRAMEWORK

3.1 Research Framework

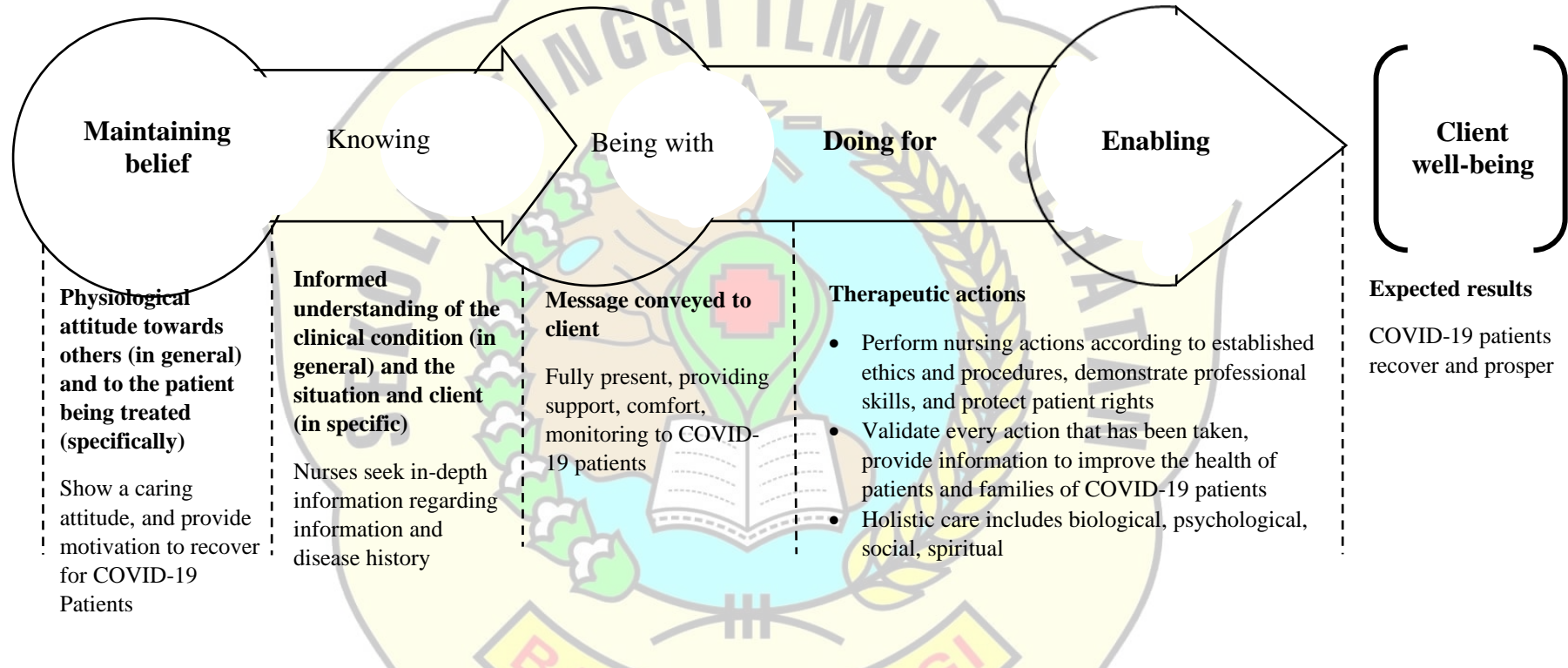
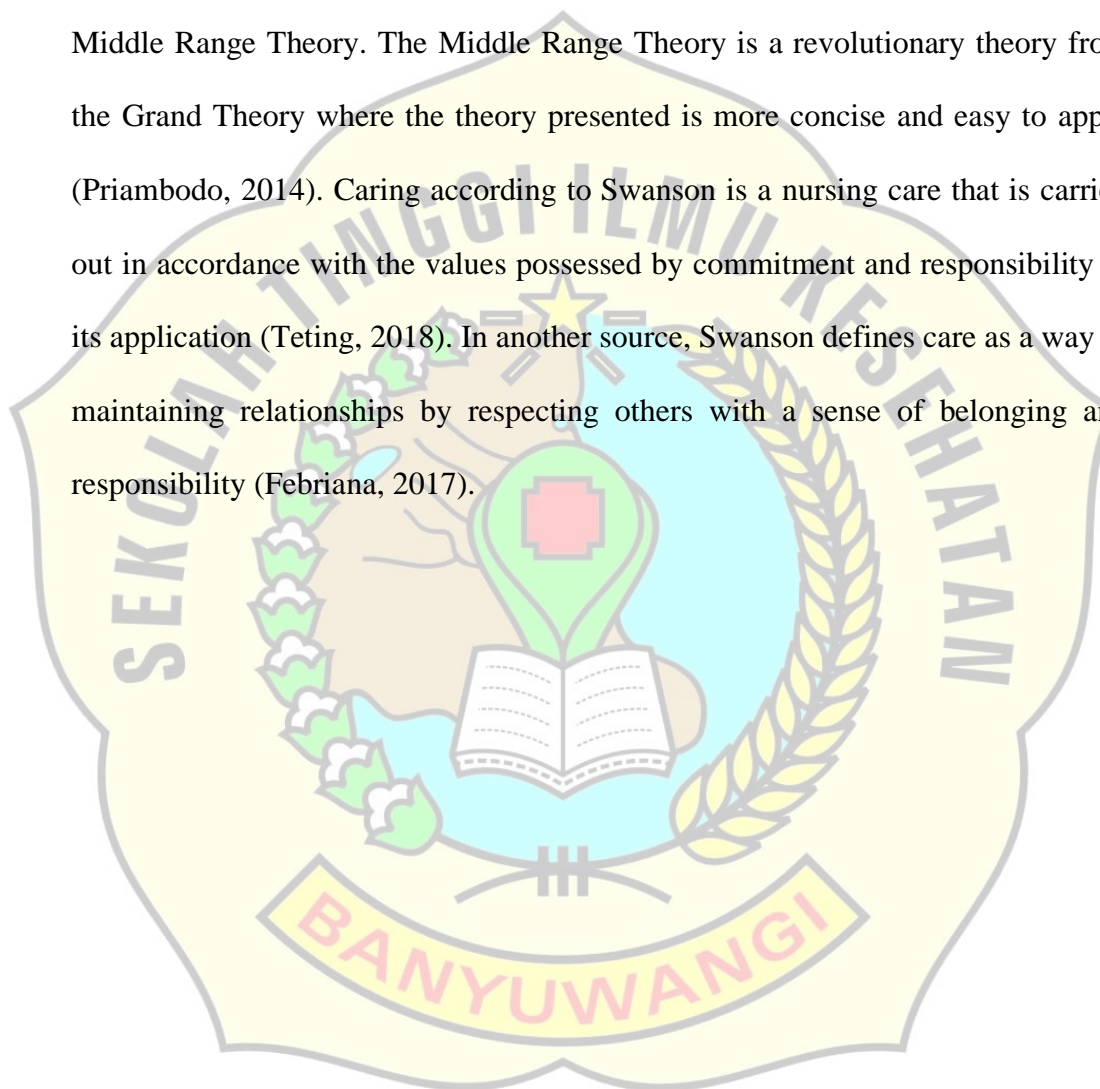


Figure 3.1 Research Framework Model Structure of Caring (Swanson, 1993)

The theoretical framework for treating COVID-19 patients based on nursing care is assessment, diagnosis, intervention, implementation and evaluation. The treatment of COVID-19 patients uses a holistic approach, which is a comprehensive approach to patients, not only on the disease and aspects of treatment and healing, but also other psychosocial aspects. Swanson's theory is a new theory called the Middle Range Theory. The Middle Range Theory is a revolutionary theory from the Grand Theory where the theory presented is more concise and easy to apply (Priambodo, 2014). Caring according to Swanson is a nursing care that is carried out in accordance with the values possessed by commitment and responsibility in its application (Teting, 2018). In another source, Swanson defines care as a way of maintaining relationships by respecting others with a sense of belonging and responsibility (Febriana, 2017).



CHAPTER 4

RESEARCH METHODS

4.1 Research Design

This type of research used a qualitative design with a phenomenological approach. This design was chosen so that participants' experiences can be explored to be more revealed so that the picture of nurses' experiences in caring for COVID-19 patients can be depicted in a real way. In addition, this study explores, analyzes and directly describes the phenomenon of nurses in treating COVID-19 patients as freely as possible from an intuition that cannot be measured directly (Steubert H.J., & Carpenter, 2011).

Descriptive phenomenology is a conscious experience experienced by participants and things including hearing, seeing, believing, feeling, remembering, deciding, evaluating, and acting (Polit, D.F., 2018). The researcher took steps with descriptive phenomenology rules, namely identifying three steps in the descriptive phenomenological process, namely intuiting, analyzing, and describing. In the first step, intuitive, researchers were totally integrated with the phenomenon of nurses in treating COVID-19 patients by studying various literatures. In the data collection process, the researcher became a data collection tool and listened to the description given by the nurse during the interview. Furthermore, the data about the experience was transcribed and reviewed repeatedly. In the second step, analyzing, the researcher identifies the essence of the phenomenon of experience by exploring the relationship and interrelationships between certain elements and the

phenomenon. Then in the third step, describing, the researcher communicates and provides a written description of critical elements or essences that are described separately and then in the context of their relationship to one another from the nurse's experience (Streubert H.J., & Carpenter, 2011).

The research method with a phenomenological approach is to explore perceptions, life experiences and understanding the essence of an individual's life. This method is was appropriate to use to explore the phenomenon of nurses in treating COVID-19 patients because each nurse has their own perception of their life experiences according to their views on themselves. With this method, it was hoped that various themes can be generated about the experience of nurses in treating COVID-19 patients.

4.2 Population, Sample, and Sampling Technique

4.2.1 Population

Population refers to the quantity or group of all units to which the study results apply. When it comes to the definition of population, it can be said that the population is made up of all the units to which the research results can be applied. In other words, the population is a set of all units that have the characteristics of the variable under investigation and can generalize the findings (Shukla, 2020). It is also stated that the population surveyed is subject to specified criteria (people, clients, etc.) (Nursalam, 2020). The population in this study were nurses at the Blambangan Hospital, Banyuwangi who had treated COVID-19 patients.

4.2.2 Sample

Participants in this study were nurses who cared for patients COVID-19. The number of participants in qualitative research should be based on information needs. Therefore, the principle in sampling is data saturation, namely sampling to a point of saturation where no new information is obtained and redundancy is achieved (Polit, D.F., 2018). Participants in qualitative studies are limited by saturation levels, not by nominal units (Denise F. Polit and Beck, 2008). The number of participants in the qualitative survey is 5 to 10. However, if the data is not yet saturated, you can increase the number of participants until the participant information is repeated (Creswell, 2007). Data saturation is achieved when participants' descriptions are similar despite different perspectives (Speziale & Carpenter, 2003). Sugiyono (2020) also stated that the sample was part of the population used. The criteria for participants in this study were:

- a. Inclusion Criteria
 1. Willing to be a participant
 2. Nurses who have experience working to treat COVID-19 patients for more than 5 months
- b. Exclusion Criteria
 1. Unable to provide information/become participant
 2. Nurses who have experience working to treat COVID-19 patients for less than 5 months
 3. Other health workers

4.2.3 Sampling Technique

The sample is part of the population that has certain characteristics or conditions to be studied (Riduan, 2015). The sampling technique used in this study used a purposive sampling technique. Purposive sampling is a sampling technique with certain considerations in accordance with the inclusion criteria (Sugiyono, 2016). The reason for using this purposive sampling technique is because it is suitable when used for qualitative research, or research that does not generalize (Sugiyono, 2016). The approach used in this research is to use observation and interview techniques.

4.3 Framework

The framework is a research flow so that it can be known clear description of the process and research (Notoatmodjo, 2010). The framework in this research was as follows:

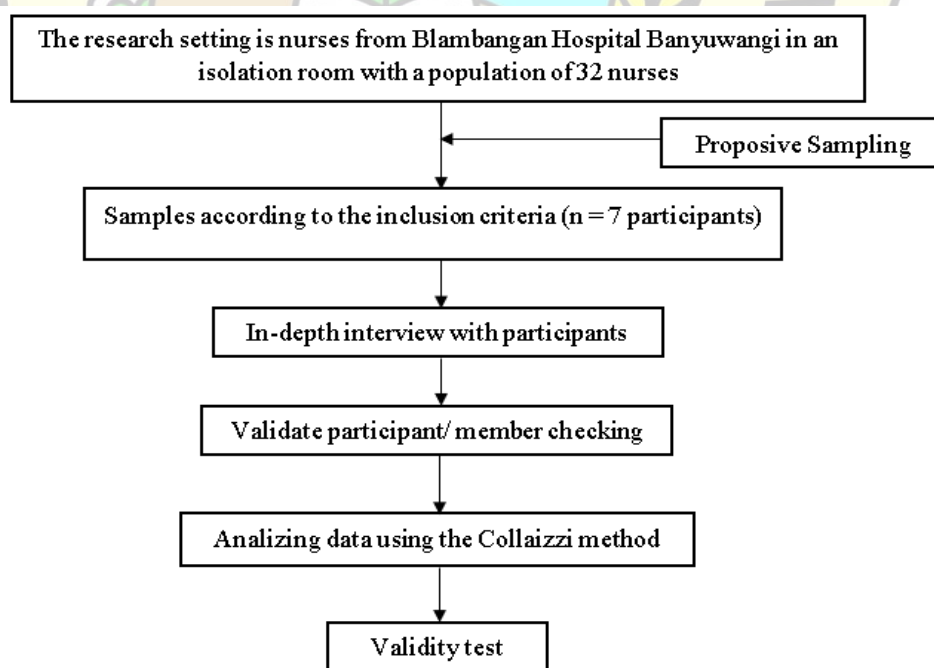


Figure 4.1 Framework for The Experience of Nurses in Providing Holistic Nursing Care for COVID-19.

4.4 Data Collection and Data Analysis

Data collection techniques are the most important step in conducting a survey, as the main purpose of the survey is to capture the data. Without technically knowledgeable data collection, researchers will not be able to obtain data that complies with established data standards. Data collection is the process of approaching the subject and capturing the characteristics needed for research (Nursalam, 2020). In this study, the data collected and used was obtained from primary and secondary sources. In addition, qualitative research was described in the natural environment (natural conditions), primary data sources, and data collection that can be performed with participant observations, interviews, in-depth interviews, and additional data collection techniques for literature research.

4.4.1 Research Instrument

Research instrument is a tool or facility used in collecting so that the work is easier and the results are better, in the sense of being more accurate, complete, and systematic so that it is easier to be processed. Variations in the types of research instruments used in science Nursing care can be classified into 5 parts including: measurement, biophysiology, observation, interviews, questionnaires, and scales (Nursalam, 2020). The tools used in the study as data collection instruments were demographic data questionnaires, interview guides, field notes, and voice recorders. Researchers conducted in-depth interviews, in order to explore or explore in depth the experiences of nurses in treating COVID-19 patients. Researchers used questionnaires

using participant demographic data which included initials, age of participants, gender of participants, length of work. In addition, the researcher also used an interview guide during the data collection process. The interview guide contains questions posed to participants, where the questions are made by the researcher himself. Interview guides are made based on theoretical foundations that are relevant to the problems to be explored in the research. The interview guide is in-depth, begins with open-ended questions, and is not rigid. Questions can develop according to the ongoing process during the interview without leaving the theoretical foundation that has been established. The interview guide was made to make it easier for researchers so that the interviews were directed and in accordance with the research objectives. In addition, interview guides were used to remind researchers of the main issues discussed (Steubert H.J., & Carpenter, 2011). The questions asked were related to the experience of nurses in treating COVID-19 patients. The interview guide has been done with content validity by the expert. The purpose of this step is to assess the relevance of each item to the desired measure. As for the elaboration of the content validity index assessment, namely items of relevance, clarity, simplicity, and ambiguity, for all of these items the expert gave a score of 4 which means the interview guide questions are relevant, clear, simple and have a clear meaning. Field notes are used by researchers to collect field note data which is a written record of what is heard, seen, experienced, thought in the context of collecting data and

reflecting on data in qualitative research in the form of documentation of non-verbal responses during the interview process (Polit , DF, 2018). The researcher also used a voice recorder to record conversations during the interview, then the results of the interview were typed in the form of a transcript.

4.4.2 Research Location and Time

This research was conducted in Blambangan Hospital, Banyuwangi and the time is November 2021 until January 2022.

4.4.3 Procedure

a. Administrative Procedures

Before researchers conducted research, researchers took an administrative approach to education or agencies first by applying for initial data collection permission to conduct research from STIKES Banyuwangi through the Bureau of Research and Community Service.

b. Technical Procedures

Data collection in this study used an in-depth interview method with a duration of 50-60 minutes. Data collection was done through direct and indirect interviews if there are obstacles in the research (through the ZOOM application). The in-depth interview method used an interview guide to be submitted to participants. The in-depth interview method used an interview guide that contains questions to be asked to participants. This could make it easier for researchers to conduct interviews, collect information, data, and then depend on

improvisation from when they are at the research location (Ghony, M., D., & Almanshur, 2012). The researcher gave freedom to the participants to express their experiences with the questions asked during the interview process so that the data obtained naturally matched the experiences of the participants.

4.4.4 Data Analysis

The data analysis method in this study used the approach of Colaizzi's content analysis. This method was chosen because it provides simple, clear and systematic steps (Steubert H.J., & Carpenter, 2011) and this method is the only one that requires validation of results to research participants (Polit, D.F., 2018). The stages of detailed data analysis were carried out with the following stages: Read all protocols to acquire a feeling for them.

- a. Make a data transcript and read all the interview descriptions that have been disclosed by the participants.

In the process of this analysis, participants' statements were transcribed from audio recordings of interviews from each participant.

- b. Extracting significant statements (statements that are directly related to the phenomenon under study).

- c. Formulating the meaning for each significant statement, the significant statement was extracted from each transcript and assigned a different color. In this stage of the analysis, Colaizzi suggested that researchers attempt

to reformulate the general significant statements extracted from participants' transcripts.

- d. Combining the meanings formulated into groups of themes. Researchers determine or regulate the meaning that has been formulated into similar groups. In other words, the meanings formulated are grouped into groups of themes.
- e. Develop a complete description of the theme that is, a comprehensive description of the experiences expressed by participants. A complete description is developed through the synthesis of all groups of themes and meanings formulated and explained by the researcher.
- f. Identify the basic structure of the phenomenon. At this stage the researcher will describe each theme that emerged as a result of research findings related to the experience of nurses in treating COVID-19 patients. The description of the results of this study will be stated in the writing of the research results.
- g. Validate the results of data analysis directly to participants to get validation from the description of the results of the analysis and to re-assure whether the themes or findings that the researcher finds through the analysis process are the actual experiences of the participants and are agreed upon by the participants.

4.4.5 Data Validity

Polit & Beck (2012) stated that to get reliable research results, the data were validated with several criteria, namely: credibility, dependability, confirmability, transferability, and authenticity.:

a. Credibility

According to Sugiyono (2020) explains that the credibility test orienternal validity with respect to the gedree of accuracy of the research design with the result achieved or the truth value of the research. Credibility is viewed by Lincoln and Guba as an overriding goal of qualitative research. Credibility refers to confidence in the truth of the data and interpretations of them. Qualitative researchers must strive to establish confidence in the truth of the findings for the particular participants and contexts in the research. Lincoln and Guba pointed out that credibility involves two aspects: first, carrying out the study in a way that enhances the believability of the findings, and second, taking steps to demonstrate credibility to external readers.

According Denzin (1989), credibility test used in this study is the triangulation method. Triangulation is the use of several methods in a qualitative data collection strategy to reduce prejudice. Triangulation refers to different references to infer a truth. There are:

1. Data triangulation includes the use of multiple data sources in conducting a study to obtain different

points of view with the aim of obtaining valid results and minimizing prejudice. Triangulation of data is divided into 3 parts, first time triangulation is done by collecting a phenomenon in different time periods. Second, place triangulation is collecting data about the same phenomenon from different places. Third, people triangulation is collecting data from different participants.

2. Researcher triangulation is carried out involving two or more researchers who are experienced in analyzing and interpreting qualitative data.
3. Theoretical triangulation is carried out by researchers using related theories or involving experts in analyzing and interpreting the data that has been found.
4. Method triangulation is triangulation carried out by using several methods in collecting data on the same phenomenon or problem.
5. Triangulation analysis uses two or more analytical techniques on the same data.
6. Multiple Triangulation explained that the researcher used several triangulation methods above to collect and analyze data.

b. Dependability

In Lincoln and Guba's work, the dependability test is a dependency that refers to the stability of the data over time and conditions. This process is an audit and research evaluation process carried out by supervisors (Mekarisce, 2020; Polit & Beck, 2010)

c. Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning. This stage is the writing examination stage, researchers can do confirmability by consulting the final researcher, and can disseminate research results at conferences or meetings (Mekarisce, 2020; Polit & Beck, 2013).

d. Transferability

Transferability, analogous to generalizability, refers to the extent to which qualitative findings can be transferred to (or have applicability in) other settings or groups. The reader is a transferability test so the generalizability of the findings depends on each reader. In addition, generalizations in this qualitative research related to the context of research findings can be applied to other wider social groups (Golafshani, 2015; Mekarisce, 2020).

e. Authenticity

Authenticity refers to the extent to which researchers fairly and faithfully show a range of different realities. Authenticity emerges in a report when it conveys the feeling tone of participants'

lives as they are lived. A text has authenticity if it invites readers into a vicarious experience of the lives being described, and enables readers to develop a heightened sensitivity to the issues being depicted. When a text achieves authenticity, readers are better able to understand the lives being portrayed “in the round,” with some sense of the mood, feeling, experience, language, and context of those lives.

4.5 Research Ethics

4.5.1 Informed Consent

Subjects must receive complete information about the purpose of the study being conducted, have the right to participate freely, or refuse to participate. Informed consent must also indicate that the data received will only be used for scientific development (Nursalam, 2020).

4.5.2 Anonymity

Participants' names are not listed on the data collection sheet. This is intended to maintain the confidentiality of the respondents and the researcher used the code on the each data collection sheet with code P (participant) example P1, P2, P3, and etc.

4.5.3 Confidentially

Confidentiality is an ethical issue in a study which is carried out by providing assurance of the confidentiality of research results, both information and other issues. All information that has been collected is guaranteed confidentiality by the researcher, only certain data groups will be reported on the research results (Wiles et al., 2018).

4.5.4 Veracity

Be honest when collecting data, literature, methods, procedures, research, and publication of results. Be honest about the shortcomings or failures of the research process. Does not recognize work which is not his/her job (Wasis, 2017)

4.5.5 Non-maleficence

Non-maleficence is a principle which means that every action a person takes does not cause harm physically or mentally (Wasis, 2017).

4.5.6 Respect for Person

Respect for person are two things that need to be considered, that is researchers must consider in depth the possible dangers and misuse of research and provide protection to respondents who are vulnerable to the dangers of research (Wasis, 2017).

4.5.7 Beneficence

Ethical imperatives to seek maximum benefits and minimize losses or risks to the subject and research errors. In this case the research must be carried out appropriately and accurately, the respondent's safety and health are maintained (Wasis, 2017).