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Original Article

Vietnamese Nurses' Lived Experiences of Hospital Isolation during COVID-19: A Qualitative Study

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Abstract

Cesarean section is a childbirth procedure performed through surgery by making an Nurses are at heightened risk of COVID-19 exposure due to their close contact with infected patients. In Vietnam, where the healthcare system faced significant strain during the pandemic, many nurses were infected and subjected to hospital isolation. However, little is known about how Vietnamese nurses personally experienced this isolation process. This study aimed to explore the lived experiences of Vietnamese nurses who were infected with COVID-19 and underwent hospital-based isolation. A qualitative descriptive phenomenological design was employed using Colaizzi's method of analysis. Seven registered nurses from a public hospital in Ho Chi Minh City, Vietnam, who had completed hospital isolation and tested negative for COVID-19, were recruited through purposive sampling. Data were collected via in-depth face-to-face interviews conducted between March and June 2022. Thematic analysis was performed to identify core experiences and meanings. Three major themes emerged: (1) Before isolation, nurses reported emotional shock, fear of transmission, and social stigma; (2) During isolation, participants experienced loneliness, worsening symptoms, spiritual coping, and insufficient professional support; and (3) After isolation, they reported lingering physical fatigue, spiritual growth, and a renewed sense of empathy and advocacy. Peer connection and spiritual practices played a significant role in emotional resilience. Hospital isolation due to COVID-19 presents not only physical but also profound psychological and spiritual challenges for nurses. Support strategies should incorporate mental health services, spiritual care, reintegration planning, and equal treatment of healthcare workers when they become patients. Culturally sensitive approaches are essential for improving pandemic preparedness and staff well-being in future health emergencies.

Keyword

COVID-19, Hospitalization, Nurses,

Background

The COVID-19 pandemic has reshaped healthcare delivery globally, pushing hospitals and health workers into uncharted territory. In Vietnam, the sudden surge in cases strained already limited resources, forcing many nurses to shift from being caregivers to becoming patients themselves. Despite significant attention to public health responses, little is known about how nurses personally experienced being isolated due to infection, especially in Vietnamese clinical contexts.

Nurses are the backbone of hospital care, often involved in high-contact duties such as bedside care, medication administration, and emotional support. These responsibilities placed them at elevated risk during the height of the pandemic. While much attention has been paid to infection rates among healthcare workers, far fewer studies have explored the psychological and existential toll of forced isolation on nurses once they contracted the virus themselves (Sun et al., 2020; He et al., 2021).

Experiencing hospitalization not as a provider but as a patient can be emotionally jarring for nurses. The inversion of roles—from healer to one in need of healing—often evokes feelings of vulnerability, fear, and loss of identity. These experiences are amplified in isolation wards, where contact with others is minimized, and the routine of care is governed by stringent protocols (Aggar et al., 2022). In collectivist cultures like Vietnam's, isolation can carry a dual burden: physical separation and perceived disconnection from familial and social roles.

Vietnamese nurses faced unique stressors. Many were isolated in state-run facilities far from home, with inconsistent access to psychological support and communication infrastructure. Cultural stigma surrounding illness, particularly one as feared as COVID-19, often intensified their emotional suffering.

Some nurses also reported shame or guilt, fearing they had failed in their protective roles or infected family members, similar to findings in other Asian contexts (Moghimian et al., 2022; Moradi et al., 2020).

Spirituality and community identity play pivotal roles in Vietnamese well-being. For many, religious beliefs, meditation, or prayer helped reframe the trauma of isolation and reconnected them with a sense of purpose and inner strength (Tuason et al., 2021). These spiritual practices may have acted as coping mechanisms, providing emotional insulation against fear, grief, or loneliness. However, no study has yet captured how these culturally embedded practices supported nurses' resilience in Vietnam during hospital isolation.

Given this context, it is essential to explore the lived experience of nurses who underwent hospital isolation due to COVID-19 in Vietnam. Such an understanding will offer not only culturally relevant insights into psychological support needs but also inform hospital policies and professional training programs. This study aimed to uncover these narratives through a phenomenological lens, allowing nurses' voices to be heard, honored, and used to improve care for future health emergencies.

Methods

Study Design

This research employed a qualitative descriptive phenomenological design to explore the lived experiences of nurses who underwent hospital-based isolation after testing positive for COVID-19. Colaizzi's seven-step method (Colaizzi et al., 1978) was used as the analytical framework to guide the extraction of meaning from participants' narratives. This design was selected to ensure that participants' subjective experiences, emotions, and reflections were central to the study's findings.

Participants

The study was conducted at a public referral hospital in Ho Chi Minh City, Vietnam, designated as one of the main COVID-19 treatment centers during the peak of the pandemic. Participants were selected using purposive sampling based on the following inclusion criteria: (1) registered nurses working at the hospital; (2) confirmed COVID-19 positive through PCR testing; (3) had completed at least 14 days of hospital-based isolation; (4) currently declared COVID-19 negative and physically stable; and (5) willing to participate in the study. Seven participants were recruited, with data saturation reached at the seventh interview. Participants were both male and female, aged between 26 and 45 years old, from various nursing departments including emergency, ICU, and general wards.

Data Collection

Data were collected between March and June 2022 through face-to-face in-depth interviews conducted in Vietnamese. All interviews were guided by a semi-structured interview protocol that had been validated by two qualitative research experts. Questions explored the participants' feelings, coping mechanisms, spiritual reflections, and perceived support during their isolation period. Interviews were held in a quiet room within the hospital compound, lasted between 45 to 60 minutes, and were audio-recorded with participants' consent. Field notes were also taken to capture non-verbal cues and contextual observations.

Data Analysis

Audio recordings were transcribed verbatim and translated into English for analysis. The data were analyzed following Colaizzi's (1978) method: (1) reading and re-reading all transcripts to obtain a general understanding; (2) extracting significant statements related to the phenomenon; (3) formulating meanings; (4) clustering formulated meanings into themes and subthemes; (5) developing an exhaustive description; (6) identifying the fundamental structure of the phenomenon; and (7) returning the findings to participants for validation (member checking). NVivo 12 software was used to assist with data coding and organization.

Trustworthiness

To ensure rigor, the study employed criteria of credibility, dependability, confirmability, and

transferability as proposed by Lincoln and Guba (1985). Credibility was maintained through prolonged engagement, triangulation of data sources (interviews and field notes), and member checking. Dependability and confirmability were ensured through detailed audit trails and peer debriefing with qualitative research experts. Transferability was addressed by providing thick descriptions of participants' contexts and verbatim quotes to allow readers to determine relevance to their own settings.

Ethical Consideration

Ethical approval was granted by the Research Ethics Committee. Participants were informed about the study purpose, procedures, voluntary participation, and the right to withdraw at any time without penalty. Written informed consent was obtained prior to data collection. All data were anonymized and securely stored to ensure confidentiality and privacy..

Results

A total of seven participants took part in this study. They included four female nurses and three male nurses, aged between 26 and 45 years. The participants came from various departments including internal medicine, emergency unit, and intensive care. The duration of hospital isolation ranged from 10 to 21 days. All participants had experienced mild to moderate COVID-19 symptoms and had completed their isolation and recovery before participating in the interviews.

The analysis yielded three main themes and multiple subthemes that reflect the nurses' lived experiences throughout the course of their infection and isolation: (1) Before Isolation: Facing the Diagnosis, (2) During Isolation: Navigating Physical, Emotional, and Spiritual Challenges, and (3) After Isolation: Recovery, Reflection, and Resilience.

Theme 1: Before Isolation — Facing the Diagnosis

Subtheme 1.1: Initial Emotional Shock

Participants commonly described a strong emotional reaction upon learning of their positive COVID-19 status. Many reported disbelief, fear, and distress, especially considering their role as healthcare providers who were supposed to protect, not fall ill. One nurse reflected:

"I couldn't believe the result. I had been so careful. When I saw the positive PCR, I cried in disbelief."

This quote encapsulates the psychological rupture experienced upon diagnosis, where professional identity clashes with personal vulnerability.

Subtheme 1.2: Early Physical Symptoms

Nurses also recalled the onset of symptoms with apprehension and confusion. Despite strict adherence to PPE protocols, symptoms emerged suddenly and were difficult to interpret at first. One participant noted:

"The fever came suddenly, and then I lost my sense of smell on the third day. That's when I suspected something was wrong."

These early signs triggered anxiety, leading to urgent testing and, ultimately, hospital isolation.

Theme 2: During Isolation — Navigating Physical, Emotional, and Spiritual Challenges

Subtheme 2.1: Isolation and Loneliness

A pervasive sense of abandonment and loneliness emerged during hospital isolation. Despite understanding the need for infection control, participants experienced emotional isolation. One nurse described:

"The silence was unbearable. I felt like I was abandoned, even though I knew it was protocol."

Such feelings intensified in sterile and impersonal ward environments, especially when participants were housed alone or with non-communicative patients.

Subtheme 2.2: Worsening Physical Symptoms

As the illness progressed, participants reported a decline in physical functioning, with fatigue and respiratory symptoms often worsening in isolation. One participant shared:

"I was too weak to even sit up for long. Every breath felt heavy, and I just wanted to sleep the pain away."

The physical strain of COVID-19 combined with emotional stress created a compounded burden.

Subtheme 2.3: Spiritual Coping

Spirituality played a key role in managing stress during isolation. Many nurses engaged in religious or meditative practices to maintain inner peace. One participant revealed:

"I chanted the Heart Sutra every night. It calmed me and gave me the strength to get through another day."

These practices helped restore a sense of meaning and control amidst the uncertainty of illness.

Subtheme 2.4: Peer Support and Communication

Maintaining connection—with family, colleagues, or fellow patients—emerged as a protective factor. Nurses who shared rooms with coworkers reported mutual encouragement:

"I was lucky to be isolated with a fellow nurse. We checked on each other and kept our spirits up."

Digital communication tools also helped participants stay emotionally grounded during isolation.

Subtheme 2.5: Gaps in Professional Support

Despite being patients, participants felt that their status as nurses influenced how other healthcare providers treated them. Many felt neglected or assumed to be self-sufficient. One stated:

"They just left the medication and walked out. No explanation, no comfort. Maybe they thought I knew it all."

This perception of professional disregard contributed to emotional distress.

Theme 3: After Isolation — Recovery, Reflection, and Resilience

Subtheme 3.1: Post-COVID Physical Conditions

Even after being declared recovered, lingering symptoms such as fatigue and reduced stamina persisted. These post-viral effects limited participants' ability to resume full duties. One nurse said:

"Even after two weeks, climbing stairs left me winded. My body just didn't bounce back."

This prolonged recovery complicated the transition back to normal routines.

Subtheme 3.2: Spiritual and Social Transformation

The isolation period also led to deeper spiritual and social reflection. Participants developed more disciplined health habits and spiritual commitments. One participant shared:

"I now wake up earlier to meditate. I feel closer to my beliefs and more at peace than before COVID."

The experience, though traumatic, served as a turning point in personal growth for many.

Subtheme 3.3: Renewed Purpose and Advocacy

Several participants expressed a desire to support others in similar situations, becoming informal advocates within their networks. As one nurse recalled:

"Now, when a colleague tests positive, I immediately call them. I know exactly how it feels to be alone."

This renewed sense of empathy and advocacy was one of the most profound post-isolation outcomes.

Discussion

This study explored the lived experiences of Vietnamese nurses who underwent hospital isolation due to COVID-19. The findings are organized into three thematic phases: before isolation, during isolation, and after isolation. Each phase reveals complex emotional, physical, and spiritual responses shaped by cultural values, professional identity, and healthcare system dynamics.

The period prior to hospital isolation was marked by profound psychological disruption. Nurses expressed disbelief and fear upon receiving a positive COVID-19 result, often accompanied by guilt related to possible transmission to family or colleagues. These findings are consistent with Taylor et al. (2020), who reported that coronavirus-related stress includes intense fears of contamination, death, and social consequences.

As frontline workers, nurses' emotional burden was exacerbated by their knowledge of COVID-19 mortality and first-hand exposure to critically ill patients. This is in line with Banzett et al. (2020), who highlighted the psychological trauma patients experience when anticipating a painful or lonely death. Furthermore, stigma and fear of social exclusion were notable, echoing findings from India and Iran (Sahoo et al., 2020; Moradi et al., 2020), where healthcare workers faced community rejection and shame.

During hospital isolation, nurses endured layered challenges: worsening physical symptoms, emotional loneliness, lack of professional support, and disrupted identity. Several participants reported feeling invisible or neglected by medical teams, particularly due to assumptions that they could care for themselves as fellow professionals. This aligns with He et al. (2021) and Moghimian et al. (2022), who found that infected healthcare workers often experience role disorientation and professional marginalization during illness.

Emotionally, participants described loneliness, helplessness, and psychological distress, paralleling studies from Kar et al. (2020) and Giallonardo et al. (2020), which reported depression, anxiety, and existential distress during COVID-19 quarantine. However, a culturally distinct finding in this study was the use of spiritual coping strategies such as Buddhist chanting, prayer, and meditation. This spiritual anchoring provided emotional stability and reflected what Tuason et al. (2021) described as "meaning-making" during pandemics.

Peer support also emerged as a key resilience factor. Participants who shared rooms with colleagues experienced reduced emotional distress. This confirms the findings by Sun et al. (2020) and Aungsuroch et al. (2020), who emphasized the protective effects of social support and interpersonal bonding in pandemic healthcare environments.

Following their release from isolation, nurses continued to experience physical limitations, such as fatigue and breathlessness, consistent with the global literature on post-COVID syndrome (Shah et al., 2021; Higgins et al., 2021). These symptoms hindered full reintegration into professional duties, raising questions about long-term occupational health support for recovered healthcare workers.

Interestingly, the post-isolation phase also brought positive transformations. Many participants reported enhanced spiritual discipline and a renewed sense of purpose. They expressed greater empathy for patients and took on advocacy roles within their professional circles. These outcomes support the notion of post-traumatic growth, where individuals find deeper meaning following adversity (Fardin, 2020; Tuason et al., 2021).

Finally, participants' calls for improved communication, faster PCR processing, and more empathetic care during isolation echo prior critiques of pandemic care infrastructure (Wang et al., 2020; Olufadewa et al., 2020). Their lived experiences offer practical insights for future emergency preparedness—especially regarding the support of infected healthcare workers.

Conclusion and Recommendation

This study sheds light on the lived experiences of Vietnamese nurses who were hospitalized and isolated due to COVID-19 infection. Their narratives reveal a profound emotional journey that spanned from fear and guilt at diagnosis, to spiritual and psychological struggle during isolation, and finally to reflection, transformation, and renewed purpose after recovery. The findings illustrate that the experience of being both a caregiver and a patient simultaneously creates unique vulnerabilities that require targeted institutional support. Psychological assistance, spiritual sensitivity, peer connection, and post-

recovery accommodations are essential components of a holistic care model for healthcare workers during pandemics.

By understanding these experiences, healthcare managers and policymakers can develop more empathetic, culturally responsive, and protective systems to support frontline professionals. In a broader sense, this study reaffirms the humanity of nurses—not only as caregivers, but as individuals with emotional, spiritual, and physical needs who deserve dignified care, especially in times of crisis.

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