Confronting the Unknown:
A Classic Grounded Theory of Registered Nurses and Assistant Nurses in Covid-19 Care

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Abstract

During the start of the COVID-19 pandemic, symptoms, spread, and treatment were not fully known. Nurses felt poorly trained and unprepared. The study's objective was to develop a classic grounded theory of registered nurses and assistant nurses in COVID-19 care by exploring their main concern and how they handle this concern. The method used was a Classic grounded theory. Eleven registered nurses and assistant nurses, and 13 articles from the two main Swedish quality newspapers describing the working situation for registered nurses and assistance nurses during the first year of COVID-19 were used. 'How to adapt to a constantly changing reality' emerged as the main concern in the situation of confronting the unknown. The theory involves two sub-core categories: Adjusting and Surrendering. There is no easy way of handling the situation. However, knowledge about how nurses use different strategies, use them in succession or shift back and forth over time, can increase awareness of how to address similar incidents in the future.

Keywords: Assistance nurses' perspective, Classic Grounded theory, COVID-19, Nurses' perspective, Qualitative research

In the beginning of 2020, our world experienced the first spread of what turned out to be a pandemic caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease was later called corona virus disease 2019 (COVID-19) (WHO, 2019). The virus was first identified in December 2019 in Wuhan, China, and the World Health Organization (WHO) declared COVID-19 a pandemic at the end of January 2020. In March 2020, the disease fully developed into a pandemic and spread to over 110 countries (WHO, 2019). During the outbreak, hundreds to thousands of people in Sweden were affected by COVID-19 daily (The Public Health Agency of Sweden, 2025), and the Swedish healthcare system was, from one day to another, faced with double messages concerning the seriousness of the infection. On the one hand, the responsible authorities and the government communicated COVID-19 as a serious risk. At the same time, the same actors communicated that the virus was relatively harmless to the public who were not in any risk group (Rasmussen, 2022). During the start of the pandemic, symptoms and how COVID-19 spread were not fully known, nor was there any prior knowledge about treatments for COVID-19 (The Public Health Agency of Sweden, 2025). Something that influenced nurses' workload, as they felt poorly trained and unprepared for working with this patient group (Bergman et al. 2021).

As previous research has described how nurses experience situations in which time constraints and insecurity influence their work (Enns & Sawatzky, 2016; Garcia-Martin et al. 2020; Liu et al. 2020), comprehensively trying to understand how registered nurses and assistant nurses in COVID-19 care handle their situation is important.

In Sweden a registered nurse requires a bachelor's degree in nursing and is licensed by the Swedish National Board of Health and Welfare, while an assistant nurse requires an equivalent to a high school diploma in nursing. The aim of this study was to develop a classic grounded theory of registered nurses and assistant nurses in COVID-19 care by exploring their main concern and how they handle this concern.

Materials and Methods

The study used the methodology of classic grounded theory developed by Glaser and Strauss (Glaser & Strauss, 1967) and further defined by Glaser (Glaser, 1978; 1992; 1998; 2003). Classic grounded theory seeks to conceptualize different patterns of human behaviour. The interviews in the study were conducted from 2022–2023. Data from eleven interviews with registered nurses and assistant nurses working in COVID-19 care were coded and analysed.

Furthermore, 13 articles from the two main Swedish quality morning newspapers (Dagens Nyheter and Svenska Dagbladet) that described the working situation for registered nurses and assistant nurses in Sweden during the first year (2020) of the COVID-19 pandemic were used. First, eleven nurses and assistant nurses were interviewed. All the participants were women; nine were registered nurses; two were assistant nurses; and the ages were between 28 and 52 years (*M*=38.5, *Mdn*=37). The nurses worked in medical, infection,

intensive, geriatric wards, and on a palliative care team in southern Sweden. The inclusion criterion was that they had worked with patients who had COVID-19. The researcher contacted the department managers at different wards at two hospitals and asked nurses and assistant nurses at their wards if they were interested in participating. If they were interested, they gave their permission for the researcher to contact them. A palliative care team was also contacted in a similar way.

All the interviews were performed via mobile phone. The participants chose where and when they wanted to be contacted. The interviews were informal open-ended conversations, and the nurses and assistant nurses were encouraged to speak openly about their situation while working in COVID-19 care. Open-ended questions were used to encourage the registered nurses/assistant nurses to explore the situation further, so a greater depth of understanding was reached. Questions such as 'Can you tell me about your situation as a nurse/assistant nurse working in COVID-19 care' and 'Can you describe your feelings working with patients with COVID-19' were used. The researcher, who is experienced in performing qualitative interviews, was attentive and adaptable to the participants' narratives.

The interviews lasted 30–60 minutes, field notes were written, and the interviews were also recorded. The field notes and listening to the recorded interviews served as a basis for the data analysis. Each interview was analysed prior to the next one, allowing the researcher to generate follow-up questions and issues to explore, what is called theoretical sampling (Glaser, 1978). Alongside this data collection and analysis, memos were written as a way to keep track of ideas about main concerns and connections between emerging concepts (Glaser 1978; 1992).

The field notes were used in the generation of concepts. It starts with an open coding of the data, involving analysis of the text line by line, as soon as possible after each interview is performed. Various questions were asked: What do these data reflect? What is actually happening in these data? What category does this incident indicate? What is the main concern of the registered nurse/assistant nurse? How do the registered nurse/assistant nurse continually handle this concern? By asking these questions, the researcher was helped to be theoretically sensitive and evade mere descriptions of the data. It also helped emphasize properties in the data that repeated themselves instead of having single incidents in focus. The process of open coding was accompanied by constant comparison. The initial codes were compared with each other as soon as they emerged. Newly generated concepts were compared to new codes, and concepts were compared to other concepts. To help guide the interviews, theoretical sampling was used (Glaser 1978; 1998; Glaser & Strauss, 1967), where new ideas that emerged during interviews were used to direct subsequent interviews as a way to illuminate these ideas. This, in accordance with the aim of grounded theory (GT), which aims to gather data to elaborate and refine emerging categories and emphasize categories related to the core concept and the

emerging theory (Glaser 1978; 1998; Glaser & Strauss, 1967).

When the core categories had emerged, the process of selective coding commenced, where the collected data and codes were delimited into specific categories and connected to the core concept (Glaser 1978; 1998; Glaser & Strauss, 1967). In addition to this coding process, an analysis of 13 articles from the two main Swedish morning newspapers (Dagens Nyheter and Svenska Dagbladet) describing the working situation for registered nurses and assistant nurses in Sweden during the first year (2020) of the COVID-19 pandemic was used. The purpose of this analysis was to compare and refine the coding performed in the interviews to confirm full saturation of the concepts. During the analysis, memos were written, and memo sorting was performed. Coding proceeded until theoretical saturation was achieved, meaning that additional data no longer generated new concepts nor further refined their properties and dimensions (Glaser 1978; 1998).

To remain on a theoretical level (rather than a descriptive level), the conceptual categories and properties were continually related to each other. According to Glaser (2003), the theory is not the voice of study participants; instead, it is an abstraction of the actions of individuals in the research area.

Ethical Considerations

Ethical approval for the study was obtained from the Regional Ethical Board in Linköping, Sweden (Dnr 2021--03698). All participants received written and oral information about the aim of the study and the possibility of withdrawing their participation at any time without need to give reasons for doing so. Confidentiality was assured according to ethical research guidelines (Vetenskapsrådet, 2017). Informed consent was obtained from all participants.

Results

Nurses and assistant nurses are henceforth called nurses. The theory of *Confronting the unknown* (see Figure 1) explains how nurses in COVID-19 care in their working situation are struggling with a pandemic disease that has taken the whole world by shock. The insecurity concerning how to treat patients, how to keep other patients from getting ill, and how to protect themselves is constantly a heavy load on their shoulders. They also at the same time see many patients die, get ill themselves or see working colleagues getting ill. The context thereby is that nurses find themselves in a constantly changing reality. In the open coding the core category i.e. what appears to account for most of the variation around the matter of concern and thereby the focus of the study (Holton & Walsh, 2017), is *How to adapt to a constantly changing reality*. This adaptation includes insecurity but also pride. The insecurity in not knowing what to do, how to do it, and what if what is done is all wrong. What if it causes the nurse or the patients to become infected? There is a struggle to handle this insecurity by confronting the unknown. Pride is experienced as doing the best possible and solving the situation as good as possible while confronting the unknown. The theory involves two sub-core categories used to

handle the main concern: *adjusting* and *surrendering*. In adjusting, nurses try to make sense and be in control of the new reality by adjusting to new routines and situations while at the same time experiencing different emotions that triggers their experiences. In surrendering, nurses release their need for control and surrender to be in a reality they cannot control.

In confronting the unknown, nurses vary their behaviour between adjusting and surrendering, depending on triggers such as feelings of sadness, anger, or mourning. The sub-core categories can seldom be completely detached; they mix and overlap each other depending on the complexity in the situation where the unknown is constantly present. One category may help the nurse find balance in the situation, whereas the other make it even clearer that there is an unknown reality where accepting or resigning are ways to try and work with the situation. The sub-core categories can thus be used both separately and simultaneously and can be evoked if nurses do not receive the support needed, which might lead them to take matters into their own hands or surrender to the situation.

Figure 1

Theory of Confronting the Unknown

(see Appendix – Figure 1)

Adjusting

The sub-core category Adjusting comprises *Recalibrating practice* as a strategy that involves several minor approaches that together strive to create a way to address the COVID-19 situation and insecurity and by that confront the unknown. By recalibrating practice, the nurses adjust continuously while they explore ways to address the situation. This continuing adjustment can become insecure when it is obvious that this knowledge seeking reveals that there are no clear rules. Authorities do not know either. As there is a lack of fixed rules or stable reference points, recalibrating requires corrections along the way and these adjustments can teach the nurses what works and what does not work. It can be about seeking knowledge in newspapers, from books about microbiology and hygiene. Go back to what you already know from school and previous similar situations. When recalibrating, the nurse is helped to confront the unknown by engaging in it, responding to it and discovering new knowledge. But it can also lead to the realization that no one knows, thus increasing fear. Seeking knowledge does not stabilize reality instead it can destabilize it.

Care Provision Struggling

When nurses confront situations in which no clear guidelines exist, they may engage in an inner dialogue to stabilize their practice: "I may not fully understand this situation, but I do understand caring. I know how to provide nursing in the best way I can. I will use the knowledge and resources available to me". In the COVID-19 situation this self-reasoning becomes a way to reclaim agency. The nurses draw on professional competence, use protective equipment meticulously, and take pride in doing what is possible, even when it feels insufficient. This commitment can generate moments of meaning and even joy, as the nurses create conditions that allow patients to have it as good as possible despite the uncertainty. In

this sense, the nurses "go their own way" by establishing a personal, provisional ground for action when formal certainty is lacking. Since no one possesses definitive knowledge about what the effective practice should be, the boundaries of right and wrong become fluid. The nurses therefore rely on an internal ethic of doing the best one can, which become both a compass and a coping mechanism.

Providing good care in such situations becomes a collective undertaking. Working side by side with colleagues, trying to make responsible decisions in an unstable situation, can strengthen a sense of solidarity and shared purpose. Working together to manage difficult situations fosters team cohesion and a sense of professional accomplishment.

This struggle, however, is not only about patients, it also often extends to caring for colleagues as well. Nurses may take on additional shifts to shield coworkers perceived as more vulnerable. In doing so, they enact a form of self-sacrifice: putting their own needs aside in order to sustain the team. This way of acting can be seen as an attempt to hold things together, involving both ethical responsibility and practical care. Care provision struggling becomes both a personal strategy and a collective act of care. It enables nurses to navigate the unknown, preserve ethical integrity, and maintain the continuity of care, even when the conditions are unstable and emotionally demanding. Nevertheless, feelings of not doing enough can be present and can lead to being sad.

Surrendering

The sub-core category Surrendering comprices *Accepting* as a strategy. Within the ongoing situation of COVID-19, nurses often confront the limits of their capacity to control events. Accepting, in this context, is not a single moral choice but a dynamic process that can be more or less voluntary. At times, it emerges willingly, a deliberate adjustment of one's expectations in light of the ongoing situation. At other times, it is a reluctant acceptance, influenced by exhaustion and persistent uncertainty rather than deliberate consent.

Accepting is achieved through a gradual adjustment to what is possible; acknowledging that no one truly knows exactly how to handle the situation, recognising the emotional and operational constraints under which care must be delivered, and releasing self-blame when ideal standards cannot be met. This process can be understood as "surrendering", not as a failure, but as a deliberate letting go of the illusion of control in a context where control is always partial and conditional. Surrendering makes room for psychological flexibility, allowing nurses to redirect their energy toward actions that are within reach.

The consequences of this adaptive stance are complex. On one hand, accepting can preserve emotional resilience, reduce ineffective struggle, and sustain functioning in extreme conditions. On the other hand, it may carry a sense of resignation or unresolved frustration, especially when it is less voluntary. Yet for nurses who remain within their roles, accepting becomes a necessary means of engaging with reality rather than turning away from it—a way of continuing to care while navigating uncertainty, moral tension, and the profound

emotional demands of the pandemic.

Being passive

Being passive represents ways nurses respond to the COVID-19 situation. Being passive can be understood as a temporary disengagement: the nurses suppress or ignore emotional responses, "pushing down" the weight of the situation without confronting it directly. It often occurs when stress and uncertainty of the work environment become too intense to process in real time, leading to mechanical task completion and emotional avoidance.

Resigning

Resignation, in contrast, is a more active psychological adaptation. Nurses who are resigning have usually attempted to influence outcomes, questioning protocols, advocating for patients, or seeking improvements, yet have repeatedly found these efforts insufficient or ineffective. Resigning is a recognition of the limits of one's influence, a conscious or semi-conscious acceptance of the realities that cannot be changed: persistent patient suffering and mortality, escalating workloads, chronic understaffing, and personal or colleague exposure to risk. Thus, nurses are resigning to the structural, situational, and moral constraints in their work.

Resigning can manifest behaviorally in multiple ways. Some nurses keep working, making the most of what is possible, while moderating their effort, concentrating on essential responsibilities, or mentally isolating stressful elements. Others may eventually leave the job, particularly when the cumulative stress, moral distress, or perceived pointlessness becomes intolerable. Here, "deal with by quitting" does not simply mean abandoning patients; it reflects a boundary-setting strategy where the nurses prioritize self-preservation in the face of unsustainable demands.

Nurses develop resigning through a process of repeated exposure to uncontrollable stressors combined with the ineffectiveness of efforts to change outcomes. Those who do not become resigned often maintain a sense of agency, focus on aspects of care they can influence, or employ adaptive coping strategies such as acceptance, support-seeking, or reflection. Nurses' behavior varies across key aspects: the degree of emotional engagement, the willingness to continue despite perceived ineffectiveness, the prioritization of self versus patient welfare, and the tendency to withdraw from the role when pressures become immense.

Ultimately, resigning can be conceptualized as a strategic adaptation when recognizing limits, modulating effort, and making difficult ethical and personal choices. It can carry feelings of pointlessness or moral tension, and it can also preserve resilience, enabling the nurses to continue functioning in an environment that would otherwise be overwhelming.

Feelings that Can Trigger

There can be different emotions that trigger the nurses' experiences.

Being Afraid

When trying to recalibrate practice as a strategy, it can cause feelings of being afraid when confronting the unknown. The nurses are aware that the situation might tip in an unwanted direction. Something that

envisions the underlying uncertainty. In the unfamiliar situation of COVID-19, the lack of solid information can create fear because it challenges our need for clarity, security, and predictability. It can also create feelings of risk when nurses do not know what is "right" in their adjustments. As recalibrating practice in the COVID-19 situation involves trial-and-error corrections there can be a worry that a wrong adjustment can lead to failure, loss of control, or negative consequences. Even though the recalibrating helps nurses explore and confront the unknown, the instability that makes exploration possible can also feel frightening. Insecurity is therefore visible in this strategy, as are feelings of stress. When afraid, the nurse can reason with her-/himself to do as good as possible, but this can also lead to the nurse resigning.

Being Sad

The care provision struggling can easily be turned into being sad because nurses are confronted with limits of their ability to act. Not knowing exactly what to do, witnessing patients die, and being unable to prevent suffering are persistent sources of emotional strain. Nurses may see patients die alone because staffing constraints prevent anyone from sitting with them, and next-of-kin are not allowed to be present. These situations highlight the nurses' vulnerability: despite applying professional knowledge and doing their best, their efforts feel insufficient.

The nurses repeatedly confront the gap between what is desired – providing comfort, presence, and support – and what is possible. This creates a cyclical pattern: insecurity increases sadness, which in turn reinforces the feeling of insecurity. Even when the nurses internally protest that a dying patient should not be alone, they must often leave to attend to other urgent responsibilities. Such experiences evoke complex emotional responses, including mourning, frustration, and anger. Sadness is thus closely bound to insecurity: it arises not only from witnessing suffering but from the recognition that no matter how much effort is invested, one cannot fully bridge the gap between ideal care and the constraints of reality in the COVID-19 situation.

Mourning

The nurses are mourning patients who cannot be saved and who are left alone because there is insufficient time to provide continuous presence; the demands of other urgent tasks constantly compete for attention. The COVID-19 regulations further complex this separation, restricting close contact and requiring protective measures such as gowns, gloves, and face masks. These necessary protections, while safeguarding health, create a physical and emotional barrier between nurses and patients, reinforcing the sense of distance and limitation in the caregiving.

The heavy workload often leaves little room for reflection on the sorrow, frustration, and grief that these situations evoke. Emotional processing is thus postponed, even as the experiences continue to weigh on the nurses. In response, nurses turn to each other for informal acknowledgment and support during shifts, sharing observations, recognizing one another's efforts, and signaling that they see and understand the emotional burdens each one carries. Conversations with family members may occur, but confidentiality rules

prevent the sharing of the full emotional content of these experiences.

In this way, the nurses' mourning and emotional strains are intertwined with both structural constraints and relational coping strategies. The frustration arising from not being able to provide the presence and care they wish to offer is mediated, in part, through peer acknowledgment and collective recognition.

Being Angry

When nurses are unable to act effectively because there is not enough time, there is a constantly 'going on' of events at the wards and no time to take a step back and think about what this can lead to. The inability to know whether one is doing the "right" thing or enough to meet patient needs generates frustration, and anger. These emotions are closely tied to insecurity, as the nurses confront the limits of their knowledge, resources, and control in a rapidly changing environment.

In response, nurses often engage in continuous negotiations between competing demands and trying to do the right priorities. This can involve stepping outside familiar routines or comfort zones, making judgment calls without clear rules, and trying to optimize care with incomplete information. The attempt to balance does not eliminate uncertainty but provides a way to act constructively despite it. In other words, balancing can be a strategy to regain agency and maintain ethical and professional integrity in the face of unpredictability.

Emotions such as anger and fear often accompany resigning, but they arise under specific conditions. Anger can emerge in response to systemic failures, ethical dilemmas, or perceived injustices, whereas fear is tied to uncertainty, personal risk, and unpredictability, such as being called in for extra shifts when already exhausted or facing exposure to illness. Anger and fear can interact with resigning. For some nurses, persistent fear or anger accelerates withdrawal or disengagement, while for others, it can motivate persistence and active engagement even under difficult conditions.

Repeated encounters with situations that trigger grief, sadness, or anger, yet offer no meaningful resolution, can bring nurses to adopt surrendering strategies. Here, nurses release the need for control and adapt by accepting the reality of an uncontrollable situation where accepting and resigning are ways to adapt to the reality that constantly keeps changing. Thus, the alternation between striving to control and accepting limits reflects a dynamic process in which nurses negotiate between action, ethical responsibility, and emotional survival in contexts marked by uncertainty and constraint.

Methodological Considerations

This study used classic grounded theory to explore the main concern of registered nurses and assistant nurses in COVID-19 care and how they handle this concern. The theory that emerged – confronting the unknown – explains latent behaviour and elucidates the strategies that nurses apply to adapt to a reality that is constantly changing.

The theory cannot claim to be representative of nurses' entire behaviour during the COVID-19 pandemic.

Nonetheless, it should be emphasized that grounded theory generates hypotheses that are conceptual and abstract of time, place, and people (Glaser, 1998). This means that although this theory is in the field of infectious disease care, it can be applied and modified to other areas, for example, when people feel helpless during radical life changes where they try to confront the unknown.

According to Glaser (1978), a classic grounded theory should be judged by its fit, relevance, workability, and modifiability. *Fit* is about how well the concepts fit the data that they are representing. This GT study was judged to have adequate fit since the strategies presented emerged from the collected data rather than from predetermined theoretical perspectives. Constant comparison was also used during the course of creating the theory. *Relevance* means that the emerged strategies are related and relevant to the main concern. This was established through the data being collected and analysed until saturation was reached. This study has *workability*, as the theory allows the prediction, explanation, and interpretation of how nurses working with COVID-19 patients perceive their situation. Therefore, the theory can identify and explain what the main concern is for the nurses involved in the study. The theory also attempts to explain variations in how nurses resolve their main concern. Finally, *modifiability* means that the theory can be modified if new data are achieved. In accordance with Glaser (1978;1992;1998), this means that a GT should be abstracted from the time, place, and persons involved. Although the idea of confronting the unknown is, in many ways, bound to the infectious disease field (given the field's emphasis on COVID-19), these strategies will hopefully benefit health professionals and be useful when they are faced with and trying to adapt to realities that are constantly changing. This theory might contribute to understanding how health professionals use the strategies listed above and to understanding behaviors. However, the theory remains at a descriptive level and would benefit further from integrating the consequences of the emotional effects of adaptation to a constantly changing reality.

Discussion

How to adapt to a constantly changing reality emerged as the main concern in this grounded theory of *confronting the unknown*. Similar concerns have been described in studies concerning assistance care and special education during the COVID-19 pandemic (da Silveira et. al, 2022), nurses' experiences during the Middle East respiratory syndrome outbreak (Al-Dorzi et al. 2016; Kang et al. 2018; Stirling et al. 2017), and psychosocial challenges during the Ebola virus disease outbreak (Smith et al. 2017). All these examples are involved in the context of infectious disease where nursing staff must handle a disease outbreak that involves a disease that is unknown and/or where treatments might not be available. This is also something that Bezerra se Lima et al. (2023) emphasize when they present difficulties and challenges when adapting to changes during a pandemic for nursing students.

In the adaptation to the constantly

changing reality, there are two overarching strategies to address the situation. Nurses are *adjusting* to what is happening or they are *surrendering*. Both strategies are seen depending on the conditions. There is also sometimes a way from surrendering towards adjusting when nurses accept that this is the way it is and, in doing so, the go from surrendering to adjusting strategies by doing as good as they can. Similar results can be seen in Butler et al. (2020) where nurses working during the COVID-19 pandemic were forced to adjust to multiple expected and unexpected forms of resource limitations which in turn required them to make difficult decisions, causing a feeling of reluctant acceptance mixed with unresolved frustration. O'Donnell and Andrews (2021) present a theory on resigning concerning nurses working in stroke care at acute settings where they see resigning as an act of energy maintenance and a coping strategy that enables nurses to continue working within constraints. This could be compared to the strategy of surrendering in the theory of Confronting the unknown, where resigning can be conceptualized as an adaptation when recognizing limits, modulating effort, and making difficult ethical and personal choices. Something that can evoke a sense of meaninglessness or ethical tension yet helps maintain resilience so nurses can continue operating in a highly demanding setting.

There is a desire to handle the situation based on the knowledge the nurses have and to realize that this is not enough to clearly show the insecurity when trying to confront the unknown. Similar concerns have also been described in nursing management, where regardless of pre-established strategies, there are difficulties adapting to new challenges that a pandemic can bring (Holanda Pinheiro et al., 2020). Something that shows the insecurity of what to do and how to do it is something that manifests itself at different levels in the work hierarchy. Naylor et al. (2021) also describes how receiving different information and recommendations about how to handle COVID-19 contributes to creating chaos in the working situation.

Naylor et al. (2021) further show how the constrained situation during the COVID-19 pandemic contributes to positive aspects such as a new and more sincere way of bonding with workmates, supporting each other, and feeling pride in being a nurse. These feelings are in many ways similar to *care provision struggling* in the present theory, where the nurses describe how they provide good care as a collective undertaking when they are working side by side to manage difficult situations, something that strengthens solidarity and shared purpose. This also shows how they trust their knowledge of nursing.

Nevertheless, the will to do good and be there for colleagues often gets worn down when nurses face challenges of a continuing lack of staff, as there are not only patients who are ill. Thus, the risk of *resigning* becomes clear. This may be related to what Holanda Pinheiro et al. (2020) describe as challenges faced in the team's work process during pandemics where colleagues become ill. Something that affects working schedules and thereby creates stress.

Stress is something that many nurses

always cope with in their work environment, where time constraints force them to prioritize which nursing actions they shall provide and which they shall exclude (Hessels et al. 2015; Hübsch et al. 2020), something that might create situations with feelings of guilt and hopelessness (Glasberg et al. 2006). In this theory, the inability to be able to be there for patients in a way that nurses consider appropriate causes feelings of *sadness*, *mourning* and *anger* where guilt and hopelessness might be present. There seems to be a divider there that leads nurses to either adjusting or surrendering strategies.

Sugg et al. (2021) show how nurses caring for COVID-19 patients consider mobility, talking and listening, nonverbal communication, communication with next-of-kin, and emotional comfort to be important parts of care that they cannot accomplish given the pandemic. Something that might lead to moral dilemmas and a negative conscience (Gladberg et al. 2006; Sugg et al. 2021). These moral dilemmas and feelings of guilt are also observed in this study, where nurses cannot do things they know are good for the patients, where they struggle with insights that they are not there for the patients in a way that they should be due to restrictions, lack of time, and constantly being wrapped in protective clothing, gloves, and face masks.

Conclusion

The theory has bearing for the studied area, where the main concern of nurses was the focus. The theory explains nurses' behavioral patterns when adapting to a reality that constantly keeps changing. This shows the complexities of being a nurse in pandemic care, where there are many insecurities as to how care shall be performed.

The theory can increase healthcare professionals' insights into how nurses effectively adapt when they are confronting an unknown reality where they are unsure how to handle the care. This can be related to diseases that appear on a smaller scale but also to pandemics as they are struggling to do a good job taking care of patients. The theory can thus contribute to healthcare being better prepared when new diseases or pandemics arrive, something that is a fact. By taking into account how nurses are adapting and what this entails, preparations can be made in advance, increasing the need to work as a team, sharing thoughts and experiences, and learning from each other and from previous events. Hopefully, the results will benefit health professionals when they are faced with and try to adapt to realities that constantly keep changing. Not only by using the strategies listed but also as a help to understand behaviors.

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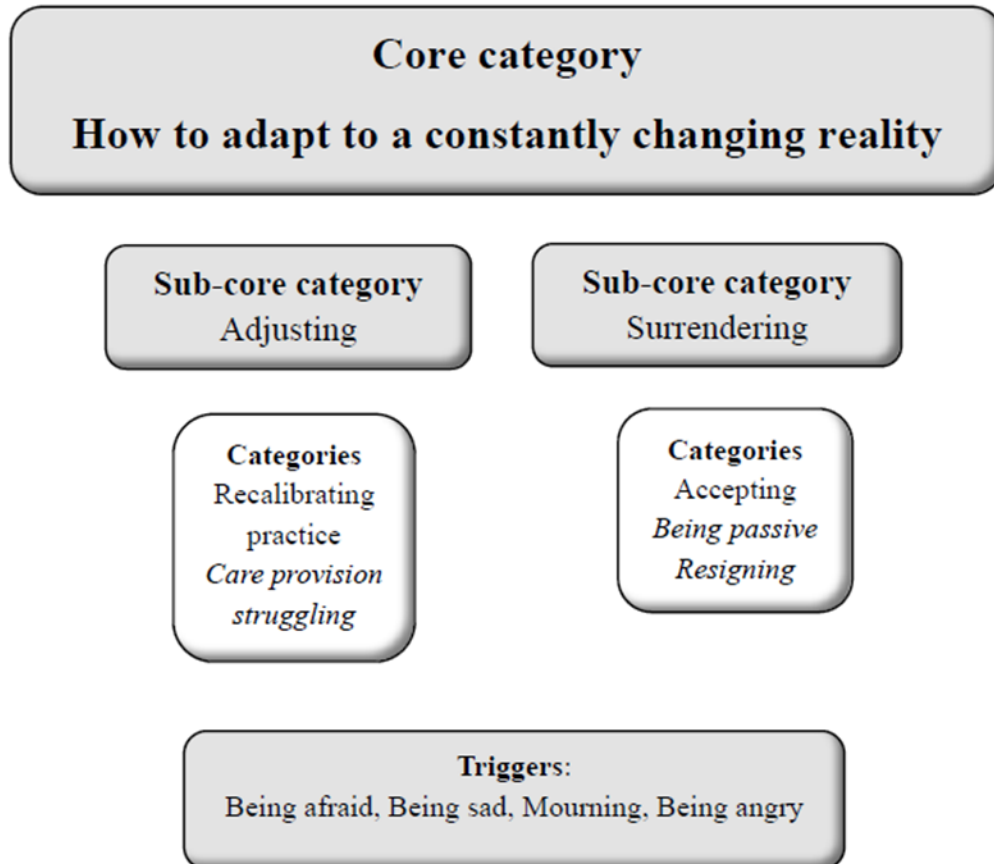
Appendix

Figure 1
Theory of Confronting the Unknown



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