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ORIGINAL ARTICLE / ARAŞTIRMA YAZISI

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COVID-19 Contagion and Death Anxiety of Nurses Working in Pandemic Clinics

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ABSTRACT

Purpose: Today the coronavirus disease (COVID-19) which has affected the whole world, has maximized the anxiety level of nurses working in the forefront by increasing their possibility of getting sick or dying and increasing the number of cases and deaths in the world and in Turkey. This study aimed to examine COVID-19 contagion and death anxiety in nurses working in pandemic clinics that are in the western region of Turkey.

Method: The descriptive cross-sectional study was conducted with 278 nurses between May 15, 2020, and June 15, 2020. The study collected the data using the Nurse's Information Form and the Thorson-Powell Death Anxiety Scale. The study used the Independent Samples t-test, ANOVA and the Tukey tests in the post-hoc test to determine the intergroup differences.

Results: The mean age of the nurses was 36.30±8.01 years and 80.6% of them were female, 70.2% had bachelor's degree, 69.2% were married. Of the nurses, 60.4% had changed their environment in the process, 75.5% needed psychological support and 53.3% experienced loss due to COVID-19. The mean score of Thorson-Powell Death Anxiety Scale was 51.17±8.18.

Conclusion: This study revealed that the nurses had a moderate death anxiety level. Factors such as fear of transmitting the disease to their family and losing them, long working hours, working in the intensive care unit and emergency service for a long time and the inability to receive psychological support had an effect on the death anxiety of the nurses.

Keywords: Death anxiety, nurse, COVID-19, pandemic

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Pandemi Kliniklerinde Çalışan Hemşirelerin COVID-19 Bulaşma ve Ölüm Kaygısı

ÖZET

Giriş ve Amaç: Günümüzde tüm dünyayı etkisi altına alan koronavirus hastalığı (COVID-19) Türkiye'de ve dünyada vaka ve ölüm sayılarının artmasına, ön saflarda çalışan hemşirelerin de hasta olma veya ölme ihtimalini arttırarak kaygı düzeylerinin en üst seviyede yaşamalarına neden olmuştur. Bu çalışma, Türkiye'nin batı bölgesinde pandemi kliniklerinde çalışan hemşirelerin Kovid-19 bulaşma ve ölüm kaygısının incelenmesi amacıyla yapıldı.

Yöntem ve Gereçler: Tanımlayıcı ve kesitsel tipteki araştırma 15 Mayıs-15 Haziran 2020 tarihleri arasında 278 hemşire ile yapıldı. Araştırmanın verileri "Hemşire Bilgi Formu", "Thorson-Powell Ölüm Kaygısı Ölçeği" (TPÖKÖ) kullanılarak toplandı. Verilerin değerlendirilmesinde Independent-Samples t-testi, varyans analzi testleri, gruplar arasındaki farklılıkların belirlenmesinde ise Poct-Hoc testinde Tukey testleri uygulandı. Testlerde anlamlılık düzeyi $p<0.05$ olarak kabul edildi.

Bulgular: Hemşirelerin yaş ortalaması 36,30±8,01, %80,6'sı kadın, %70,2'si lisans mezunu, %69,2'si evlidir. Hemşirelerin %60,4'ünün bu süreçte yaşadıkları ortamı değiştirdikleri, %75,5'inin psikolojik yardım gereksinimlerinin olduğu, %53,3'ünün COVİD 19 nedeniyle kayıp yaşadığı saptandı. Thorson-Powell Ölüm Kaygısı Ölçeği puan ortalaması 51,17±8,18 olarak bulunmuştur.

Sonuç: Bu çalışma hemşirelerin orta düzeyde ölüm kaygısı yaşadığını ortaya koymuştur. Hastalığı ailesine bulaştırma ve onları kaybetme korkusu, uzun çalışma saatleri, yoğun bakım ve acil serviste uzun süre çalışma ve psikolojik destek alamama gibi faktörlerin hemşirelerin ölüm kaygısını arttırdığı bulunmuştur.

Anahtar kelimeler: Ölüm kaygısı, hemşire, Kovid-19, pandemi

Every culture has different attitudes toward death. In addition, people's perception of death as a phenomenon and their anxiety regarding death are shaped by the general attitude of their culture (1,2). The perception of death is also formed as a result of individuals' personal experiences and develops depending on what they have seen concerning death, the age period they are in, and their religious and cultural values. Hence, everyone's perception of death is unique (3,4).

Nurses are among the healthcare professionals who encounter death most frequently (2,5). A person dying affects not only their family negatively, but also those nurses who have been maintaining the individual's care and treatment for a long period of time. This also causes nurses to experience mental issues (4,6). Kang et al. (2020) indicate that the negative feelings experienced by nurses who constantly work with hospice patients will eventually wear them out psychologically (7). Some studies have also stated that nurses caring for hospice patients think about the death of their relatives and their own death, and thus experience death anxiety (8–10).

The coronavirus disease (COVID-19) which has affected the whole world today is a serious infectious disease resulting in death for people of all ages and sexes (11–13). The World Health Organization (WHO) accepted that COVID-19, which spread across the world in a very short time, was an international health problem and declared it a pandemic on January 30, 2020 (14). The Occupational Safety and Health Administration (OSHA) identifies COVID-19 as a high-risk infectious disease because it spreads from person to person rapidly, and states that the highest at-risk group facing this infection is healthcare professionals (15). According to a report by the International Council of Nurses (ICN) dated 11 March 2021, more than 3000 nurses worldwide have died from the virus (16). Nurses are the healthcare professionals who work with patients the most frequently and for the longest periods of time. Nurses working in close contact with patients during the struggle with COVID-19 have provided nursing services in every unit and at every age group where the COVID-19 pandemic has been seen (17,18). Guan et al. (2020) stated that 3.5% of patients in China, and Lázaro-Pérez et al. stated that 10% of patients in Spain, were medical personnel (19,20). During the process nurses have maintained all necessary treatment and care of patients, especially in respiratory tract applications which require very close contact, such as intubation, aspiration, resuscitation and mouth care, despite having limited protective equipment (21,22). Nurses in Turkey have continued to work not only in hospitals, but also in tasks such as case identification during the pandemic, infection control, following cases in home lockdown and contacts and society training (22). During the pandemic, most nurses have had to be separated from their family, children, parents and partners for months due to social isolation (22,23). In particular, the increase in the number of cases and deaths in Turkey and around the world increased the possibility that nurses would become sick and/or die and greatly increased their anxiety level. In addition, death anxiety in nurses brought significant consequences in terms of social life. The first of these consequences was that society excluded nurses, like most other healthcare professionals, because they were considered a group with a high risk of contamination. Another one is that nurses have faced problems such as long working hours, tiredness, burnout, depression and anxiety, as well as other personal, social and economic problems caused by the pandemic, and have required treatment for these (24).

In order for nurses to provide effective care and psychosocial support to hospice patients and their families, it is important that their levels of death anxiety be determined. This study aimed to examine COVID-19 contagion and death anxiety in nurses working in pandemic clinics that are in the western region of Turkey. The following research questions were proposed for this purpose:

•What is the death anxiety level of nurses during the COVID-19 pandemic?

•What are the factors affecting a death anxiety level of nurses?

METHODS

Sample

The study was a descriptive cross-sectional study. The universe of the study comprised 504 nurses working in two hospitals where COVID-19 cases were intense in the western region in Turkey between May 15, 2020, and June 15, 2020. Sampling was carried out using the power analysis method. The sample size was calculated at 5% margin of error and 95% confidence level (sample=266). The data forms were sent to the electronic mail addresses of all working nurses with permissions from relevant institutions. Of the nurses responding, 14 reported that they did not want to participate and 278 completed the forms and comprised the sample of the study.

Measurement Tools

The Nurse's Information Form: The information form includes questions regarding the socio¬demographic and working conditions and their psychosocial state during the COVID-19 pandemic.

The Thorson-Powell Death Anxiety Scale (TPDAS): The scale was developed by Thorson and Powell (1992) (25) and Turkish validity and reliability was conducted by Karaca and Yıldız (2001) (26). The 5-point Likert scale has scores from 0 to 4 ("strongly agree", "agree", "undecided", "disagree", "strongly disagree"). The lowest and highest possible scores obtainable from the scale are 0 and 100, respectively. When evaluating the scale, scores between 0-25 indicate a low death anxiety level, 26-50 indicate a mild death anxiety level, 51-75 indicate a moderate death anxiety level, and 76-100 indicate a high death anxiety level. The scale has four subscales (anxiety about losing physical and mental functions, anxiety about the next world, anxiety about decaying and spoiling, anxiety about experiencing pain and torment in the death process). An increase in the score for all these subscales is interpreted as an increase in death anxiety. The Cronbach's alpha value of the scale was 0.84 in the study by Thorson and Powell and 0.79 in the study by Karaca and Yıldız (25,26).

Statistical Analysis

The study evaluated the data using the SPSS 22.0 (IBM) package program. The study evaluated the descriptive data using number, percentage, mean and standard deviation. As a result of the Kolmogorov-Smirnov test the study found that the data was normally distributed. Therefore, in evaluating the data the study used the Independent Samples t-test, variance analysis and the Tukey tests in the post-hoc test to determine the intergroup differences. A significance level of $p<0.05$ was accepted in the tests (27).

RESULTS

The mean age of the nurses was 36.30±8.01 years, 80.6% of them were female, 70.2% had bachelor's degree. The other demographic characteristics of the nurses are demonstrated in Table 1.

Approximately 60.4% of the nurses had changed their environment during this process. Of the nurses, 75.5% needed psychological support during the pandemic, 28.1% had caught the COVID-19 infection, 72.7% had a family member who had caught COVID-19, and 53.3% had experienced a loss due to COVID-19. The COVID-19-related other information of the nurses are demonstrated in Table 2.

Table 1: Participants Demographic Characteristics (n=278)

	n	%
Age	**36.03±8.01**	
Gender		
Female	224	80.6
Male	54	19.4
Education		
Associate	39	14.0
Bachelors	196	70.5
Postgraduate	43	15.5
Marital status		
Married	194	69.8
Single	84	30.2
Having a child		
Yes	191	68.7
No	87	31.3
Years of service		
>5 years	51	18.3
6-10 years	76	27.3
<11 years	151	54.4
Working unit		
*COVID-19 clinics	177	63.7
Intensive care	68	24.5
Emergency	33	11.8
Working hours / Day		
8-16 hours	137	49.3
24 hours	141	50.7
Presence of chronic disease in the family		
Yes	249	89.6
No	29	10.4

**COVID-19: coronavirus disease 2019*

In the study the Cronbach's alpha coefficient of the TPDAS was 0.75. The mean total scale score was 51.17±8.18; the anxiety about losing physical and mental functions subscale score was 14.91±4.61, the anxiety about the next world subscale score was 13.18±3.20, the anxiety about decaying and spoiling subscale score was 8.37±2.67, and the anxiety about having pain and torment in the death process subscale score was 13.69±3.46.

The comparison of demographic characteristics and COVID-19 related information of the nurses with TPDAS scores are demonstrated in Table 3.

Table 2. Data of Participants on the COVID Pandemic Process		
	n	%
Psychological support requirements		
Yes	210	75.5
No	68	24.5
Changing the environment during the pandemic process		
Yes (n=168)		
At your friend	12	4.3
In the town hall.	20	7.2
In the hospital guesthouse	33	11.9
In hotel	103	37.1
No	110	39.6
Contracting COVID-19		
No	200	75.9
Yes	78	28.1
COVID-19 positivity in family/relatives		
Yes	206	74.1
No	72	25.9
Death/loss due to COVID-19		
Yes	151	54.3
No	127	45.7
Effects of the pandemic process		
Fear of getting sick	89	30.8
I can't see their children	19	6.6
Stay away from family	50	17.3
Fear of contagion	103	35.6
People acting like they're contagious	28	9.7
Coping with loss *		
Cry	223	77.2
Praying	239	82.7
Sharing with those around you	208	72.0
Using medication	47	16.3
Natural acceptance	37	12.8
** More than one answer to this question has been accepted.*		

DISCUSSION

Some studies have demonstrated that in a period of epidemics people have an increased sense of existential anxiety and think about their death more often (17,28). This study aimed to examine COVID-19 contagion and death anxiety in nurses working in pandemic clinics that are in the western region of Turkey. The fact that we conducted the study in pandemic hospitals in the western region of Turkey where cases spread rapidly, reveals the strengths of the study, especially considering that the nurses who volunteered to participate did so despite the difficult working conditions in the first days of the pandemic.

The study evaluated death anxiety in nurses in the pandemic process using the TPDAS. The nurses had a moderate level of death anxiety (51.17±8.18). The study conducted by Yiğit and Açıkgöz (2021) found that nurses had a high level of death anxiety. Kang et al. (2020) stressed that the psychosocial problems of healthcare professionals are greater than those of the general population and that these problems should not be ignored. Nurses' attitude toward death negatively affects their death anxiety and the quality of care they provide. According to Matsui et al. (2010) high death anxiety in nurses negatively affects their ability to offer quality care to patients and their attitude towards caregiving (29).

The ICN defines nurses as the largest occupational group that is at the forefront in dealing with epidemics. During this process nurses take on difficult tasks under extraordinary conditions to protect the life of patients and cure them (16). In our study, comparing the TPDAS and subdimension scores according to the gender of the nurses, the male nurses obtained higher scores in the anxiety about losing physical and mental functions sub-dimension scores, the anxiety about the next world sub-dimension scores and the anxiety about having pain and torment in the death process sub-dimension scores; however, the difference in scores was not statistically significant ($p>0.05$). The study by Yiğit and Açıkgöz found a similar result (30). It can say that the result of the current study is associated with the fact that nurses working on the frontlines in the COVID-19 pandemic work under the same conditions without any discrimination by gender.

Our study found that the age of the nurses did not affect death anxiety. We can say that this result is associated with the rapid spread of the COVID-19 infection, its impact on people of all age groups and the despair felt by nurses in the face of the rapidly worsening condition of the patients they are caring for. The studies conducted by Galehdar et al. (24) and Peters et al. (31) on death anxiety found that younger nurses have a stronger death anxiety than nurses of a more advanced age and have greater difficulty coping with emotional issues.

Table 3. Comparison of Descriptive Characteristics of Nurses and Death Anxiety Scores						
	n (%)	**Fear of isolation and immobility**	**Fear of the finality of death**	**Fear of burial and decomposition**	**Fear of pain**	**Total score**
Gender						
Female	224 (80.6)	14.86±4.37	13.16±3.15	8.38±2.61	13.62±3.32	50.04±8.58
Male	54 (19.4)	15.14±5.51	13.27±3.45	8.31±2.96	13.96±3.98	50.70±11.43
		t=-0.409 p=0.68	t=-2.311 p=0.81	t=0.181 p=0.85	t=-0.635 p=0.52	t=-0.473 p=0.63
Marital status						
Married	194 (69.8)	14.58±4.38	13.02±3.24	8.41±2.68	13.69±3.46	49.68±9.36
Single	84 (30.2)	15.67±5.03	13.55±3.10	8.27±2.67	13.79±3.45	51.30±8.71
		t=-1.819 p=0.07	t=-1.276 p=0.20	t=0.410 p=0.68	t=-0.327 p=0.74	t=-1.360 p=0.17
Education						
Associate	39 (14.0)	16.15±4.85	12.64±3.10	8.15±2.28	13.43±3.29	50.38±8.86
Bachelors	196 (70.5)	14.66±4.61	13.20±3.15	8.37±2.74	13.70±3.48	49.95±9.02
Postgraduate	43 (15.5)	14.95±4.29	13.60±3.50	8.55±2.74	13.86±3.58	50.97±10.30
		F=1.70 p=0.18	F=0.933 p=0.39	F=0.232 p=0.79	F=0.159 p=0.85	F=0.229 p=0.79
Years of service						
>5 years	51 (18.3)	14.80±4.24	13.35±3.08	8.19±2.72	13.43±3.36	49.78±8.23
6-10 years	76 (27.3)	15.52±4.72	12.92±2.92	8.27±2.68	13.75±3.70	50.47±8.91
<11 years	151 (54.4)	14.64±4.67	13.26±3.38	8.48±2.67	13.75±3.38	50.15±9.66
		F=0.933 p=0.39	F=0.373 p=0.68	F=0.788 p=0.68	F=0.179 p=0.86	F=0.868 p=0.91
Working unit						
COVID clinic	177 (63.7)	14.84±4.40	13.27±3.22	8.40±2.70	13.54±3.34	48.75±7.50
Intensive care	68 (24.5)	13.94±4.19	12.85±2.81	8.45±2.55	13.50±3.38	50.07±9.15
Emergency	33 (11.8)	17.30±5.73	13.18±3.20	8.06±2.80	14.87±4.03	56.63±11.61
		F=6.18 **p=0.0002**	F=0.506 p=0.60	F=0.265 p=0.76	F=2.21 p=0.11	F=3.222 **p=0.04**
Working hours/Day						
8-16 hours	137 (49.3)	15.89±4.68	13.38±3.51	8.40±2.72	14.05±3.70	48.65±8.35
24 hours	141 (50.7)	13.97±4.35	12.99±2.86	8.34±2.64	13.34±3.17	51.72±9.75
		t=3.540 **p=0.000**	t=1.025 p=0.30	t=0.168 p=0.86	t=1.701 p=0.09	t=2.821 **p=0.005**
Presence of chronic disease in the family						
Yes	249 (89.6)	14.57±4.33	13.06±3.04	8.26±2.55	13.49±3.31	49.35±8.44
No	29 (10.4)	17.89±5.78	14.48±4.16	9.34±3.45	15.44±4.17	57.17±12.12
		t=-3.762 **p=0.000**	t=-2.318 **p=0.02**	t=-2.075 **p=0.03**	t=-2.923 **p=0.004**	t=-4.482 **p=0.000**
Need for psychological support						
Yes	210 (75.5)	14.61±4.42	13.08±3.00	8.12±2.51	13.48±3.27	49.30±8.43
No	68 (24.5)	15.85±5.06	13.50±3.76	9.13±3.06	14.35±3.91	52.83
		t=1.702 p=0.19	t=6.029 **p=0.01**	t=5.812 **p=0.01**	t=2.169 **p=0.01**	t=7.765 **p=0.006**
Contracting COVID-19						
No	200 (75.9)	14.57±4.33	13.06±3.04	8.26±2.55	13.49±3.31	49.35±8.44
Yes	78 (28.1)	17.89±5.78	14.48±4.16	9.34±3.45	15.44±4.17	57.17±12.12
		t=7.75 **p=0.006**	t=5.96 **p=0.01**	t=8.80 **p=0.003**	t=4.64 **p=0.03**	t=7.33 **p=0.000**

COVID-19 positivity in family/relatives						
Yes	206 (74.1)	14.50±4.38	13.16±2.96	8.25±2.57	13.56±3.35	49.49±8.49
No	72 (25.9)	16.09±5.06	13.23±3.84	8.72±2.93	14.06±3.75	52.12±10.82
		t=-2.547 **p=0.01**	t=-0.151 p=0.88	t=-1.283 p=0.20	t=-1.069 p=0.28	t=-2.108 **p=0.003**
Death/loss due to COVID-19						
Yes	151	13.95±3.88	13.09±2.79	8.19±2.42	13.18±3.29	48.43±7.93
No	127	16.06±5.13	13.29±3.64	8.59±2.95	14.29±3.56	52.24±10.13
		t=-3.895 **p=0.000**	t=-0.497 p=0.62	t=-1.237 p=0.21	t=0.276 **p=0.007**	t=-3.518 **p=0.001**
t= Independent Samples t-test; F= Variance analysis (ANOVA); p<0.05						

In our study there was no significant difference between the nurses' marital status, state of having children and death anxiety. However, the study by Yiğit and Açıkgöz in Turkey found that nurses who were married and had children had a high anxiety level and that single nurses considered their own marital status to be an advantage (30). Nevertheless, the study conducted by Ariapooran et al. found that single nurses experienced a high level of psychosocial problems (18).

In the current study there was no significant difference between the nurses' years of employment in the profession, educational level and death anxiety. We can say that the reason why the study found no significant difference between the nurses' professional experience, educational level and death anxiety was associated with the fact that all the nurses participating had encountered with COVID-19 for the first time, had limited information about the disease and worked under the same conditions. Galehdar et al. stated that as the professional experience of nurses increases, their anxiety level also increases, and this is related to having increased responsibility in the workplace (24). The study by Yiğit and Açıkgöz stated that nurses' educational level did not affect death anxiety; however, working in shifts and for long hours leads to more anxiety over a period of years (30).

The study found that 75.5% of the nurses needed psychological support and the nurses needing psychological support had a high level of death anxiety. In previous epidemics, such as the Severe Acute Respiratory Syndrome (SARS) in 2003 (32), the new influenza A/H1N1 (swine flu) in 2009 (33) and the Middle East Respiratory Syndrome (MERS) in 2012 (MERS) (17), it was reported that nurses working in the frontlines experienced anxieties concerning the risk of getting infected, transmitting the disease to family members, and the limitations imposed on their personal freedoms. The ICN reported that a significant proportion of healthcare professionals carrying out their duties in past epidemics had symptoms of sleeplessness, anxiety, depression and posttraumatic stress disorder, and that some of them still had these symptoms three years later (16). Galehdar et al. reported in their study that nurses experienced intense stress due to the severe workload caused by separation from family, sleeplessness and lack of staff in the pandemic, and they needed psychological support (24). Kang et al. reported that nurses living with their family had a great fear of death (7). The current study found that the nurses were not able to receive the psychological support which could have reduced their anxiety during this process, and their coping methods were crying (77.2%), praying (82.7%) and self-medication (16.3%). Matsui et al. reported in their study that religion is a strong mediating factor and that "most nurses accept death as a natural part of life and a door opening to the next world" (29).

In the current study the nurses working in the emergency service and COVID-19 intensive care unit had higher death anxiety scores than the nurses working in other units. We can say that this result is associated with the higher risk of infection for nurses working in intensive care units, their close contact during interventions, especially intubation, mouth care and feeding, and an increase in the number of critical patients and deaths in intensive care units. In addition, the fact that intensive care nurses work continuously for 24 hours a day, are separated from their families, and the risks posed to their own lives and the lives of their relatives increases death anxiety. This anxiety may reduce the physical and mental strength that is necessary in the efforts to prevent the disease from spreading and to heal those who have caught the disease. Moreover, when nurses feel responsible, unsuccessful and inadequate because of the death of a patient whom they have cared for,

this will increase their anxiety. In their study, Ariapooran et al. found that nurses working in the intensive care unit and emergency service had a high level of anxiety (18). The results of the current study are in agreement with the literature. In particular, the emergency services, where the first contact is naturally made with the patient in the COVID-19 pandemic, are the most dangerous environments for those providing healthcare services (11). According to the data concerning the COVID-19 pandemic in Italy, Whiteside et al. found that the infection rate in healthcare professionals working in emergency services was approximately 10% (34). In the current study, among the reasons why nurses working in the emergency service had a high level of anxiety about catching the disease and dying, were the high population of patients applying to the emergency service, the inadequacy of personal protective equipment, working for longer than 24 hours in total and a lack of staff.

The current study found that the nurses who had a chronic illness in their family and who had experienced a loss in their family due to COVID-19 had a high level of death anxiety, which was noteworthy. Separation from family due to the pandemic, inability to intervene in the health problems of relatives, and the high risk of death in people with a chronic illness increase death anxiety in nurses. In addition, the fact that there was insufficient information about the disease at the beginning of the pandemic, and that most of the people who died were of advanced age and had a chronic illness, increased the nurses' anxiety. The study conducted by Hu et al. in China found that nurses who had lost their loved ones had a high level of anxiety (10). Fernandez et al. stated in their study that nurses had a high level of anxiety about themselves and their families (23). The study by Yiğit and Açıkgöz found no correlation between the presence of a chronic illness in relatives or loss of relatives and death anxiety (30).

Study Limitations

The most important limitations to the study were that the data was collected via the internet. At the time the data were collected, the number of cases in Turkey was quite high. Nurses were working more than 24 hours. They had limited time to look at and reply to their emails. These caused the study to be completed with a limited number of data. In addition, the study was conducted with nurses working in western region of Turkey and the study did not include all nurses.

CONCLUSION

This study revealed that the nurses had a high fear of catching the COVID-19 and a moderate death anxiety level. Factors such as fear of transmitting the disease to their family and losing them, long working hours, working in the intensive care unit and emergency service for a long time and the inability to receive psychological support had an effect on the death anxiety of the nurses. The presence of a chronic illness in the family and the loss of relatives also increased death anxiety. Our primary goals should be to protect the physical and mental health of nurses who work in environments where there is a high risk of transmission of the virus, and to enable them to work efficiently. We also recommend that hospital administrations support healthcare professionals as this may minimize their anxiety about their own health, the health of their families and their daily lives, and increase their productivity at work.

Ethical Considerations

Ethical approval was obtained from the Scientific Research Ethics Committee of the relevant university (decision no. KAEK/2020-12). The study was conducted in accordance with the principles of the Helsinki Declaration. The nurses were informed about the study with the text at the beginning of the questionnaire and those who agreed to participate in the study filled in the questionnaire.

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