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RESEARCH

BEHIND THE MASKS: RECONSTRUCTIONS OF NURSING CARE IN FRONT OF COVID-19

POR TRÁS DAS MÁSCARAS: RECONSTRUÇÕES DO CUIDADO DE ENFERMEIROS FRENTE À COVID-19

DETRÁS DE LAS MÁSCARAS: RECONSTRUCCIONES DEL CUIDADO DE ENFERMEROS FRENTE AL COVID-19

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ABSTRACT

Objective: to analyze the nurses' narratives about their daily practice in coping with COVID-19 and its implications for their personal and professional experience. **Method:** this is qualitative research that used oral history as a methodological reference based on the Comprehensive Sociology of Everyday Life. The sample consisted of the snowball technique and 30 nurses working on the front lines of fighting the pandemic, from health units in different regions of Brazil, participated in the study. Data collection took place through interviews with a semi-structured script, via open-access virtual communication platforms, from June 2020 to August 2021. **Results:** they are organized into two categories: a) reconstruction of care in the face of the unknown COVID-19; b) every human being needs to be taken care of. It is noteworthy that the fight against the pandemic occurs in precarious working conditions and inadequate use of personal protective equipment, with daily changes in procedures in the face of the unknown. As a result of the constant confrontation with death, there are reports of mental health problems, revealing the nurses' weaknesses and the recognition of the need for self-care. **Conclusion:** the nurses' narratives showed that daily experiences made it possible to reframe the care of the other and themselves, in search of improvements in working conditions and recognition of the role of professional nurses in coping with COVID-19.

Keywords: Nurses; Pandemics; COVID-19; Delivery of Health Care; Self Care.

RESUMO

Objetivo: *analisar as narrativas de enfermeiros sobre sua prática cotidiana no enfrentamento da COVID-19 e suas implicações em sua vivência pessoal e profissional.* ***Método:*** *pesquisa qualitativa que utilizou como referencial metodológico a história oral fundamentada na Sociologia Compreensiva do Cotidiano. A amostra foi constituída por meio da técnica de bola de neve e participaram do estudo 30 enfermeiros atuantes na linha de frente do enfrentamento da pandemia, de unidades de saúde das diferentes regiões do Brasil. A coleta dos dados ocorreu por meio de entrevista com roteiro semiestruturado, via plataformas virtuais de comunicação de acesso livre, de junho de 2020 a agosto de 2021.* ***Resultados:*** *estão organizados em duas categorias: a) reconstrução do cuidado frente à desconhecida COVID-19; b) todo ser humano necessita ser cuidado. Ressalta-se que o enfrentamento da pandemia ocorre em precárias condições de trabalho e uso inadequado dos equipamentos de proteção individual, com mudanças diárias de procedimentos diante do desconhecido. Em consequência ao enfrentamento constante da morte, há relatos de agravos à saúde mental, revelando fragilidades do enfermeiro e o reconhecimento da necessidade de autocuidado.* ***Conclusão:*** *as narrativas dos enfermeiros mostraram que as vivências cotidianas possibilitaram ressignificar o cuidado do outro e de si, em busca de melhorias nas condições de trabalho e reconhecimento da atuação do profissional enfermeiro no enfrentamento da COVID-19.*

Palavras-chave: *Enfermeiras e Enfermeiros; Pandemias; COVID-19; Atenção à Saúde; Autocuidado.*

RESUMEN

Objetivo: *analizar las narrativas de los enfermeros sobre su práctica diaria en el afrontamiento del COVID-19 y sus implicaciones para su experiencia personal y profesional.* ***Método:*** *investigación cualitativa que utilizó la historia oral como marco metodológico fundamentado en la Sociología Integral de la Vida Cotidiana. La muestra estuvo conformada por la técnica de bola de nieve y participaron en el estudio 30 enfermeros que trabajan en la primera línea de combate a la pandemia, de unidades de salud de diferentes regiones de Brasil. La recolección de datos se realizó a través de entrevistas con guion semiestructurado, a través de plataformas de comunicación virtual de acceso abierto, desde junio de 2020 hasta agosto de 2021.* ***Resultados:*** *se organizan en dos categorías: a) reconstrucción del cuidado ante el desconocido COVID-19; b) cada ser humano necesita ser cuidado. Es de destacar que la lucha contra la pandemia se da en condiciones laborales precarias y uso inadecuado de equipos de protección personal, con cambios diarios en los procedimientos ante lo desconocido. Como resultado del constante enfrentamiento con la muerte, se reportan problemas de salud mental, revelando las debilidades de los enfermeros y el reconocimiento de la necesidad del autocuidado.* ***Conclusión:*** *las narrativas de los enfermeros mostraron que las experiencias cotidianas permitieron replantear el cuidado del otro y de ellas mismas, en busca de mejoras en las condiciones laborales y el reconocimiento del rol de los enfermeros profesionales en el afrontamiento del COVID-19*

Palabras clave: *Enfermeras y Enfermeros; Pandemais; COVID-19; Atención a la Salud; Autocuidado.*

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INTRODUCTION

Mask? It is personal protective equipment (PPE). In the health sector, it is a mandatory item for prevention and safety, both for the professional who provides care and for the person who receives it. Thus, until the advent of CORonaVIrus Disease-19 (COVID-19), a certain identity was outlined, understood here as characteristics and concepts previously established or elaborated according to a worldview or a "must be",[1] of the professional of health in their daily performance.

However, when in December 2019, the world was faced with a new disease that soon entered the context of major pandemics, due to the changes caused in the social, economic, and political life of the world population, this has changed.[2,3] Despite the existence of other coronavirus infections, COVID-19, caused by the SARS-CoV-2 virus, alarmed the population of all countries due to its high transmissibility and high lethality rate. All sectors of society changed their activities or adapted to another routine in the face of imposed measures that would enable to contain the disease, including social isolation, constant hand hygiene, and the continuous use of masks in daily contact.

Thus, the mask becomes an item of social identification,[1] which constitutes the recognition of belonging to a new tribe.[4] That is, situations and experiences produce changes and the subject assumes new forms and is recomposed through interactions, of "being together". The identification here is based on emotion, on the feeling that unites people, in this specific case, in the face of illness and death.

Since receiving the news of the pandemic, institutions and professionals began to organize, equip, train, and prepare all the necessary resources, based on the experience of some countries and the situation at the time, so that quality care could be provided and for a more serious crisis could be contained.[5,6]

In this sense, in February 2020, the National Contingency Plan for Human Infection (*Plano de Contingência Nacional para Infecção Humana*) by the new Coronavirus SARS-CoV-2 was created in Brazil, which sought to integrate the service network and carry out surveillance, laboratory support, infection control, pharmaceutical assistance, risk communication and management.[7]

The scenario experienced by the population and more specifically by health professionals in coping with the pandemic continues due to many uncertainties and instability of a disease without a precise clinical picture and effective treatments, requiring a lot of involvement, study, and dedication in all areas of practice and science. In this context, Nursing is inserted as a profession with strong traces of bonding, welcoming, and qualified to listen, with a scientific basis, protocols, and laws that regulate its exercise and which, when having direct contact as its primary action, faces restrictions to develop care.[8,9]

At this time, given the COVID-19 pandemic, nurses, both in management and in care, are faced with the worsening of several factors that are reflected in their ways of working, such as increased workload, daily changes in their actions, increased demand, and very severe patients, family, and social distancing, generating physical and emotional overload.[9,10]

The nurse who works on the front lines of the current pandemic see themselves as professionals during the chaos and with the need to provide dignified care as a human being, as someone who belongs to a family, with social relationships outside the job, and with the desire to stay alive. Knowing that life is permeated by unpredictability and that social facts allow for different meanings,[11] professionals often find themselves between the limits of living and get sick.

In this context, fragilities are inserted, which increase the possibility of injuries and illness and affect people's quality of life.[12]

Knowing that the COVID-19 pandemic expands the understanding of the health-disease process linked to the current exposures and the relationship of these exposures with macro and microstructures,[11,12] to know what interferes in the health practices of the nurse becomes relevant.

Masks? If, on the one hand, it is protective equipment necessary for the safety of oneself and the other, on the other hand, symbolically and, by hiding the facial expression, it camouflages behind possible emotions and feelings that have been constituted in the experience of the COVID-19 front-line nurse. We believed that "behind the masks" there are many individualities, particularities, and subjectivities that are not shown in the daily work and life of nurses.

Studies on COVID-19 treatments, vaccines, new and old care technologies, and many uncertainties have expanded. Hence, given the new scenario of life, work, and the exercise of care, we wonder how the nurse feels. Behind the masks, what are the stories being constructed in the daily lives of nurses against COVID-19? How is care being reconstructed in the day-to-day health care of nurses on the front lines of the current pandemic?

OBJECTIVE

To analyze the nurses' narratives about their daily practice in coping with COVID-19 and its implications for their personal and professional experience.

METHOD

This is a qualitative study that had an oral history as a methodological reference and the Comprehensive Sociology of Everyday Life, according to Michel Maffesoli as a theoretical reference. We believe that, through oral history, the meanings of the facts can be approximated and even re-signified according to the experiences of each person in a given phenomenon. Also, the chosen theory allows highlighting individual and collective experiences in daily life and their subjectivity. This theoretical-methodological conjunction enables to bring out unique aspects of the human side of nurses in their practice against COVID-19.[11,13,14]

The main types of oral history are the oral life history, which addresses the collaborator's existence; thematic oral history considered a document conducted by the researcher to seek clarification and delimitation of a subject; and the oral tradition, which addresses myths that remain in communities and bring representation to the present day. Oral history can be classified as a hybrid, when there is a direct collection of testimonies from records or individuals and there is a dialogue with documents already written; and in pure, where only what has been said is considered.[14]

The thematic oral history narrative genre was used in this study in the hybrid model, by prioritizing the lines and content of the interviews used here as a technique and analyzing these together with existing documents and publications.

As a study setting, we proposed health units where nurses work and where there is the possibility of having representatives from the most diverse Brazilian realities, aware from the beginning that the collection would not take place in person because of the distance imposed by the pandemic. Then, we opted for the collaborators from various Brazilian regions, using the snowball technique, in which initial participants are chosen, considered "seeds", and they indicate new participants, and so on consecutively.[15]

The inclusion criterion is to be active in the front line of the fight against COVID-19, regardless of the location or level of activity, as well as other criteria such as race, age, marital status, and time since graduation. We interviewed 30 collaborators as they are called in oral history. The research began with three participants (seeds) who were recruited for convenience in the state of Minas Gerais. The choice was mainly due to the engagement shown in acting on the front line of the pandemic, both in the care and management areas, as this is the state of origin of the study and also because they work at different levels of health care (primary care, Urban Mobile Care Service and intensive care unit). As the intention of the research was to cover the various regions and there was no adherence of participants nominated through the snowball technique in the states of Goiás, Roraima, Amapá, Tocantins, and Paraná, these five respondents were selected through the nomination of acquaintances and contact with Regional Nursing Councils.

After completing the 30 interviews, there was data saturation, identified by the empirical approximation of the data because even with different histories, experiences of COVID-19 are similar among nurses. This is an integration with theory and finding, through careful and sensitive analysis by the researchers, that the narratives presented would contribute to the construction of the history of nurses in the experience of the COVID-19 pandemic.

As mentioned above, due to the social isolation measures still established in the Brazilian territory at the time of the research, data collection took place from June 2020 to August 2021. The interviews were free and with easily accessible communication platforms with an average duration of 20 minutes. After contacting the collaborators, the return took place on the same day. This agility was facilitated by an employee already making prior contact with the other, information given by the participants. The semi-structured script contains guiding questions that encompass experiences regarding COVID-19 in the personal and professional lives of nurses before and during the pandemic, as well as their impressions and contributions to the history of the pandemic.

The initial invitation was made by telephone, via the WhatsApp® application, or by email, with pertinent information and clarifications on the study proposal. Upon acceptance, the Informed Consent Form (ICF) was sent via e-mail for signature and returned to the researcher, in addition to the verbal consent that is recorded at the beginning of each interview. This was scheduled on a date and time defined by the employee, as well as the digital medium of choice for the performance, using video recording by the WhatsApp® application and the Google Meet® platform.

For each recorded interview, as indicated by the method, the oral code was transposed into the written one and sent to the employee for verification of the transcript within the requested period of one week.

The production of the final document took place through transcription when the recorded content is converted into the written text; textualization, in which questions are removed and merged with the narrative and the text is organized by theme or chronology; and transcription or elaboration of a recreated text according to the analysis proposed by oral history. For this analysis, after validation of the transcript and approval by the collaborator, the researcher reads the narratives, with a focus on valuing the experience of each subject, their individualities, and subjectivities contained in the lines that enable the identification of their daily experience. Subsequently, categories were organized and we performed the interpretation and the intersection with other existing texts and references in the literature.[14]

We followed resolutions 466/2012, 518/2016, and 580/2018, which deal with research with human beings. The research began after approval of the project by the Research Ethics Committee (*Comitê de Ética em Pesquisa*) of the Universidade Federal de Minas Gerais (CAAE: 32998620.80000.5149, Opinion 4.082.361). Participation was voluntary and, to guarantee the anonymity of the participants, we used letters representing the states as a code, accompanied by the age of the employees.

RESULTS

Twenty-one of the 30 collaborators in this research are women and nine were men, between 25 and 46 years old, and training time from 3.5 to 22 years, with the majority from 10 to 20 years. Regarding marital status, 17 people are married, 11 are single, one is in a stable relationship and one is divorced.

The operating scenario includes all levels of care: primary health care (PHC), Mobile Emergency Care Service (SAMU), Emergency Care Units (UPA), mixed unit (comprising primary care activities and observation beds and hospitalization), hospitals, and intensive care unit (ICU). Of the total, 13 nurses work in the ICU, where the care and longer stay of patients are concentrated. The "snowball" technique is used to indicate the participants have contributed to the network of contacts already built.

The narratives transcribed here were organized into two categories: "reconstruction of care in the face of the unknown COVID-19" and "every human being needs to be cared for", in which the main vulnerabilities experienced by the study nurses in dealing with the pandemic are described and interpreted and its implications for practical care.

1 Reconstruction of care in the face of the unknown COVID-19

The advent of the pandemic introduced different changes in the daily activities of employees, which range from the physical structuring of services to adequate care to meet the needs of patients with COVID-19. However, experiencing changes, both in personal and professional life does not always happen simply and calmly. Especially in the present case, the unknown exposed vulnerabilities of professional practice. In a profession in which physical contact is inherent, how can it be carried out while complying with humanized precepts that govern the care provided?

The nuances of this exposure reveal the precarious working conditions, the inadequate use and scarcity of personal protective equipment (PPE), and the harm to mental health, stories of in the subjectivity of each one for the collective construction of coping with COVID-19:

> *Much has changed. We started very rawly because right at the beginning of the pandemic here, we soon needed to set up the ICU. So, we have already started to assemble the inflows and outflows of professionals, the issue that they could not stay in this unit and that they would have to be dressed all the time. We started with the unit without working air conditioning and then we were dressed throughout the period with restrictions on drinking water, restrictions on going to the bathroom, restrictions on eating, and being more isolated* (AC40).

> *Ah, I think professionals need to be heard. There is a lot of pressure for us who are at the edge.* [...] *The lack of health structure for public service workers, I think it had a lot of impacts. At the peak of the hospitalization, where we had 15 patients there and the 15 were confirmed, the 15 were intubated. There wasn't that. We're dealing with something hitherto unknown, all the time with different information and I realized that a lot of people got stuck in that. So, I think that if it could happen, if I could go back, I think health worker support for the Nursing team, specifically, would make a big difference.*

> *A big difference. I won't even discuss working conditions because I live different realities. I have working conditions even though there are two public services, but they are quality public services. They end up running away from reality a little. But I have reports from colleagues who are working in an impractical way. They are there relying on luck. I hope they do not get sick, for not allowing a patient to die* (RJ42).

> *And even we have difficulties with PPE. I don't know if this is a reality at the (sic) level of Brazil, but here, for example, we've reduced the workload, it's so much that I'm here now talking to you. Due to lack of PPE, we had to organize so much to reduce the time during the day, so that we didn't need, for example, to wear two masks, in two shifts, and besides that, we had to take turns. We are a unit that has 3 teams and we make a system of alternation within the unit between nurses and nurses, technicians and technicians, doctors and doctors, to meet the unit's demand as a way to save personal protective equipment. What the Ministry also recommends that we have primary care protocols, essentially at this time of the pandemic, how the community health agent will be attended to. The community health agent is not involved in this process at this time, also due to lack of PPE. We know that they were supposed to continue the visits, prioritizing the most needed visits at that time, the elderly, the chronically ill who are unable to go to the unit. Or at times they go because they need it, but our community health agents are at home for lack of PPE or also taking turns with one agent a day for lack of PPE for everyone. Then, the feeling is of a step backward from an achievement that we had (PB40).*

In addition to the need to rewrite the daily practices of providing care in the face of the unknown, dying is a constant variable and, together, touching the already inert body for preparation, a present activity in Nursing practice highlights certain weaknesses.

Although falling ill and dying are part of everyday Nursing, illness and death from COVID-19 give new meaning to the work of collaborators daily. Dealing with a high number of cases, with the lack of hospital beds, with closer deaths, increases fear and anxiety regarding the present experience. Even after almost a year, the care conducts are rewritten daily and the total isolation of the patient, especially the one who is hospitalized, brings reflections on himself, on the family, on the relationship with the other in the face of human illness. When dying, the family member no longer says goodbye, as is culturally determined, the preparation of the body in Nursing practice became differentiated to also avoid contamination:

> *I think that one thing that is important to mention about COVID, at least it was the reality here in Manaus, many lives were lost and the criteria here were very sad. A large number of people were buried on the same day, in mass graves, 4 to 5 coffins were piled up in this way. That's how it was for people, for loved ones very bad because they had to stay in front of the cemetery, they could only accompany one person and the others stayed there, they couldn't watch over their loved ones, they couldn't even see the funeral and then they didn't even know where they were buried because it was a mass grave with 30 coffins, stacked 5 at a time. So, a sad situation. Very close to me there was a person who lost his father and she stayed 3 days to get his body in the cold room so he could bury it. When she went to bury it, it had to be in a mass grave. She didn't accept it and the city hall was touched by her cause and managed to cremate. So, well, it's a sad situation for family members. It caught my attention. When I heard the audio of this situation that I'm reporting to you, it was very moving. If you put yourself in that person's shoes, you can't even attend your loved one's funeral. This is very sad* (AM39).

> *For example, the protocol for us that was instituted, which is something quite different, is the protocol for preparing the body of the patient who died from COVID. It's a very different protocol because, for example, here in our reality we would send the body to the morgue, wrapped in the sheet. And now here you can't. We have to put it in one, like that in a TNT, put it in two bags, we have to make identification on the patient's chest. We have to take a picture where we take it from the chest to the patient's face for the family to recognize because you can't enter to recognize it. So, these are things that have been emerging now, but we see that it is already being well followed. It is being followed to the letter* (PI29).

> *Now we are more used to madness. But it was pretty insane. Brasília was at a peak now. So, it's been pretty insane, we lost a lot of patients. I had a technique that she also had and she had to be taken away because she started crying and screaming in the middle of intensive therapy saying that she couldn't take it anymore, you know? We lost colleagues, so it was very difficult* (DF43).

Narratives that write a hard and sad story alongside an official one, which is reported by the media, present a local and global statistic that increases every day. But these are numbers that do not portray the face of a family member wrapped in protective layers to prevent possible contagion or the distancing of buried bodies without a name, perhaps unknown but gathered for the same reason, identified only by a photo.

The story was written by nurses about the 21st century pandemic in Brazilian realities from North to South.

Every human being needs to be taken care of

The knowledge of the unknown to be cared for in nurses' daily practice shows other issues. The main one, which goes beyond changes in protocols and techniques, is precisely the fact that professionals recognize that they have weaknesses, feel human and realize that their care is the basis for assisting the other:

> *I think that the pandemic showed us how vulnerable we are, right? This issue exacerbated what is to have other more important things for us to pay attention to. So, I think you could see our fears, even you as a health professional are afraid of getting infected, of passing this on to the family. That situation of the health professional being a superhero is not quite like that. We are not superheroes, we are also vulnerable and the biggest fear of health professionals, I believe, is for you to pass this on to your family, your loved ones, right? I think that was very clear to me at this time of the pandemic (AM39).*

> *And then it was very strong, it was very traumatizing to see this because we saw a lot of people die, I saw our colleagues die, I saw our routine change because, with everything closed, we only worked and went to the supermarket. And the month of May was the worst because it had the most hospitalizations, the most deaths, the most lack of vacancies, the most stress, wow... it was living every day in fear of dying and in fear of losing someone you love, of not knowing what tomorrow would be like. It is interesting because death is a common element in our life as health professionals and also as humanity, as human beings, it is a certainty. But, living this so close and seeing so many people suffering together, at the same time, and not only because of the disease, but because of the disease's sequelae and what came with the disease was people closing their stores, people not being able to take buses, anyway, wow, a movie set. A historical fact is difficult to be experienced and assimilated. I left therapy, I left everything. But I kept my monthly appointments with my husband. He came and I went and then in July I also went to Aracaju for the first time in the pandemic, I stayed at the house of a friend who is almost a sister. She tried to commit suicide, she is a nurse too, she works with COVID. It was a very unique situation in my life because I was there. She was medicated. She didn´t die because I took her to the emergency room on time and we managed to reverse the situation. But that traumatized me a lot and it was just when I was getting better. And then this episode made me rethink my absence from therapies. I do weekly psychotherapy and that was the episode that made me return. My therapist was already talking to me, asking me: "So, are you more comfortable? Wants to go back?" Always made me feel very comfortable to come back whenever I wanted and then I went back to therapy in July. I reduced the pace at which I work, but it's still long, it's still big. But I started to deal with it differently. In the beginning, I was desperate, I wanted to know everyone's news. In June I couldn't stay at this frantic pace anymore. My mind couldn't make it anymore and so it was very difficult. In the beginning, their colleagues didn't want to help, they didn't want to expose themselves, they didn't want to work. I took on a lot of things, I took on laboratory things, I took on management things, I got into fights with people in management to organize things better, seeing at the end what was happening. I made some threats to go to the police station, related to death, and in the end, things worked out. I am a person that I try to be very honest, very correct, very technical. So, my scream was another cry for help. I think that's it (AL30).*

> *I think it's interesting for us to point out the professionals' two views, right? What we talked about at the beginning is the professional, the human being, the nurse as a professional, and he as a normal person, right? This insecurity that we had. We have to value all professionals a lot. Not only in Nursing, but all professionals who worked on the front line, which is this internal war of living in a... it cannot be said to be unexpected, but a situation that people had no control over. How can I use a word... that we didn't know, right? Living as a stranger, but facing it there with determination and professionalism, got it? That you go over yourself, your family. The human being is very programmed like this, you first. You always take care of the other while you're ok, you're fine with yourself, your people are fine, so you can better exercise care for the other (NP32).*

We notice that there are many vulnerabilities behind the masks. The pandemic and the crisis caused by it in the personal and professional lives of nurses show the need for care for the caregiver, in addition to caring for the other.

DISCUSSION

The narratives show experiences of nurses in daily life, possibly routine, somewhat anonymous, silent and silenced, but highlighted by the pandemic, and bringing new reflections in the sense of recognizing the need to take care of oneself, in addition to taking care of the other.

The history of Nursing carries with it a construction based on caring for the other, carried out by people of goodwill and who were carrying out a charity, which ensured their salvation. It was established as a profession, also, with the idea of submission to the medical class, exhausting journeys, low salaries. For this reason, there is a need to maintain more than one link. Mental problems arising from this whole context did not start today.[16-19]

Despite scientific growth and the search for more recognition,[20] real changes are little seen. In this sense, the pandemic and all the installed works as a mirror in which the professional needed to see himself, that is, in a broad context of health or disease of a pandemic, with weaknesses that permeate material, cultural and political conditions[12], it was necessary to look inside. The experiences happen through the established relationships and the analysis of macro and microstructures.[11]

In this sense, it is clear that health practices can be renewed.[12] However, there are stigmas or an identity in the work of nurses[1]. Thus, in addition to the need to plan the routine of services, which has been transformed, it is necessary to understand that nurses have limits permeated by their human, physiological and emotional sides that need to be considered.[21]

In addition to the nurse being a relevant professional in health work and in the team to perform different functions, from disease prevention and health promotion to highly complex management and care, he is someone who can get sick, who feels pain, who cries, which can die and still infect people close and loved. The look was expanded beyond the one who "only" provides care and the number of sick and dead people so publicized in the media.

It is necessary to live daily life with its meanings, particularities, subjectivities and not only with the eyes of society.[1,4,11]

We can highlight here the importance of guaranteeing dignified and adequate working conditions. During the pandemic, the capacity of some institutions and governments to guarantee professionals the structure, concerning the physical, materials, and personnel, was restricted so that COVID-19 could be faced in all its magnitude.[9,22]

The heterogeneity of each Brazilian region and its consequences in the fight against the pandemic is known; however, investing in workers' health and providing access to quality care is to think of service with better quality in general, anywhere.[23]

In the care at the time of death and body preparation, although Nursing is a profession guided by techniques, prescriptions, and protocols, it cannot be dissociated from care, on the human side and from the entire emotional and affective relationship that exists among professionals, patients, and family members. In this sense, rational means open space or walk together with subjectivity and situations not observed before.[1]

A study highlights that the deaths that occurred in the pandemic and the entire context that permeates them transmit images that only confirm the scenario of exclusion, pain, and violence that exist daily in the country.[24] The results of this research also refer to the humanization of care. When there is a search for more autonomy, co-responsibility through policies, in addition to including differences in the planning and care processes,[25] would attention to health professionals not be a new way of planning and caring? This is one more side presented by the pandemic: humanizing care is also taking care of yourself.

In general, when understanding Nursing as a social practice, considering all its aspects is important and this means understanding the weaknesses there are, both in the professional and personal environment. By analyzing them and understanding their health situation, it is possible to develop and transform individual, collective, and existing services practices in search of a better quality of life. We can observe that the individual component is linked to the social component and the programmatic component.[12]

Given the different discussions about risk and the certainty of how dynamic and unique the work process and the experiences of each person are,[12] it is not intended here to present Nursing as a risk group, define specific actions or characterize these professionals as equal.[1] However, by knowing the conditions of life and work, being closer to the professionals, and using light technologies (so talked about and recommended in the nurse's practice) also for these professionals, harm can be minimized.

We can highlight that when considering identifications, it is not necessary to break or set aside the existing identity. It is necessary to think that the changes experienced every day must produce constructions of this subject that consider the subjectivities and the same in its entirety, including its appearance, representations, and professional life.[1]

What happens, above all, is that, when seeing oneself as a member of this tribe,[1,4] formed by the "new normal",

in facing the unknown, illness, and death, it is necessary to establish new knowledge arising from everyday life to reorganize the health care that has been built in the experience of each health professional.

FINAL CONSIDERATIONS

The nurses' narratives about their daily practice in coping with COVID-19 reveal weaknesses related to the existing working conditions, the use and availability of PPE, the damages caused to mental health, and coping with death and body preparation.

All of them had a relevant implication, which was the possibility for nurses to observe and reflect more on their practice, especially on self-care.

At this time of the pandemic, adequate working conditions are necessary so that professionals do not get mentally ill. The participants in this research had the opportunity to see limitations and potentialities and to reframe their work in Nursing through the need for their care. We expect that the recognition of these needs goes beyond the role of nurses and reflects improvements in the health area.

Limitations of the research may refer to experiences belonging mainly to the country's capitals, which generally have more resources. We suggest further studies in small and medium-sized cities that address the issue and consider the daily life of nurses and their subjectivity so that these professionals are seen in their entirety.

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