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Original Research Article

A qualitative study to assess lived experience of patients with COVID-19 at a tertiary care hospital, Uttarakhand

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ABSTRACT

Background: Most people infected with the COVID-19 virus faced physical symptoms like mild to moderate respiratory distress but recover without requiring special treatment and also experienced psychosocial barriers like fear stress and stigma related to this pandemic.
Methods: A Phenomenological study for COVID-19 positive patients was conducted during 2nd outbreak of COVID-19 at tertiary care hospital. Purposive sampling technique (maximum variance) was employed to collect information from COVID-19 patients admitted in COVID-19 isolation ward. Sample size was based upon data saturation which was achieved after 8 interviews. Participant's inclusion criteria as aged above 18 years, one COVID-19 positive report by RT-PCR method and admitted in IPD. Questionnaire was administered through WhatsApp video call using 'cube call recorder' and it will be recoded with consent of the patient for the purpose of assessing data validity at later stage of research. Ethical permission was obtained from research review board of the institute.
Results: Patients admitted in COVID-19 ward narrates mixed emotions of physical parameters health like severe body ache, respiratory problems like dyspnea, fever, weakness and cough as well psychological stress, tension and fear of loss of life. Opposed to this study our study participants narrate that doctors and nurses assist patients in their daily activity of living like provide timely medication food and warm water and assists during urination and defecation as patients unable to do so. But patients were experienced marginalization due VIP culture in the ward and hospital.
Conclusions: Patients with COVID-19 experienced physical as well as psychosocial issues during hospitalization and at home due to lack of COVID-19 related information.

Keywords: Lived experience, COVID-19, Stress, Stigma

INTRODUCTION

Corona virus 2 (SARS-CoV-2) is an acute respiratory syndrome, designated as COVD-19 infected most people and experience mild to moderate respiratory illness and recover without requiring special treatment.

COVID-19 Patients with comorbidities like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious complication.[1]

At the time when study started, there were no specific vaccines or treatments for COVID-19 initiated. However, there are many ongoing clinical trials evaluating potential treatments.[1]

Prevention of spread of COVID-19, causes as well as decelerate of transmission were well informed in advance. Common parameters to control infection transmission by maintaining physical distance (minimum approx. Three meter), isolated from infected individuals,

frequent washing of hands or using an alcohol-based rub, wearing mask and not touching face.[2]

Respiratory etiquette practice (coughing into a flexed elbow) is the utmost requirement to prevent spread infection via droplets of sneeze cough and saliva.[2,3]

This pandemic exposed the infancy stage of medical preparedness to combat prevalent infections and had influenced majority of humans all over the world. COVID-19 is related with a high pace of infectivity, which has prompted a notable dread and tension of getting tainted.[1,3]

All the nations over the world were imposed lockdown, a serious limitation on the free movements of individuals. The writing on research center testing, preventive measures and the board conventions to handle the exceptionally infective infection are ever-extending. Indeed, even the information identified with the emotional well-being issues in the forefront warriors/medicinal services laborers is all around archived.

Isolation of COVID-19 infected patients were further needed to prevent spread of infection therefore persons with COVID-19 infection were kept in isolation wards. Patients with COVID-19 faced the psychosocial issues like, the fear of death, and associated stigma, and mental distress.[4-6]

Not only those who infected with COVID-19 or their family but lives of every individual broadly have been substantially affected by the pandemic.[6] As a result of increase in COVID-19 diagnosed cases, fear and anxiety have sparked leads to stigma and discrimination developed towards patients, as well as people who have contact with those infected patients.[6,7]

In general, the experience and feelings of COVID-19 patients is neglected. There are scarcely any online journals/YouTube recordings of the patients with COVID-19 about their real-life experience (about how they had battled with the contamination, the amount they felt during the confirmation and so on.) during their clinic remain, yet no descriptive data is available.[5,6]

Person infected with COVD-19 face extreme fear, Alienation and stigma. Patients have to live without families and their loved ones and it affects their quality of life.[8] Exploring lived experiences of patients, problems faced by them during hospital stay will help to plan effective stay strategies and policies related to confronting, exploring and managing COVID-19 effectively.

The fear and anxiety of COVID-19 were so severe that an adult male committed suicide. As per a person of deceased male, he took this step due to an extreme fear and suspicion that he had contracted the deadly virus while being hospitalized for a treatment of urinary tract infection.[9]

Apart from these psychological issues patients face huge economic burden. COVID testing itself is very costly in many semi government and private hospitals. Loss of work due to lockdown, upon those expenses of COVID treatment leads to economic crises in economically weaker population. Interpersonal coping strategies adopted by the survivors will be helpful for other patients. Additionally, exploring the physical, psychosocial burdens and experienced by patients about hospitalization during this outbreak will be vital as well.[10]

Research question

Research question is: How were the lived experiences of patients with COVID-19 admitted at tertiary care hospital, Uttarakhand?

Objectives

Objectives were to assess the real-life experience of patients with COVID-19 Admitted at AIIMS Rishikesh, Uttarakhand.

METHODS

A phenomenological study for COVID-19 positive patients was conducted during 2nd outbreak of COVID-19 from October to September 2020 at AIIMS Rishikesh. Purposive sampling technique (maximum variance) was employed to collect information from COVID-19 patients admitted in COVID isolation ward. Sample size was based upon data saturation which was achieved after 8 interviews. Participant's inclusion criteria as aged above 18 years, one COVID positive report by RT-PCR method and admitted in IPD. Participants excluded who were Suspected cases of COVID-19, patients coming to OPD settings, patients with negative COVID report, children and patients with any comorbidities. After receiving an informed consent of participants and ethical clearance from institute ethical committee, baseline socio-demographic responses were filled by one of co-investigator, who was posted in COVID-19 IPD. Second phase included a semi-structured Interview schedule followed by web-based video recordings of interviews. Questionnaire was administered through WhatsApp video call using 'cube call recorder' and it will be recoded with consent of the patient for the purpose of assessing data validity at later stage of research. It will be a WhatsApp call video recording, so there will be no risk of infection transmission/disease spread. Informed consent obtained from each subject before collecting data. Ethical permission taken from institutional ethical committee.

Validity and reliability

Data collection tool validation was obtained from 7 experts. Lincon and Guba's criteria was followed to

established level of trustworthiness. Well established research methods were employed, researcher's "reactive commentary" and video-taping was done to capture information accurately to maintain credibility, dependability by peer debriefing/scrutiny), interview transcriptions were checked by an independent person for conformability and detailed reporting of the research process and thick description of findings for transferability of the data.

Data analysis

Immediate debriefing after the interview and notes were made during the interviews. Viewing and listening to the video and transcribing the content as written notes. The content of the video was matched with notes and non-verbal behavior was also considered. Thereafter Transcription and translation of verbatim into English from Hindi, English transcripts were checked by an independent person for objectivity. Coding of data in RQDA software and thematic analysis: accurate themes and subthemes were generated.

RESULTS

Sociodemographic profile of the participants was included as the basic information like age, gender, religion, education, marital status and occupation and clinical profile.

Young to middle-aged adults made up the majority of participants (37.5% aged 18-30, 25% aged 30-45, and 25% aged 46-60) only one participant (12.5%) was older than 60 years. The sample skewed heavily male, representing 75% of the participants and only 25% were female. Most participants lived in urban areas (75%). In terms of religious affiliation, 75% identified as Hindu, 12.5% as Christian, and 12.5% as Muslim. A large majority of the interviewees were married (75%), while the remaining baseline was split between unmarried (12.5%) and divorced or separated (12.5%) individuals. The cohort was highly educated; 62.5% held either a graduate (37.5%) or post graduate (25%) degree. The remaining participants were evenly split across intermediate, high school, and no formal education levels (12.5% each). Professionally, private-sector employment was most common (37.5%), while government jobs, homemaking, self-employment, students, and farming each accounted for 12.5% of the group.

All 8 participants (100%) suffered from symptomatic COVID-19. Illness severity required the vast majority (75%) to be admitted to a COVID ICU, while 25% were treated in a general COVID ward.

Over break, 62.5% resolved their active infection within 15 days, whereas 37.5% experienced an active infection lasting longer than 15 days. Additionally, 37.5% of the participants had other family members also suffering from the virus. A significant 75% of the interviewed patients reported having no prior knowledge regarding the prevention and treatment of COVID-19.

Thematic coding Table 2 for qualitative analysis based on interview transcript is given below the main themes, sub-themes, and the patient's exact statements.

Table 1: Socio-demographic profile of participants included in interview (n=8).

Variables	N	Percentage (%)
Age (in years)		
18-30	3	37.5
30-45	2	25
46-60	2	25
>60	1	12.5
Gender		
Male	6	75
Female	2	25
Religion		
Hindu	6	75
Christian	1	12.5
Muslim	1	12.5
Marital status		
Married	6	75
Unmarried	1	12.5
Divorced/separated	1	12.5
Educational status		
No formal education	1	12.5
High school	1	12.5
Intermediate	1	12.5
Graduate	3	37.5
Post graduate	2	25

Continued.

Variables	N	Percentage (%)
Residential area		
Rural	2	25
Urban	6	75
Occupation		
Govt.	1	12.5
Private	3	37.5
Home maker	1	12.5
Self-employed	1	12.5
Student	1	12.5
Farmer	1	12.5
Duration of active COVID-19?		
0-15 days	5	62.5
>15 days	3	37.5
Severity of illness?		
Symptomatic	8	100
Asymptomatic	0	0
Type of ward admitted ward/ICU?		
General COVID ward	2	25
COVID ICU	6	75
Any family member suffering with COVID-19?		
Yes	3	37.5
No	5	62.5
COVID-19 knowledge (prevention and treatment)?		
Yes	2	25
No	6	75

Table 2: Theme subthemes and their examples (n=8).

Themes	Sub-theme	Verbatim quotes/references
Exemplary medical and nursing care	Going beyond duty	"Dr. Sahil was with me, so you can understand that Dr. Sahil worked as an HA (attendant). He took the cylinder and accompanied with them (hospital staff)". Nursing and junior staff: Work hard day and night in PPE kits.
	High institutional trust	"The treatment available here at AIIMS is not available anywhere else..." The staff's approach was extremely helpful and supportive with positive attitude.
Systemic decline and ward disparity	Non-COVID ward mismanagement	"This non-COVID ward is not that good; the system is not good... On the fourth floor, the system is not right there, the care is also not good."
	Infrastructure deficit	"Please keep dustbins in the COVID ward... If anyone needs to throw something away, they have to keep it on bed until housekeeping comes."
Support staff negligence	Shift negligence	"Housekeeping duty is till 7 o'clock but they leave at 6 o'clock..."
	Neglect of patient dignity	"We can't get out of bed, we're on oxygen... the diaper was dirty, but the housekeeping staff didn't come. I'm embarrassed to tell you all this."
Clinical skill gaps and patient safety	Incompetence in emergency equipment	"There are no trained people here to put on NIV masks, only 1-2 out of 10 are trained... Oxygen dropped from 95 to 45 while putting on the mask."
	Avoidable ventilator escalation	"Time was lost because he wasn't able to put on a mask... then he was put on a ventilator and you know who can come back from ventilator..."
VIP culture vs healthcare equity	Institutional favoritisms	“Gopal Singh Rawat (OSP) was admitted in the COVID building… At night, two attendants used to sit near him on a chair… They were cleaning him, giving him water, changing his clothes.”
	Marginalization of common patients	"Another patient came in... he was feeling very cold, he was shivering. I told the attendant, 'Brother, give him a blanket...' He said he was fine and left and never came back."
Psychological resilience	Transmission of negativity Therapeutic environment Willpower for survival	"Patients should also have self-confidence and willpower, if the willpower is low then the patient will die... My willpower is strong, that is why I survived."

Exemplary medical and nursing care

Doctors, nursing officers and junior staff are worked hard day and night in PPE kits and staff' approach (behavior) was extremely helpful and supportive. Contradictory to this housekeeping staff was found to be 'in-sufficient in number as well as work efficiency'.

Going beyond duty

As verbatim code state that hospital provide an extraordinary care during the initial admission till discharge the COVID positive patients.

Example Dr. Sahil was with me, meaning you understand that even Dr. Sahil did the work of HA. An attendant handled the bed, Dr. Sahil took the cylinder and with him, I would hardly think doctors do this work. they cooperate so much, Dr. Mihir: Dr. Sahil is there, they saved my life, they cooperated so much.[1]

Example there was no body except a doctor and a nurse. That nurse was with me for 2-3 hours and was giving me medications and treatment and was consoling me. After three hours my leg pain and backache got relieved and I felt better. Then I felt that I can breathe properly before that I was unable to breath properly. Then they told me that we are shifting you to the ward, they gave me dress to change and informed my husband and collected all my bags. Then I was shifted toward top floor on wheelchair. In the ward they asked me how are you? are you ok? I said yes I am ok, then I felt that I will be better now, before that I was just wondering what will happen and what had happened to me and…… about the hospital staff, nursing staff, they all actually very cooperative and hard working there is no doubt in this, I can see them working day night, Of course they have been working in such pressure very nicely and this is all junior staff, salute to them, they are really nice, I was admitted in private hospital also, there are taking care of everything, they are fully wrapped in PPE kit, or really helping each and every patient here. And normally they are very good with the gestures, with their talks, everything they look very reasonable.[5]

High institutional trust

The public has strong faith in premier government hospitals like AIIMS, which have become synonymous with excellent medical facilities and life-saving care.

When I came here then I felt much relived and I felt that I got my life back. How can someone recover such big problem in just three hours. But this was the knowledge of doctors they know how to treat and what to give to us so that we can feel better. They are also humans, it's their knowledge and expertise in the field that I got recovered in 3 hours and can sleep properly at night which I was unable to sleep from last 5 days. Knowledge is everything, nurses follow the order of senior doctor that now you give this or that to us, and we felt better, and it a big deal.

In my experience I was having so much problem at home, and in the hospital, I felt relieved in 3 hours. What should I tell, I will never forget this in my lifetime. I am fully satisfied, I am ready to give in writing, or if someone wants to take my interview in front of everyone, I am ready to speak, I got my life here. I felt that just in 3 hours I got my life, who does it in this time, I was dying in last 5 days, they have treated me in 3 hours it's a big deal, I slept well that night.[2]

Treatment is going on, doctors are telling, don't worry so I felt better that I had come to a good place. I am very much satisfied with the service of doctor nurses and attendants.[3]

I was feeling nothing like illness or disease and feeling normal even asking Dr. that when will be get my discharge and dr. Replied that my report come positive even I, have no symptom like cold etc. so nothing to do special, stay calm don't panic and face the problem with courage.[6]

Systemic decline and ward disparity

Majority of admitted participants were in the severely high-risk category. they had health problems like diabetes (insulin dependence), hypertension (HTN), and heart disease (two heart stents) and hospitalized due to worsen medical condition like fever, body achae, sore throat and dropped in oxygen level (SpO_2). The ward contained clean, well-ventilated cubicles for six patients each. The entire ward was fully air-conditioned. All six electric charging points behind the bed were faulty. Despite two complaints, they remained unrepaired, preventing patients from heating water for steam. Behavior a female patient in a nearby bed caused a lot of negativity in the ward due to her constant crying and wailing, which disturbed other patients. She was later moved.[5]

COVID ward mismanagement

You have to be strict to staff a bit and for housekeeping as well. Please keep dustbins in the front COVID ward, if feels really bad. Like if someone has to through anything they have to keep it on bed unlit housekeeping arrive. We have to keep it with us until housekeeping arrive, if we through it down then it does not look good, and the housekeeping lady will then say that what have you done.[3]

Infrastructure deficit

Power points are there behind every bed, not a single one working behind my Bed, nothing is working. I have complaint regarding it twice, these are charging points, these are 6 points, but none of one is working, I have to heat the water to take steam but I can't do.

They said there is no place/beds, but then I got admitted in 15-20 minutes.[8]

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Support staff negligence

Shift negligence

Dust on medical furniture (tables) despite regular floor cleaning and lack of high-level sanitization as per COVID protocols. This interrelationship between healthcare workers and patients, and a healing environment, are crucial for the smooth functioning of any hospital and for rapid recovery, according to WHO. Appreciating frontline staff who work under immense pressure and improving the environment for peace of mind are both complementary.

Whomever this, the request that we have made, it is fulfilled…. I think I have a problem with a health care worker. My problem is that the housekeeping staff who are not doing mopping… but in a place like COVID ward, they have to bring sanitization to the upper level, they are doing it but it is in sufficient.[5]

The arrangement is also not good. Yes, on the 4th floor, the non-COVID ward started on the 5th date itself, but the system is not right there, the care is also not good. I am saying, look, all patients are equal whether it was sent by you or Parveen ji, or it was sent by the director Sahib or it was a direct patient His life is as precious as yours. Now there was a case in front of me. Another patient came with me on the 5th on the COVID building, we were in front of the bed.

Just 4-5 days ago when I came here that morning, at 11 am, that patient had a cold too much, he started shivering, there came an attendant and I told him brother give him a blanket, he has a cold too much. Right after saying ok, he left, then another one came. I said brother, he did not come back, bring him blanket, he is feeling cold too much. Well, he also went away saying I could not get up, I was on oxygen, it was my helplessness.[1]

Neglect of patient dignity

The discomfort faced by patients due to small but significant logistical deficiencies like unavailability of dustbins in rooms and storage of used utensils points to the poor management of the hospital.

Sir like any hospital, aa…. there is a lack of positivity. The positivity is too much prevailing here, so my suggestion is to make the environment little better, may be little music, little something is highly recommended here for this place, because here panicky, fear, pain, nervousness I am constantly looking here, But I think there should be at least a very light music that is soothing, giving pleasure, either it could be religious I don't know but that will help to make the environment much better towards positive. So, this is very much important.[5]

If someone brings food from us, he says, keep it at the gate and give it now, I said wow brother wow. They used to keep the food on the ground near gate and did not hold food in their hands. See, make this arrangement, if the food comes, at least keep the table, at least hold it on the hand, don't put the food on the ground. When an attendant visit, he will get food up and then we will get it. I was outside that day and I said madam I said do not despise it, keep it in your hands, she said we don't take it in hands like this. I just had my breakfast now, some things can only be known I after experiencing like this.[8]

first 3 days were quite difficult for me. I was feeling the pain of needles that was inserted now they are not giving me any medicine nor injection. I faced difficulties in making contact with my family members as unable to call for 4 days after admission. I was unaware to the fact that phone was allowed here.[6]

Biggest problem is duty timing is not right for those who are your housekeeping, here in private ward its ok but there, duty is up to 7 they leave at 6. we can't get up from bed, if we can get up, then why do the patients call housekeeping? we are on oxygen we can't get down, they keep saying we are coming, diaper was dirty, but housekeeping didn't come. I am feeling ashamed in telling all these things. Please improve housekeeping management, housekeeping bother a lot. Here in private ward its fine, proper time utilization is there, but there the condition is not good.[1]

Clinical skill gaps and patient safety

Incompetence in emergency equipment

Information given by patients exposes the negligence and serious lack of clinical skills of the healthcare support staff, which is a major negligence and violation of human rights for any hospital.

Then a girl came to attendant then said to her, she is feeling very cold and the situation will get worse, then she went to send two attendants, they said, "Baba, nothing will be happening, will be cured and put a NIV mask on him." As long as the NIV masks fit him, there are no trained people here to apply NIV masks, out of 10 only 1-2 are trained. They were doing here and there for applying mask, when he started applying NIV mask, oxygen was 95, it came 95 to 45 while applying mask. They were not able to put mask.[4]

Avoidable ventilator escalation

The bed was elevated, then again lowered and put on the mask and the time got wasted by the mean time. Then a pipe was put into his mouth and he was putted, on the ventilator. and you know who can come back from the ventilator, someone out of 100s can come back

VIP culture v/s health care equity

This theme highlights the discriminatory treatment patients receive in hospitals based on their socio-political status.

Institutional favoritisms

For influential people like the Chief Minister's OSD, multiple attendants are deployed overnight in the hospital and excessive service is provided as per protocol.

In COVID building OSP OD CM, Gopal Singh Rawat was admitted, that room was of 4 beds, first they shifted on patient and then another. They told me also that we are shifting you to other are, I asked why, what's the matter please tell me, why are you shifting you have already shifted two patients, because that person is OPS, what we are saying to you. Then I called up and then they said okk keep him there.

We two were there in that room for two days. They were serving OSP sir so much. At night, two attendants used to sit in a chair nearby him, then I said patient is patient, its ok he is OSP, means they were cleaning him and giving him water, also were changing his clothes. I said the limit is over, brother: If we are calling housekeeping, then they are not even coming over an hour and there. This is OSP Sahib, and some 5-6 men used to surround them. As if a he has become a king, don't know what will happen if just in case CM came, 1 attendant would sit in a chair all night there. I am saying that patient is patient everyone is equal. He is OSP, I am not that's why they ignored me and treated him. They were Serving him like this as if he is their son in law. I said, brother, what is happening? Their family members were bringing juices for 4 times a day, some are bringing packets with food, no one was stopping them even once.[1]

Marginalization of common patients

Hospital staff repeatedly ignore even basic requests from common patients, such as asking for a blanket when they feel cold. Another patient came with me on the 5th on the COVID building, we were in front of the bed. Just 4-5 days ago when I came here that morning, at 11 am, that patient had a cold too much, he started shivering, there came an attendant and I told him brother give him a blanket, he has a cold too much. Right after saying ok, he left, then another one came. I said brother, he did not come back, bring him blanket, he is feeling cold too much.[5]

Psychological resilience

This theme reflects the patient's mental attitude and positivity in fighting a serious illness (such as COVID-19).

Transmission of negativity

Crying or depression in other patients on the same ward can have an impact on others. To prevent this, it is possible to place seriously ill patients in separate (private/semi-private) wards.[3]

Therapeutic environment

Soft instrumental music or soothing natural sounds should be used to reduce hospital anxiety. Meditation or spiritual sessions are also helpful for patients' mental calm. Treatment requires more than just medication, but also intimate communication. Patients should also be counseled to ensure they understand hospital rules and behave appropriately with the staff.[7]

Willpower for survival

The patient's strong belief that along with treatment/medications, his strong mental willpower was the main reason for recovery from the pandemic (COVID-19).

Examples of experiences

For positive patients, just maintain your will power, the patient will go half the way, if you put your hands on his waist 4 times, saying you are fine, you are fine, some patients will be cured. That thing is not there, a because the will power of the corona positive patient ends. He is upset that I will die. If the doctor goes twice a day and puts his hand on his waist, he will be fine. His power will increase.[8]

'*Yes, I would say that spread awareness about how we can combat corona, we can only do this and help each other, we can pick someone to hospital who don't have transportation, we have to help each and every one*'.[2]

'*I can't see someone like this, I can't see someone in pain, I will go to Ganga ji for prayer and I would do good for others as much as I can*'.[3]

'*From last 1 month and 4 days I have been here, I came here on last 16, my will power is strong, so I survived, if will power is less then*'.[1]

DISCUSSION

Patients admitted in COVID ward narrates mixed emotions of physical parameters health like severe body ache, respiratory problems like dyspnea, fever, weakness and cough as well psychological stress, tension and fear of loss of life. Half of patients admitted were lived with

co-morbidities like diabetes and cardiovascular problems like hypertension and coronary artery disease. Same results were discussed by Sahoo et al has documented the narrative real-life experiences of patients admitted in COVID-19 isolation wards. In which author highlighted those patients admitted in isolation wards face extreme fear of death, stigma, and internalized guilt. They go through huge mental distress.[4] Also, by Busby a COVID-19 survivor has expressed his feelings of fear of impending death through a news interview, and called it as most terrifying experience of his life.[8]

Wang et al conducted two subprojects to assess the lived experience of individuals fighting against the panic and discrimination of COVID-19. The authors through experience projects have published various narratives on web explaining the effect of COVID-19-fear, PTSD, stigma.[5] Opposed to this study our study participants narrate that doctors and nurses assist patients in their daily activity of living like provide timely medication food and warm water and assists during urination and defecation as patients unable to do so. But patients were experienced marginalization due VIP culture in the ward and hospital.

Das published an article on psychological impact of COVID-19 on patients diagnosed with COVID-19 where he documented that active or recovered/ suspected patients can have Anxiety, sleep problems, restlessness, depression, insomnia, obsessive symptom, fears of contracting illness, stress disorders, grief, suicide.[6] In this research it was found that psychological impacts on patient's like crying and depressive talk of the patients in same ward leads to negative environment and spreads negativism. For such patient's isolation room or timely counselling may sought, and advocates therapeutic environment by playing soft music and television to minimize the depression and fear related to COVID-19.

Assumptions

Patients surviving with COVID-19 face psychological, social, economic problems.

Delimitations

The study is delimited to the COVD-19 positive patients admitted in COVID isolation area.

CONCLUSION

Patients with COVID-19 experienced physical as well as psychosocial issues during hospitalization and at home due to lack of COVID-19 related information. Patients who had higher education and knowledge about COVID-19 infection experienced less fear and stress and showed dissatisfaction of hospital services in compared to less educated and rural background patients. Accurate and timely information and protocols related to pandemics may prevent confusion among general public therefore it will improve the patient's services in the hospitals and communities.

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