

# COVID-19 in Critical Care Units: Rethinking the Humanization of Nursing Care

We are 3 nurses and an associate professor in nursing science working in 3 diverse university hospitals in Italy. Me, Stefano Bambi (intensive care unit [ICU] staff nurse), and Prof Laura Rasero in Florence (Tuscany); Alberto Lucchini (ICU head nurse) in Monza (Lombardy); and Pasquale Iozzo (nurse manager) in Palermo (Sicily). We have written this editorial to offer to all our colleagues our point of view on some fundamental issues related to the coronavirus disease (COVID-19) pandemic, especially related to the humanization of care.

The unexpected outbreak and the drastic measures required to contrast the COVID-19 pandemic have rapidly changed our personal and professional lives.<sup>1</sup> The lockdown and social distancing measures enforced by governments heavily affect our private life and the same possibility to take care of our personal needs.<sup>2</sup>

For the first time in our age, common people are globally experiencing a sense of deep emotive instability, transience, and awareness of their mortality.<sup>3</sup> These feelings are amplified by the 24 hours' coverage given by media and by the daily reports about new cases and number of deceased people.

As critical care nurses, we have experienced a new challenging working scenario inside the COVID-19 ICUs.<sup>4</sup> In these setting, we are called to provide the usual high standard care of patients, and we are also experiencing and trying to cope with the additional problems caused by the personal protective equipment (PPE), which have proved to be extremely heavy and uncomfortable to wear especially for long periods.

Moreover, the hardest trial we have to face now is to offer exactly the same “human” treatment and care to our patients, as we have done before this dramatic pandemic.

Wearing PPEs represent an important hindrance for communication with patients. They cannot see our faces, and often, we cannot clearly hear what they say, because of the noise of high-flow oxygen therapy or noninvasive ventilation systems and the caps and hoods of PPEs that

cover our ears. The white sterile overalls make everyone indistinguishable, to such extent that patients cannot understand if the person at their bedside is a nurse, a doctor, a physiotherapist, or a nurse aid. We write our name and profession on the front and back of the suits to help patients identify us and to decrease their level of disorientation and anxiety. However, the use of communication charts and tables often overcomes the limitations in hearing.

COVID-19 ICU patients usually stay in isolation rooms. They cannot receive any visitors with the exception of health care workers. Data collected in a US research shows that the median length of ICU stay for this specific illness is 14 days (interquartile range, 4–17 days).<sup>5</sup> This condition increases not only patients' fears of dying without having the chance of seeing their loved ones again, but also origins a general sense of loneliness and depression and increases the risk of delirium. Our hospitals have responded to the pandemic emergency beginning with policies that limited the number of visitors. Soon after, hospital managers simply decided to suppress any kind of visits. This hard (but necessary) choice has completely erased the concept of “open ICU” at once.<sup>6</sup> Therefore, we need to rethink about new (or enhanced) solutions to provide the highest possible level of humanization in the care offered in our COVID-19 ICUs.

First, we should reconsider the prejudices related to the use of personal mobile phones in ICU. Outdated researches showed that mobile phones could cause potential interferences with the functioning of monitoring devices.<sup>7</sup> Currently, this opinion is no longer supported, because the new mobile phones (4G) seem to exert no interference at all with medical equipment. Furthermore, current medical devices are designed to operate safely under any condition.<sup>8</sup> The use of personal tablets and cellular phones could be an important way to maintain contact with patients' significant relations.

The introduction of TV or radio sets could also help patients to mitigate their sense of isolation from the rest of the world, improve their mood, and keep them updated about what is happening outside “the hospital walls.”

Because ICU diaries and music therapy sessions have shown their positive effects in the humanization of general care,<sup>9,10</sup> we believe that this opportunity should be also offered to COVID-19 patients. Intensive care unit diaries can provide the possibility to reconnect the patients' minds to the events experienced during their stay in ICU, especially when they were sedated or during phases of "floating" levels of consciousness. Moreover, there is evidence that ICU diaries are effective in preventing patients' depression and improve their quality of life.<sup>9</sup>

Where available, early assessment of patients' emotional frailty and psychological support could be a fundamental resource to prevent or relieve posttraumatic stress disorders, anxiety, and depression.

Follow-up services for ICU survivors, which are effective in improving ICUs' survivors' mental and physical health,<sup>11</sup> should be enhanced and remodulated, taking into account the psychological consequences determined by isolation and by the alienating health care environment of COVID-19 ICUs.

Among all these issues, we cannot forget the relatives' needs. When persons affected by COVID-19 enter the hospital, they literally disappear from their relatives' life. Information about their health status is provided by doctors only by phone; even, the announcement of death is made in the same way, by phone. This condition is very tragic and depersonalizing. This necessary "hard" way to manage communication, besides the unavoidable pain due to the loss of their loved ones,<sup>12</sup> can turn into pathological forms of dysfunctional grieving. We think that outpatients' follow-up programs must also take into consideration the assessment of relatives' needs, especially of those who experienced a loss in COVID-19 ICUs.

Furthermore, rethinking the humanization of nursing care during the COVID-19 age should comprehend also the psychological wellness of critical care nurses.

Qualitative research will explore the experiences of COVID-19 ICU's nurses and their moral distress in taking forced triage decisions caused by the shortage or lack of health care resources, lifesaving technologies, and mechanical ventilators.<sup>13</sup>

Moreover, the quality of communication and the working climate inside COVID-19 ICUs should be investigated. We have much to learn from this experience.

Lastly, qualitative data should be collected about the effects of lockdown and self-isolation on critical care nurses' private lives during and after the pandemic. Hospitals should offer psychological support for nurses during (and after) the unprecedented emergency we are experiencing.

This event has had a deep impact on our lives, minds, and relationships as health care professionals and human beings.

Some of us have experienced the crisis of the lack of ICU beds and faced, for the first time, the process of determining the priority of patients' admission in critical care

units. Others, at the beginning of the pandemic surge in Italy, have been working inside the ICUs for 14 days consecutively, in a quarantine regime, for having been in contact with "unsuspected" COVID-19 critically ill patient.<sup>14</sup> They have experienced fear for themselves and their families, a sense of separation from their loved ones, and the fatigue due to the prolonged work shifts, facing a "not well-understood" virus, its modality of transmission, and the devastating effects on intensive care patients.

Most of us, skilled for the care of extracorporeal membrane oxygenation patients, have been quickly reallocated to COVID-19 ICU, supporting the colleagues in these hard moments. Our hospital management has excellently responded to this emergency, generating new ICU beds.<sup>15</sup> Lots of freshly graduated nurses have been hired to increase the number of nurses in new ICUs, but this policy has obviously reduced the level of skill mix. Therefore, we have been challenged from the need to provide adequate work environments and mentorship programs for our "young" colleagues.

During these first moments, especially in March 2020, we have faced all of this, sustained by "high levels of adrenaline" generated by our desire to save lives and help our new colleagues to become soon independent in ICU patient management.

Outside the hospitals, some of us have conducted a solitary life due to the quarantine and the lockdown extended to the whole national territory and with the aim to protect their older relatives, partners, and children. The hours and the days free from work were always the same, marked by the continuous sound of incoming WhatsApp messages, phone calls, and emails informing about continuous adjustments in the hospital policies and organization to face the developing aspects of this emergency. A frequent sense of anxiety and uncertainty undermined the quality of our sleep and rest.

Then, after the 15th of April, when the national situation has slowly improved, a sense of general hope has occurred in all of us. However, paradoxically, our levels of adrenaline have decreased, and a significant sense of fatigue took the place of the initial energy that had sustained us during the first phase of the emergency.

Now we are slowly trying to return to a "new kind" of normality, given that the Italian lockdown has stopped. This is the moment to make good use of our experience and learn some important lessons that could help in the future. The first issue is to find daily effective ways to relax and rest even when our level of adrenaline is remarkably high, and we feel no sense of tiredness. This is important because the lack of sleep produces a sense of long-lasting exhaustion and can undermine our professional and emotive performance.<sup>16</sup> The second issue is to break the chain of stress and find daily time free from digital communication bombing (giving a stop to calls, mails, and social medias), in order to recover adequate levels of personal energy and

detach from the heaviness of this situation.<sup>17,18</sup> Third, psychological professional support for health care workers (where available) should not be undervalued, because symptoms of posttraumatic stress disorders have been reported by personnel who lived this pandemic emergency in the “frontline.”<sup>19</sup> Recurrent dreams about hospitals scenarios can be a sign of deep personal psychological discomfort.<sup>20</sup>

As Barack Obama warned for potential pandemic in 2014,<sup>21</sup> we cannot exclude that these kinds of emergencies will not occur again in the future. Therefore, we should spend time looking for innovative solutions and find ways to maintain focus not only on the clinical aspects of these menaces, but also on the humanization features of the care toward patients, families, and also toward ourselves.

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