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NURSES EXPERIENCES WITH COVID-19: NARRATIVES FROM THE PICU

Editorial

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Note: Although this issue of *Pediatric Intensive Care Nursing* (PICN) is dated December 2020, we delayed publication to better capture growing experiences related to the COVID-19 pandemic. This issue of PICN was actually published in April 2021.

As the COVID-19 pandemic has persisted, nurses have consistently emerged as key leaders in this very difficult battle. Although we have been hearing a great deal about the impacts of this pandemic, nurses' experiences have been generally under-recognized – and pediatric nurses' even less so given the widespread view that children have not been significantly impacted by COVID-19. In this issue of PICN, we want to contribute to the redressing of this major imbalance by drawing attention to the pandemic experiences of nurses within the pediatric intensive care unit (PICU), so we can better understand their nursing experiences as well as the lives of the children and families that they work with.

We reached out to PICU nursing colleagues in many regions of the world to invite them to share their COVID-19 stories. I received many personal replies, describing numerous heartbreaking and distressing experiences – stories that many nurses did not feel comfortable publishing because they feared reprisals because their stories could publicly reveal serious problems that they felt had to be addressed internally. I imagine that we may be hearing more about these concealed stories in the future.

Fortunately, in this issue, we are able to publish six extraordinary stories submitted by PICU nursing colleagues in Brazil, Italy and the United Kingdom. I am deeply grateful for the support of **Orsola Gawronski** (RN, PhD; ESPNIC Nursing President; researcher, Bambino Gesù Children' Hospital, Rome, Italy) and **Mavilde LG Pedreira** (RN, PhD; Full Professor, Paulista Nursing School, Federal University of São Paulo, Brazil) for helping us recruit these six authors to submit these amazing narratives.

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Editorial

These six stories illustrate a wide range to extremely difficult challenges that were confronted by these nurses within their PICUs, and the tremendous strength and courage that they mobilized to help ensure the best possible care for the children and families that they cared for. Their stories are immensely inspiring! We are indebted to them for generously sharing their stories – helping us better understand their experiences and those of so many other PICU nurses around the world.

NOTES

- If you are interested in rereading our previous PICN issue, which was published during the rise of the first wave of the COVID-19 pandemic, please click here

- For analyses of child/youth COVID-19 impacts experienced by children and youth more broadly, not solely within the PICU, you can consult these analyses published by my VOICE Childhood Ethics research program:

General Impacts

Campbell S, Carnevale FA. Injustices confronted by children & youth during the COVID-19 pandemic. Medium; 2020 Jul 19.
Available here

Global Child Health Impacts

a) Campbell S, Cicero Oneto C, Saini MPS, Attaran N, Makansi N, Passos dos Santos R, Pukuma S, Carnevale FA. An Ethical analysis of COVID-19 impacts from a global child lens: It's time to prioritize children's rights! Montreal: Institute for Health and Social Policy—Learning from COVID; 2020 Oct 28.
Available here

b) Campbell S, Cicero Oneto C, Saini MPS, Attaran N, Makansi N, Passos dos Santos R, Pukuma S, Carnevale FA. Impacts of the COVID-19 pandemic on children: An ethical analysis with a global-child lens.
Global Studies of Childhood. 2020 (pre-print).
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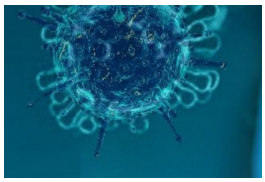

NURSES EXPERIENCES WITH COVID-19: NARRATIVES FROM THE PICU

United Kingdom

Kate Baptiste, Bristol Royal Hospital for Children, Bristol, UK

The Covid-19 pandemic has had a strange impact on the winter workload in paediatric intensive care (PIC) in the UK. So far we have not had a single patient admitted with *respiratory syncytial virus* (*RSV)*, so aside from a few randomly busy weeks here and there, we have been oddly quiet. The opposite has been true of adult critical care with an unprecedented demand on their services and a winter like we have never seen. With demand for adult critical care trained nurses outstripping the supply, the obvious next step was to look to PIC for help. In the UK, undergraduate nurse training is separated for adult and paediatric nurses, meaning paediatric nurses may have never cared for an adult before. However, our PIC nurses had essential critical care skills and were desperately needed, so it was agreed that they could be redeployed on a shift-by-shift basis to help in adult ICU.

Our PIC nurses were, as you may imagine, filled with trepidation. Some nurses felt better after their first shift but often their anticipated fears made way for fears based on the reality. Our PIC nurses eloquently told us what the problems were; they were children's nurses and had never nursed adults; 12.5 hours in full PPE was exhausting; they had relatives that were vulnerable, and they didn't want to take Covid-19 home to them; they felt out of their depth and were working outside their experience. Measures were put in place to support those who needed it, for example regular debriefs; videos on how to get to the various critical care areas; snack packs to take with them due to a lack of facilities in temporary staff rooms; regular check ins during their shift. These helped somewhat, but many of our nurses were still struggling.

The staff room was full of conversations about their experiences. Some sad, some funny, some a bit gross. A good shift was chalked down to whether their patient had died or not and how many 'code browns' they had to clean up. There is a world of difference in this area between adults and children, for example the bowel management systems! The jury is still out on whether they were preferable to a type 7 stool over the sheet! I said that we should write a book of our experiences, so we could read it back in years to come and remember our contribution. Our nurses would continue to check on the patients that they had cared for, unsettled by the lack of continuity; delighted if they were discharged from ICU, saddened if they died. They often reported feeling like they were just caretaking for a shift and not able to make the same impact on their patient's care that they were used to.

Sadly, they underestimated the impact that they had. As the pressure eased, we began to send fewer nurses, less frequently, and feedback began to come to us from the adult ICU staff. Stories of the wonderful things that they had done. At the very minimum, our PIC nurses are very competent ICU nurses, which was invaluable to the adult ICU nurses. They knew that they could trust them to provide safe and effective care and this enable them to focus on their own patient(s). Alongside this general praise came some specific examples of exceptional care.

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For example, a young woman had been in hospital for nearly a year and had not seen her family for a long time. A PIC nurse cared for her one shift and made it her mission to ensure that this woman could see her loved ones and succeeded, making this woman's Christmas.

More stories like that were fed back to us, stories of the impact our PIC nurses had with their focus on family centred care that is so important to us in PIC. Stories of the extra phone calls or video calls to families, stories of the music they played for their patient and the empathy they showed.

Often PIC nurses were referred to as 'the loveliest nurse I've ever met'

Often PIC nurses were referred to as 'the loveliest nurse I've ever met'. We were told that you could often tell if a PIC nurse had cared for a patient because of the personal care provided, for example patients having their hair brushed or getting a shave. That level of care is much easier to provide if you only have one patient to care for, and the adult nurses were often caring for two.

It appeared that just 'caretaking for a shift' enabled our PIC nurses to provide exceptional care that impacted on the patient for much longer than the length of their shift. How the adult ICU nurses have endured the relentlessness of the Covid-19 pandemics effect on critical care is amazing, but the PIC nurses that stood on the front line with them should be very proud of the contribution that they have made.

Now the second wave of infections is winding down in the UK and we prepare to 'recover', we must all take some time to process our experiences, the impact that they have had on us and hope that we don't need to do it again.

Foto: Y. Hansenne, Belgium

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Italy 

Michela Di Furia, Bambino Gesù Children's Hospital, Palidoro, Italy

It's been a year now, since that terrible moment when we realized that the world would have changed shortly after.
My memory goes back to January 2020, when on T.V. we heard the terrible news: China was struck by great numbers of deaths caused by an unknown, powerful virus, causing fever, pneumonia and even death only after a few hours from the first symptoms.
I listened absently. I had quite a lot of theoretical preparation, guidelines and protocols for upcoming pandemics, such as SARS, Ebola, Avian, which luckily we had never had to implement in Italy.
Then the worst day came: On February 21st in Ro' in the province of Ferrara, the first Covid-19 victim. From that moment on, the news became increasing shocking, deaths increased in just a few hours and the death-toll became more and more dramatic. Intensive care units were swamped with work as plenty of people complaining of breathing difficulties were admitted every day.

Our rush to save lives had only just begun. Covid-19 caught us emotionally unprepared. All health workers in Lombardy worked desperately hard and sometimes they were powerless against this overwhelming number of deaths.
There were images of nurses kneeling down, exhausted by the endless hours of work.
I remember moments of great fear. At that time I was the nurse manager of the emergency room and intensive care. I couldn't sleep at night for the anxiousness of being on the front line.
It was a race against time: The Civil Protection Department set up a medical tent to admit children to hospital and the A&E department had to be redesigned. The intensive care unit had to be transformed into a COVID unit. And then there were the training courses to learn the dressing and undressing procedures and how to use personal protective equipment and all the medical devices, which until then, were just kept in storage. Every day we prepared ourselves and reviewed what to do and how to do it.

On March 20th 2020, our first patient with a suspected COVID-19 infection was admitted.
The girl was called Luna, she had a high temperature and breathing difficulties. She arrived at the emergency room. I could feel terror and fear entering her bones and invading her entire body. She paralyzed us. We started managing the patient in a way that today we deal with confidently and safely, but in those days was frustrating and scary. We admitted Luna to the isolation room and through the thick glass we communicated and could the see the fear in her eyes.

From then on, many cases presented and over time our terror turned into courage. We had to fight and be resilient, otherwise fear would have killed us. We supported and encouraged each other. We cried under the endless showers before going back home, our faces scratched and bruised by those tight masks. If we wanted to win the battle against an enemy that wanted us helpless and confused we had to be strong and, above all, clear minded.

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We have to care for our children at any cost. They are our strength. Seeing them fight and hope is our lifeblood.
At the beginning they were isolated in these terrible rooms, alone, with a doctor and a nurse whose faces were hidden behind steamed-up glasses, in coveralls and gloves. We tried our very best to reassure them and their parents. They cried and prayed.

My memory goes to Daniel's mother, to her despair. I went out to give her some information and sent her home to rest. She asked me how her son was, and I told her that he was resting. He was critical. She fell at my feet, squeezed my legs and begged me not to let her son die. I got a lump in my throat, I felt as if a hand was squeezing my neck. She left me breathless. We hugged each other against every social distancing rule. I hugged her, deep down I hugged myself. A long, endless hug.

The world has changed. They called us heroes, they told us we were just doing our job.

I think nursing itself makes us proud every day and makes us aware of our role.

Then we had a good idea: The Mobile Phone. Until now it has been the most powerful means of communication for parents and children to reunify. All the negative, fearful moods vanished. Some children, like Samuele gave us a call after discharge just to say Hello. Winning such a difficult battle creates strong bonds with people.

And then there were our homes. Months and months of isolation. Away from everyone. My nephew Francesco, my greatest joy, was born on February 20. Lockdown began on March 9. I couldn't see anyone anymore. My old parents and my very young nephew to cuddle. Friends. Everything changed. Strict and clear social distancing rules. No more hugs and kisses, but only masks. We used to feel invincible, instead a virus has shown us how weak we are. Endless queues for everything. No more long walks, the despair of those who lost their jobs.

The world has changed.
They called us heroes, they told us we were just doing our job.
I think nursing itself makes us proud every day and makes us aware of our role.
Nurses are not heroes as they recently called us, they have always been the same so far: very competent, trained, responsible professionals with a very high sense of duty.
Nurses' cultural background consists of: "knowing", professional knowledge, "Knowing how to do" nursing techniques, and in "knowing how to be" referring to relationship and communication skills.

Finally, last December the first vaccine against COVID-19 arrived in Italy and we started hoping again.

Dear COVID-19, you have taught us a lot and your lessons will be hard to forget: You have turned the world and our lives upside down, but we know that soon we'll say farewell and never meet again.

Dedicated to my warriors: Nurses, doctors, heroic children and their great families.

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Brazil 

Jeniffer Lorenzi, Cíntia Riograndense, Kelly Sauer Carvalho, Hospital Moinhos de Vento, Porto Alegre, Brazil

Certainly, the year that has passed and the one that has already arrived has brought us countless situations that unfortunately have become commonplace and sad. Among the many possible stories to share, the most sad and touching are those that end up marking us. It is one of those that I will share.
She was a 'syndromic' patient, with associated co-morbidities, an only child, a baby that was desired and idealized by her parents. The father was a physician and the mother was heading towards the conclusion of her undergraduate nursing program; which did not differentiate them from other parents, but certainly made us put ourselves in their place at all times, since they were not lay people and helpful toward all possible outcomes.
With the arrival of the pandemic, we had changes in the flow and presence of visitors and family members in the hospital.

Supported by Article 12 of Law 8,069 of the Statute of Children and Adolescents (in Brazil), pediatric patients are entitled to accompaniment at all times. What was different in our PICU before the chaos, was, in some specific moments, both fathers and mothers were restricted inside a closed space. The work was difficult in the beginning, and even today this difficulty is still perpetuated in explaining, or rather, making it understood that after some time, only one accompanying person/parent was permitted, and that child-parent exchanges must be made from the outside. Unfortunately, parents could no longer share the pain of bad news, the joy of the evolution of their child's condition, impotence in the face of situations that are beyond the control of love and knowledge and are at the mercy of science.
The weight of this experience was even heavier, considering that one of the weight-bearing pillars is faraway, even if separated by only a few meters or even just by the cold wood of the door.
Being a mother and warmly empathetic in any situation within my workplace, it is impossible not to have tears welling up and my eyes watering on a sad day. With news of palliative care, this mother says to me: "It has been very difficult, you know, nurse? It hurts a lot in here to receive this news and not have the support of my husband to help give me courage, to strengthen each other to help each other face things in a somewhat calmer way.

At that moment, I realized that I could talk to the team, so that we could draw up an action plan so that there would be in another environment, or in some online way, to maintain communication with these parents. I could feel the anguish in that mother's heart, as if at that moment I was a helpless person, and that I could not intervene at a time when there would be no possibility of exception to the rule. After the episode, and realizing that a crucial moment in the life of the parents and in ours to communicate bad news, could be mitigated with an act of empathy, humanization and dignity, I managed, with concession with the SCIH and consensus within the multidisciplinary team, to establish a place to gather this couple (and other couples), and the physicians, and other professionals, in an ante-room that was previously used as a play space for young children. Now the same room that made our children smile and warmed the hearts of our children, had become the room, which is perhaps not warm, but it is certainly less cold than receiving bad news, with no other heart to approach and listen to as soon as possible. Signaling that we are never alone.

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United Kingdom

The importance of compassionate leadership during a pandemic

Dr Julie Menzies, Birmingham Women's and Children's NHS Foundation Trust, Birmingham, UK

As health care professionals we have all felt the call to arms and the imperative to unite with colleagues in meeting the COVID tsunami. However, many staff have had to shield or experienced dilemmas about working because of their own health or that of significant others. In addition many have experienced challenges in their personal life; either related to COVID-19 or completely unrelated, which have impacted their ability to work. What is it like for those who cannot respond to the call and how do we support them?

During the first UK COVID-19 wave in March 2020 the focus was on clinical care delivery with staff redeployed to face the anticipated COVID tsunami. In England paediatric critical care provision was reviewed, seven units were repurposed as adult ICUs and a number of PICUs increased bed capacity to maintain national PICU provision (Sinha et al 2021). As a Nurse Researcher on a unit that remained a dedicated PICU I suspended all my research activities and undertook refresher sessions to support my return as a (slightly rusty) bed-side PICU nurse.

Despite all the challenges I felt professionally satisfied that I was making a meaningful contribution to the COVID-19 effort, initially through clinical work, and then from May in facilitating COVID-19 research set up and delivery. I was even able to publish an article to promote the value of research nurses during a pandemic and the place of nursing research; two topics I'm passionate about (Menzies et al 2020).

By the summer however I was in a challenging place at home. My 8 year old child suffered an extreme deterioration in his behaviour and emotional regulation and by September he was starting to experience difficulties in the school environment too. My husband and I were desperate to understand why this was happening, to navigate a range of services we had no prior knowledge or experience of and to find the right ways to support him.

I was fortunate that working from home and working flexibly outside of usual office hours, was possible within my role. This enabled me to be physically present and to deal with the challenging situation at home. However as the second wave came in January 2021 and my employing hospital started deploying staff to work in adult ICUs in completely separate hospitals, we were all asked to consider how best we could support front-line PICU and adult ICU provision.

I have over 20 years' experience in PICU, so I know how it feels when a unit is short-staffed and the frustration and distress when we cannot provide the standard of care we aspire to. I felt a huge professional moral responsibility to return to the clinical front line to show collegiality and support colleagues, and experienced crushing guilt when I realised this was not possible; I couldn't do it. Our whole family was burnt-out, stressed and emotionally drained.

I knew that I did not have the mental capacity to work in a new environment of adult

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notice if things were hard at home. I also felt the uncertainty over how long I needed 'special consideration' for. I couldn't say give me **X** amount of time and my domestic situation will be resolved and I'll be back fully flexible and ready to re-redeploy as needed.

COVID was impacting on all children's community and mental health services and waiting lists were increasing exponentially. Agencies kept telling me how pivotal it was that I was calm and regulated to be able to help and support my children; extremely challenging with the loss of social networks, family support and childcare and school closures. I started to have doubts about whether I was going to be able to continue working at all, whether I might have to go off sick or leave my job altogether which I found very distressing.

I had taken some time off when things first deteriorated at home to navigate services and focus on stabilising things at home, but found that this was not that helpful for my own mental health. I missed work, missed having a professional identity as well as that of 'mum' and having a break from thinking about the challenges at home. It felt like I was asking for special treatment; *I'm experiencing a difficult time, I want to work but I can't do the roles that you really need covering…*

Reflecting on this now I can see that this is a situation many of us will sadly experience. Factors outside of our control are likely to affect our ability to work at one time or another. Personal ill-health or injury, the ill health of others, carer responsibilities, bereavements; these events will happen and they will impact on our ability to work for varying amounts of time. We will all need some special consideration at some times of our life and it can feel very difficult to ask for it, particularly when this occurs during something as monumental as a pandemic.

Compassionate leadership means sustaining the principles of empathising and helping, even at times of high pressure and high demand

However supporting staff in this way can be pivotal in retaining them within the organisation and even the profession. West & Chowla (2018) identify there are four key elements of compassionate leadership: attending, understanding, empathising, and helping. Leaders who incorporate these elements into their management demonstrate that supporting and enabling staff is a worthwhile endeavour for the organisation. I was lucky enough to be on the receiving end of this type of leadership. I was supported to work from home, signposted to services; but without feeling that it was prescriptive, regular check-ins were offered in ways and times that worked for me, paperwork was completed without drama and things that impeded my ability to work at home, such as my NHS laptop not connecting to a home printer were addressed speedily. Most importantly, despite the pressure services were facing, this pressure was not transferred to me, so nothing added to my guilt or moral distress.

The result is that I was able to stay working throughout the second wave of COVID-19. Not in a front line role, but in a way that was constructive and enabled other staff to be released to support adult ICU. Sadly things at home continue to be difficult, but being on the receiving end of compassionate leadership means I continue to work and to enjoy the sense of purpose this gives me.

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This in turn gives me energy to be my best self at home. I asked my (amazing) manager how she was able to make space to support me, whilst dealing with an overwhelming workload.

Her response was that she believed that her team were the most important component of care provision and every member of staff was worthy of her time and energy.

Demand related to COVID-19 would eventually pass and usual services would resume again and we needed to sustain our workforce to get through this challenge. The message I heard was that I was a valued member of staff and that my wellbeing, and that of my family, were important and that they wanted to support me as best they could. This was a really powerful message for me.

Compassionate leadership means sustaining the principles of empathising and helping, even at times of high pressure and high demand. In fact demonstrating these skills at these times is probably even more important to a stressed workforce.

COVID-19 has placed huge strain on our nursing workforce and we need to ensure staff wellbeing continues to be a priority as we recover from this challenging time.

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Foto: Y. Hansenne, Belgium

NURSES EXPERIENCES WITH COVID-19: NARRATIVES FROM THE PICU

Brazil

Children isolated from their families in the PICU: from anguish to a glimpse of new possibilities

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Ana Marcia Chiaradia Mendes-Castillo, School of Nursing, University of Campinas, UNICAMP, São Paulo, Brazil

The COVID-19 pandemic has changed work processes in our PICU. The isolation of new cases, isolation, restrictions for visitors and family´s presence, besides several other measures, which were applied in order to reduce the spread of the virus and ensure the safety of patients, families and healthcare team. Being a nurse in the midst of uncertainties and fear of the pandemic was one the biggest professional challenges we have ever experienced and it certainly brought us transformations and reinterpretations about care, as well as pediatric patients along with their families that will not be forgotten.
This brief narrative aims to describe two situations that we have learned a lot from, and how they have changed our practice and us.

Our Pediatric Intensive Care Unit (PICU) is located in a large university hospital in Brazil. It is composed of 20 beds, 18 of them in a common room observed by a nursing station, and two isolated beds. Due to the pandemic, the suspected or confirmed cases of COVID-19 had to be allocated to one of the two isolated rooms, without room sharing. The unit where the daily presence of parents was valued with a collective room for families to rest at night started allowing only one parent to stay during the day. The family room was temporarily disabled.

In one occasion, as soon as COVID-19 cases started to increase in Brazil, in mid-April 2020, there was a period that the PICU was closed to all family members and friends, because of the high number of suspected cases simultaneously hospitalized in the unit. When the number of isolated children exceeded the two isolated beds the children had to be placed in the common room, next to each other, consequently all family members were no longer allowed, including those whose children were hospitalized for other causes.

At the time, COVID-19 tests that were available used to take about 14 days to get the results. Besides that, about six suspected children and another ten children hospitalized for other reasons were isolated from their families for two weeks. The health care team kept in contact with the children’s parents by phone, however the families didn’t have access to direct, or indirect, communication with their child.

The high level of tension and uncertainty hovering in the PICU in these two weeks was evident. Apprehensive professionals and agitated children without their parents resulted a strenuous work environment. The effort to search alternatives to decrease this anguish was, frequently, interrupted by the urgency in establishing new protocols, norms and routines related to the work. The families, extremely anxious and worried, used to call several times a day for news, hoping to be finally able to be with their children.

Children isolated from their families in the PICU: from anguish to a glimpse of new possibilities

After 14 days, the happiness of receiving all negative test results and having the opportunity to call the families to tell them the news was thrilling. As we work from a perspective of child and family centered care, the impossibility of having their presence participating in the child's hospitalization was difficult and especially challenging. We won't forget each family reaction when I (Erika) called to tell them the good news - that they could be at the hospital again.
Families are used to receiving calls from hospitals only when it comes to bad news, so their reactions were indescribable. They went from apprehension to tears of happiness, not only for the relief of getting negative results for the disease, but also, and mainly, for the happiness of having the permission to be with the their child again in the PICU after so many days of anguish.

To see children again with their parents made even the most suspicious professionals, still resistant to recognizing the family as part of the care, realize the relevance and meaning of that moment.

As thrilling as it was to tell them the good news, it was also a welcoming of them again. As the families arrived, the sweetness and tenderness of the reunion took over the PICU; bringing back the hope that once threatened to leave us with the suffocating and overwhelming statistics. To see children again with their parents made even the most suspicious professionals, still resistant to recognizing the family as part of the care, realize the relevance and meaning of that moment. Our forces were renewed, without even knowing how much we would still need them, to face a hard battle that was just beginning.
In a second situation, a five years old boy with Down Syndrome was hospitalized as a COVID-19 suspected case, because of respiratory distress. Following the protocol, he was hospitalized in an isolated room and his mother´s presence was not allowed. This family came to the hospital from another city during the night and the mother was unable to go back home, so she was accommodated to spend the night in a meeting room.
We realized early in the hospitalization that the child had altered cognitive development and was highly dependent of his mother to perform basic activities, especially for eating and communicating. The mother's absence worsened his respiratory state due to agitation and aggressiveness, making it difficult to provide good care.

When we took care of the child and evaluated his family structure, we identified that there was a situation of social vulnerability. The mother and son lived in a shelter for people who were victims of domestic violence. After informing the shelter about the situation, the mother was informed that, due to her son's suspected COVID-19 infection, she would not be able to return until getting the test results. When investigating the family social support network, we found a general lack of support resources.

Situations like this do not make us indifferent. It was difficult to see a mother with nowhere to go, and her son getting worse while isolated. Believing in nursing care as being, primarily, at the service of the child and family, implies, in exceptional situations, defying protocols, questioning routines, and promoting discussion between the team and managers, to ensure what we believe as integral care.

Children isolated from their families in the PICU: from anguish to a glimpse of new possibilities

We promoted an internal mobilization to get the authorization from all who were responsible, so the mother could be with her child in the isolation room. We did it, and the child's improvement was rapid and encouraging.

Undoubtedly, the isolation imposed by COVID-19 reinforced something that we have known for a long time: the damage caused for a child who is hospitalized without the presence of the family can be worse than the disease.

Driven by experiences such as those described here and by the desire to change this situation, minimizing suffering by bringing families closer to children in the moment of inevitable isolation, we reflected and searched for intervention alternatives. Reading reports in the media and scientific literature about the use of technology to facilitate communication between families and patients created the desire to develop a pilot project to bring family, child, and team as well, closer through a tablet with Internet access. Managers approved the project and we got a tablet to make this intervention in our PICU in September 2020.

Since then, families that need to be separated from their children in our PICU, either due to isolation because of COVID-19 or other reasons, have the possibility of using this tool to maintain communication with their child. Being consistent with the principles of family-centered care, we make the family feel free to use technology the way it believes is the best for them. Some families ask for daily photos, others prefer to interact with children through video calls. Other families want to see their child sleeping. We have observed, even in an initial and empirical manner, that families greatly enjoy this possibility; they express gratitude for the alternative of using this resource to maintain communication and contact with their child - , even if it is indirect.

The COVID-19 pandemic has imposed significant changes in all areas of our society. It is unacceptable for us nurses to remain the same while facing everything we have been experiencing daily. The challenges imposed on daily life at the bedside of critical care can bring us down, or motivate us to find strategies to overcome them. We choose the second option; to be resilient in our practice, care and way of seeing the new world that is right in front of us.

We are not heroes—The flipside of the hero narrative amidst the COVID19-pandemic: A Danish hospital ethnography

The aim of this paper was to explore how the media and socially established hero narrative, affected the nursing staff who worked in the frontline during the first round of the COVID19-pandemic.
This paper presents an analysis and discussion of the consequences of being proclaimed a hero. Link to article

NURSES EXPERIENCES WITH COVID-19: NARRATIVES FROM THE PICU

United Kingdom

Working in an Adult ICU as a PICU Nurse

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I, like most, had seen the news and heard the stories about the mounting pressures adult services were experiencing through this '3rd wave' of the COVID19 pandemic. Although I was relieved that the PICU world had been spared of the relentlessness of this awful disease, myself and my colleagues frequently discussed the feelings of 'moral distress' that we hadn't been doing 'our bit' on the 'frontline' battle against COVID.

January 1st 2021: Message sent to PICU Staff: 'Is anyone able to help and support ITU @ XXX for any hours please?'

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I am a Senior Sister in a 31 bedded general PICU, one of the largest PICUs in the UK. I regularly have the responsibility for the coordination of admissions and discharges, bed management and staff allocation. Whilst I've had 'tight' shifts in terms of staffing, this message made me sit up and take notice. We frequently move staff from department to department to maintain patient safety and quality, but as a standalone PICU we never asked staff to come from an adult hospital across the city; this must be really serious.

I was really nervous, worried that I was out of my depth, - going to a huge adult hospital that I've never even been inside of, let alone worked in. I hadn't done any adult care since 2004 as a care assistant during my student years, and I've offered to go to an adult ICU that was overcapacity in a pandemic; I just had to hope I could help, and not hinder.

I needn't have been nervous. The coordination team were kind and welcoming, and helped me donn, I felt safe. The department was full, and busy but calm. Rows of proned patients, some my age, some my parents age, some a patient for weeks, others days, all on this COVID 'battle'.

It quickly became apparent that there were many similarities between PICU and ICU - same drugs, tubes, and observations to document - just more of them and definitely bigger sizes. Whereas the clinical skills definitely had many comparisons, the next task of personal care was a little out of my usual 'skill set' to say the least. I was handed a bowl and towels - *'Do you mind giving this patient a shave please'* .

Once I had established that the patient was well enough sedated to tolerate my unpractised hand and that he wasn't either heparinised or so coagulopathic that my first ever attempt at a shave would do more harm than good; I got to it, and made a decent job of it even if I do say so myself!

The rest of the shift was steady and calm, assisting with turns and cares and the occasional infusion. I asked staff how ICU had been in the previous months. The nurse I worked with explained how the 2 bedded bay we were working in was double capacity last April.

Nurses Experiences with COVID19 - Working in an Adult ICU

She described how hard not only the practicalities of providing care in a restricted space was, but her worry about the lack of dignity for the patients being cared for so closely together, and the moral distress and pressure it had put on herself and her colleagues when those patients moved to end of life comfort care and having a deceased patient so close to one in the next bed. She hoped things would not get 'as bad again'.

Sadly this was not the case and within days the Hospital where I'm employed offered a 'mutual aid' response to 3 adult hospitals across the city. Many of my colleagues offered their full contracted hours. Others, including myself, agreed to work a portion of hours within adult ICU for 3 months.

Each week I worked a shift in ICU, delivering direct care for COVID positive patients. Throughout January, each week I could see patient numbers increasing, 3 patients in a bed-space made for 2, then 4 patients with staffing ratios of 1:3, 1:4; just as the nurse on New Year's day had feared.

I overheard the conversations from the nurses coordinating staffing and allocation, as I do frequently for my department *'30 staff short tonight …I just can't cohort any more of these patients together, they are just too sick for one person, I just don't know what else to do'*. I've had similar conversations to maintain my own department and experienced huge guilt that despite my best efforts I'm leaving the next shift short-staffed.

I am the one going home and not having to deal with the shift that is '1 or 2 nurses short' you're leaving behind; it's a stomach swirling mixture of relief and guilt. Relief it's not your shift, and the guilt at feeling relieved. These feelings just don't go away easily; COVID ICU staff have been dealing with this now for a year and with staff shortages that were previously unimaginable.

The emotional drain on these teams is massive, and yet they were all so kind, supportive and welcoming to all of us from paediatric services that had come to help. That will never leave me. The patience and smiling eyes peeping through PPE and the genuine conversations of '*We are so glad you're here, the PICU team have been amazing'* and *'You're really brave to come here, it's an awful place to be'.*

I wasn't brave, I was terrified! I just wanted to do the 'right thing' and I do think that as a nurse the innate feeling of wanting to always help, will drive us to do just that. I've learned a lot from my cross site experiences which I will take forward in my practice.

The importance of staying calm even in the face of overwhelming capacity issues, to value the braveness, ingenuity and adaptability of our nurses and most of all the importance of kindness. Every situation can be made more tolerable by kindness to colleagues, patients and families, the teams we work with and I will strive to model this in my leadership.

Events and Announcements

Join the Xperience of the 31st Annual Meeting of the European Society of Paediatric and Neonatal Intensive Care (ESPNIC 2021) ESPNIC 2021 Xperience will bridge the physical distance between us and bring the most cutting-edge knowledge from all parts of the world.

XXXV National Congress of the Spanish Society of Pediatric Intensive Care SECIP - More information on the event website.

European Society of Paediatric and Neonatal Intensive Care (ESPNIC) New Online Courses
Read more on the course **registration website**

Instructions for Authors

Pediatric Intensive Care Nursing is an international journal which promotes excellence in clinical practice, research, education and management, and provides a forum for the exchange of knowledge and ideas. The editors welcome articles on any topic of interest to pediatric or neonatal intensive and critical care nurses.

Manuscripts submitted to *Pediatric Intensive Care Nursing* must not have been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), and must not be concurrently under consideration by any other journal. Once accepted for publication, manuscripts become copyright to *Pediatric Intensive Care Nursing* and may not be reproduced without permission from the editors.

Format

Manuscripts must be written in English; either American or British spelling may be used but must be consistent throughout. Manuscripts should be typed double-spaced, using Arial or Times New Roman font in at least 11-point, with margins of at least 2 cm or 1 inch. Number pages consecutively beginning with the title page. The preferred length for research, clinical and review papers is 1000-2500 words, excluding references. Submissions to Spotlight on PICU should not exceed 1500 words. The sections of the manuscript should be in the following order.

Title page

- Title should be concise and informative, and typed in bold capitals.
- Names (first name, initial(s) and family names) of authors in the order in which they are to appear.
- Include a maximum of 4 qualifications for each author
- Institutional affiliation(s) of each author
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Abstract

An abstract not exceeding 250 words is required for all submissions except those for Spotlight on PICU. For research studies, the abstract should be structured under the following headings: Background, Methodology, Results (or Findings), Conclusions.

Body of text

Use headings to structure the paper. The type of paper will determine the headings, e.g. for research papers the main headings will be Introduction, Background, Methodology/Methods, Results/Findings, Discussion, Conclusion. Up to 2 levels of headings may be used. Papers reporting research conducted in humans or animals should include a statement that the study was approved by the relevant body or bodies.

References

The list of references should only include works that are cited in the text and that have been published or accepted for publication. References such as “personal communications” or “unpublished data” cannot be included in the reference list, but can be mentioned in the text in parentheses.

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