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NURSES EXPERIENCES WITH COVID-19: NARRATIVES FROM THE PICU

Editorial

Franco A. Carnevale, RN, PhD
Editor, Pediatric Intensive Care Nursing
Montreal, Canada

This is our third annual issue of PICN that has focused on the COVID-19 pandemic which has persisted in many forms throughout the world. Two years ago (Dec 2019 PICN issue, posted in March 2020), we tried to capture PICU nurses' initial experiences during the first wave of the pandemic. Last year (Dec 2020 PICN issue, posted in April 2021), we delved deeper into the experiences of individual nurses by recruiting six extraordinary personal narratives submitted by PICU nursing colleagues in Brazil, Italy and the United Kingdom.

This year, given the continued and cumulative impacts of this pandemic, we decided to continue with personal narratives, asking authors to also reflect on their reflections and lessons learned throughout this pandemic - on what has helped them manage the many challenges that they have encountered.

Despite the extreme busyness and fatigue that PICU nurses have been dealing with, we are proud to publish 11 narratives that have been submitted from 6 different countries (within 5 continents); i.e., from Brazil, Israel, Namibia, Portugal, Singapore, and the United States.

Note #1: *Although this issue of Pediatric Intensive Care Nursing (PICN) is dated December 2021, we delayed publication to better capture the unfolding experiences related to the COVID-19 pandemic. This issue of PICN was actually published in March 2022.*

Note #2: *At the time of this publication, the world's attention has been also captured by the disturbing events taking place within the Russian invasion of Ukraine. As an international PICU community, we are understandably concerned and distressed by the more than 1 million children that have been displaced by this time and the many children who have been critically injured or have become ill within this tragic situation (see: Children's health caught up in Ukraine conflict, by S. Ahsan, The Lancet, 2022, 399(10329), Pages e14-e14)*
We are also deeply concerned about our PICU colleagues who are struggling to attend to these needs under unthinkable conditions. Our thoughts are also with all the people of Ukraine. Moreover, this tragedy has highlighted the importance of remembering the many other populations in the world, including children, whose lives have been immensely overturned by political and military actions in recent years. We hope to devote an upcoming issue of PICN to the pediatric critical care nursing implications of political and military actions.

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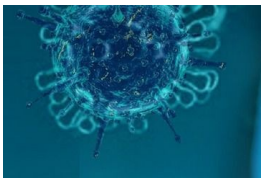
NURSES EXPERIENCES WITH COVID-19: NARRATIVES FROM THE PICU

Editorial

These narratives highlight numerous immense challenges confronted by PICU nurses around the world, including: working while immensely short staffed and fatigued; caring for isolated children when their family members cannot be present; working with more highly distressed parents; working with PPEs; caring for critically ill adults, including pregnant women; dealing with the constant stress of infecting your family – sometimes feeling stigmatized within your personal social circles; dealing with being redeployed to other unfamiliar clinical settings; dealing with negative public reactions to pandemic measures; and, feeling like your own health and safety are constantly jeopardized.

These narratives also highlight the tremendously inspiring and frequently courageous actions mobilized by PICU nurses who have repeatedly tried to make these very difficult conditions better or at least less bad, including: rallying to optimize isolated children's contacts with their families through digital media, visits through glass barriers and occasional "breaking the rules"; giving up your own vacation time so your peers can travel to see their own families; and all out "stepping up" to do all the hard things listed above because they have the required precious expertise and because their communities relied on them.

In reading these narratives, we are all reminded of the extraordinary depth of expertise and personal passion and generosity that PICU nurses contribute to their local communities and our global populations. That said, PICU nurses are humans who are suffering as well, whom we need to care for. Let's read their stories and turn to each other see how we can continue to help each other, while also using these stories to turn to others (interprofessional colleagues, administrators, policymakers, etc.) to ensure that they understand the experiences and needs of PICU nurses who have to be better supported to continue to do what we all need them to do!



NOTES

· If you are interested in rereading our previous PICN issues, published during earlier phases of the COVID-19 pandemic, please click here

· For an analysis of child/youth COVID-19 impacts experienced by children and youth more roadly, not solely within the PICU, from a global perspective, see my team's work: 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) go to link

Nurses' experiences with COVID-19: A view from Portugal

Rui Bacelos Silva, PICU/NICU Nurse Lisbon, Portugal

Over these almost two years in which we have lived daily with this pandemic, many challenges and changes have already been experienced. At the beginning, with the uncertainty and fear of what could come and happen with this pandemic, later an adaptation to a new reality and, currently, with the expectation, often frustrated, that the day will come when we will be able to return to our old "normal". This applied and still applies on a personal level but also on a professional level.

Fear and uncertainty quickly gave way to anxiety and stress levels that became difficult to manage. The adaptation of the structure of the services and the dynamics of the professionals had to be quickly changed, and so it continues to this day, with constant changes in the rules and guidelines on our daily practice.

There is a state of fatigue and almost burnout in many of the professionals who provide daily care at the hospital level. It was no different in the PICU context; although this virus does not affect the pediatric population as severely or as frequently, there have been some changes on the work dynamics and communication between the different teams (staff allocation and breaks distribution, shift patterns, management of personnel expectations, new protocols in place).

One of the main consequences that this pandemic brought to PICU was the limitation of visits and accompaniments by parents/caregivers to their children. With the restrictions and constraints placed and imposed to contain the spread of Covid-19, parents were prevented from being present as they would like in a process as complex and stressful as an ICU admission.

Being able to efficiently organise the team members, keeping them motivated to do their best with an increasing demand, is one of the main challenges that I have experienced.

Parents were also subjected to higher-than-normal levels of stress because both could not be with their child, patients felt more helpless and anxious because they did not feel that their safe harbor was there for them. For instance, this has greatly impaired family-centered care, compromising the success of breastfeeding, skin to skin care and sensorial stimulation at the NICU environment.

Thus, humanised care, collaboration in care and family-centered care, which are central to nursing care, were somehow neglected. This had and will have consequences in the future for the actors in the care process, which are still difficult to assess. Another consequence was the need for an adaptation on providing care with full PPE's on, which created a challenge and difficulty to perform some high-skilled techniques.

It should be noted that, fortunately, throughout this time of pandemic that we have been experiencing, in our Unit few children appeared with serious illness due to SARS-CoV-2, whether in the context of an acute illness or in the context of the PIMS syndrome.

However, due to the need for physical restructuring of the different aspects of the Unit, as well as the redefinition of the circuits of children in the different services of the pediatric department, our care had to be constantly put to the test due to a frequent need of adaptation.

Nurses' experiences with COVID-19: A view from Portugal

Rui Bacelos Silva

This caused high levels of frustration and fatigue among professionals, which was transmitted and passed on to the children's and their caregivers. With the constant news and alarms that sound with the overload of health services, they suddenly find themselves placed in the middle of a hospital environment, even more frightening than usual.

I, as head of one of the nursing teams of PICU and NICU, felt that it was and continues to be highly challenging to adapt my actions and decisions to the frequent changes in rules and structural organisation. Caregivers who are frustrated and unhappy for not being able to take an active part in the hospitalisation process as they would like is something that I must also have to deal with.

Furthermore, being able to efficiently organise the team members, despite all the absences that have been caused by illness or prophylactic isolation, keeping them motivated to do their best with an increasing demand, is one of the main challenges that I have experienced.

All these events placed the health caregivers in a more visible position to the public and came to give us all an insight regarding the need for more staff to improve quality.

Despite all these challenges and difficulties over the last couple of years, we can learn and integrate some ideas and practices with what we have learned from all this. Firstly, it gave us a better awareness of the importance of the use of appropriate protective devices when making contact with patients, highlighting the importance of correct handwashing by health caregivers and family caregivers.

All these events placed the health caregivers in a more visible position to the public and came to give us all an insight regarding the need of more staff to improve quality of care. And finally, it gave us an understanding of the impact/consequences of the restrictions of visiting/attendance of caregivers during hospitalisation, learning new ways to engage and to promote caregivers' involvement in care, such as video calls, pictures sent through cell phone devices or diaries.

Many deprivations and challenges have been placed on us throughout this pandemic. This event had and will have such an impact on the entire population that we can hardly get a clear idea of its magnitude. Our nursing care for the critically ill child and their caregivers continued to be provided in a professional manner, meeting their varied and different needs.

Despite all the difficulties and paradigm changes that these last few years have brought us, we will continue our work, our mission, with the same commitment and dedication.

COVID-19 Care in the PICU – from Pandemic to the New Normal

USA

Shannon Boyle, Pediatric Intensive Care Unit, Children's Hospital of Philadelphia

Our PICU's journey of preparedness for providing pediatric critical care during the COVID-19 pandemic began in 2014, six years before the actual COVID-19 pandemic emerged. In 2014, during the outbreak of Ebola Virus Disease in West Africa, our hospital anticipated the need to possibly provide care for a child with Ebola and worked to create a specialized, contained isolation unit within the PICU.

We spent countless hours training nurses, physicians, and respiratory therapists who volunteered to care for this unique patient population. From then on, we maintained a constant state of Bioresponse readiness which included online education, in person training, simulations, and functional exercises. All this work proved to be essential in our preparedness for the COVID-19 pandemic.

As COVID-19 spread across the globe we were able to seamlessly ramp up and prepare for the arrival of COVID-19 at our hospital. Despite the many unknowns related to this new virus, our trained team of Bioresponse staff felt prepared and ready to face this challenge.

"Not Normal" – spring/summer 2020

In March 2020, during the early days of the pandemic, and with so many unknowns, the care of a patient with COVID-19 was very far from normal. We activated our contained isolation unit in which we could care for one to three patients. This was an enclosed space within our PICU that required badge access to enter and exit. Along with the arrival of COVID-19 came the decline of other hospital operations. Fewer patients were coming in for appointments, surgeries, and tests. This allowed us to reassign some staff from other areas of the hospital to assist with COVID-19 operations.

Communication was our biggest challenge while wearing PAPRs

We utilized staff from Infection Prevention & Control and Environmental Health & Safety as resources within the isolation unit to ensure the unit environment was safe for both patients and staff. They also ensured that staff donned and doffed their PPE correctly, and that equipment and supplies were decontaminated and stored properly. For PPE staff wore powered air purifying respirators (PAPRs) that covered their entire head.

We limited the number of staff who entered the patient rooms to conserve PPE due to early concerns about supplies being quickly depleted. We also wanted to limit any unnecessary potential staff exposures, so only those essential to the bedside care of the patient were allowed in the room.

Communication was our biggest challenge while wearing PAPRs. Face to face communication was difficult because of the noise from the fan blowing air through the PAPR hood. Use of any type of phone was impossible. Instead, we used Skype on iPads for staff to communicate from within the room to staff outside the room. This facilitated quick communication and it helped the staff feel less isolated while in the patient's room for extended periods of time. Simple dry erase boards were useful for making lists and writing down quick questions.

COVID-19 Care in the PICU – from Pandemic to the New Normal

Shannon Boyle

Often it was a list of supplies needed in the room, or a list that prioritized the care that needed to be done, or sometimes even a simple smiley face to say you're doing a great job and I'm here if you need help!

Physical assessment was another significant challenge. When wearing a PAPR staff were unable to use a traditional stethoscope. Instead, we used a wireless Bluetooth stethoscope connected to an amplifier that projected the sounds from the stethoscope throughout the room.

Visualization into the patient's room was sometimes difficult related to window location or equipment position in the room. Some rooms were equipped with a web cam that allowed staff outside the room an up-close view of the patient from a computer screen. This was helpful for consulting services and attending physicians who were supervising

The nurses who spent their twelve-hour shift behind the walls of the isolation unit demonstrated true teamwork and leadership.

Fellows because we were limiting the number of staff members who entered the patient's room both to prevent potential exposures as well as to help conserve PPE. Nurses used this web cam to view IV pumps and ventilators. The zoom feature was precise enough to allow us to see the patient's ID band. This web cam provided video only, no audio, so we still relied on our iPads with Skype for communicating.

***"More normal"* – fall/winter 2020**

After six months of caring for COVID-19 patients it was clear that the pandemic was not going to end anytime soon. And at the same time hospital operations were beginning to return to more normal, pre-pandemic ways. The heavy use of resources dedicated to the COVID isolation unit could not be sustained long term.

Also, the isolation unit staff were now much more knowledgeable, comfortable, and confident with COVID-19 procedures than they were 6 months prior at the beginning of the pandemic. We began utilizing our leadership nurses in the safety roles that were previously covered by Infection Prevention & Control and Environmental Health & Safety.

For PPE staff were more often wearing N95 masks with eye protection instead of PAPRs. This not only improved efficiency of communication and physical assessment, but this PPE was able to be donned and doffed independently by the staff member, unlike the PAPRs. With a healthy supply of PPE available to our staff we began introducing all roles back to the bedside of COVID-19 patients, this included consulting services, PT, OT, Child Life and Social Work.

At this point our contained isolation unit ran like a well-oiled machine. The nurses who spent their twelve-hour shift behind the walls of the isolation unit demonstrated true teamwork and leadership. They navigated new challenges seamlessly and worked to develop solutions independently. They became the experts in COVID-19 patient care.

COVID-19 Care in the PICU – from Pandemic to the New Normal

Shannon Boyle

They formed a unique bond when working with only 2-3 other nurses behind the closed doors of our isolation. They demonstrated the epitome of teamwork, innovation and flexing to meet the needs of the patient.

Despite all the challenges we faced when providing care to COVID-19 patients in a contained isolation unit while wearing extensive PPE and with limited staff present, our team was able to successfully care for even the most critically ill children, including those who required CPR and ECMO cannulation.

"*New Normal*" – spring/summer 2021

One year into the COVID-19 pandemic we began "normalizing" the care of these patients. We stopped co-horting them in a contained isolation unit and started caring for them within the general PICU population. We identified that the key components to the success of this transition was clear/consistent door signage, situational awareness for all staff on the unit, and ease of access to essential supplies.

Caring for COVID-19 patients in the PICU during the pandemic required our staff to work in ways they never had before.

New signage was created for the patient doors to indicate the special precautions needed while maintaining patient privacy related to HIPPA. These signs were quite large and colorful with the goal of ensuring staff paused before entering the room. We announced the rooms numbers of all COVID-19 patients during our multiple daily staff huddles.

And finally, we placed a supply cart outside of each room which contained all the essential PPE and communication supplies necessary for COVID-19 patient rooms: signage, N95s, goggles, white boards, iPads, and disinfecting wipes.

We created a COVID-19 lead RN resource role that was covered 24/7 by the same nurses who provided care to these patients in the contained isolation unit. They had become the true experts in providing safe care to this patient population. They rounded continuously on the COVID-19 patient rooms, ensuring all the correct procedures were in place: signage, PPE, environmental safety, etc.

Some of our PICU nurses had never cared for a patient with COVID-19, so these lead RNs were essential in educating and supporting the rest of the nurses on our unit. They also became a hospital resource as more COVID-19 patients were being seen areas throughout the hospital such as radiology and other inpatient units.

Caring for COVID-19 patients in the PICU during the pandemic required our staff to work in ways they never had before. They were thrown into the uncharted waters of caring for critically ill children during a pandemic. And just as they always do, our PICU nurses rose to the occasion and faced the challenge with both grit and grace.

Nurses' experiences with COVID-19: A view from Singapore

Pei-Fen Poh, KK Women's and Children's Hospital, Singapore

Singapore is a city-state, situated in Southeast Asia with a population of about 6 million, with two tertiary PICUs. One third of our nursing population are foreign trained nurses who have served the local population for many years. Due to the strict restrictions such as compulsory mask wearing, social distancing, group size and strict border control the pediatric population was less impacted by the initial COVID waves. However, as the country begin to loosen its restrictions, the unvaccinated pediatric population of less than 5 years of age contracted the COVID virus at an unprecedented rate.

Although our PICU did not receive the first pediatric COVID patient until recently, we had to adapt our care model to accommodate regular non-COVID, suspects and confirmed patients at the beginning of this pandemic. In order to allow the current PICU to function as a clean unit, we set up a satellite unit which was 2 levels up from our current location, at the admission of any suspected cases, two nurses will be deployed to nurse the child. We struggled in the beginning and at the same time were reminded of the importance of good teamwork and camaraderie, that we sometimes took for granted.

At the satellite unit, we depended on each other and other non-PICU trained staff nurses. The isolation ward nurses were very helpful and were already experts in the isolation protocols and test procedures. They were very keen to help, and at a very short time were alluded to many PICU procedures including setting up of the High Frequency Oscillator Ventilator and even ECMO cannulation.

Knowing that the pandemic is likely to go on, nurses from the isolation wards had cross-training at the main PICU to better prepare them for future ICU cases and to support the PICU trained nurses. The effort had indeed paid off, with nurses from both units feeling more at ease caring for patients in the satellite PICU.

While Singapore COVID cases continued to remain low, neighbouring countries were experiencing daily peaks. Among our PICU nurses, we have foreign nurses whose families were at home, fresh graduates who have yet to visit home since graduation, new mothers who had returned from their maternity leave. The strict travel restrictions and quarantine requirements made it impossible for foreign nurses to visit their family.

During such times, we had nurses whose parents, grandparents and relatives who succumbed to the COVID-19 virus and they felt so helpless as they could not grieve as a family. Despite these sorrows, they continued to show up at work to support our PICU patients. During meal breaks, you could hear mothers of young children sobbing at the corner as they chat with their children who could no longer recognise them.

Nurses' experiences with COVID-19: A view from Singapore

Pei-Fen Poh

During these very tough times, PICU nurses, regardless of nationalities lean onto each other for support

During these very tough times PICU nurses, regardless of nationalities lean onto each other for support. We participated in carer support activities and cried together as a team. Recognising the challenges faced by our foreign nurses, efforts were made to facilitate home visitations while ensuring service operations.

Local nurses gave up their annual leave slots so that our friends could travel home, serve quarantine and spend time with their families. To date, almost all our foreign nurses had visited their home country, they return feeling refreshed and ready to face the current wave of COVID infection that are affecting our pediatric population.

With the pandemic passing its two years mark, with no sign of ending, ICU nurses, as the final line of defence, have endured unparallel strenuous work situations and environment. Staff wellness should be made priority to safeguard this defence system, where the most critical patients could get the high-quality care they deserve.

Photo: Y. Hansenne, Belgium

Nurses' experiences with COVID-19: A view from Israel

Ismael Kher, Rambam Medical Campus, Haifa

Today is Tuesday, February 1, 2022. It is my second day in quarantine during the fifth wave and my third quarantine since the onset of the Coronavirus pandemic. I am bombarded with a lot of numbers: how many people have been tested, infected, verified and, unfortunately, passed away, not to mention all the other statistics. That's how we've been for two years.

I just landed from my journey in eastern Africa when we all received the news about a coming pandemic, Covid-19. The whole world just stopped and shut down. There were no more flights and no more trips; everyone had to live in their own bubble. My own bubble was the hospital, and more specifically the Pediatric Intensive Care Unit, Ruth Rappaport Hospital in Haifa, Israel.

There were so many preparations, drills, instructions and arrangements for the new visitor, COVID-19. This new visitor presented very quickly with two healthy little girls and an adolescent boy; three young patients, diagnosed with life-threatening conditions evoked by the body's immune response to the infection; it passed by safely with our dedicated, intensive treatment which included multi-organ support while actively learning and teaching our colleagues.

Despite those experiences we didn't understand what Coronavirus really was. Then our visitor decided he was not explaining himself enough; so, he revealed himself a little bit more through a healthy young man who was so sick that he needed the highest level of intensive care - mechanical cardio-pulmonary support, namely the ECMO machine.

In a white suit, I spent the time taking care of an anesthetized man who was isolated in a ventilated room, a kind of capsule. My contact with the outside world was only through a small window at the top of the door and my voice, which came out through a very heavy smothering mask. I just could not figure out what to do at the very first moments. The doses of the medication, volumes, sizes and responsibilities were all much bigger than what I was used to, and my new role in the care unit was confusing, not withstanding my experience in taking care of every little detail of my immature patients; I felt a bit lost.

I experienced mixed feelings of fear, curiosity, heaviness, stress and butterflies in my stomach as the new journey was interrupted by the groggy patient's waking up and moving his arms and head in a way that put the equipment he was connected to at risk of damage. I rushed to hold him and give him more anaesthetic drugs to make him sleep again so that he would not hurt himself at that moment; a second later, I found myself talking to him. He answered me with a nod; that's what he was capable of.

Nurses' experiences with COVID-19: A view from Israel

Ismael Kher

We had a little conversation, after which he fell asleep again. Meanwhile, my heart rate was back to normal rhythm.

We experienced everything during this period starting from joy, grief, stress, frustration, success and failure.

Somehow after this event, I felt I finally had my feet on the ground. Then, the journey across this ocean continues, being hurtled from one wave of COVID-19 to another. Together with a wonderful and special team, we successfully treated more than twenty patients on ECMO machine in addition to our full capabilities and diverseness equipment, thankfully most of them were dismissed home healthy. Whereas the others, unfortunately, passed away.

We experienced everything during this period starting from joy, grief, stress, frustration, success and failure. We talked to our patients, danced with them, encouraged them, but also sadly said goodbye to some of them.
Like every end of every journey, there are conclusions. Ours were a great sense of pride in the special and extraordinary success, in the remarkable treatment and in the a unique relationship with the patients, families and colleagues.

Meanwhile, it doesn't seem that the new visitor is about to leave us; in fact, he is not a visitor anymore, he's part of us, our work and life.
He taught us that staff members are also a family, that patients are part of our lives and that a pandemic is a peak that we shall pass through, just like what my guide on the climb to Kilimanjaro taught me to do, walking " Poly poly" slowly in small steps to discover the special magic of the unknown!

RAMBAM Health Care Campus

Experience report of neonatal nurse specialists during the Covid-19 Pandemic

Brazil

Flávia Simphronio Balbino. RN. PhD[1], Jade Cardoso Muniz. RN. MSc in progress [2], Ana Paula Dias França Guareschi. RN
1, 3- Nursing professor. Universidade Federal de São Paulo 2- Master student. Universidade Federal de São Paulo

Over the last two years, we have certainly experienced fast and intense moments. When the World Health Organization declared the Covid-19 pandemic in March 2020, in our practice as nursing residents and tutors of the residency program in neonatal nursing, we could not imagine how much the pandemic would change our lives, habits and routines.

We work in a Neonatal Intensive Care Unit (NICU) of a university hospital in the city of São Paulo that has 31 beds and is a referral center for premature newborns with malformations and high complexity demands. The moment of the birth of these babies is known to be permeated by an avalanche of ambivalent feelings. Parents express joy and hope, but also experience uncertainties, fear and insecurity that demand embracement by the health team in order to meet their needs and favor the presence of the family in the NICU.

In our service, parents have always been encouraged to bring family members to meet the baby, especially their siblings and extended family members such as grandparents and aunts/uncles, as these participated in the pregnancy and construction of the environment for the arrival of the newest family member. However, the changes imposed by the Covid-19 pandemic affected all that and introduced restrictions to the presence of parents, affectionate contact with close people and even the natural physical contact within a family.

As nurses working in this unit, we also experienced moments of uncertainty and doubts about something new and unknown that invaded our lives. Until that moment, we knew the virus had a high rate of transmissibility, we knew its symptoms and the possibility of leading to death. Back then, studies did not provide clear information on the most vulnerable age groups. The preparation of protocols was in progress and they were made available concomitantly with the advancement of knowledge about the disease.
These were difficult times of professional and personal losses, we lived amid the insecurity of ensuring our care and that of our family members, as we were seen as people who could transmit the Covid-19 virus for being in an environment considered at risk. In addition, there was the challenge of offering family embracement and guaranteeing their presence with the baby without the risk of contamination.

Recommendations by the health agencies regarding isolation and reduction of people circulating in the hospital and the contraindication to the presence of grandparents, siblings and other members of the support network in the NICU[(1)] were challenging and one of the most difficult situations experienced as nurses in this unit. Although numbers of infected pregnant women and infected newborns (NB) were much lower compared to those of the general population, women in the pregnancy-puerperal cycle and newborns were classified as a risk group.
With each ordinance and rules, new strategies were instituted in the NICU in order to guarantee care for NBs, given their immature immune system and greater susceptibility to infection by SARS-CoV-2[(2)]. In the face of this scenario, we understood the need to review changes for offering better family embracement in this context.

Experience report of neonatal nurse specialists during the Covid-19 Pandemic

Flávia Simphronio Balbino, Jade Cardoso Muniz, Ana Paula Dias França Guareschi

The presence of asymptomatic parents was ensured by the health team through guidelines on hand hygiene, use of masks and alcohol gel, as well as body temperature checks at the hospital entrance[1,3]. Afterwards, they were asked to complete a questionnaire about their health status, contacts or trips to/from affected areas in the previous two weeks, and/or if they had had any recent flu-like symptoms.

With the pandemic evolving rapidly and even in the face of risk and uncertain situations, team members organized themselves to grant the request of families to be with their NB. As a way to mitigate this distance, the team started to make video calls, took pictures of the baby and sent them through one of the parents' cell phones and organized video calls with the extended family to introduce the new member to the family.

We started to establish greater contact by telephone to share information with parents about NBs' clinical conditions at pre-scheduled times with the neonatologist physician responsible for care; we organized religious gatherings such as baptisms and blessings via video calls with religious leaders. Another strategy was to accept parents' requests. For example, when they came to bring clothes for the babies, they asked us to put a specific cloth inside the incubator, so the NB could smell a bit of their home, their room and their family. Then and there, we understood that parents wanted their children to have a part of them present.

We identified an increase in anxiety, insecurity and sick leave in nursing residents due to psychiatric demands triggered by the pandemic.

Every day and very quickly, we learned to deal with NBs born to mothers admitted with a suggestive or confirmed diagnosis of Covid-19, isolated in a specific room inside the NICU, according to the recommendations available in the literature on prevention of the spread of the disease. The presence of parents continued to be encouraged according to each case, considering the surveillance implemented as a safety measure and reinforcing care with the use of masks, gloves, and personal protective equipment (PPE) in the unit. Social distancing practices were also reinforced between parents and staff while staying at the NB's bedside. It was necessary to close the support rooms in the wing outside the NICU used by parents for coffee breaks/snacks and rest, as we were unable to control the distance between them. Visits by other family members were restricted and individually scheduled on a case-by-case basis.

In the academic sphere, as professors, we have experienced profound changes and challenges, because even though face-to-face classes had been suspended, we had to continue to offer theoretical content and the in-service training of the Neonatal Nursing Residency program at UNIFESP, and provide care as well.

The entire curriculum had to be reorganized to offer remote activities, adjust internship shifts and reconcile practical activities at the NICU, ensuring the safety of nursing residents with the provision of personal protective equipment such as hats, gloves, disposable aprons, goggles and masks. In addition, we had to organize ourselves to accompany the nursing residents on a daily basis for the provision of care for NBs and their family with excellence. We identified an increase in anxiety, insecurity and sick leave in nursing residents due to psychiatric demands triggered by the pandemic.

Experience report of neonatal nurse specialists during the Covid-19 Pandemic

At times, we felt powerless in the face of an enemy so feared throughout the world, while at the same time, as the only support of those nursing residents who were away from their families to continue their training as neonatal specialists.
Among the major challenges, we identified that many professionals were contaminated because they did not know how to properly use the PPE. Thus, we organized ourselves to support the NICU by training nursing residents to be training multipliers on proper handling of hand hygiene protocols and updating of Infection Prevention and Control measures in accordance with recommendations of the Control Commission of Hospital Infection of the institution, based on the guidelines of the Centers for Disease Control and Prevention (CDC).

In addition, we offered classes with guidance on the proper handling of hand hygiene protocols for parents and members of the unit's support team and cleaning staff. These classes were designed by nursing residents using games and dynamics about myths and truths related to the topic as teaching strategies.
After two years, we understand the pandemic better. We are currently more prepared to provide safe care in the pandemic scenario. The participation of families in the care of their babies is a reality again with all adaptations imposed by the pandemic. The NICU environment became happier again. However, masks are still a PPE present and mandatory in all areas of the hospital. A fact to be analyzed is that hospitalized NBs do not know the human face without this accessory, thus, it is essential to use different types of communication in the interaction with these babies.

After two years, we understand the pandemic better. We are currently more prepared to provide safe care in the pandemic scenario.

The pandemic has impacted the lives of families who have lost loved ones, and changed many people's conception of health. We also know the pandemic left many physical, psychological and emotional sequelae among health professionals who faced this disease side by side with patients that only time will tell. Corroborating this thought, there is the testimony of a resident nurse of the program who reported that: "*being present at the hospital during the pandemic was challenging. It wasn't easy to be away from the family for so long, failing to socialize. It was no different among my resident colleagues, as most left their cities and states of origin to attend their residency program, which increased the distance from their families. Working in a NICU is very difficult given all peculiarities permeating this environment, added to the impositions of the pandemic period, without the support of other close people and someone at home to share the mishaps of the day to alleviate them. Classes were changed, practice workshops were suspended, and group discussions abandoned. The adaptation to a new teaching strategy composed of distance activities was complex and only gradually the teaching of practical activities was emphasized, discussing day-to-day learning as we provided care to newborns and their families within the NICU. It is interesting to analyze this after I've finished my program, as it did not bring me any harm as a specialist, but I missed having my closest teachers in face-to-face meetings by my side, adding to my personal and professional training. However, I gained attitudinal skills in adapting to new hospital contexts and solving problems".*

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Nurses' experiences with COVID-19: A view from Namibia

Beatrix Callard, NICU specialist nurse and APN, Central Hospital Windhoek

Everyone has a COVID story. Mine is not worse or better than yours, it is simply ***my*** story. By December 2019 I was settled comfortably into our NICU when stories of a new respiratory virus made the headlines. Initially I only glanced at these stories with half interest. When stories of Italy, Belgium, and the rest of Europe started to follow and the word 'pandemic' crept into our everyday vocabulary I started taking note.

Expect surprises, this is war and we'll have the answer in five years

Namibia, a vast arid land, is situated on the southwest coast of Africa. Previous viruses, like SARS or H1N1 had not significantly affected us. However, with high TB, HIV and malnutrition rates coupled with an already overburdened health sector, this unknown, virus had the potential to wreak havoc. Early in 2020 our government and Ministry of Health and Social Services had taken an active step toward emergency response preparedness in the event we register a COVID positive case. Mid-March 2020 our first imported case was reported in the press. Though initially successful in containing the spread, our numbers didn't stay low. We moved from wave to wave and from one form of lockdown to another.

Sometime, during our first lock-down it occurred to me "this is war". A few would exploit the majority and the black market would thrive. Uncertainty ruled the day for most and some spoke of denial or conspiracy. Schooling, travel, commerce, industry, health care – everything came to a standstill or was reshuffled. When friends or colleagues asked me for an answer, I replied that we might know the details in five years to come. Fear was everywhere.

I love working in our NICU at the Central Hospital in Windhoek, Namibia. The NICU is a 31-bed unit running an average daily occupancy rate of 150-175% and where each nurse cares for 4-8 patients, depending on the acuity and staff availability of the patients in the ward. I was one of three nurses trained in child critical care.

I fell into the low-risk category, so I volunteered for frontline service. As a trained NICU nurse and Advanced Nurse Practitioner, I felt I could contribute at least the basics of infection control, isolation protocols, ventilatory support, ethical decision-making skills into an adult care setting designated for COVID patients.

Initially I assisted with the modification of a local clinical set up as a triage centre. By May 2020 I was called back to my own hospital to help set up the newly designated COVID ICU. The COVID ICU was inclusive of a designated theatre for COVID positive patients. We even set up our own laundry facility in the unit.

Everything felt different. Meal breaks and bathroom breaks needed consideration. Working in PPE and moving things across the line into and out of the infectious zone required planning and extra time. ET tubes and airways seemed huge - almost dangerous.

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Beatrix Callard

I could no longer turn patients on my own, resuscitation required the effort of my whole body, not just by thumbs.
Drug calculations had to be done several times to confirm that the volume to be injected really was so much more than the 0.7ml or 1.5ml I was used to administering. I had an obsessive caution toward avoiding drug calculation errors.

As I was heading up a team of young volunteer nurses from various departments, we set about training, teaching, practicing. Most of our team were recent graduates. Certainly, none of us were COVID experts. Only a few had some critical care experience or knowledge of ventilators, continuous infusions, inotropes etc. But we had two things in common: a willingness to serve, and a willingness to learn. We understood that no matter how well we planned, COVID 19 would always throw us a curveball. We adopted the philosophy of 'expect a surprise' and when it comes 'do what you can with what you have'. We had to remind ourselves of this every day when we were confronted with knowledge or service gaps. Sometimes we did well, sometimes our inadequacies were heart wrenching.

We understood that no matter how well we planned, COVID 19 would always throw us a curveball. We adopted the philosophy of 'expect a surprise' and when it comes 'do what you can with what you have'.

Contemplating the general population and what we may expect in our COVID ICU, I anticipated that our first COVID positive patients might be a pregnant mother in need of emergency C-Section, a child in need of appendectomy or a patient requiring orthopaedic surgery post motor vehicle accident (Namibia has the highest motor vehicle accident fatality rate on the continent). I was adamant that our unit be prepared for these eventualities. And so it came!

Our first patient was 28 weeks pregnant; she had been referred from a regional facility to the national facility due to uncontrolled hypertension and difficulty of breathing as well as confirmed COVID infection. After much back and forth the patient was transferred to the clinic for admission and subsequently to our ICU for an emergency C-Section secondary to preeclampsia. The infant was a feisty little boy who seemed to be born fighting. By then the international consensus was still that newborns were to be separated from their mothers. After careful planning and execution, we had transferred the premature baby to the NICU and had arranged for expressed breastmilk to be sterilized and sent to the NICU.

However, we did not account for the severe stigma on COVID 19 patients and staff working in the COVID units. So, within 12 hours the 800g baby was transferred back to the COVID ICU, back to his mother. The two staff members on duty received a crash course in skin-to-skin mother care, milk expression and essential newborn care. Mom in turn received the same instructions. When the initial NGT became dislodged and the staff on duty were unable to successfully reinsert it, I telephonically took mother through the steps of cup feeding and breastfeeding. Mom took to her role like a superstar!

Nurses' experiences with COVID-19: A view from Namibia

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Because we considered the pair low risk patients, we gave mom the number for the nurses' post and asked her to call us when she had a need. One morning, during shift changeover, mom called us in a panic because baby Daniel was not well. In those early days donning required 10-15 minutes to ensure all was in place.

That morning we were donned and at the bedside in less than two minutes. Daniel had aspirated a little milk but was fine. His oxygen saturation and respiration were normal. During their time with us in the unit Daniel gained weight steadily and did not have a single nosocomial infection. He was discharged well ahead of what we would consider 'usual length of stay ' for his cohort in NICU. A year later, staff from our unit called mom to sing 'happy birthday' to Daniel.

Not long after baby Daniel, we were surprised again. Johnathan* was a toddler with acute abdominal pain and because his mom had tested positive, we had to admit him in our ward without a confirmed result. At the time we had other COVID positive patients in the ICU and were reluctant to admit him.

However, he needed an urgent laparotomy, but the surgical wards were unwilling to admit and isolate a toddler suspected of being COVID positive. His result came out negative, and we were faced with a situation where a negative patient was now considered exposed and in need of isolation due to positive contact.

Again, we were following our then 'normal' guideline which dictated mother child separation. But fear and stigma around patients suspected of having COVID forced us keep mother and child together. Considering what we know two years later, this was a blessing in disguise. Eventually he too was discharged without any further incidents and remained COVID negative.

The first and second wave went by relatively moderately. Not because we didn't experience loss or trauma, but we experienced less so in relation to other countries. Throughout this time, we had a good idea what to expect by keeping an eye the numbers in neighbouring South Africa. After the second wave I was called back to the maternity ward.
Then, in May 2021, we noticed a change. Elderly parents with co-morbidities their children. Suddenly young men died from severe illness. Increasingly our resources were strained. Pregnant mothers were severely affected and more and more children became ill. Namibia gained international notoriety for its increased case fatality rate and an 'out of control' infection rate with daily cases reaching up to 2,000.

This we came to know as the Delta wave. All in all, Delta was a shock to our collective system. Even greater staff shortage, patient overload, service interruptions, confusion surrounding management and an unprecedented number of maternal deaths hit us from all sides. We had not seen the like of this in the first two waves.

**pseudonym*

Nurses' experiences with COVID-19: A view from Namibia

Beatrix Callard

Seasons, months and even years have passed since COVID-19 was identified and named. Instead of talking about events in relation to months and years, I find, events are related to in waves: before the first wave, during lockdown in the second wave, when Omicron came, is there a fifth wave?

Group or office conversations always revert to COVID results, jabs, shots, pro or anti vax, masking or not masking, social distancing, working from home. It's time for a new topic and new season. I am yearning to go about mask free. Most of all - I want to hug.

As others, we experienced the burden of isolation, fear of infection, losing our first patient, our first maternal death, not socializing, patient and family separation – even in death and burial. Maybe the stigma placed on us was hardest.

This pandemic, I believe, has brought out the best and worst in us.

It has torn us apart and brought us together. It has advanced medicine and science and taken us back to basics.

To the point that people ran away from our ICU front door after ringing the bell for service delivery. Majority of colleagues were afraid of us and reintegration after our mandatory isolation was difficult. I have lost count of the number of times I was told "don't bring your COVID".

Still, we had moments to celebrate. We danced to 'Jerusalema', celebrated each individual's birthday, held a braai, and organized a team competition with relevant topics to encourage learning. We became family. In all of this, we celebrated that not a single front line staff member in our unit became infected with COVID while serving in the unit during the first seven months of the pandemic.

Our first staff members to be infected were community acquired infections and occurred after the Ministry closed the designated accommodation facilities due to cost factors.

This pandemic, I believe, has brought out the best and worst in us. It has torn us apart and brought us together. It has advanced medicine and science and taken us back to basics. We have seen price gauging, exploitation and generosity. In it, we have grown as people and learnt to appreciate the things money can't buy.
Many have devastating stories to tell. We do too.
Yet, overwhelmingly, my story is positive.

My story is of challenge, growth, friendship, ingenuity, family, learning, teaching, blessing, resilience, investment. I have met people outside of my normal circle of influence. I have journeyed this road with people who have sacrificed, laughed, cried, built up, lost, rebuilt and who gave despite their loss. I thank everyone with whom I have had the honour to journey with.

Survival Narrative – Supporting Families of Chronically Ill Children Staff Plan Safe Celebration for Patient's 1st Birthday

USA

Allen M Davis, Children's Hospital of Philadelphia

As many have experienced through the pandemic, creating connections with the families of chronically ill children has been an adventurous struggle.

At the Children's Hospital of Philadelphia, a unit part of Critical Care known as the Progressive Care Unit (PCU) is dedicated to the care and training of national and international technology dependent children. Many of these patients are tracheostomy and ventilator dependent.

Even before achieving medical stability caregiver training begins as we prepare these children for discharge. Medical stability, surgery, and community resources such as home nursing availability can be a barrier for children being able to achieve discharge.

A PCU patient was celebrating his first birthday during the height of a winter surge of COVID cases. The patient is one of seven children in a loving and well connected family.
With current visitor limitations, the PCU established a plan to allow the patient and family to experience a special birthday, while keeping the patient safe.

Although medically complex, a plan was coordinated to have the patient taken down to the atrium by windows that look out onto a garden. The patient's mother, two respiratory therapists, and two nurses transported the patient on his birthday to see his family and friends.

The patient's family had signs, cheered, sang, and played the guitar to wish the baby greetings on his first birthday. He was able to experience the love and joy of a birthday party, while safely monitored inside of the hospital by our team.

This experience brought joy not just to the family but to the nursing staff and critical care team members that made this experience possible.

Nurses' experiences with COVID-19: A narrative from Israel

Hikmat Khoury, PICU, Rambam Medical Campus, Haifa

Covid 19:

an Outrageous Rough disaster which came strongly into our lives and demanded New standards All over the world

Covid 19: an **O**utrageous **R**ough disaster which came strongly into **o**ur lives and demanded **N**ew standards **A**ll over the world (CORONA).

It filled us with a lot of sadness and bad memories since the first days with unforgettable views when it all started in the Far East and then continue to spread quickly to many other countries.
Our PICU unit with 15 beds is the biggest in the North of Israel and one of Rambam Medical Center hospital. The third biggest hospital in Israel with a high capacity of beds started getting organized to treat the high numbers of patients by developing new guidelines and protocols for the upcoming pandemic. Also, the underground emergency hospital was prepared for the treatment of patients. Staff was trained to be able to deal with these critically ill patients, ECMO dependent patients included.

Two months after the pandemic started, a very dramatic surprising decision came up: a part of our unit was transformed into an "ECMO UNIT FOR COVID-19 PATIENTS " for all ages. The decision was frowned upon by our staff because on one hand we are a pediatric staff, most of us have not worked with adults before. Thus, it was scary and stressful. Due to the direct contact to the patients, there was the risk of getting contaminated and maybe even to transfer the virus to a family member, especially to the elderly. We did not know much about this pandemic, but then it was a very dramatic and fatal thing for us. But, on the other hand, we are a very professional ECMO certified team and our highest value is to save lives.

During the second and third waves we treated 30 patients above 18 years old in very critical situations. They were supported with ECMO, unfortunately some of them did not survive and it was very hard and irregular to meet so much death in such a small amount of time in our unit.

All of them had big families but they were not allowed to visit and to be by their loved one's side when they needed them due to their critical condition.

Talking about this, it takes me back to one of the critical patients with severe ARDS supported with ECMO, who survived. A.F. was a 15 years old who was admitted to PICU unit from another hospital in a very bad condition. He was alone, no one was with him, as his father and mother were hospitalized in other hospital with severe pneumonia, too.

The first week he was under sedation, but later he was awake and aware. He started to ask about his parents. Unfortunately no one from the family came or tried to call the unit to ask about him and the staff had no information about the parents, so we couldn't answer his questions.

Nurses' experiences with COVID-19: A narrative from Israel

Hikmat Khoury

He was very sad and depressed, we were sad for him, too. He even cried once and we cried with him and tried to assure him " they will call and come when they can ".
It did not helped much, he was still very worried about them.

Two weeks later a cousin called. The parents were still hospitalized, he said. We asked for a special permission for her to come and to be with the poor boy.
A week after, the mother was discharged and on the same day she came to see her son. It was a very emotional meeting that left us all in tears. Behind the window she waved her hand, and told him how much she loves him.
When she came into his room, she hugged him strongly but carefully, in order not to make any damage to the life supporting equipment. Many tears and waves of excitement filled the room, hugs and kisses from both sides.

In times like these we shine, these are the moments that make us feel proud and happy to be nurses

In times like these we shine, these are the moments that make us feel proud and happy to be nurses; this is our purpose, helping people and saving lives, even if sometimes it is so hard and seems to be unrealistic and an impossible mission.

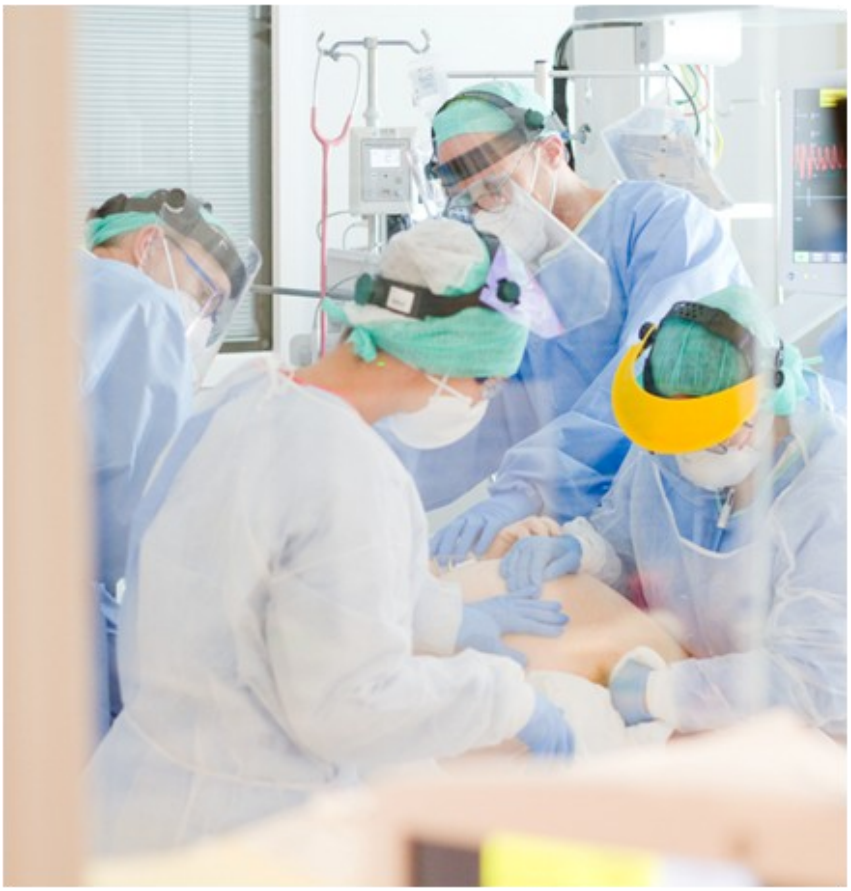

Photo: Y. Hansenne, Belgium

Nurses' experiences with COVID-19: A view from the United States

Lan Miller, BSN, RN, CCRN, Pediatric ICU

On the eve before the end of mask mandates in our local school, my children are talking excitedly to finally be able to see their teachers' faces. Could this be how we finally emerge out of the COVID-19 pandemic?
The conversation takes a serious turn when the high schooler says that some students are concerned it is too soon. I explain that for some it may not be as easy to let go of a life that we all lived for the last two years. Some students may have lost a loved one, experienced severe COVID or have post COVID infection complications. This emotional trauma drives their decision making and we need to be patient, but most importantly kind.

People complained that grocery stores had empty shelves.

The same supply shortage impacted hospitals too.

I started to think about the emotional trauma of PICU nurses during the last two years. I saw the most amazing group of nurses just pivot and then pivot some more. PICU nurses were deployed to the emergency room or other high census units, then we were screeners at the entrances of the hospital, then we became part of the Code C team for emergency intubation while still trying to be available for our most vulnerable population.

Hospitals had to scramble for supplies that had been marked up due to supply and demand. They were charged ten times the amount for N95s that were scarce. Those who failed to pass fit testing were supposed to have access to PAPRS. These hoods were made available only to doctors and respiratory therapists. Staff bought masks on Amazon just to have something in an emergency. For those who did pass their fit test, they needed to wear the same N95 mask until it was visibly soiled. Then it was one mask per shift. The mask then went in a container to be sterilized and reused. Gowns were in short supply. Reusable gowns were reintroduced to our hospital.

There was a supply chain issue with people being the shortest supply. Amazon and Target, with their competitive salaries, were enticing our transporters and central distribution team. Nurses were asked to transport patients and being tasked to inventory our supply room. Then, nurses were leaving. The remaining nurses just had to do more with less.

People complained that grocery stores had empty shelves. The same supply shortage impacted hospitals too. There was a saline flush shortage one week and alcohol pads another. Some central lines had been back ordered for months. We borrowed from other hospitals but always figured out a way that was best for the patients.

As the world became more comfortable with COVID, our units started to fill up with non-COVID patients again. We saw an increasing number of cases of diabetes and some were newly diagnosed. We saw more patients with sickle cell pain but it was actually a complication of COVID, not low hemoglobin. These patients did not need blood transfusions but more respiratory support.

Nurses' experiences with COVID-19: A view from the United States

Lan Miller

Influenza was almost zero but children came in with respiratory syncytial virus, Adenovirus, Human metapneumovirus, or rhino/enterovirus. Our oncology population seemed to double overnight.

We were always asked by the parents of our patients if we had any COVID patients. Sadly, the answer was yes. We saw children who had mild COVID infection but were now hospitalized with MIS-C so severe that they needed IVIG administration. We saw children who needed to be on high flow oxygen therapy. We saw children who required mechanical ventilation. We saw children who needed to be transported to a higher acuity PICU facility that could provide ECMO.

We were tasked with family preservation. We had to keep children whose parents were sick in the ICU. Once, we set up three beds in one room so the siblings could stay together. We set up FaceTime so these families could connect to each other.

Sometimes we were asked not to share updates. We had children whose family members had passed away from COVID while they were battling COVID. Her parents wanted the child to improve first because they did not want her health to deteriorate with the news.

Not only family members but sometimes patients would lose a parent. We all took turns putting on all the PPE to keep one patient company. We risked exposing ourselves and our families, not wanting children to be alone.

During COVID so many people were working from home or furloughed. Pastors, nutritionists, and other ancillary support provided aide via FaceTime. Those left at the bedside had to support each other. Morale was at an all-time low. The same people who were calling us heroes were now calling us sheep. Everyone wanted to disagree over masks, vaccines, and social distancing. Trying to educate the public was met with hate. People accused us of using fear to intimidate them. The answer was always to provide self-care since everything else was out of our control.

Why? Why would anyone want to be a PICU nurse?
Because we celebrate our victories.
When the patient is finally extubated, we celebrate.
When the patient takes their first step after being in bed for a month, we celebrate.
When the patient finally gets to go home, we celebrate.
We are together for each other and our community.
Having the thank you letters and appreciation from our patients is amazing but having a child who wants to give you a hug is priceless.

(Lan Miller)

A singular experience applying FCC amid the pandemic

Brazil 

Lígia Simões Ferreira[1], Maria Angelica Marcheti[2]
1-Specialist in Nursing. MSc. Instituto Integrado de Saúde. Universidade Federal de Mato Grosso do (INISA/UFMS).
2- Nursing Professor. Instituto Integrado de Saúde. Universidade Federal de Mato Grosso do Sul (INISA/UFMS).

My story begins in December 2020, when I took on the care of children in the pediatric emergency room of a teaching hospital in Campo Grande, Mato Grosso do Sul state, Midwest Brazil. At that time, the covid-19 pandemic had reduced the number of nurses at critical-care units, a fact that demanded new planning arrangements from managers. Thus, after six years working at the nephropediatric unit, caring for children with chronic renal failure, I found myself assigned to spend my shifts at the pediatric ER - a task I promptly accepted, given my interest in expanding my knowledge of children's care in emergency situations. To cope with this assignment, I had to prepare myself in order to deliver the best possible care for both children and families - a context made more crucial by the ongoing pandemic.

Within my first week there, I was taken off-guard by the arrival of a seriously ill child, a nine-year-old boy who was admitted to the ER with complaints of fainting spells, loss of consciousness, fever, and vomiting, which led the medical team to tentatively diagnose it as meningitis. Still vivid in my mind is the image of the young patient asking for water and begging his father to stay close and not leave him alone. We were, however, in the middle of a pandemic, and the team, complying with the protocol then in place, had to ask the father to leave the room. Only staff remained, to provide the child with all necessary care.

At that moment I chose to break the rules and asked the father: "Would you want to be present and see everything that is going to happen?" And in no time he replied: "Yes. I want to be close to him."

After my initial care delivery, I assigned another nurse to the task so I could reach the father and explain the new circumstances to him. He told me that covid-19 was to be suspected in the family, as the child's mother was exhibiting respiratory symptoms. While we talked, however, I noticed that something worrying was taking place in the ER, so I asked the father to wait while I checked. The boy's clinical condition was worsening and his consciousness fading, and he had to be transferred to the red zone, where equipment and support for urgent care were within reach.

That was the moment I realized the child might already be carrying the Corona virus, but I could only think of the distress of a father who might never see his son again - in case of death, use of mandatory sealed body bags or coffins would ensue, with no further contact between child and family. A few but lengthy seconds went by, while I anxiously searched not only for compassion and empathy, but for everything I had learned about Family-Centered Care (FCC) from my advisors during my master's research years.

At that moment I chose to break the rules and asked the father: "Would you want to be present and see everything that is going to happen?" And in no time he replied: "Yes. I want to be close to him." Then I brought a chair and placed it so he could follow every development from outside the ER. He watched the child being intubated and placed on a respirator, and saw every effort we made for his son to feel as comfortable as possible while traversing those days of struggle for life. When we completed our procedures, I said to the father: "Now you can approach and stay here close to him, if you want."

A singular experience applying FCC amid the pandemic

Lígia Simões Ferreira, Maria Angelica Marchetim

And his words were: "Thank you so much. Whatever happens, I'll know you have done everything you could. I've seen you doing it." That same night, the patient was referred to the Pediatric Intensive Care Unit (PICU) of another hospital in the city, where he remained for over 20 days in serious condition.

He eventually recovered to the point that, at discharge, he was walking unaided and smiling. For me, the most difficult part was knowing that other parents and extended-family members were not allowed access to their children, who had to remain in isolation rooms in the PICU.
On the rare occasions where a family member was given permission to do so, taking turns was not permitted, which placed a huge burden on one parent - usually the mother. I wondered how staff could be so insensitive to both family and child. I tried talking to them, but was not heard, on grounds that the risk of contamination was too high for staff and other patients. No argument could counter this real scenario.
This made me very uncomfortable and concerned, because I know that bedside company of a significant being makes a huge difference, for child and family alike. My suffering was deeply felt, for I wished I could change that reality, but had no hint on how to do it.
Today, reflecting on this experience, I believe that putting FCC principles into practice requires the entire team be sensitized and trained to partner with family members, seeking ways for minimizing their suffering, even while a pandemic evolves. On that occasion, I was able to perceive the benefits of studying and applying the principles of FCC to a real situation. I saw a child remain confident because his father was there, and a family grow grateful for being given the choice to decide to be present to support their child at such a difficult moment.

Today, reflecting on this experience, I believe that putting FCC principles into practice requires the entire team be sensitized and trained to partner with family members, seeking ways for minimizing their suffering, even while a pandemic evolves.

Our team at the ER learned from the experience. In the rush to save the boy's life, we put our own lives at risk. This made us review the protocols and adapt them to prevent exposure of staff and other patients. To this day, we are thankful for life, and for no one in the team having developed severe forms of the disease. I manifested the first symptoms of Covid a few days later, but they proved mild. Despite the great risk experienced, our team was thankful for witnessing a unique experience, in which a family had its need to be with its child met, despite the pandemic setting.

The father's gratitude and confidence in the team mobilized me to seek ways to improve the protocols then in place. We joined efforts with the permanent-education division to sensitize and train health professionals to include families in the scope of care provision, taking into account the fact that a family feels responsible for the care of its members in all circumstances. By opening up to the family's experiences, we professionals can become stronger to face adversities together and build new ways to support families at difficult moments.

There is still much to advance in this path, but I believe we are on the right track. We have revised protocols to keep the family together with its loved ones whenever possible and, when physical presence is not an option, we now make use of virtual strategies to render these moments as minimally traumatic as possible.

Nurses' experiences with COVID-19: A perspective from Israel

Latifa Kabat, Rambam Medical Campus, Haifa

At the end of 2019 Corona virus was identified, which on 11 March 2020 was characterized as a pandemic and it started to spread throughout the world.
A mysterious virus with an unknown nature, variable symptoms and complications.

Nurses have been working on the frontline to fight the COVID-19 pandemic - facing a high risk of infection because we work closely with patients. Health care providers now encounter many physical, mental and emotional challenges.
Like all people, when the COVID virus started to spread I was overwhelmed, fearing the unknown, hearing of people around me getting infected, not knowing what to expect from this virus.

My name is Latifa Kabat, I'm a nurse at the pediatric ICU in Rambam hospital.
Although we are a Pediatric unit, COVID had no rules, our unit started admitting adult patients, patients that required ECMO support, due to the fact that our staff is qualified to operate the ECMO.

These patients were parents, grandparents, sons, daughters, neighbors, and friends, all fighting this horrible virus alone in an isolated room

These patients were parents, grandparents, sons, daughters, neighbors, and friends, all fighting this horrible virus alone in an isolated room.
It was a very challenging transition from pediatric patients to adults, two completely different worlds.
During this time I was blessed with my first pregnancy, filled with excitement and hope.

People started taking COVID vaccines, but it still wasn't authorized to pregnant women, so I took standard precautions making sure not to get infected. Also, at that time the majority of patients were very elderly and with underlying diseases, not healthy young people.
A few months into COVID we started seeing younger people, not only the elderly. Suddenly we had two young women in their 30's admitted in our units, from perfect health, no underlying diseases, one was 28 weeks pregnant, the other 35 weeks pregnant that had to undergo an urgent C-section before being put on ECMO.

I wasn't allowed to work with COVID patients because I was pregnant, but I saw them through the cameras, they were awake. I stated to think about myself in their situation. The pregnant woman, how scary it must be, during what was supposed to be the happiest time of her life, now all alone in a room, not knowing how the ECMO might affect the fetus, lying in a bed attached to many machines and cables, seeing her blood come out of her body through the ECMO cannulas.

She wasn't allowed to get out of bed, naked wearing only a diaper, fully dependent on the staff for every need she had, bothered by everything, hurt by every movement, all the time thinking about herself and her unborn baby.

Nurses' experiences with COVID-19: A perspective from Israel

Latifa Kabat

One day she suddenly collapsed, we immediately prepared the room nearby in case the doctors needed to deliver the baby. She was very scared, she didn't want to deliver her baby this way, she wanted her husband by her side holding her hand, she wanted to see her baby for the very first time and not have it taken away from her urgently.

I couldn't help but imagine myself in her situation, I started sweating, felt my heart racing, I was short of breath, I couldn't stand up and they took me to the ER. I went home crying, very terrified, thinking this could happen to anyone of us, no one was in the safe zone.

I felt suffocated by the injustice that no woman should go though this experience, not them nor me.

Events and Announcements

The 9th Joint Congress of the EAPS+ESPNIC+ESPR will take place from 7-11 October 2022 in Barcelona, Spain.

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
- Address, telephone and fax numbers and email address of corresponding author

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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Editor Franco A. Carnevale, R.N., Ph.D., Montreal, Canada

Email: franco.carnevale@mcgill.ca Fax: 1-514-398-8455
Postal Address: School of Nursing, Wilson Hall (room 210)
McGill University, 3506 University St., Montreal, Quebec, Canada H3A 2A7

Associate Editor Irene Harth, PN, Mainz, Germany

Email: irene.harth@unimedizin-mainz.de
Johannes Gutenberg University Medicine Mainz, Department of Paediatrics 109 AE2
Langenbeckstr. 1, DE 55101 Mainz, Germany