Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Australian Critical Care 34 (2021) 117–118

Contents lists available at ScienceDirect

Australian Critical Care

journal homepage: www.elsevier.com/locate/aucc

Editorial

2020 the year we wish never was

1. Introduction – from the Editor-in-Chief

In the 12 months since severe acute respiratory syndrome coronavirus 2 and coronavirus disease 2019 (COVID-19) became a household name, health practitioners and researchers have worked tirelessly to understand the virus and disease through research and shared clinical experiences and provision of health care to those affected. The effort of clinicians and researchers is phenomenal, and the volume of information produced staggering. In the last 12 months, more than 72000 articles have been published and listed in PubMed. There are many more available through preprint servers.

Like many journals and publishers, *Australian Critical Care* has worked hard to ensure high-quality and relevant information about COVID-19 is shared with our readership. To promote rapid dissemination, we have made COVID-19–specific publications freely accessible. Although continued submission of articles dealing with COVID-19 continues, we felt it was timely to bring these together in a special issue that includes 11 articles, some of which are researched based and some of which are experiential. The included articles focus on areas of patient management including nutrition,[1] coagulation,[2,3] and communication.[4] Others have focused on the impact on the health workforce including staffing,[5,6] personal protection,[7,8] psychological wellbeing,[9,10] communication,[4] and family visiting[11] Some give a brief insight into the reality of providing critical care during a pandemic, which has seen health systems in some areas of the world incomprehensibly stretched and critical care clinicians tested like never before.

For many of us in Australia, we cannot even image what our international colleagues face each day. To this end, I have asked the *Australian Critical Care* Editor, Dr. Elizabeth Scruth, to share with us her experience working in the United States.

2. The lived experience of nursing during the COVID-19 pandemic

As an Australian intensive care unit (ICU) nurse now living and working in the United States in California, I never thought I would be involved in a huge activation of medical teams that was, and is still, needed to deal with COVID-19. In California, the virus has impacted everyone, and our lives will never be the same again. To date, California has experienced 3.5 million cases of COVID-19, with 45,000 deaths. These numbers are staggering, and while the COVID-19 cases are decreasing, we are now at the stage of implementing mass vaccination centres. The United States of America is on the verge of vaccinating 1.5 million people a day. The vaccination process has been fraught with issues as the vaccines are managed by the federal government and then distributed to the individual states – and the amount of vaccine varies each week. Healthcare workers on the front lines were the first to get vaccinated – tier 1 and, then, the most vulnerable including those aged 75 years and older. Considering the population of the United States of America, it will take at least the rest of this year to vaccinate everyone eligible.

Although for most of Australia, mask wearing has not been a regular requirement, we have been wearing them for a year. Ongoing intermittent lockdowns have impacted our economy, with unemployment rates increasing daily. Nurses have experienced shortages of personal protective equipment, and many ICUs had to revert to team nursing owing to shortages of staff. Retired staff members have been asked to return to clinical care, and student RN interns have been employed to assist in areas of greatest need.

To manage the increased number of patients requiring hospitalisation, MASH-like units have been built in record speed to accommodate the critically ill as many hospitals no longer had ICU beds available. As California faced critical shortages of ICU beds, ICU rooms that were built for one patient were often configured to accommodate two patients. At one point, during the COVID-19 surge, the Public Health Medical Director in California communicated to the population by television informing us that there were no ICU beds left in one county, pleading with everyone to wear masks and stay home; there was no guarantee that if anyone was to become ill, they would be able to be admitted to hospital.

The human toll the virus has taken cannot be underestimated. For nurses on the front lines, it will be felt long after the pandemic. It has become routine for ICU nurses to support patients and families using online technology to communicate in the moments before intubation, both knowing that the outcome of the disease could likely result in death. The ICU nurse is left to hold the hand of the dying patient, over and over again. Moral distress, anxiety, and depression affect many.[10] The long-term consequences on the health of survivors, the economy, our health systems, and clinicians are yet to be fully understood. While we continue to care for the critically ill, we must also begin to consider what care might be needed for our workforce who has been managing the unimaginable.

References

[1] Chapple LS, Fetterplace K, Asrani V, Burrell A, Cheng AC, Collins P, et al. Nutrition management for critically and acutely unwell hospitalized patients with coronavirus disease 2019 (COVID-19) in Australia and New Zealand. Aust Crit Care 2021;33(5):399–406.

[2] Collett LW, Gluck S, Strickland RM, Reddi BJ. Evaluation of coagulation status using viscoelastic testing in intensive care patients with coronavirus disease 2019 (COVID-19): an observational point prevalence cohort study. Aust Crit Care 2021;34(2):155–9.

https://doi.org/10.1016/j.aucc.2021.02.002

[3] Cordier P-Y, Pierrou C, Noel A, Paris R, Gaudray E, Martin E, et al. Complex and prolonged hypercoagulability in coronavirus disease 2018 intensive care unit patients: a thromboelastographic study. Aust Crit Care 2021;34(2):160–6.
[4] Freeman-Sanderson A, Rose L, Brodsky MB. Coronavirus disease 2019 (COVID-19) cuts ties with patients' outside world. Aust Crit Care 2020;33(5):397–8.
[5] Marshall AP, Austin DE, Chamberlain D, Chapple LS, Cree M, Fetterplace K, et al. A critical care pandemic staffing framework in Australia. Aust Crit Care 2021;34(2):123–31.
[6] Ridley EJ, Freeman-Sanderson A, Haines KJ. Surge capacity for critical care specialized allied health professionals in Australia during COVID-19. Aust Crit Care 2021;34(2):191–3.
[7] Rajamani A, Subramaniam A, Shekar K, Haji J, Luo J, Bihari S, et al. Personal protective equipment preparedness in Asia-Pacific intensive care units during the coronavirus disease 2019 pandemic: a multinational survey. Aust Crit Care 2021;34(2):135–41.
[8] Liu S-Y, Kang L, Wang C-H, Chu H, Jen H-J, Lai H-J, et al. Protection procedures and preventions against the spread of coronavirus disease 2019 in healthcare settings for nursing personnel: lessons from Taiwan. Aust Crit Care 2021;34(2):182–90.
[9] Altmayer V, Weiss N, Cao A, Marois C, Demeret S, Rohaut B, et al. Coronavirus disease 2019 crisis in Paris: a differential psychological impact between regular intensive care unit staff members and reinforcement workers. Aust Crit Care 2021;34(2):142–5.
[10] Hammond N, Crowe L, Abbenbroek B, Elliott R, Tian DH, Donaldson LH, et al. Impact of coronavirus disease 2019 pandemic on critical care healthcare workers' depression, anxiety and stress levels. Aust Crit Care 2021;34(2):146–54.
[11] Bloomer MJ, Bouchoucha S. Australian college of critical care nurses and Australasian college for Infection Prevention and control position statement on facilitating next-of-kin presence for patients dying from coronavirus disease 2019 (COVID-19) in the intensive care unit. Aust Crit Care 2021;34(2):132–4.

Elizabeth Scruth, RN, PhD
NCAL KP Tele Critical Care Program, Clinical Quality Programs and Data Analytics, NCAL Quality – Kaiser Foundation Hospital and Health Plan, 1950 Franklin Street, Oakland, CA 94612, USA