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EDITORIAL

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COVID 19—A message from Italy to the global nursing community

During these difficult times, it is not easy to learn all the nursing lessons from the COVID-19 epidemic in Italy. It is not easy because—at the time of writing—Italian nurses are in the middle of this emergency that shows no sign of diminishing. Whatever is said today can change completely after only 24 hr. As a global community we have only known about this virus for a few months, but it has invaded lives, hospitals and homes, subverting habits, practices and protocols. Some of the lessons learned will emerge later—after reflection and retrospective analysis. However, some things are now so evident that sharing them now is vital to help prepare those who are getting ready to face this emergency.

The first lesson is the vital importance of personal protective equipment (PPE)—both in terms of amount and suitability. In Italy the lack of suitable PPE, in particular, appropriate masks—as the ordinary surgical masks are of no use—has played a key role in spreading the infection among health workers. This lack of appropriate protection for those working on the front lines translates into a drastic daily loss of health professionals. It has been estimated that one tenth of those in Italy who are COVID-19 positive are physicians and nurses, but this could be underestimated due to the presence of infected professionals who are without symptoms (Anelli et al., 2020; Sorbello et al., 2020). It is to their enormous credit that many nurses continue to provide care conscious that the minimum levels of protection cannot be guaranteed.

With the global pandemic now accelerating in areas of the world yet to see Italian levels of infection, it is vital that PPE equipment is procured and delivered to the COVID-19 front-line critical care environments. Protecting staff—as well as being an ethical duty of healthcare providers—is also essential to prevent reductions in skilled staff due to illness when they are needed more than ever. Time is precious in this pandemic—Italy did not see it coming—many other areas of the world can. The importance of PPE for staff cannot be emphasized enough. Learn also from Italian nurses' experiences of the harm long-term use of PPE: facial lesions and sores produced by the pressure and sweat caused by masks and goggles worn far beyond the usual time frame in normal clinical practice. Further research will be needed on this—with the manufacturers of PPE being involved. But in the immediate situation healthcare providers can advise on self-care for those staff having to wear PPE for protracted periods (Suen et al., 2020). To help limit face lesions caused by the pressure of masks and goggles, the Italian National Institute of Health (Istituto Superiore di Sanità) organized online courses for health professionals to help them deal with this issue, among others related to keeping safe against Covid-19. More ergonomic masks, goggles and PPE will need to be available in the future.

Another very challenging issue, especially at the beginning of the outbreak, has been the antigen or viral testing of front-line staff, unfortunately in most cases this was not possible due to the very rapid spread of COVID-19 infections, because there were not enough testing kits available and places where these analyses could be conducted (Paterlini, 2020). We also recognize that the lack of antibody testing resulted in an inability to tell who had had the infection but now had immunity—and could therefore safely return to work. More recently, some Italian Regions are starting to conduct tests on all front-line staff and on the entire population, but it has taken several precious weeks of time to implement this. So, this is another important lesson for the global community.

An additional emotional burden facing nurses is the fear of introducing the virus into their own homes and exposing family members to COVID-19. It is important that nurses and other health professionals are trained in the correct procedures to manage uniforms and other belongings to minimize such a risk. If possible, staff should be encouraged and supported to use alternative accommodation to reduce the risk of family transmission. Policy makers need to ensure they provide appropriate logistic and financial support to help with this course of action. This also creates a sense of isolation for healthcare workers who are already highly stressed. It highlights that this epidemic is wreaking a huge emotional toll on all healthcare professionals in Italy. The long-term support needs of these staff can be planned later—but the importance of trying to provide some psychological support for staff—including the opportunity to speak about their experiences and fears—if only briefly—should be an important part of the acute response to COVID-19.

Front-line COVID-19 care giving is exhausting—especially over long hours—at some point replacement staff will be needed to enable others to take some rest and restore their energy. Many of these replacements may be returning to practice or unfamiliar with critical care environments—the importance of training and providing PPE for these staff should not be neglected due to the urgency of the need to plug gaps in the care teams. To healthcare providers and policy makers in areas at the start of their COVID-19 epidemic, our message is to plan for the replacement of staff in critical care areas—think about how this will be done, how they can be prepared and how you plan to recall recently retired nurses back to the hospitals.

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Another learning point is about communicating with patients. In the intensive care units, patients, nurses and physicians are alone, without the supportive mediation of the family members and relatives meaning communication among nurses, physicians and patients is much more difficult, exacerbated by all the protective clothing and equipment they must wear. We have learned that patients need to communicate and need to know what is happening to their families who are outside the hospital. To facilitate communication, nurses are using every possible means available: white/blackboards; post-its; sheets of paper and cards. If possible, patients should be encouraged to keep and use personal devices. Nurses and other health professionals also need to think about how they communicate with relatives remotely—sometimes to give the worst news imaginable. In the past informing a relative of the death of a loved one over a medium like Skype® or video calls with iPhones would be unthinkable—it is now a daily occurrence. This task is clearly a very painful one for front-line healthcare staff, who realize even more the crucial importance of having a dear person close by when a loved one is dying. In future we recommend that every possible means—whether it is special protective equipment for relatives or the availability of improved audio-video communication devices available for all patients in the intensive care units—be explored and used if at all possible.

Another issue regarding the death of patients in solitude is the spiritual care patients may require. In Northern Italy the COVID-19 pandemic has also caused the deaths of many hospital chaplains—with others ill and therefore unavailable for patients. Indeed, some Italian bishops have called on front-line health staff to provide spiritual comfort to dying patients. This was a totally new experience for nurses and physicians, who were not prepared for this type of spiritual care and have had to rapidly learn how to comfort patients dying in total solitude and isolation.

The Italian COVID-19 experience has also seen nurses—working with medical colleagues—making decisions about care provision with significant ethical implications and lessons. Decisions about who receives care, in what form and when to withdraw care have been redefined by COVID-19. The pace these decisions require to be taken—often with limited discussions with family members—create substantial issues around healthcare ethics. In the face of the current emergency these issues may have less resonance, but in the future will be subject to closer scrutiny. This pandemic obliges health professionals to take very tough decisions dictated by rationality and necessity, but there needs to be a great deal of support and encouragement, to ensure that such choices are solidly rooted in noble values.

One last but very important lesson from the epidemic is the need to plan for the possibility of caring for patients in their own homes. We have learnt that hospitalization is not necessary for everyone and can even be harmful. Home care may be a more viable option. Moreover, this would enable to reduce hospital stay and facilitate the fast discharge of recovering patients, thus increasing the availability of beds and other hospital resources. However, to take care of patients at home community nurses and general practitioners must have all the equipment and instruments they need in order to be able to do their job properly. Therefore, it is important to educate large numbers of primary and community-based health professionals who, with all the necessary equipment and means, and in collaboration with general practitioners, can take care of patients directly in their own homes. It is also vital that this also included ensuring the infection control measures are in place to protect others living in the same dwelling.

To conclude, 2020 is the Year of the Nurse, celebrating the bicentenary of the birth of our colleague Florence Nightingale, but it will surely be remembered also as the year of the COVID-19 pandemic. Like Florence Nightingale in her days during the Crimean War, nurses today are the 'heroes at the battle front'. No world congress, no conference and no expert in nursing could have better demonstrated and made everyone understand who nurses are and what they really do.

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CONFLICT OF INTEREST

No conflict of interest was declared by the authors in relation to the study itself. Note: Mark Hayter is a JAN editor.

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