


The Experiences of Intensive Care Nurses in Advocacy of COVID-19 Patients

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Abstract

The lack of face-to-face interactions with families, the increase in the number of patients admitted to the ICU, nursing staff shortages, and inadequate personal protective equipment has created many challenges for nurses in advocacy of the COVID-19 patient with life-threatening conditions. This study aimed to explore the experiences of intensive care nurses in the advocacy of COVID-19 patients. This study was performed using a qualitative content analysis method with Graneheim and Lundman approach, Iran, 2020. Data were collected through semi-structured interviews with eighteen clinical nurses from the intensive care units of three hospitals. Themes extracted from the nurses' statements were promoting patient safety (informing physicians about the complications and consequences of treatment, preventing medical errors, protecting patients from threats), respecting the patients' values (providing comfort at the end of life, providing a comfortable environment, commitment to confidentiality, cultural observance, respect for individualism, fair care), and informing (clarifying clinical conditions, describing available services, and being the patients' voice). ICU nurses in health crises such as COVID-19 as patient advocates should promote patient safety, respect patients' values, and inform them. The results of this study could help enhance the active role of intensive care nurses in the advocacy of COVID-19 patients.

Keywords

intensive care unit, nursing, patient advocacy, COVID-19, qualitative content analysis

Introduction

Patients are considered vulnerable if they cannot express their needs and protect their rights (1). COVID-19 patients are vulnerable due to isolation, restrictions on family visits, and unfamiliarity with the disease and treatment. On the other hand, the patient's anxiety about an unknown disease, lack of knowledge of the recovery process, and early discharge for the release of hospital beds highlight nurses' responsibility as important advocates of these patients (2). Najafi-Ghezaljezh emphasized the importance of advocacy of COVID-19 patients in making appropriate treatment and care decisions (3). Implementing the advocacy role of nurses requires their awareness of the meaning of patient advocacy.

The different studies have described patient advocacy in different settings, statuses, and stakeholders in various forms and meanings. Brazilian ICU nurses play their advocacy role as providing a caring relationship, fulfill a commitment, empowering, making room for interconnection, risktaker, being a moral agent, and creating a trustworthy

atmosphere for recovery (4). Based on perioperative department nurses' experiences, patient advocacy is defined as being the voice, communicating with, safeguarding the patient, and establishing trust between the nurse and patient (5). Iranian intensive care unit (ICU) nurses described the patient advocacy as empathy with the patient (including understanding, being sympathetic with, and feeling close to

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the patient) and protecting the patients (including patient care, prioritization of patients' health, commitment to the completion of the care process, and protection of patients' rights) (6). Also, nurses from a regional hospital in Ghana have described the role of advocacy as being empathetic, nurturing, ethical, assertive, and persistent (7).

During the current COVID-19 pandemic, ICU staff have experienced an unpredictable course of COVID-19, rapid deterioration of patients' health, infections among colleagues, and prolonged daily contact with infected patients. These factors cause them to face severe stress (8). Also, the high number of patients admitted to the ICU, nursing staff shortages (9), being in an environment with complex decisions and new care tasks and shifts complicated by cumulative patient losses has created many new challenges for nurses (10). Despite these challenges, nurses need to support their patients because neglecting patient advocacy has consequences for patients and nurses. The consequences for patients include loss of self-control, increasing dependency, and endangerment of patient safety (11), and the consequences for nurses include decreased job satisfaction, self-esteem, and efficiency (11,12).

The new and complex conditions created by the COVID-19 crisis require a new and comprehensive definition of patient advocacy. Since we do not know how Iranian ICU nurses perceive and establish their roles as advocates for COVID-19 patients, this study aimed to clarify the meaning of advocacy of COVID-19 patients according to their experiences.

Methods

This study was conducted using the qualitative content analysis method by Graneheim and Lundman approach. When there is insufficient knowledge about a phenomenon or existing knowledge, the content analysis approach is useful (13). Thus, considering insufficient knowledge about the dimension of advocacy of COVID-19 patients in intensive care units, this research method was used. Also, the content analysis provides a deep understanding of the participants' experiences of patient advocacy (14).

Setting and Participants

Participants were selected using the purposeful sampling method from teaching hospitals of Qom, Iran (15). Inclusion criteria included having a bachelor's degree and higher education in nursing, at least three years of work experience in the intensive care unit, and willingness to participate in the study. Exclusion criteria included having a degree in nursing assistance and incomplete interview. Participants were eighteen nurses from the intensive care units of three hospitals. Participants were selected with maximum variance (type of hospital, gender, age, education level, and job position) (Table 1).

Table 1. Characteristics of Study Participants.

Characteristics	Number	
Gender	Male	9
	Female	9
Educational level	Bachelor	12
	Master	4
	PhD	2
Job position	Clinical nurses	13
	Head nurse	3
	Supervisor of ICU	2
Clinical experiences	<10 Years	6
	10–20 Years	8
	>20 Years	4

Data Collection

To collect the data, in-depth semi-structured face-to-face interviews were conducted from March 1 to May 26, 2020. In total, 18 interviews were conducted with 13 Clinical nurses, three head nurses, and two supervisors of ICU that lasted between 45 and 60 min. The interview's general question was open-ended and included "What do you do to advocate patients with COVID-19?" After answering the question, based on the purpose of the research, probing questions such as "give an example, explain more about this." semi-structured questions, for example: "What does privacy mean to you in this case?" were used to clarify further details to the phenomenon. The interviews were conducted by the first author of the article in Persian at the right time and place with the participants' coordination. The first author did not guide the participants to predefined answers and allowed categories to extract from the data that the participants generated. The interviews were recorded with the consent of the participants and were transcribed verbatim in Microsoft Office Word (ver., 2007). Data collection continued until the development of categories and data saturation. The categories seemed saturated after the 16th interview. However, two additional interviews were conducted to ensure that no new data emerged and no new conceptual code has emerged. Some ambiguities did not allow for in-depth data extraction in the two interviews, which did not allow the interviewees to re-interview for further exploration. These two interviews were excluded from the study.

Data Analysis

Interviews were recorded with the consent of the participants. All interviews, was transcribed with Microsoft Office Word software and analyzed by Graneheim and Lundman. In the first step, each interview was transcribed word by word. In the second step, each interview's text was read several times word by word, sentence-to-sentence, and paragraph-to-paragraph to obtain a sense of the whole. In the third step, the meaning units of each interview were determined and coded. The all author analyzed the data and

revised minor disagreements after the research team discussion. In the fourth step, the codes were categorized according to the similarities and differences to the subcategories and categories. The categories were compared based on differences and similarities and presented into three final themes. Also, all the codes, subcategories, and main categories were given to one external reviewer. An external reviewer approved the accuracy of extracted data (16).

Trustworthiness

Credibility was established through maximum variation sampling, member checking, peer checking, and prolonged engagement with the participants and the data. In peer-checking, two nursing academic staff outside the research team with experience in qualitative research reviewed and approved the findings (17). Dependability was supported for all research steps documentation. For conformability, research team discusses, review and accept the extracted codes and categories. Also, standards for reporting qualitative research were adopted for transparency of all aspects of qualitative research (18).

Results

In total, twenty interviews were conducted. Two interviews were excluded from the study. Eighteen nurses with average age 38 ± 4 and clinical experience 16 ± 3 participated (Table 1). Most of the participants were clinical nurses and had a bachelor's degree.

Three themes emerged from nurses' statements: (1) promoting patient safety: "informing physicians about the complications and consequences of treatment," "preventing medical errors," "protecting patients from threats," (2) respecting the patients' values: "providing comfort at the end of life," "providing a comfortable environment," "commitment to confidentiality," "cultural observance," "respect for individualism," "fair care," and (3) informing: "clarifying

Table 2. Themes and sub-Themes.

Themes	Sub-themes
Promoting patient safety	Informing physicians about the complications and consequences of treatment Preventing medical errors Protecting patients from threats
Respecting the patients' values	Providing comfort at the end of life Providing a comfortable environment Commitment to confidentiality Cultural observance Respect for individualism Fair care
Informing	Clarifying clinical conditions Describing available services Being the patients' voice

clinical conditions," "describing available services," "being the patients' voice" (Table 2).

Promoting Patient Safety

The nurses did not consider the crowds of patients and the fear of COVID-19 as a justification for neglecting the patient. They stated that they were responsible for supporting the patient's safety. According to quotes, patient safety is achieved by informing physicians about treatment complications and consequences, preventing medical errors, and protecting patients from threats.

Informing Physicians About the Complications and Consequences of Treatment. Most ICU nurses state that they help physicians choose the best treatments by closely monitoring the patients' reactions to the treatments and continuously informing physicians.

"Physicians do not know the specific treatment of COVID-19... they test different methods. By carefully monitoring the problems of each of these methods such as cardiac arrhythmias, I help physicians choose a method with less complication" (p2).

Preventing Medical Errors. In the high density of COVID-19 patients admitted to ICU, it seems that medical errors are also increasing. Nurses prevented medical errors through accurate patient monitoring, supervision of novice colleagues, documenting and reporting medical errors. A female nurse said:

"I report the mistakes both to the authorities and my colleagues... when my coworker has such information in his mind, she will not repeat it" (p3).

Protecting Patients From Threats. Nurses prevented falls by raising the bed rails, teaching them how to get out of bed, and safely walk after long bed rest. The nurses' remarks reflected their worry about the rapid onset of pressure ulcers in COVID-19 patients. They tried to constantly change the patient's position, keeping the skin dry and carefully monitoring the patient's fluid status. These measures were taken while the beds of all patients in the ICU were equipped with air mattresses.

"Her mobility was reduced due to shortness of breath and severe weakness... We regularly changed the patient's position and used an alternating pressure mattress to prevent pressure sores." (p2).

In the critical cases of COVID-19, acute dyspnea, and life-threatening arrhythmia, in the absence of a physician in the ward, ICU nurses used appropriate medicine to save the patient's life, based on standing orders.

“The physician was not available due to the busy emergency room. I saw a bigeminy PVC on the patient’s monitor. I informed the head nurse. According to the standing orders, according to the standing orders, I administered 75 mg of lidocaine as physician order, and the patient’s rhythm converted to a sinus rhythm” (p6).

Respecting the Patients’ Values

The study results indicate the nurses strive to respect the patients’ values by providing comfort at the end of life, providing a comfortable environment, commitment to confidentiality, cultural observance, respect for individualism, and fair care.

Providing Comfort at the end of Life. Participants stated despite worrying about a high risk of infection, the dying patient should not be left alone. Nurses provide comfort for end-of-life patients by reducing pain and shortness of breath. In addition, family visits to these patients are often prohibited; nurses will allow families to make a telephone call with patients (measures such as playing family voice for the patient with a headphone, playback a pre-recorded comforting words from a family member).

“Although the condition of the hospital was critical and our workload in the ward was very high, we tried to make the patient have a phone or video calls with his family if possible ... We even transmitted the patients’ wills to their families by phone in writing”(p7).

Providing a Comfortable Environment. Nurses used the voice of the Quran, music, and humor to support their patients emotionally. Also, reducing unnecessary noises and lights and adjusting the environmental temperature and humidity made the patient feel comfortable. A female nurse commented:

“patients were annoyed by loud noises. By reducing the volume of the phone and dimming the room, we provide a more comfortable environment for patients” (P16).

Commitment to Confidentiality. The participants were committed to protecting physical privacy and maintaining the confidentiality of medical records. Regarding the importance of patient privacy, a female chief nurse said:

“COVID-19 patients did not like others to know they had COVID-19virus disease. We would not allow anyone to accessed the patients’ medical information without their permission” (p1).

Cultural Observance. Nurses respected the patient’s attitude, values, religious and spiritual beliefs. A female nurse said:

“She wanted to pray ... I helped her to ablution and turned her position to the Qibla” (p 13).

Respect for Individualism. The nurses stated that they respect the preferences and wishes of the patients in the treatment program. They helped patients with treatment methods, outcomes, and informed decisions. A male nurse said:

“ I will explain everything I want to do for her, of course, as long as the patients’ lives are not in danger” (p9).

Fair Care. The nurses stated that they observed a commitment to care for all patients, regardless of economic, educational, religious, or gender differences. A male nurse said:

“COVID-19 affects people of all races, both rich and poor; I provide care equally to all patients without discrimination” (p11).

Informing

The nurses inform patients of their clinical condition and health care setting. Also, they act as the patient’s voice and communicate the patient to the healthcare team.

Clarifying Clinical Conditions. The participants stated that they inform patients of their conditions, alternative procedures, treatments and tests, and discharge processes to assist them in making appropriate decisions. They also educate patients about the health services available in the community and how to prevent the spread of infection to others and prevent re-infection. A male nurse said:

“Plasma therapy was prescribed ... I told her that this plasma was prepared from patients with improved COVID-19 contain antibodies that could improve her condition” (p15).

Describing Available Services. Participants informed patients about insurance and health-supportive services to benefited their rights in the health care system. A female chief nurse said:

“He was a poor old man ... I told him that the treatment of COVID-19 was free, and he should not worry about the cost of treatment” (p1).

Being the Patients’ Voice. COVID-19 patients have difficulty communicating with their families and physicians because of isolation and intubation situations. The nurses emphasized that they acted as a patient liaison. They informed the health-care providers of the patient’s preferences and made sure that the patient understood the information provided by the healthcare team members.

A female nurse said: “ When the patient does not understand what the doctor says... I would explain the doctor’s words in a simpler way” (p8).

Discussion

According to the results of this study, promoting patient safety, respecting the patients' values, and informing are the main attributes of patient advocacy. Promoting patient safety is the first attribute of patient advocacy. Hospitalized patients have less control over their care and are exposed to various risks, so they need people to advocate for them (1). The study results showed that in the pandemic of COVID-19, the nurses maintain the patients' safety by informing physicians about the complications and consequences of treatment, preventing medical errors, and protecting patients from threats. According to the results of this study, respecting the patients' values is the second attribute of patient advocacy. In line with this, Baldwin claimed that respecting the patients' values is at the heart of patient advocacy (19). Most nurses believed that dealing with patients from different cultures and that patients were nearing the end of their life led them to pay more attention to the value of the patient. The final attribute of patient advocacy is informing that includes clarifying clinical conditions, describing available services, and being the patients' voice. Rainer argued that powerless patients need people to speak for them and intercede on their behalf (20).

Choi et al. conducted a field study for identifying the nurses' advocacy role and practices in public hospitals in Hong Kong. They concluded that nurses play an important role in ensuring safe practice in hospitals by reducing the risk of sudden changes in patient's conditions and the hospitalization process and correcting near mistakes of coworkers to prevent harm (21). According to the results of our study, the advocacy role of nurses in COVID-19 patients, in addition to using various methods to reduce harm to patients, includes valuing and informing patients to participate in treatment decisions.

Tiscar-González et al. conducted a qualitative study to explore the advocacy role of nurses in cardiopulmonary resuscitation. They found that three essential issues in advocacy of patients during cardiopulmonary resuscitation include accompanying patients at the end of life in the field of medical dominance, maintaining a pact of silence, and submitting to legal uncertainty and concerns (22). We found that advocacy for COVID-19 patients at the end of life included providing comfort, commitment to confidentiality, cultural observance, respect for individualism, fair care, and patient participation in treatment decisions.

Davoodvand et al. argued that the empathy with the patient (understanding, being sympathetic with, and feeling close to the patient) and patient protection (patient care, prioritization of patients' health, commitment to the completion of the care process, and protection of patients' rights) are the main characteristics of patient advocacy (6). Unlike the current study, Davoodvand et al. did not consider promoting patient safety and respecting the patients' values as attributes of patient advocacy. Also, Davoodvand et al. introduced empathy as characteristic of patient advocacy. Empathy is

the process of seeing the world as others see it. It also is a non-judgmental understanding of others' feelings when they communicate with us (23). Therefore, empathy should be considered as antecedents of patient advocacy, not its characteristics.

Nsiah et al. argued that advocacy involved protecting patients, being patients' voice, providing quality care and interpersonal relationships, and educating patients (24). The results of our study showed that in addition to the themes expressed by Nsiah, respecting the patients' values is one of the main attributes of patient advocacy. We aimed to identify the meaning of advocacy for COVID-19 patients admitted to ICU. Most Iranian COVID-19 patients admitted to ICU have different cultures and are nearing the end of life. These factors have led nurses to pay too much attention to patients' values, culture, and beliefs.

Sundqvist et al. state that providing dignified care, providing safe care, and a moral commitment are the characteristics of perioperative patient advocacy (25). The results of our study showed that in addition to the characteristics expressed by Sundqvist, informing the patient to participate in treatment decisions is another attribute of patient advocacy. In the theme of providing dignified care, Sandquist mentions only the issues of treating the patient respectfully, establishing trust, and vicarious autonomy. While in our study, issues such as providing comfort at the end of life, providing a comfortable environment, commitment to confidentiality, cultural observance, and fair care have also been considered.

Conclusion

ICU nurses in health crises such as COVID-19 as patient advocates should be promoting patient safety their patients, respecting patients' values, and informing them. Nurses have active roles in promoting patient safety through informing physicians about the complications and consequences of treatment, preventing medical errors, and protecting patients from threats. Nurses have an important and effective position in respecting the patients' values by providing comfort at the end of life, providing a comfortable environment, commitment to confidentiality, cultural observance, respect for individualism, and fair care. Informing includes clarifying clinical conditions, describing available services, and being the patients' voice. The real experiences of nurses presented in this qualitative study can help design prescriptive advocacy models for COVID-19 patients with life-threatening conditions. To realize the issue, it is recommended to conduct grounded theory studies in patient advocacy in special situations such as COVID-19 patients.

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.


Ethical considerations


This study approved by the Ethics Committee of Qom University of Medical Sciences, (Ethic code: IR.MUQ.REC.1399.174). Informed consent, anonymity, confidentiality, and freedom of participants to withdraw from the study were considered

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