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.

Anaesth Crit Care Pain Med 41 (2022) 101064

Contents lists available at ScienceDirect

Anaesthesia Critical Care & Pain Medicine

journal homepage: www.elsevier.com

Editorial

From operating theatre to "out of the walls" COVID-19 ICU and return... or not!

ARTICLE INFO

Keywords:
COVID-19
ICU
Quality of work life
Shortage of staff

According to PubMed, nearly 10,000 medical articles published since 2020 mention the keywords "COVID" and "ICU". Among them, less than 2% have qualitative methodological approach. Investigating the quality of life at work of caregivers or the quality of care provided to patients and their relatives requires questioning the professionals to probe the ground [1].

In the article presented in this issue, Guessoum et al. [2] still push the originality. They explored the medium-term experience (after 4 and 8 months) of caregivers who usually do not work in intensive care units (ICUs). Most of them usually work in the operating theatre (OT), from where they have been called upon to reinforce the teams involved in the critical care of COVID-19 patients admitted to "outside the walls" ephemeral ICUs during the first wave of the COVID-19 pandemic, when medical resources were very close to being exceeded, in France as in many other countries around the world.

This article is interesting to read for several reasons.

In these ephemeral ICUs, investigating the unusual settings and their positive or negative effects on these caregivers' work experience should help to answer the fundamental question about what to do and how to do it, the next time we will be faced with a similar situation, as well as the morbid-mortality reviews or the feedback from the November 2015 terrorist attacks, which greatly contributed to improving the management of a massive influx of victims [3].

The particularity of the first wave of the pandemic was the unknown length of the massive influx of patients. Mathematically, two solutions can be considered to balance the resources: to decrease the number of patients admitted in ICU (triage) or to increase the ICU bed capacity at the hospital ("outside the walls" ICUs). About the last solution, the study of Guessoum et al. aims to propose some ways to improve organisational practices.

Among the practices denounced by the caregivers because of the increased workload, some seem to depend little on the will of the managers (time dedicated to dressing and undressing, feeling of insecurity in front of the risk of contamination, etc.). By contrast, some of them seem to be contingent and could have contributed to the flight of caregivers from the ICUs observed during the COVID-19 crisis. Identifying some of these causes could make it possible, if not to attract new staff, at least to prevent further resignations if the situation was to recur.

Some measures should be corrected in an obvious way, without further discussion:

- The reported dehumanisation of care should make the caregivers give up excessive "biopower" [4] in favour of the beneficence towards patients and their relatives and their autonomy: how can banning the presence of relatives (who are informed about the risks of infection and who are willing to incur them) and personal items or personalised plasticised photos or posters on the wall of the room may be argued [5]? To help over worked ICU caregivers, the dressing of relatives may be carried out by the usual OT staff, made available by the surgical schedule cancel; the mobile palliative care teams may support the relatives.
- The prohibition of funeral rites must be duly justified.
- Psychological support and listening teams for caregivers from the time they are transferred from the operating theatre to ICU until they return and even after, must be intensified, by calling on private psychologists if the institution's own psychologists are not numerous enough. Team or individual supervision need to be made available on a regular basis, at least monthly.
- If open spaces must be required to admit more patients "outside the walls" of the ICU, it is necessary to separate the spaces to ensure a minimum of privacy (opaque dividers). Earplugs and masks should be offered to conscious patients [6].

Some measures put in place in times of crisis can become sustainable or even be developed:

- Strengthening teamwork by valuing small victories (applause after extubation), companionship and sharing of expertise between caregivers from different backgrounds.
- For relatives who cannot come to the hospital, providing patient news by phone (schedule to be defined according to the availability of both relatives and caregivers) and allowing video-mediated dialogue with patients.

The most relevant question that seems to be implicitly raised by the authors concerns the choice of anaesthetist staff from the OT to reinforce the intensive care teams.

https://doi.org/10.1016/j.accpm.2022.101064

This choice presents obvious advantages:

- They have knowledge of airway management, mechanical ventilation, anaesthetic drugs...
- In France, during residency, all anaesthetist physicians have received a training both in anaesthesia and intensive care medicine, even if this may be out of date.

Despite these advantages, there is a significant gap between the practices. In the OT, practice is characterised by:

- Sedentary, especially during long surgeries, in a rather quiet environment.
- Anaesthetist physicians and nurses interact with only a few colleagues during the day.
- They take care of only one patient at a time.
- Anaesthetist nurses do not interact with relatives.
- Confrontation with death is very rare.
- Some intensive care techniques (renal dialysis, ECMO, etc.) are exceptionally used.

Finally, one can wonder whether the non-specialist nurses who usually work in the medical or surgical units would not have been less disrupted.

Regardless of the caregivers called in, training times must be formalised so that everyone can practice without having to worry "about their lack of competence in intensive care, which engendered a sense of illegitimacy and a fear of harming patients" [2]. ''Express'' training has proven to be insufficient, in particular for requisitioned nursing students, to enable them to carry out the same missions with self-confidence as ICU caregivers.

On the other hand, usual ICU caregivers felt much devalued by the equivalence of skills awarded to extra caregivers who had ''benefited'' from these express trainings. This non-recognition of the expertise of ICU caregivers, acquired over years of experience, added to the latent worsening of the quality work life, exacerbated by the COVID-19 crisis, has motivated many of them to leave a profession which does not make sense anymore.

Rather than sporadically adding caregivers who have little or no previous knowledge of ICU techniques, and imagining them proficient in record time, maybe it would be more efficient and more beneficial for everyone's quality of work life to create and maintain an ''ICU reserve'', which can be immediately mobilised during crises. This reserve would be made up of theoretically trained volunteer caregivers whose knowledge would be maintained, and teambuilding reinforced through regular periods of practice in the ICU, within the designated staff to which they would be attached. These reservists, if it is illusory to hope that they will be as efficient as the ICU caregivers who have acquired their experience over the months and years, could nevertheless be immediately functional and effective.

If it becomes necessary to use even more staff, it would be more functional to propose a temporary taylorised work organisation: preparation of drugs outside the room by the ward nurses (in order to save on dressing and undressing sessions), the particularly time-consuming prone position, dedicated to a "specialised" team, made up of physiotherapists, members of the usual OT staff (surgeons and nurses); support for families (and patients) entrusted to psychologists (with back-up from private psychologists if necessary) and to palliative care teams.

Gradually, these extra care workers who are not reservists could carry out more and more diverse tasks.

To stop nurses from fleeing hospitals, it is urgent to think collectively about solutions to improve their quality of work life of these ''heroes'', so that they regain their motivation to work in ICU in post-crisis conditions.

Measures that are only financial in the form of a specialty bonus, granted to some and not to others, will not be enough: the recognition of their expertise and a real consideration of the conditions of practice of these professionals must be carried out. Promoting multi-professional exchange sessions, support meetings for caregiver teams, adapting the caregiver/patient ratio according to the needs of each one, are paths that could allow these professionals to rediscover collective work and restore meaning to their profession.

Conflict of interest

The authors have no conflict of interest to declare.

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Available online 25 April 2022