COVID-19: Never Seen Anything Like This Ever!

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“The single biggest threat to man's continued dominance on the planet is the virus.”

Joshua Lederberg, PhD
Nobel Laureate^{1(p1)}

Before December 2019, COVID-19 was an unnamed virus associated with pneumonia cases in Wuhan, China. By January 30, 2020, the World Health Organization (WHO) had declared the “outbreak” to be a “public health emergency of international concern.”² On February 11, 2020, the WHO gave this novel coronavirus a name—COVID-19 (genetically related to SARS-CoV-2). One month later to the day, the WHO officially declared the outbreak was now a pandemic. On March 11, 2020, President Donald J. Trump declared the COVID-19 pandemic a US national emergency. By April 16, 2020, more than 2 million people across the world have become infected and more than 130 000 have died, and we were not close to peaking in the United States.³ This is how quickly everything has changed. COVID-19 had virtually shut down

most societal functions across the world. Healthcare was under siege, battling unprecedented COVID-19 volumes and acuity that was capricious and not well understood—all consequences of a novel coronavirus.

Treating infectious diseases is a common duty in healthcare. Most American healthcare workers (HCWs) of this generation have lived through numerous pandemics—AIDS (1981), severe acute respiratory syndrome (2002), swine flu (1976 and 2009), Middle East Respiratory Syndrome (2012), and Ebola (2014). Yet, tenured and generally unflappable healthcare professionals have similar responses when describing COVID-19—“I have never seen anything like this before...ever.” Why? What is it about COVID-19 that is creating such chaos?

This battle is unique. COVID-19 has impacted nursing and nursing practice in unexpected and unnerving ways. Contributing factors to the chaos include the following:

1. Global personal protective equipment (PPE) shortage: COVID-19 is a highly infectious respiratory disease, and PPE is central to safe nursing practice. Nurses have seen firsthand that COVID-19 does not discriminate by age (despite early reports that the older adults were most at risk) or number of comorbidities. Healthy young patients

were suddenly and rapidly succumbing to fulminate respiratory failure. American nurses had watched COVID-19 march across the globe, and the death toll ballooned while the PPE supply dwindled. One nurse stated: “I have been a nurse for 40 years and lived through many pandemics, but I have never had to worry that I would not have adequate PPE or disinfectant wipes that I needed to keep me safe. I know it is not anyone's fault but this is real and terrifying.”

2. Highly communicable virus with no herd immunity: The spread of COVID-19 has been impressive. So much is not known with this novel coronavirus, and the only effective method to slow the spread is to isolate. The phrase “social distancing” is a new and powerful phrase that has colored our existence as a result COVID-19. To “flatten the curve” of viral spread and acute care demand, hospitals across the nation quickly adopted a “no visitor” policy. In 42 years, I have never seen this occur in healthcare. The agonizing result of this imperative is that COVID-19 patients were dying alone. The moral distress felt by nurses watching end of life occur in

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isolation has been traumatic and emotionally exhausting. In the United States, under normal circumstances, dying alone is not culturally acceptable. However, this was not a normal circumstance. The federal and state governments called for elongated “stay-at-home” mandates (by April 2, 2020, this order applied to 96% of Americans), which resulted in panic buying of food and staples (i.e., toilet paper—who would have ever imagined that toilet paper would be so valuable) across the nation. The lack of certainty of food and supplies created a threat to personal safety, and there was no time frame for when this would end.

3. Fear of taking COVID-19 home to loved ones: Hand hygiene, diligence to proper PPE use, and persistent wiping down of equipment and work areas did not alleviate the dread of potentially “taking COVID-19 home to my loved ones.” Nurses described in detail their elaborate methods to eliminate the risk of bringing the virus home post shift—they all had a routine and lived to it without deviation because the lives of their loved ones depended on it. Knowing the carnage of COVID-19 kept nurses from hugging their children or kissing their spouse. Many slept in separate bedrooms or fully self-quarantined in a separate part of their homes, never getting closer than 6 ft to each other. This virus had robbed them of peace and intimacy that fills one's soul.

4. Potential rationing of health-care: The signature of this pandemic was high volume, acuity, and consumption of resources. We had watched the pandemic countries before us grapple with rationing ventilators and withdrawal of care secondary to demand-exceeding supplies. In anticipation of this dynamic, US hospitals and ambulatory surgical centers across the nation early on responded by halting elective surgeries and procedures to conserve PPE, technology, and personnel. Moreover, Washington state and New York were 2 of the 1st states to experience the supply/demand inequity curve and developed COVID-19 triage of care and resuscitation policies to align finite and dwindling resources to serve patients with the highest probability of survival. Other states quickly followed suit understanding that this was a probable reality and required thoughtful planning. Unprecedented action, which was unfathomable to a nurse's practice just a few months ago, is a consequence of this virus. This generation of civilian nurses often shared that “I was trained to save lives, never this.” The resultant moral distress was real and palpable. There was a heaviness in the conversation reflecting the inability to reconcile the new reality.
5. Team disruption: As many hospital units transformed to COVID-19 units, nurses were displaced to new units or became COVID-19

specialists with no understanding of what this virus was or how to treat it. Across the nation, we were all learning as we went—this was a novel coronavirus, and we had no roadmap. Expanding ICU capacity and maximizing every negative pressure room meant that high-acuity nursing care was relocating to nontraditional areas. Teams became fractured, communication was interrupted, and nursing practice was challenged by continual and rapid changes. Even PPE practice changed numerous times in a matter of weeks. What mask to wear, under what circumstances, and for how long changed many times—even when strictly adhering to the Centers for Disease Control and Prevention guidelines. The constant iteration of practice, although important and necessary, created frustration and confusion. Nurses were simply trying to do their job and stay safe—not easy in times of rapid and constant change.

6. Child care, school, and social events closure: With little or no notice, states called for temporary closure of schools and childcare centers to slow the spread of the virus. This quickly (within a week) moved to permanent school closures for the foreseeable future. Nurses with young children were now facilitating online education or endeavored to home school. College-aged children returned home as universities closed across the nation. Graduations were canceled,

weddings were postponed, and it was impossible to even hold a funeral for a loved one who had passed. Churches, restaurants, professional sports, movie theaters, gyms, salons, and “nonessential services” were directed by the government to close in nearly every state across the nation. Humans are social beings, and social interactions all came to an abrupt halt. Life had dramatically changed, and no one was comfortable.

7. Economic meltdown: The COVID-19 virus became politicized in the United States, and at times, the effects of illness took a 2nd seat to bipartisan banter that did not lead to collaborative problem solving. Some of our nation's leaders have been criticized for their slow response, but when the shutdown of nonessential services occurred, the economic impact across the world resulted in a precipitous decline, and COVID-19 was to blame. The US stock market fell from historic highs in 2019, only to close with the worst 1st quarter in history in 2020. Spouses, family members, and neighbors were losing jobs at record rates. Many nurses reflected that “they were glad that they at least had a job, so many are losing everything.” The Federal Reserve Bank of St Louis reported (on March 24, 2020) that unemployment is predicted to skyrocket to 32% as a result of the COVID-19 crisis—higher than the peak of the

Great Depression.⁴ Whether the reports were accurate or not, the media around COVID-19 messaging was continual and grim. Fear of being able to provide for one's family was paramount and preoccupying.

Each of these categories, alone and collectively, represents a major disruption in nursing, nursing practice, and personal well-being. This crisis strikes at the core of the 1st three levels of Maslow's hierarchy of needs—physiological needs (survival), safety needs, and love and belonging. These levels represent “deficiency needs,” meaning if the levels are met, a person feels nothing, but when they go unmet, then anxiety ensues.⁵ Furthermore, post-traumatic stress disorder and depression may occur in some individuals when these foundational levels are not met.

The Nurse Leader's Call to Awareness and Action

Leaders across the world represented that “we are at war” with an invisible, tenacious, and unpredictable “enemy” virus. On April 5, 2020, Queen Elizabeth II gave a rare public statement to address the COVID-19 crisis calling this an “increasing challenging time” with “disruptions that have brought grief to some, financial difficulties to many and enormous changes to the daily lives of us all.”⁶ She further said “the pride in who we are is not part of our past, it defines our present and our future.”

Nurses take pride in the 18 consecutive years (2020) of number 1 ranking in the Gallup Poll for public perception of honesty and ethics.⁷ Public trust of nurses calls nurses

to lead through the present and future battle of COVID-19. This coveted and hard-earned trust relationship must similarly bridge nurse leaders to direct care nurses. This will come through calm, resolve, and relentless dedication to optimize patient and HCW outcomes. Well-defined strategies and an abundance of courage promise to determine our success.

The Chinese symbol for crisis has 2 symbols—one is danger, and the other is opportunity. When Winston Churchill purportedly said, “Never let a good crisis go to waste,”⁸ I believe he was calling for leaders to find the opportunity. Nurse leaders may lack the COVID-19 roadmap, but make no mistake, there is no lack of ingenuity and insight to overcome the circumstances. Nurse leaders are being called to several key opportunities, including the following:

1. Learning from others and proactive planning: Hope is not a strategy, and no leader will ever be criticized for overpreparing. Understanding what is occurring and developing a strong plan of proactive readiness will allow for fireproofing versus firefighting. Nurse leaders need to be stealing shamelessly from those who have executed successful strategies to expand acute care capacity, conserve PPE, mitigate workforce illness or burnout, enhance communication, optimize technology, and implement creative solutions to nursing practice challenges. COVID-19 required nurse leaders to make rapid and difficult decisions and, in some cases, without

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sufficient information. Having the ability to confer with chief nursing officers from across the nation is a safety net opportunity.

2. Change management: Rapid change, in times of crisis, calls for refreshing one's understanding of strategies of change management theories such as Lewin,⁹ Kotter,¹⁰ McKinsey & Company,¹¹ ADKAR,¹² and Kübler-Ross.¹³ However, the warp speed of COVID-19-induced change may require nurse leaders to accelerate teams through the phases of change theory that would normally move organically at an unsubscribed pace. The difficult nature of this pandemic is that the pace imposes a sprint response when in fact this was a marathon event. Monitor the resilience of your team.
3. Communicate, communicate, communicate: With transparent and timely communication comes trust and respect—even if the message is difficult or uncomfortable. Prethink and understand the priorities and concerns from those you serve, and when possible, start the conversation there. The consequences of COVID-19 are real, and they lived it daily. Listening and acknowledging the impact of the new normal is essential and results in trust. The noise of rumors and uncertainty will evaporate with timely and truthful communication. Nothing replaces face time; nothing surpasses authentic caring. If you are willing to be present in their

work environment, this telegraphs that you also believe it to be safe. Nurse leaders cannot fix all things, but they can connect in meaningful ways. “Run to the roar and be present.”

4. Leveraging influence: Nurse leaders are at pivotal decision-making tables and needed to know key priorities and how to move colleague stakeholders to quicker conclusions than generally comfortable. As care changed, it was important that nursing workflow in areas of technology, human resources (HR), policy development, ethics, and care delivery modifications was important to ensure that the nursing workflow was considered. An example of this was working with HR, talent acquisition, nurse educators, and nursing leadership to fast-track hiring, onboarding, and orientation for rapid deployment of nurses. In addition, ICU nurses are of the highest demand with this disease. Rapid cross-training and upskilling to ICU practice required nurse leader influence to help the team move quickly and differently. Nurse leaders need to use relationship influences to gain support for working outside the normal comfort zone. Moreover, influence is most easily accepted when supported by data first and qualitative perspective second. The refrain to that end—the data do not lie! Let your influence banner be patient centered and your message be forward thinking.

5. Recognition: It has been heartwarming to watch the world spontaneously and universally demonstrate gratitude for the work of those fighting COVID-19. At 8 PM, the people of the United Kingdom stop what they are doing and break into a several-minute applause for HCWs. The streets of New York City erupt in applause when an ambulance passes. Each evening at 7 PM, these tough New Yorkers went to their windows and clapped loudly in unison for the healthcare heroes. “Thank You” signs were prominently placed across the nation, and hearts and rainbows were hung on doors—all to recognize the valiant teams battling this virus. The result was that many HCWs around the world were brought to tears. Nurse leaders also have the opportunity to create a daily ritual of appreciation that messages the respect and appreciation for the frontliners. The use of social media internally and externally provides a powerful tool to showcase and celebrate team contributions—simple, easy, and so very impactful.
6. Psychological impact of the COVID-19: The COVID-19 “emotional workload” is different than the acuity workload. It is a phenomenon that applies to all HCWs dealing with this event and is measured in the moral distress experienced. This begs for the application of a tool to fully understand the

experience impact. One physician assistant described this best: "...I have never had an experience like this before... the fear in our patient's eyes.... I'm at a loss for words. I want to talk but there are no words." How this virus is being experienced may be different across individuals, but the feeling of emotional workload certainly can be described by most, even at the executive level. Our workforce needs leader support to stand up support forums, programs, and respite opportunities to respond to this emotional workload—not only for today but also for the many months to come. There will be long-lasting psychological effects of this pandemic.

7. Contributing to the science: This being a novel coronavirus, with so many implications to nursing practice, calls for robust nursing research in this area. COVID-19 nursing research could frame the future of care delivery for these patients and, more broadly, pandemic care. Nurse leaders need to be asking what is needed and how to support the development of a rigorous scientific study of COVID-19. Nursing scholarship is an important priority that can get lost in operational focus—the opportunity exists to elevate nursing research in the Division of Nursing Strategic Plan.

Hopefully, COVID-19 will be a once-in-a-lifetime experience. This

time has awakened the world to the power of a novel virus. The emotional workload of COVID-19 has undoubtedly left an indelible mark of fighting and surviving a pandemic war. There will be lessons learned related to our practice and our lives—nursing and nurses will not be the same; we will be better. The transformations in care delivery and demonstrated agility during this time will be evidence supporting that, indeed, we can do things differently and more swiftly than we ever imagined. COVID-19 has created new alignments across the world—a spirit of “we are in this together”—and could potentially change the world optic to heal past deep divides and offered hope for future partnerships that may extend beyond healthcare. As the world recovers, the international community of nurses should evaluate the future roadmap of our leadership role and opportunities in future pandemics. I have always believed that nurses are uniquely positioned to ensure the humane response to the pain inflicted upon humanity.

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