Reflections on working as a nurse in ICU at The Royal London Hospital during the COVID-19 Pandemic

By Robert Christie

I have worked as an ICU nurse at the Royal London Hospital (RLH), on and off, for the past 13 years. However, I took a break from ICU in 2017 when I moved into trauma research, before taking up a secondment in 2019 as a Trauma Nurse Co-ordinator in the wider hospital. The weekend of the 14th and 15th March 2020 stands out in my mind as my own personal COVID watershed moment. Although I didn't know, it was the last time I would work as a Trauma Nurse Co-ordinator.

I was aware that the Adult Critical Care Unit (ACCU) on the hospital's 4th floor had already started to deal with a number of COVID-19 cases, albeit confined to side-rooms and nursed in strict isolation. The possibility of redeployment was being talked about in e-mails, and Clinical Nurse Specialists (senior nurses in expert clinical roles within a set specialty area) were being asked to disclose their previous clinical experience and where they could work if they should be required to return to bedside nursing. The wards were busy with their usual caseloads and normal care was being provided, but the corridors and public areas of the hospital had an emptier feeling to normal and things felt different that weekend. Wherever I went in the hospital, there seemed to be an unspoken air of anticipation and trepidation. Earlier in the week I had listened to medical colleagues discussing what they were hearing from their counterparts in Italy, Spain and France about the overwhelming number of ICU admissions they were experiencing. Meanwhile at RLH, it felt increasingly like we were standing on the shore, watching the waves getting rougher and feeling the water splash around our ankles, as we waited for a metaphorical tsunami that was still out of sight but felt palpably close.

On 17th March I went into self-isolation as my partner developed Covid-19 symptoms. Unable to access a test (hospital staff were not being tested at that point) I was forced to remain at home for the next 13-days, reliant on TV news broadcasts, work e-mails and text messages from friends and colleagues for a sense of what was happening in my hospital and others up and down the country. On 23rd March, the UK Government imposed a nation-wide lockdown of all non-essential activities and services. During this time I remember the feeling of apprehension at what was happening; frustration at not being able to go to work and play my part as an ITU nurse when we'd never been needed more; and disbelief as daily life became defined by more and more social restrictions, and the sense of fear of this virus and what it could do to my loved ones became clear.

The Royal London I returned to on Monday 30th March seemed like a completely different hospital to the one I had worked in only a fortnight earlier. Redeployed straight to ACCU, it felt like I was entering a war zone. The environment, equipment and faces were all reassuringly familiar, but everything felt different – from the 'Donning & Doffing Stations' for personal protective equipment (PPE) located at the entrance to the patient bays on ACCU, to the way in which all areas of the unit – not to mention the staff - were now classified as either 'clean' or 'contaminated' Having been away from hands-on critical-care nursing for almost 3-years, I felt apprehensive about returning under such strange and

unprecedented conditions. But I also felt oddly convinced that I would be OK, and that I was doing the right thing – not just on altruistic grounds but also (more selfishly) for me personally. I had needed and enjoyed my time away from ICU, but I had missed it and my sense of being 'a fish out of water' had been growing for some time. Right from that very first day back on the unit, even in such strange and uncertain times, it felt like coming home. I felt I was back where I belonged.

Thereafter, my overriding memories of nursing through the first wave of the Pandemic appear as a series of snapshots; moments during each shift which I can replay in my mind at will. I can remember my nervousness the first time I put PPE on, during my very first day back on ACCU, and went into the bays on the unit which usually accommodate a maximum of 4 patients each. I found two extra patients in each (6 in total per bay), nursed on beds in between large clinical trollies with no curtains around them, and with everything that would normally be attached to a large 'gantry' suspended from the ceiling (bedside monitor, infusion pumps, suction equipment, etc) crammed together on a small dressing trolley or clamped hurriedly to a mobile drip stand, with cables trailing everywhere and bed sheets suspended from the same drip stands to provide makeshift screens. Many of the patients were attached to unfamiliar new ventilators or anaesthetic machines, as we'd already started to run out of the ones we normally used.

I remember the start of each shift, where over 50 staff were putting on PPE all at the same time – some in silence, others engaging in nervous banter and offering to help with gown strings and the writing of names and roles on plastic aprons, (as once the masks, goggles, face shields and hair caps went on, all hopes of determining the personal identity of the person you were working alongside was lost). The nervous introductions as you went into each bay, side rooms having long been abandoned as impractical and logistically impossible to staff safely with the overwhelming need to barrier-nurse such large numbers of patients who were so critically-ill. The way in which we had to allocate roles to each member of staff in our area of the unit for the duration of the next 12-hours, based on a hurried chat with them of their previous experience and what they felt able to safely do under the supervision and guidance of the ICU staff. As ICU nurses, we usually work on a strict 1:1 basis with any patients on a ventilator, but now we were being told to prepare for working on a 1:6 ratio in a worst-case scenario, with support from the non-ICU trained staff who had been redeployed. Fortunately, you quickly developed an intuitive sense of the skill-set, competency and experience of your redeployed colleagues in a very short space of time, (many of them from theatres or other critical care areas) and more often than not came the feeling of relief and a heavy burden lifted when you realised that they could be left, often autonomously or semi-autonomously, to provide much of the hands-on care, monitoring and observation that the patients required round-the-clock.

It is my firm belief that the redeployed staff are the only reason why we did not become completely overwhelmed as a critical-care facility. When I first heard that the plan was to redeploy staff from all areas of the hospital, including those with no previous critical-care experience at all, I was sceptical. Treating staffing like little more than a numbers game seemed risky to me, although the urgency to create more critical-care capacity out of thin air didn't really leave scope for much else. In the event, my reservations proved ill-founded. Flooding the ICU with more 'boots-on-the-grounds', more 'pairs-of-hands', was exactly what

stopped us from sinking beneath the weight of demand on our service. Similarly, the ability to mobilise staff so rapidly, and the willingness of matrons, middle-managers and lead clinicians to acknowledge the extraordinary conditions in which we found ourselves, and support staff in new and very different ways of working (which in many cases proved surprisingly effective), helped to raise morale and foster a sense of camaraderie, focus and joint-purpose which enable us to go to work each day. The ACCU Practice Development team deserve a special mention here, as they strived to achieve in a matter of days what it usually takes years to do, by up-skilling well over 200 redeployed staff – many of whom had no previous ICU experience – while simultaneously supporting their own colleagues on the shopfloor. Their efforts were as heroic as they were herculean, and they went above and beyond to ensure all staff were as well prepared as they could be and felt supported.

Anyone who has ever worked in a hospital will know that they can be incredibly tribal places, with professional and departmental hierarchies which can be hard to overcome. Similarly, the National Health Service can often feel anything but national, with hospitals, services and care so often configured in different ways, or divergent systems in use from one place to another. And yet, for the first time in my 23-year nursing career, it really did feel during the initial COVID Pandemic as though everyone in the hospital, and the wider NHS, came together with the aim of meeting the surge in demand for beds and uniting with a common purpose. Of course, this was only possible because most of the rest of hospital activity closed down or was reduced. As the COVID surge continued, this enabled the ACCU to branch out and takeover other departments including Theatre Recovery and the Paediatric Critical-Care Unit. And then, in early May, we were able to move into the brand new, purpose-built COVID ICU designed and fitted-out on the (previously empty) 15th floor of the hospital. This, for me, was when it started to feel like we might, for the very first time, be winning the battle against the virus at RLH. The COVID ICU was completed in 5-weeks by a construction team who worked round the clock 24hrs-a-day and had to transport many of the materials by hand up the 30 flights of stairs (two between each floor). It was spacious, light and airy. It was also open plan, with all support facilities (ie. storage rooms, blood gas analysers, medicine storage, etc.) located within the contamination unit, meaning that there was no longer a need for 'clean' and 'dirty' teams to co-exist within the same clinical area. And the views over the City and North East London were truly spectacular – particularly on night duty with the lights of the city all around us, slowly replaced by summer daylight as dawn crept slowly over the hospital each day.

But it isn't all positive memories. There are other, less comforting snapshots. The wailing of a patient's wife and daughters as they tried their best to say goodbye to their husband and father via an iPad on a 'Zoom call'. The elderly lady whose hand I held as she died at 11pm on a Saturday night shift, despite all of our best efforts. My memory of these times is of the doctors who stood with us, shoulder-to-shoulder, and helped to carry the burden of care. The Paediatric Registrar who spoke with that family over the internet and supported them through the process of treatment withdrawal, palliation and death with such humanity and compassion, despite being separated by many miles and under enormous pressure from the rest of her workload. The Respiratory Registrar who stood with me, as the elderly lady quietly slipped away and the numbers on the bedside monitor gradually drifted down. At times like this it felt like we were having to do more than just care. We were also bearing witness. Acting as a poor substitute for someone's family and loved ones. Holding the

hands of strangers and telling them they were loved, because the people who should have been there to do that were unable to be. Because we couldn't let them. These were the worst times, when it felt like professional boundaries had to be crossed and emotional barriers, gradually and carefully erected over many years, were pulled down in days. Death is not unusual in ICU, but not in such vast numbers or over such a short space of time as we were seeing with COVID. Similarly, so much of end-of-life care in ICU focuses on supporting the families of those who are dying and giving them the space and time to be present and prepare to say goodbye. We couldn't do this fundamental part of our jobs, and it meant we had to be the poor substitute in too many cases. These were the times when it became too much. Too ghastly for words. I only had a couple of moments like this, and as such I was one of the very lucky ones.

And then it was over as quickly as it had begun. At the beginning of June, approximately 6-weeks after we had opened the 15th floor COVID ICU, it was winding down and we only had a handful of patients there recovering from COVID-19. When the penultimate patient was transferred from the 15th floor to a ward bed, the final patient was transferred back down to the old ACCU on the 4th floor (newly de-contaminated and now back up and running with our near-normal caseload of patients) and the COVID ICU was cleaned and closed. Of the four COVID ICU wards which had been created, we had only used one (Ward 15C), and by the time it opened the first wave of COVID-19 in London had already passed its peak.

So what now? That is a question we have yet to answer. At present, the UK seems in the grip of a second surge in virus spread, although the knock-on effect upon hospital and ICU-admissions has been slower and more gradual to-date. At the time of writing, the 15th floor remains ready and waiting and contingency planning for a second surge in ICU demand is underway, but compared to our counterparts in the North, admission numbers remain stable with a slow (but steady) increase of patients on a weekly-to- fortnightly basis. Whether this will change – and how quickly – remains a subject of conjecture in which the whole country is participating. So far, the second time round feels different. This time we are more prepared for what to expect and have become more proficient in anticipating the twists and turns of the disease we are battling, even if the treatment remains largely empirical and supportive rather than curative.

It is still too early to write the final chapter on COVID-19. Indeed, it may be that we have only just finished the prologue. What is clear is that it seems likely we will have to learn to live with this new disease for some time until a vaccine becomes available. But whatever the future holds in store, in a strange way I will always be grateful to COVID-19 for the opportunity it afforded me to realise where I belonged as a nurse, and the route it gave me back home to ICU at the Royal London Hospital. In the event, I was never asked to look after more than 2 mechanically ventilated patients at any one time, and I think the lowest our ratio of ICU nurses-to-patients dropped was 1:3. And we were admirably supported by staff who were redeployed and willing to work outside of their comfort zone for weeks-on-end without fuss or complaint; many of whom hadn't done bedside nursing or shift work (let alone nights!) for years. My feeling is that these were the true hospital heroes of COVID-19. I know it was not like this in all hospitals and I count myself lucky and privileged to belong to a hospital which, while not perfect, has staff who prove time and time again their ability and willingness to innovate and come together to do whatever is required to

meet the needs of the patients they are called upon to serve. The events of 2020 have been unprecedented in so many different ways, and the situation we find ourselves in is far from over, but I am glad that I could play my part and - like many before me – I am proud to be able to call myself a Royal London Hospital nurse.

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