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LETTER TO THE EDITOR

COVID-19 pandemic and nurse teaching: Our experience

Juan Carlos Molina Ruiz, Jose Luis Guerrero Orriach, Maria Luisa Bravo Arcas, Angela Montilla Sans, Rocio Escano Gonzalez

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Abstract

In this letter to the editor, we would like to show in our hospital how our nurse team manage formation during coronavirus disease 2019 pandemic.

Key Words: COVID-19; Anesthesia; Critical care; Nurses; First wave; Training

Core Tip: Coronavirus disease 2019 pandemic in the begging was a great challenge for healthcare workers as there was few non-standardized information in non-trained staff in undesigned areas for critical care attendance. Thus, formation was essential to spread our increasing knowledge of the virus and increase number of trained staff to deal with these specific patients.

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TO THE EDITOR

We read with high interest the article by Wang *et al*[1] showing a protocol of remote training for nurses dealing with coronavirus disease 2019 (COVID-19) patients in intensive care unit (ICU) which combines traditional teaching and the use of new technologies to improve spread and quality of what is taught. In our ICU, joint work between nurses and anesthetists, was key in achieving results during the first wave.

However, a system such as the one proposed by the authors would be useful in the next waves or future pandemics.

During the first wave of the pandemic, almost all health care systems and centers collapsed from all around the world with serious difficulties in logistics, infrastructures, self-sufficiency and human personnel to face high request of health resources[2,3]. To our personal point of view, we consider lack of trained and prepared healthcare workers one of the main factors that contributed to our limited and suboptimal approach to patients at the beginning of this pandemic[4].

The needs from an infectious disease in which transmission among healthcare personnel has proven to be one of the main routes of contagion urges the creation of programs and protocols as described in this article.

In our case, we faced the first wave in an extreme situation in which, thanks mainly to our nurse team, a new critical care unit came up from an area previously designed for obstetrics and pediatric care and was set up to be completely operational just three hours before our first COVID-19 critical care patient was admitted. Even though it was a huge challenge at first, due to the lack of critical care trained personnel it became necessary to include non-specialized workers in those new and undersigned areas. In our hospital we did not do a protocol as shown in the article commented, which would have been very useful though. Instead, we sought for a balance between inexperienced and experienced nurses in which nurse team leaders taught formation, working skills and leadership.

We believe that online training should not be limited to staff that deals with COVID-19 critical patients and we propose that our working routine should be taught to other healthcare workers less experienced in critical care areas.

One of the biggest challenges we faced in this pandemic was how quickly all healthcare staff needed to adapt to the use of personal protective equipment, a situation completely new but of major importance as a failure in putting on or removing this equipment would be a source of spreading the virus among other patients or workers[5,6]. In our hospital, this task was assigned to our anesthesiologist trainees who took as an example other reference hospital protocols in our country and designed practical workshops designed for teaching all critical care staff. They also taught how to do complex treatment, such as how to intubate and how to prone intubated patients.

To summarize, we agree that these contactless protocols are necessary to standardize our ways of assessing and performing techniques in our critical care patients. We believe this formation should also be extended to physicians.

FOOTNOTES

Author contributions: All authors make equal contributions to the manuscript.

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