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FEELINGS EXPERIENCED BY THE NURSING TEAM IN COVID-19 ICU AND ITS IMPACTS ON MENTAL HEALTH

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ABSTRACT

Objective: To understand the feelings experienced by the nursing team of a COVID-19 Intensive Care Unit (ICU), in the face of the novelty of the pandemic.
Method: a descriptive, exploratory and cross-sectional study with a qualitative approach, following the COREQ guide, carried out with 12 nursing professionals from a COVID-19 ICU in a university hospital in southern Brazil, in 2022. The semi-structured interview technique was used and the Atlas.ti software was used to categorize the testimonies, with Minayo's thematic content analysis.
Results: The participants highlighted feelings such as fear, insecurity and stress, as well as the need for training and professional qualification to work in critical patient care sectors.
Conclusion: The care provided to patients affected by COVID-19 in the midst of the disease pandemic brought to professionals feelings related to anxiety, depression, and stress.

Keywords: Nursing. Covid-19. Mental health.

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INTRODUCTION

On January 30, 2020, the World Health Organization (WHO) declared the outbreak of the novel coronavirus a Public Health Emergency of International Concern (PHEIC), which is the Organization's highest level of alert as provided for in the International Health Regulations. This decision improves coordination, cooperation, and global solidarity to stop the spread of the virus, requiring health services around the world to fully restructure as well as adopt a series of measures aimed at preventing infection among workers and the population in general (RAFAEL et al., 2020).

The COVID-19 pandemic has presented itself as one of the greatest global health challenges of this century. At the beginning of this pandemic, due to the lack of scientific knowledge about this virus, the high speed of dissemination, and the ability to cause deaths, uncertainties about coping strategies (WERNECK; CARVALHO, 2020).

In Brazil, the challenges are even greater, considering the size of the country, varied health care conditions, unequal access to education; social inequality, with populations living in precarious housing and sanitation conditions, without systematic access to water and in a situation of agglomeration (WERNECK; CARVALHO, 2020).

This scenario within the Brazilian health system has brought a series of concerns, including those of a professional nature, justified by the need to reassess COVID-19 prevention protocols among workers due to the risk of exposure to the virus (GALLASCH et al., 2020). In addition, the issues related to Patient Safety, which already permeated a global concern, considering the damage caused, most of which is avoidable, have become even more evident.

In the hospital environment, the nursing team remains 24 hours in direct care of patients, thus being more susceptible to infection by the coronavirus (SOUZA & SOUZA; SOUZA, 2020). Due to the length of stay with the patient, nursing serves as a link in the multiprofessional health team, with the objective of improving workers' health and patient safety (MIRANDA et al., 2021).

Health care, when provided in an unsafe way, results in one of the main causes of death and disability and also in large financial costs on the world stage (WHO, 2021). Regarding the context of the care provided daily to patients and the repercussions on the health of the professionals involved, the occurrence of serious incidents or those that result in the death of the patient can bring serious consequences such as mental illnesses,

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feelings of guilt and self-criticism, which can affect the professional performance and personal lives of these workers (WHO, 2021).

As a result of health work, work-related mental health has been gaining space in national and international discussions (FERNANDES et al., 2018). The interdisciplinary approach has sought to understand the theme, given the complexity and the various factors involved.

Caring for the mental health of health workers and responders during the COVID-19 pandemic is essential for the safety of workers and patients. It will be very common for these professionals to feel emotional distress in the face of this situation, which does not mean that they cannot continue doing their work or that this is a weakness. Managing the mental health of professionals and psychosocial well-being during this period is as important as managing their physical health mainly so that they can have a better ability to fulfill their roles and develop their activities (OSHA, 2020).

In view of the above, the study in question aimed to: understand the feelings experienced by the nursing team of a COVID-19 Intensive Care Unit (ICU), in the face of the novelty of the pandemic.

METHODOLOGY

This is a descriptive, exploratory study with a qualitative approach to data using the COREQ guide. The study site was an ICU for the care of patients affected by COVID-19 of the Unified Health System (SUS), in a university hospital, in southern Brazil. The ICU had 70 beds and was intended for the exclusive care of patients affected by COVID-19. The care of these patients was carried out by a multidisciplinary team composed of nurses, physiotherapists, psychologists, social workers, physicians and nursing technicians.

The study participants were selected from a previous sample of 106 professionals, who joined a matrix study and who made up the nursing team of the COVID-19 ICU, composed of 230 individuals. Of the 106 who participated in the first phase of the study, 20 of them were identified with altered levels of quality of life at work (QWL), anxiety, depression and stress (ADE), concomitantly, totaling 20 professionals. Among these 20 professionals, only those who were still working at the hospital in question, who were not away from work, regardless of the reason, during the interview period, and who did not have a conflict of interest with the study (occupying a hierarchically superior position in the nursing care team) were considered, totaling 12 nursing professionals.

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Data collection was carried out in the first half of 2022 and took place individually, in person, in a private, safe and interference-free place, after telephone contact to schedule the interview. The semi-structured interview technique was used, performed by a nurse interviewer trained in data collection, through a script with open questions, in an attempt to know the factors that contributed to the change in the levels of ADE and QWL in the interviewed professionals. To characterize the participants, a structured instrument was used, containing labor and social identification information.

After the interviews, which lasted an average of fifteen minutes, they were transcribed. The data were imported into the Atlas.ti software, allowing an exhaustive reading of the content, followed by the formulation of the registration units and the creation of the categories. The testimonies were analyzed using the content saturation technique (FONTANELLA; RICH; TURATO, 2008). For the analysis of the interviews, Minayo's framework was used, classified as thematic (MINAYO, 2008). The validation of the thematic units resulted in the following category: Work-related feelings in the face of the novelty of the COVID-19 pandemic, subdivided into *Fear and insecurity of the beginning of work in the COVID-19 ICU, Professional skills for care in the COVID-19 ICU, and Reflections of routine in patient care.*

The study was approved by the Research Ethics Committee of the institution involved under Opinion No. 2,588,565. In compliance with Resolution 466/12, after explanations about the objectives and other ethical aspects, the participants signed the Informed Consent Form. The professionals were informed that their participation would be voluntary and that they could withdraw from the research at any stage, without any damage or loss. In the transcription of the testimonies, and in order to ensure the anonymity of the participants, the following conventions were adopted: NFS (Nurse) and NT (Nursing Technician) and the numerical sequence according to the order of interviews.

RESULTS

SOCIODEMOGRAPHIC AND OCCUPATIONAL CHARACTERISTICS OF THE SAMPLE

The study had 12 participants, including 4 nurses (33%) and 8 nursing technicians (67%). Of these, 11 (92%) were female, with a mean age of 30 years, two (17%) were single and eight (67%) were married/in a stable union; four (33%) had completed higher education and four (33%) had a postgraduate degree. Also, eight (67%) were hired through the Simplified Selection Process (PSS); six (50%) worked at night and nine (75%) of them

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had another job and 12 (100%) reported feeling overloaded. The length of work in the unit ranged from two to 18 months, with an average of 8.4 months. Of these, seven (58%) report that they did not have training to start working in the sector.

FEELINGS RELATED TO WORK IN THE FACE OF THE NOVELTY OF THE COVID-19 PANDEMIC

Fear and insecurity of starting work in the COVID-19 ICU

The beginning of activities in the COVID-19 ICU, due to the absence or little experience in intensive care associated with the new care arising from the care of patients affected by the coronavirus, was marked by a lot of distress, fear, insecurity, among other feelings reported:

> [...] you're going to come to COVID, turn around. We didn't have time to go through [...] due to the pandemic, we didn't have this adaptation, either you do it or you do it. So that's really what happened. We went to COVID! [...] I wasn't afraid to come here, I think the fear was when we got there we were faced with several situations [...] in the beginning it must have been difficult, I think for everyone [...] (1NFT).
>
> [...] The first three days were desperate because you can't master everything that has to be done [...] (2NFT).
>
> First of all, I was afraid, because at the time it was a pandemic, it was very strange, it was very unknown... an unknown disease. There were many people dying, health workers too (3ENF).
>
> [...] he wasn't invited, we were forced to [...] in fact, no one wanted to, right... It was a business that brought fear to us, to the family, to everyone... I went because I need to work, but if I could say no, I would have said no (1TE).
>
> Look, at first it was very scary, it was all very unknown [...] At first it was very scary, those people there with a lot of medication and adrenaline all the time. As an employee, seeing the death of a patient, it was very difficult, but the desire to win was greater, so we were always there and attentive to everything and everyone (4TE).

Professional skills for care in the COVID-19 ICU

Thus, another important point that should be highlighted is that professional training is not focused on a particular specialty and with the pandemic, the workforce predominantly comprised the care of patients in need of intensive care. Thus, the inexperience with complex care interfered with the work routine, leading to it being considered a stress factor for the professionals within the unit, as mentioned in the following statements:

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> At first it was very hard, because then I had never been in the ICU [...] At first it was very difficult, because like... We had people, like me, who came without knowing anything [...] I don't know anything, I'm leaving! because I don't know how to take care of a patient like that (1NFT).
> [...] It is rare for those who arrive and are lucky enough to stay one day, two days of training, of follow-up in the sector, with another nurse. Usually, we arrive here and fall into the dance (2ENF).
>
> [...] it was very difficult because I had never worked in the ICU [...] I have always worked in wards, I have more than 20 years of nursing and always in a ward. Then, coming across the same serious patients as those with COVID was very difficult [...] there were people who had never stepped foot in an ICU and had just taken an [undergraduate] course. And then it was very difficult because I had no idea what it was like to work; and then, go straight to the ICU that had no one to work. Wow, it was very complicated! [...] These new [professionals], like, they help a lot, but they were not prepared, they have already entered directly there. It was very difficult... thus, it is not their fault, but they did not have this knowledge (1 Thess).
>
> [...] The employees didn't know how to work, they had no experience, they didn't have a nurse with experience, they had almost nothing... There was no one with almost experience. We ended up suffering from it [...] qualifying left a lot to be desired [...] Qualification! That we deal with extremely serious people in COVID, it's different from you messing with a general ICU... which is trauma and other things than COVID (3TE).
>
> [...] had never worked in an ICU. It was even more tense (4TE).
>
> [...] We had no training when we entered; They do continuing education, as the subjects appear, they come to the sector and do the training... of [infusion] pump, of dressing... we have that (5TE).
>
> I think training, training, training... I also think that the people were thrown into there a lot [...] we know that the critical patient is another type of vision, another type of care and the people had no idea. So, there was a lot of training (6TE).
>
> [...] There was a nurse, as if she were a nurse teacher in there, the people came in and she helped in the first days... it helped, it was wonderful (8TE).

Reflections of routine in patient care

In addition to the stressors already mentioned and the difficulties encountered by nursing professionals, care fragility was evident due to the exhausting routine in the COVID-19 pandemic scenario, along with the work overload of multiple working hours, non-standardized care routines, lack of response/improvement to the care provided because the behavior of this type of virus in humans was not yet known, in so many different strains and waves, in such a short time. This indicated feelings of too much vulnerability in patient safety, as described in the following statements:

> [...] There are some that we see that the body itself will not be able to solve. But there is one that you see that theoretically would have every chance of recovering and not recovering (2NFE).
>
> [...] there were many people, many patients, it was a lot of rushing and so you had to find a way and learn and know how to do it (3NFT).

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> [...] with the team without ICU experience, let's say that for every 10 technicians, 2 with ICU experience and the rest no one. So, this part was kind of complicated, but we survived [...] technicians who left the general ICU and went to our ICU during the periods... I think there were almost two per period. So these people became a reference for others, to be able to help work, help get to know the routines, implement routines... because no one had an ICU routine [...] It was tense, because it was like that... we were two nurses per period, sometimes the nurse had time off and couldn't get overtime and was a nurse to be able to teach... sometimes from zero to each person (4NF).
>
> [...] I was afraid that someone would do something wrong to our patient and you would respond (1ST).
>
> Maybe an overload of work because everyone has always worked in two bonds... And then, because in that institution I did it like that... but there you do so, here you don't do it (2TE).
>
> [...] It was very difficult, we lost a lot of patients because of that... oh... I'm going to wait to divide the picture and it will stress and add up, because like this... from the moment you are inside an ICU you are to work, it is not about taking shifts to be in the "woo, woo", pray and do things. The ICU patient doesn't wait, the nora [noradrenaline] is expiring or the nora is ending... the sedation was good, but a clue, a vasopressin that was very stressful (3TE).
>
> The professional part was very much in "having", it was a team that was not trained, a team totally unprepared... This also weighed a lot, because we end up seeing many things, not only from nursing, right?... but even the medical part; A set [...] (6TE)

The professionals feared for the safety of the patients in their care and, as a result, for their own safety. In addition, the team's responsibility in relation to the recovery of these patients is perceived in the statements.

DISCUSSION

The pandemic has exacerbated a chronic scenario of the fragilities of the nursing team's work environment, the reports translate the feeling of experiencing an unsafe environment with unknown practices.

Such reports expose that health professionals were exposed during the pandemic to overload, fatigue, large-scale deaths, frustrations related to the quality of care, threats, aggressions and increased risk of being infected, they were also exposed to the feeling of fear and uncertainty that negatively influence the behavior and general well-being of these professionals and, consequently, they interfere with sustaining the quality of health care for the population (SCHMIDT et al., 2020; ORNELL et al., 2020).

In addition to the above, it is worth considering that, in response to the pandemic, a mental health crisis did indeed occur among nursing professionals. Because they are directly linked to the care of cases of the new coronavirus, they experience stressful

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situations, in addition to those already experienced in health services, including concerns, fear, and insecurity about the health of themselves and the population. With this, it was possible to reflect on the main implications of the pandemic for nursing professionals and the main support resources under development, especially related to the identification and management of stressful situations (RAMOS-TOESCHER et al., 2020).

A study conducted in the Philippines pointed out that the pandemic may have affected the quality of nursing care, resulting in care not performed and compromised care, increasing care risks and increasing the possibility of errors, affecting patient safety (LABRAGUE, SANTOS, FRONDA, 2022).

In Brazil, a study related the number of notifications and incidents between patients affected by COVID-19, patients with Severe Acute Respiratory Syndrome (SARS) and without SARS, managing to state that patients with COVID-19 had 30% more incidents when compared to patients with other SARS and when compared to patients without SARS, patients with COVID-19 had 60% more incidents. Pressure injury in patients with SARS-CoV-2 was 3.7 times higher than in patients without SARS (HERMANN et al, 2023).

The consequences of the pandemic in the hospital environment, due to the global crisis faced as a result of the need and urgency of care for these patients, compromised (largely) the physical and emotional safety of health professionals (WHO, 2021).

The need to solve the problems that occur daily due to the (until then) unknown scenario of this pandemic and the shortage of professionals, resulted in solutions such as the redistribution of personnel to functions unknown to them – a scenario of most global health systems (WHO, 2021). The hiring of nursing professionals to perform new functions for them was characterized as a practice in the hospital under study, given the scarcity of professionals specialized in intensive care and the need to increase the number of beds.

Stress related to the work environment can be defined as the harmful physical and emotional responses that occur when the demands of the job exceed the capacities, resources or needs of the worker (COX et al., 2002). Important factors related to work considered sources of stress are: the social relationships of the work environment and physical consequences and psychosocial aspects. Imbalance in these proportions favors stress and has negative consequences for workers' health (MADEIRA, 2010).

Thus, in view of the reports, the relevance of greater qualification to work in specialized sectors and with training focused on patient safety is ratified. There is a real need for professional training and constant updating of knowledge for health professionals,

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especially professionals allocated to ICUs, due to the demand for efficiency and skills in dealing with interpersonal relationships, the possibility of conflicts and the work process due to overwork and stress (NUNES et al., 2013).

As part of the "solution", the hiring of professionals with little or no experience emerged from the need to increase ICU beds around the world due to the pandemic, a fact that is no different in the study in question.

At a time of Public Health Emergency, it is understood that many professionals are extrapolating formal shifts and going beyond to be able to save lives, but it is essential that stops between shifts or shifts are preserved and carried out. The Organic Law of the SUS, No. 8,080, of September 19, 1990, guarantees the promotion and protection of the health of workers subjected to the risks and injuries arising from working conditions, as well as the recovery, rehabilitation and assistance to victims of work-related accidents, diseases and injuries (BRASIL, 2020).

In this study, there are several reports of how inexperience affected the mental health of professionals, either due to fear and insecurity in performing their duties or the fear of a professional colleague making a mistake and also because they had to teach their colleague to perform care – until then basic – in intensive care. In Thailand, newly graduated nurses have demonstrated feelings of stress, discouragement, and fear due to inexperience (SARNKHAOWKHOM et al., 2022).

The work in ICUs is carried out continuously for critically ill patients, who are highly dependent on invasive and non-invasive technologies in their treatment. Excessive workloads, living with the pain and death of patients under the care of the teams and the performance of laborious procedures contribute to the physical and mental exhaustion of professionals. There may even be repercussions for the quality of life of professionals (CATTANI, 2021). In this context, acting ethically and responsibly in the face of work overload becomes conflicting (MIRANDA et al., 2021).

The emotional deterioration to which nursing professionals are exposed in the work environment are expressive factors regarding the social determinants of stress-related disorders, such as depression, pathological anxiety, panic, phobias, psychosomatic diseases, the so-called Common Mental Disorders (CMD), or any other pathology, demonstrating that the work environment directly interferes with health, leading to stressors, no matter the position or position they occupy within the institutional organization. The professional who does not correspond to the demand of the work is often even coerced

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to simulate an emotional or motor behavior that is inconsistent with his real feelings of aggression, fear, irritability and, as a result, generally depressed (SANTANA, 2018).

Thus, the worsening of mental health can intensify as there is a need to adapt to harmful stimuli, requiring intense emotional participation and continuous persistence. In these cases, there is exhaustion due to adaptive failure due to emotional efforts, to overcome a persistent situation, or when the worker does not have adequate emotional stability to adapt to stimuli that are not so traumatic (SANT'ANA et al., 2020).

In several statements, the feeling of insufficiency in the face of the care provided (or that should be provided) is observed, with the patient as the victim of the whole scenario. However, the reports indicate that in addition to the patient, these health professionals are characterized as the second victim, that is, they suffer physical and emotional exhaustion when health care is not provided as it should and/or when it generates an adverse event.

Already known in the literature since 2000, the term "second victim" refers to the impact of adverse events on health professionals, including psychological, cognitive, and even physical damage (TARTAGLIA; MATOS, 2020).

In a study in Jordan, with pediatric nurses during the pandemic, high levels of *burnout*, low quality of life, and high occurrence of nosocomial infections were obtained as a result (KHATATBEH et al., 2023).

With the effects of the pandemic, especially the number of deaths, there was an increase in the recognition of risks related to care at a global level and with this, several actions emerged to promote safer care (WHO, 2021).

The reports of the nursing team under study show actions in an attempt to improve care for patients affected by COVID-19, including training, maintaining a nurse for educational support, and reassigning experienced professionals to assist the others. This strategy was also used in a hospital in São Paulo, which obtained satisfactory results with training through supervised bedside practice (SILVA; VALÉRIO; CUNHA, 2023).

The challenges of seeking to improve the response to the pandemic highlighted (even more) the importance of emergency training and the efficiency of actions in the face of the problems faced, such as data from a survey conducted with nursing managers, who reported the level of pressure as unprecedented during the pandemic (MANSOUR; SHOSHA, et al. 2022).

The proposed improvements in care and training were seen as insufficient for some professionals, so it is necessary to reflect broadly on the professional training of the nursing

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team. In addition, the fragility of the patient safety culture causes professionals and institutions to deal with adverse events/incidents/errors in a way that is harmful to the health of this professional and to the institution, since, when there is no safety culture based on the improvement of care and work processes and, consequently, of care, There is no safer health care. There is a latent and urgent need for measures to support health professionals, in addition to a welcoming and empathetic vision so that the safety culture to be applied at the bedside and in all work dynamics by these professionals is improved.

The declaration of the end of the COVID-19 pandemic by the WHO does not mean that efforts and care are suspended. It is urgent that special attention be paid to both the professional and the patient who has experienced hospitalization due to coronavirus infection; whether in the offer or in the receipt of care.

CONCLUSION

With the advent of the COVID-19 pandemic, health institutions were led to generate immediate responses to the problems that occurred, such as, for example, hiring personnel with little or no experience and exhausting workloads to already experienced professionals, which left deep marks on their mental health due to the routine in the midst of this pandemic. In addition, the work environment prior to the onset of the pandemic, which was already fragile, caused the care practice to indicate risks to both patients and health professionals.

In this study, it was observed how much the unsafe environment can affect the mental health of these professionals and, in view of this, it is up to us to question what will be the challenges and solutions proposed for change in this and other scenarios. There is an emerging need to bring together the themes of occupational health and patient safety in health policies, since they are correlated with each other, that is, if occupational health is not seen, patient safety will not be improved (and vice versa).

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