Gave All for the Greater Good

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In March 2020, I was an executive assistant, a non-clinician, and never worked in a patient-facing hospital environment. As Covid-19 cases grew, the hospital directed non-patient facing members to work remotely. An administrative assistant and I for the department planned to alternate weeks working from home. On Monday evening, first day I was home, my manager called. Said there was a need for experienced workers for admin support in a Covid ICU. Work would be in person until my redeployment ended. It was early in the pandemic, and I felt, if I didn't go, the department administrative assistant or someone else would be sent in my place. I agreed to go and was charged with reporting to the unit the next day.

By mid-March, except for infusions or life-saving care, all units that had been used for critical care patients receiving transplants were converted to Covid ICUs. I arrived at a newly converted unit working in an office inside the unit when the call came. All units would be under lockdown conditions until further notice. Non-patient-facing personnel were relocated outside the unit (I moved five more times during my redeployment tenure). Personnel in the unit were required to increase their PPE to include white Tyvek cleanroom coveralls (known as "bunny suits") along with goggles or a full-face plastic shield, masks, and latex gloves. This was standard for all nurses and doctors who worked 12-hour shifts in the unit.

My office outside the unit served as a private meeting place where the unit director and lead night nurse would meet with the lead day nurse and other team members at 7am to discuss patient turnover. These meetings dealt with two topics consistently – manpower shortages and deaths. It was more than the number of patients, but the frequent change of new patients infected with Covid-19 as others died. The time before the pandemic, deaths were confined to one or two over a reasonable amount of time. During the early months of the pandemic, we lost two or three patients every one to two days. Their bodies were transported to the back elevator in a black morgue bag. A newly admitted patient under anti-contamination cover and full oxygen would take over the empty room.

Emergency Use Authorizations were not issued because the medications that are now in standard use for treatment of mild to moderate Covid-19 symptoms were still in development. The vaccine would not go into circulation among healthcare workers until

December 2020. Nurses and doctors used techniques of physically turning patients periodically, but there wasn't more than treating respiratory symptoms. If there was a Code Blue situation, medical staff performed CPR which meant exposing themselves to an infected patient to preserve life. There were many patients transitioning to end of life or had died.

Manpower issues in the initial phase of the pandemic dealt with keeping track of nurses. Nurses, doctors, respiratory therapists, and the like were reassigned from different areas of the hospital. Some who were scheduled to work and were "missing" were either quarantining at home due to contracting the virus or were quickly sent to another unit that was short staffed. Print outs of duty rosters had names scribbled in ink or pencil – mostly first names – anywhere on the page. It was my challenge to identify team members and where they worked on every shift.

Traveling nurses came to New Orleans as the city was under lockdown due to having the highest infection rate in the state and country. They stayed in hotels and worked for weeks, but their initial indoctrination to the hospital staff was challenging. Initially they were treated as new hires and were required to complete 20 electronic modules on hospital standards (later this practice was waived as the pandemic grew). Although the time would have been limited in their completion, most who arrived wanted to go straight to the unit to treat patients. Some came with colleagues and wanted to work together in the same unit. This wasn't always possible as assignments were based on critical need. Due to the urgency of patients' conditions, training was done as patients received treatment. There was no time to ease newcomers into routines or acclimate them to the working habits of other team members. They learned as they went at rapid speed.

An additional task for nurses was being a conduit between the patient and family members. Lockdown prevented patient family members, friends, and even caregivers from entering the hospital let alone visiting patients. Communication was confined to either calls or video facetime between the patient and family members via the nurse. This drew team members closer to the patients they were treating. Time was always of the essence to have these connections. In a 12-hour shift, there could be a few of these sessions per patient. Some patients couldn't speak due to being on a ventilator, so the most that could be done was showing the family the patient as they lied in the hospital bed via video. Seeing their loved ones take their final breaths in some cases. I witnessed team members emotionally withdraw or sometimes react to a patient's death in the break area outside the unit. Tears, cries of frustration, and exhaustion overcame a few. Offered comfort or gave them space. Then they put on their PPE and returned to the unit repeating the process of

treatment as the cycle of life and death continued. We were all on edge and lived there for months. “It’s a fluid situation” became the unofficial Covid ICU motto on every patient’s progress. And we kept the process going.

Some patients had mild symptoms and were stable enough to be discharged. They were alive; it was always considered a win. Patient families couldn’t visit the unit but would send gifts as gestures of gratitude to specific staff members or the entire unit. Cards and flowers arrived. Children’s colorful drawings dotted the walls of the break room. Art projects to hang on doorknobs were displayed. Some shipped snacks or had food delivered to the unit for team members. A couple were homemade meals of paninis or desserts. All these offers were a welcome respite.

My position involved timekeeping for over 100 team members associated with my unit. Provided office supplies and checked on deliveries. Put up signage concerning safety protocols. A new duty was issued as the pandemic continued. Due to lockdown, team members working 12-hr shifts were not permitted to eat or drink in the unit. Because they had to doff all PPE prior to leaving the unit and then put PPE back on before re-entry, they tried to go if they could without drinking water. They wore three layers of clothing while physicially active on the floor, so they needed refreshment. The unit director asked me to get a barrel to fill with ice and water bottles to be kept in the unit for both shifts. During my three months, I maintained the barrel with icing down water bottles a few times a day and towards the end of the day for the night shift. It doesn’t seem like much, but meant a great deal given the circumstances.

There wasn’t time to consider my personal health or anxiety during my tenure at the Covid unit. I felt a part of the team and making a difference. During this time, administration professionals day happened. Due to the work, it never crossed my mind the day was coming. The unit director brought me a small bouquet of flowers in a gray plastic water pitcher used in patients’ rooms. Also, a card and candy purchased from a school fundraiser. Even in the most difficult times, some work to connect with others.

Upon my transition back to my department, I spoke with the unit director about the other team members rotating back to their departments as a new group would arrive. She lamented the change and I asked why. She then extended her arm out with her palm facing downward. Lowering her index finger, she curved it into a hook. She explained that caring for ICU patients meant you had their lives in your hands. In some cases, you were holding their lives at the very end of your fingertip. It was the difference between life and death. When she left a patient’s room, she knew the current team would carry out orders without

question. An unspoken trust was developed where everything that could be done would be done. Now training would need to be worked into the schedule which was tough.

All of us were tested daily and in different ways during the pandemic in the Covid ICUs. No matter how we developed as medical professionals and humans, many patients died despite our best efforts. The virus didn't discriminate and was relentless, but so were we. Success was measured in helping every single patient to the best of our ability until the level of care was no longer needed. We all made a personal sacrifice by risking our physical and mental health to help others who had no one else to turn to but to us.

All was done until nothing more could be done. That is the lasting legacy that will remain for those who stepped up to the challenge of healthcare during the pandemic.