436

Inside a COVID ICU with an LNC

Laura Chung

What's it like to work in a med-surg ICU during a pandemic? Laura Chung gives a first-hand account of her challenges and how her work impacts her family. Her insights provide a sobering reminder of how much we owe to our dedicated front-line medical workers.

Key points of this episode of Legal Nurse Podcast:

- Medical workers are now universally wearing masks and goggles, regardless of who they're treating, and IV pumps and ventilators are kept outside patients' rooms.
- She pinpoints a key factor that would lessen the ravages of the pandemic.
- Laura offers a prediction on the lawsuits that may follow from preventable flaws in the response to the epidemic.
- Laura offers a prediction on what may follow the vaccination process
- She calls for a nurse or nurses to be added to the COVID Task Force.

Patricia: Hi. This is Pat Iyer with Legal Nurse Podcast. And today we have with us a nurse who has special experience in today's environment. She has experience as a nurse for 20 years, working both on the East Coast and the West Coast, working as a staff nurse and in a variety of positions. She also has a master's degree in Nursing Education and Healthcare Leadership. She went to Regis College and currently lives in and around the San Francisco area. Welcome to the show, Laura.

Laura: Thank you so much for having me, Pat. It's an honor to be here.

Patricia: Can you tell our listener what kind of unit you work in now?

Laura: Sure. I work in a MSICU which stands for med-surg ICU. And we're actually the designated COVID receiving unit. So, any patients that are sick enough to need critical care come to our unit.

Patricia: Okay. And how long has your unit been in that position of being the designated unit?

Laura: Well, I guess when things first started to get bad with COVID, we were designated. So, I think we got our first patient in the beginning of March. And we've had more patients, so we've been up to 11 or so COVID patients, then we'll go back down. And now we are seeing an influx once again of really sick COVID patients.

Patricia: Okay. And we are recording this on the first day of December, to give our listener the timeframe. Can you tell our listener how the unit has evolved? What kinds of changes have occurred in the unit over time, from when you first started getting patients in March to now?

Laura: Sure. I would actually argue that nursing has changed more in this past six months than it has throughout my 20-year career. There have just been so many intense changes. One of the biggest changes is universal masking. So, I have a picture of myself in February in the unit, titrating some IV pumps. And actually, my hair is able to be seen and I'm not wearing a mask. And it almost seems like a step back in time, because now we are fully covered. We always wear something over our hair. We always wear masks, except if we are in the break room for a brief moment when we're eating.

And I really think that there have been some good changes that have come about because of this whole pandemic to help protect nurses. So, another change is that we are now wearing eye protection any time we are within six feet of a patient. So, we have goggles or glasses that actually have splash guards on the top and sides as well to protect our eyes. And it doesn't matter if we're going into a COVID room or not, we are supposed to wear them. I have seen a bit of resistance. But I'm all for it; any extra protection you can give me, I am there with it.

So, some other changes that we've had, even now when we are emptying urinals, emptying Foley catheters, we actually put a chux over the toilet or over the hopper to prevent backsplash, just another protective measure that we hadn't been doing. And I really think it's important to protect our nurses. We're the largest group of healthcare providers, so why not take these extra protective measures?

A few other changes in the unit, Pat, if you had told me a year ago that we would keep IV pumps and ventilators outside the patients' rooms, I would have said, "You're crazy. There's no way." But we actually use extension tubing for all of our IV medications for our COVID

patients. And we keep the pumps outside of the room. We thread the tubing through and as well as the ventilator machine, and this is to conserve PPE. Because the ventilators and pumps alarm so much that literally as soon as you step outside of a room, the pump would probably alarm for whatever reason, and you would have to go back in and don all that PPE. And it's just such a waste of PPE, when we only have a certain limited amount right now. So that's another huge change that I never would have thought would have happened.

Patricia: A lot of changes. And when you were talking about the resistance that some of the staff feel, I was thinking about the nurse who's been in the headlines recently for making comments on Facebook about how she is opposed to wearing masks or doesn't wear masks, I'm not sure exactly what she said. I do know that her employer suspended her. Can you comment on that story?

Laura: Well, I know there has been a lot of resistance, but to me, personally, I think you're protecting yourself as well as protecting the patient. We actually mask patients now as well if they're not ventilated. And it's just a measure of protection that is necessary. I think masks did become this big political debate, unfortunately. But I just go by the science, and I think that's, hopefully, what people are trending towards. And the science shows us that wearing a mask drastically decreases the spread of COVID. So, I can't understand why anyone would be against that, especially a nurse in that position. I always see nurses as examples to the public. So, it's unfortunate.

Patricia: And that's probably why she got suspended.

Laura: Yes.

Patricia: Because of the image of nursing. In addition, the other headline that's been around is the CEO of a hospital, I believe it was North Dakota, who made a statement to the staff that he didn't have to wear masks because he had recovered from COVID. But I don't think anyone knew he had COVID to begin with. And he and the hospital system had an agreeable parting of ways after that headline came out as well. The headlines are certainly filled with stories right now, as we're recording, about how hospitals are at the breaking point, trying to figure out how to accommodate more patients, converting offices into hospital rooms, making rooms semiprivate.

And then there's the controversy of the, I believe it was North Dakota, where the nurses who were COVID positive were being told they should come to work. And they would work with COVID patients, even though they were testing positive. Presumably, no one else in the hospital would come in contact with them while they were COVID positive. I don't understand that rationale, but I believe that the hospital felt desperate that they didn't have enough nurses to be able to take care of the patients.

Laura: Yes. And it's so unfortunate right now. There is definitely a shortage of nurses, especially ICU nurses. We're lucky in our hospital, we've had a plan since the beginning. We've surge-trained a lot of nurses that used to be in critical care. So, nurses that are now in cath lab, or PACU, post-anesthesia care unit, they surge-trained with us and did a shift or two with us in February and March to kind of get their feet wet again. So, we're okay right now, because we do have a lot of travel nurses helping us out. But we're hoping, if we do see those really high numbers, that we'll be able to call on those nurses.

Patricia: And the comment about travel nurses that I've been reading in my obsession with the news, I have to tell you, I got pulled back into the news after successfully resisting it for years, but when COVID hit …

Laura: Didn't we all?

Patricia: … wow, I was looking at the headlines. The difficulty with travel nurses, that I have read, is that it used to be that you could pull them, like when New York and New Jersey were having such terrible problems in the spring, travel nurses came from different parts of the country. But now that there are simultaneously many areas, particularly in the Midwest and West, that are in trouble, there aren't enough travel nurses to pull into those areas.

Laura: Yes. And I will say that, here in California, we are known for having very good ratios. We have very good support here in California. So, I have to say that we do have a lot of travel nurses that came out here because they do realize that we will have better staffing. And I used to be a travel nurse myself and ended up staying in California because of the ratios, which we always try to maintain. And as of now, we do have enough help. But I can see where in other states—everyone knows the Midwest is surging right now—do people really want to go

there and know that they'll be put into difficult situations? And I just feel for all of those nurses that have such sick patients and limited support right now.

Patricia: What is it like for you working in the ICU, where you used to be able to have family members at the bedside, at least for some period of time with the patient? What is it like for the patient and the families to be separated?

Laura: Pat, it is such a difficult situation, and it is just heartbreaking for all of us. Obviously, with our COVID patients, we don't allow any visitors. With our other medical surgical patients, we've gone back and forth where they've allowed one visitor for the length of stay. Now we're back to having no visitors at all, except in end-of-life situations. And it's just heartbreaking for everyone.

We do have an iPad that we allow patients and families to FaceTime. So that's something. Sometimes, we just call the family, and I put my phone on speaker and let them talk. It's tough, too, we've had a lot of language barrier issues. So that's a whole other thing to deal with. Sometimes, families are calling, and they can't really communicate their needs, so we do our best to get translators. But we've just had some heartbreaking situations where patients have died, basically, by themselves.

And we've always been an open visiting unit, we've always had families at the bedside. And I mean, I've let in 20 people, sometimes. And that has been one of the hardest things for us, to have these poor patients just be by themselves and not have their family nearby, and to have to call, as the chart nurse on duty and, through a translator, let the sister of a patient know that her young brother has passed away from the effects of COVID. It's just so heartbreaking.

I really do think that's been one of the toughest things for us ICU nurses to get used to, is not having the family there when patients are in their final moments. And it's just so hard right now.

Patricia: And are you seeing people who are there for prolonged periods of time?

Laura: Yes. Our COVID patients stay for weeks, unfortunately. It just seems like the disease affects them so strongly. It just takes ahold of their

lungs, and they will be on a ventilator for two, three, four weeks, getting to the point where they might need a tracheostomy. It is not a quick fix at all. I know there was so much confusion with ventilators, especially in the beginning, but it's not like we put a patient on a ventilator for two or three days with COVID. For a simple pneumonia or a sepsis, maybe we would; maybe we'd be able to wean them quickly. But with COVID, these patients require proning. So, we have to, oftentimes, flip them onto their bellies to help expand their lungs, because their lungs are just so compromised. So, we'd prone them while they're on the ventilator. And it is a lengthy time that they are on the ventilator until we can begin weaning them. It's usually weeks.

Patricia: I can think about all those expert fact witness cases that I wrote that reached that magic, I'm remembering, about 14 days, two weeks on the ventilator. And then there were discussions of, can we wean them? Can we wean them? Or do we have to trach them and get them off on that? Then they would try a weaning trial, and the patient would start getting into respiratory distress, back on the full ventilatory support. And it seems like that would be your daily life right now.

Laura: It is. It is, and just the proning of patients. It sounds simple, turn the patient on their stomach. It is not when they are intubated, when they're on the ventilator, when they've got six, seven, eight medications infusing into one little line. They have tubes, multiple other tubes. So, helping prone a patient is really an orchestra. It's like an orchestra, every person in that room is needed. We have the respiratory therapist, we have lift team to help us actually physically turn the patient, because, oftentimes, these are big patients. We have one to two nurses, one to two respiratory therapists. So, ideally, it takes five or six people to turn the patient on their belly. And so, we're all in there in our PPE. And it's just such a commitment by the staff.

And I just want to give a shout out to our respiratory therapists, because I think everyone knows about doctors and nurses, but they don't get the recognition that they should, because they are right there at the patient's bedside, managing the ventilator, managing their airway, making sure that that tube doesn't come out. So, my thanks to them.

Patricia: Yeah, you just made me think about the proximity of the respiratory therapist, and also to anesthesiologists, who have got their face down close to the COVID patient in the process of providing care.

Laura: Yes.

Patricia: And then how long can they stay on their stomach before you have to repeat the whole process and get them on their side or back?

Laura: So, we usually keep them proned for 12 to 18 hours, and then we turn them back. Depending on how much time we need on their back, it could be anywhere from 4 to 6 to 12 hours, and then we would prone them again. Each patient is a little bit different; we have to see how they tolerate it. We really have to be careful with their skin, we've had a lot of skin issues.

And every two hours, when the patient is proned, we are actually rotating their arms and face and head and neck to make sure that they don't get breakdown, to make sure that their joints and muscles and bones don't get stiff. So, we actually have to rotate them. We call it the swimming position. And we bring their arms up and down to make sure that they get that rotation, because often they're paralyzed as well, so they can't move on their own. So, we have to do that for them.

Patricia: I'm just thinking about all the people and all the resources. And the Legal Nurse Consulting Conference that we held in October of 2020 included Diane Krasner, who is a wound care expert, who talked about the increased incidents in pressure sores in ICUs, partly due to this whole acuity issue, partly due to the COVID skin phenomena, where there's decreased circulation to extremities. And we always thought, well, people are going to be spending all their time laying on their back. And certainly, you're describing where there's a variation necessary. Typically, we would, as nurses, not position people on their stomachs. It's not one of those, side, back, side. No, no, stomach? But it's all changed because of the need to help support the lungs.

Laura: Yes, it's another huge change in nursing once again. Maybe before all this started, we would be proning one patient that had a really bad pneumonia sepsis issue. But now, in our COVID pod, we'll probably have six patients being proned. And just the number of resources that

it requires is huge. The amount of PPE. Again, we're going in at least every two hours to rotate their arms, head, and neck, so it's just a huge undertaking.

Patricia: And I think that everyone right now is hanging on to the hope that the COVID vaccines which, as we are recording this, are being tested, being found to be effective, plans being worked out to who gets them first. Is it the people in the nursing homes? Is it the healthcare providers? Someone suggested, in one of the articles that I read, you should give it to all the people who refuse to wear masks because then you can take out the super spreaders. What are your thoughts about how a COVID vaccine is going to work to reduce what you're seeing right now?

Laura: Right. Well, I am very hopeful for a vaccine that comes out soon. I do think distribution is going to be really challenging because we don't have a national health plan. We don't have anything national, so it's going to go state by state. And I do think there are going to be distribution issues, for sure. And then, also, when people think, vaccinate the frontline workers first, I don't think people realize all the healthcare providers that work in the hospital to make things possible.

So, we're not just talking doctors, nurses, respiratory therapists, we're talking environmental services, the people that are going in those rooms every day, in those COVID rooms, cleaning the rooms, they're very high risk, laboratory, pharmacists, anyone that is in the hospital really needs to be vaccinated. So, it's just a huge undertaking.

And then rolling it out to the nursing homes, the general public. So as much as I do want to put my faith in the vaccine, I really think that we need to continue masking, social distancing, handwashing, those basics can't go away. And we have to continue those even though I know it's just been such a long journey, and we're all sick of wearing masks. But we've just got to continue it right now. Because, sure, the vaccine will help but rolling it out, it's going to be a long process.

Patricia: And from your perspective, working in a critical care unit, when you walk in the door, what is your routine for fear of bringing home, potentially, the virus to your family? You have kids, you have a husband, how do you handle that and how do your coworkers deal with that, I would think, constant concern about how do I separate

myself from this hospital so that I can go to a home and feel like I'm safe?

Laura: Right? It is tough. We're very careful at the bedside, especially in the break rooms. We have two break rooms that we use. We try to not eat across from anyone. So just all those little measures in the hospital, we're very careful. We even mask as soon as we get out of our car in the parking lot, we have to do that. And then when I get home, I'm sanitizing everything, even my name badge gets sanitized, my water bottle, everything. And then, completely strip down. We do have hospital scrubs that we wear.

But then when I change to go home, I even get out of those scrubs as well and get right up to the shower. My kids are older, so they know, "Don't touch Mommy. Don't go near her." But it's exhausting, just thinking about all those protective measures that I have to do to keep my family safe. And we are very strict about staying in our own little bubble. My poor kids haven't really had a play date with any other children since March. So, we are very strict about making sure that we are safe when we're at home. We're distancing, we're masking. And my kids are all on board with that because they know how important it is. And they'll even point out, if they see someone without a mask, "Mommy, why don't they have a mask on? Don't they know better?"

So, really educating your kids about how important it is to do all those measures, the handwashing, the distancing, and the masking. I can't say it enough.

Patricia: I have heard about healthcare providers who are living in the basement, who get food on a tray at the top of the steps to keep completely away from their family.

Laura: Well, my husband and I are both frontline workers, so I don't know. I wouldn't trust my kids to run things by themselves.

Patricia: Does your husband work in a hospital as well?

Laura: Yeah, he's a hospitalist, so he's right on the frontlines as well. And we just do everything we can to stay safe, and just interact with our own little pod as few people as we can. Because we would feel horribly guilty if we ever spread it to someone else. And, luckily, we have a good PPE situation at the hospital right now, thankfully. We've had a

few supply chain issues but, overall, we've had enough PPE. So, we're very thankful to work for the place that we do.

Patricia: There's also some discussion, as we're recording this, and the administration, the presidential administration will be changing at the end of January, of appointing a nurse to the COVID Task Force. I don't know where that discussion lies, but what do you think a nurse could bring to a national task force?

Laura: Well, absolutely, I think nurses are the largest group of healthcare providers in the U.S. We are also the most trusted profession. We've gotten voted that year after year after year. And I was really disappointed to not have a nurse on the taskforce initially. And I did tweet President-Elect Biden about adding a nurse to his taskforce. I have not heard of one being appointed yet. But I know that the ANA, American Nurses Association, has been active, and AACN, they've been actively pursuing that. And I just think that nurses are able to educate patients and the general public in a way that's really understandable. Again, we're very trusted by the public. So, I really think that a nurse, or nurses, multiple, could be so beneficial to helping the public with this.

Patricia: I think you're right. And I'll be curious to see how that all plays out. The other thing that I'm watching with great interest is whether President-Elect Biden will make a national law requiring masks, as opposed to the governors of certain states saying, “No, we're not going to enforce this.” Even down to some states have differences from township to township about their regulations. And in Florida, where I live right now, Governor DeSantis has renewed his law that says, no, you may not require masks in your township. What do you think would happen if there was a national mask mandate?

Laura: Well, I do think it would help things, overall. But I do think there would be a lot of resistance as well. And it's tough coming in and enacting it when we're already eight months into the pandemic, rather than enacting it initially. And again, this is where I see a nurse could be really helpful for educating the public about why it's necessary. And just for people to know that this isn't forever, that we're wearing masks now so we can return to normal life, hopefully, and get rid of COVID. So, it'll be interesting to see how this all plays out with the change in administration, for sure.

Patricia: I know. My personal opinion is it's unfortunate it became politicized as early as it did, and the science didn't take over to help people understand the necessity. I find it hard to believe that there are people who still don't believe that COVID exists, that they're calling it a hoax. There was a headline, just in the last couple of weeks, of somebody who was being intubated in a COVID unit who was saying, "I can't have COVID." just before he had the tube put down his throat, "COVID doesn't exist. This isn't real. This isn't happening to me."

Well, how could you have such denial? That's what I don't understand. And I find human nature to be endlessly curious. For me, I like to know why people do what they do. I'm interested in people's motivations and levels of knowledge, particularly as it relates to healthcare. I don't have any explanation for why people think that COVID doesn't exist. Have you encountered that belief at all in the patients that you take care of or in other people who say to you, "You're working in a COVID unit? COVID doesn't exist."?

Laura: I have, unfortunately, encountered that with families of patients that have it, and just the disbelief, trying to explain to them via the phone, of course, because they can't visit, any patient that has COVID we have to assume that the whole family has it, so we can't let anyone in. But yes, I have encountered that, and it's just so unfortunate. And I guess it did stem from all the political issues in the beginning and the lack of belief in science. To have to tell a family member that their loved one died of COVID, and they really just didn't even believe that it existed, it's such an issue and it's such a sad problem to have. And just thinking if we'd been better about masking in the beginning, maybe so many people wouldn't have died. And it's just so, so hard right now.

Patricia: Do you have any parting advice for the legal nurse consultants who are listening to this or watching this podcast on our YouTube channel?

Laura: I would say that one of the biggest issues right now is going to be healthcare workers and their access to PPE. I could see that being a huge legality issue in the months ahead, where if a healthcare worker did contract COVID, and they didn't have the proper PPE provided by their workplace, I could imagine that person would take legal issues with the hospital. So, I really do think that so many legal issues are

going to stem around PPE and healthcare providers' access to it. So, I would definitely start paying attention to these issues right now.

Patricia: I just saw a statistic that there have been 884 healthcare providers who have died from COVID. And it's in the hundreds of thousands, I think it was maybe 240,000 people in the healthcare profession had gotten infected. That number, the second number, it's a little unclear in my mind, I just read this statistic yesterday. So, by the time you listen to this, the number will be different.

Laura: Right.

Patricia: But a phenomenal number of people who we have lost from COVID.

Laura: It's just heartbreaking. And to think that it could have been prevented with better access to PPE. And in the beginning, just it was just such an unknown, is it transmitted through surfaces, is transmitted and airborne, and the policies and procedures kept changing so rapidly. I mean, literally, I would have two days off, and then there would be a new policy, and I'm sure that's true of other places as well. And then just the lack of PPEs, so N95s or the respirators, people would wear those for days on end as they were caring for patients. And then they would, unfortunately, contract it because those masks, they were single use, they're not meant to be worn multiple and multiple times.

So, it just is such a terrible situation for these healthcare providers that are trying to help people, and then they're kind of lambs to the slaughter. They didn't have the equipment necessary and there was no national plan to roll out PPE. It was going state by state, facility by facility. And facilities were paying exorbitant amounts to get PPE. So, it's just a very unfortunate situation. And I hope now that we're better supplied throughout the nation with PPE, but I did hear, even in the Midwest, that they're short on gloves. It's just those basic things that you have to have when caring for any type of patient, let alone a COVID patient. So, unfortunately, we are still having supply chain issues.

Patricia: Yes. If somebody, who is listening to this program or watching it on the Legal Nurse Business Podcast channel, wants to connect with you, what would be the best way for them to reach you?

Laura: Sure. Well, I'm on LinkedIn. I love that platform and I love meeting nurses from around the world. LinkedIn under Laura Bouchard Chung. And then my website is BCLegalNurse.com. BCLegalNurse.com. So, I'd love to hear from nurses around the world.

Patricia: Okay, perfect. And let's spell your name. L-A-U-R-A, and Bouchard is B-O-U-C-H-A-R-D. And Chung C-H-U-N-G?

Laura: You've got it.

Patricia: Perfect. Well, thank you so much, Laura, for sharing your perspective. You have a unique view of what's happening in the critical care units and the hospitals. And I appreciate you sharing how your unit has evolved. It sounds like you've been in a state of innovation, trying to figure out how to solve problems, conserve PPE, communicate with each other, and communicate with the equipment, which you've moved outside of the room.

And we've talked about some of the psychosocial issues for family members who are separated from their loved one, for the families of healthcare workers who are affected, and the new routines that you've had to develop in terms of making sure that you're not bringing COVID into the house, as well as we've had some chance to talk about the political issues that have made this a challenging problem to resolve.

And hopefully, with changes in policies, the availability of the vaccine, better compliance with masking, and social distancing, and keeping numbers of people down, we can get through this and see the other side of it. Right now, it's hard to see the other side.

Laura: Yes, absolutely. I heard a quote that was really powerful to me. And it said, your choice to give up the last seven or eight months of your regular life could very well be the reason why someone is alive today, and it will always have been worth it. So, I would say just keep up those measures, keep masking, keep social distancing, please, to help us get through this. And there is a light at the end of the tunnel.

Patricia: Thank you, Laura. And thank you to you who's been watching this on our YouTube channel or listening to this on the audio channels. I don't know if you realize, you can also get the transcript of our shows by

going to podcast.LegalNursebusiness.com and requesting to be on the list of people who receive notification when our transcripts are ready. Sometimes, you want to go back and listen to a program, but you realize you don't have enough time and you want to go right to the part that you're curious about, and you can use the transcript in order to get a quick overview or reminder of what our guest covered.

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