ISSN: 2318-8413 DOI: 10.18554/refacs

REFACS

What we learned from the COVID-19 pandemic: reflections and experiences of a nurse

O que aprendemos com a pandemia da COVID-19: reflexões e vivencias de uma enfermeira

Lo que hemos aprendido de la pandemia de COVID-19: reflexiones y experiencias de una enfermera

Received: 01/03/2021
Approved: 05/08/2021
Published: 14/10/2021

Yeda Aparecida de Oliveira Duarte[1]
Luciana Mitsue Sakano Niwa[2]
Pamella Cristina de Carvalho Lucas[3]
Carla de Lima Silva[4]
Shirley da Rocha Afonso[5]

This article aims to reflect on what has been learned from the COVID-19 pandemic. The method used was the theoretical-reflective one based on literature and on field experience from Brazil and other countries. The considerations are based on three thematic areas: *Experiencing COVID-19*; *The impact for the elderly*; and *Gerontological Nursing*. The experience of the pademic shows the lived experiences of a nurse specialist in gerontogeriatric nursing and shows the assistance in the pandemic, their process of becoming contaminated, as well as the assistance return in a necessary reinvention. The impact on the elderly is the issues of isolation and distancing, the vulnerable elderly, solidarity, the importance of the private initiative, the look at long-term institutions and the experiences of elderly people in the pandemic. In Gerontological Nursing, knowledge and updating are necessary and the reaffirmation of the specialty in Nursing, as well as, that care is a significantly personal act and includes assuming the importance of the existence of the other.
Descriptors: Pandemics; Covid-19; Aged; Nursing.

O presente artigo tem por objetivo refletir sobre o que se aprendeu com a pandemia da COVID-19. O método utilizado foi o teórico-reflexivo baseado em literatura nacional, internacional e na vivência de campo. As considerações se baseiam em três áreas temáticas: *Vivenciar a COVID-19*; *O impacto para os idosos*; e *A Enfermagem Gerontológica.* O vivenciar a pandemia apresenta a vivencia de uma enfermeira especialista em enfermagem gerontogeriátrica e mostra o assistir na pandemia, seu processo de contaminar-se, bem como o retorno assistencial em um necessário se reinventar. No impacto aos idosos tem-se as questões dos isolamento e distanciamento, o idoso vulnerável, a solidariedade, a importância da iniciativa privada, o olhar sobre as instituições de longa permanência e as experiências de idosos na pandemia. Na Enfermagem Gerontológica tem-se que o conhecimento e atualização são necessários e o reafirmar da especialidade na Enfermagem, bem como que o cuidar é um ato significativamente pessoal e compreende assumir a importância da existência do outro.
Descritores: Pandemia; Covid-19; Idoso; Enfermagem.

El presente artículo pretende reflexionar sobre lo aprendido en la pandemia de COVID-19. El método teórico-reflexivo utilizado se basó en la literatura nacional e internacional y en la experiencia de campo. Las consideraciones se basan en tres áreas temáticas: *Vivenciar el COVID-19; El impacto para los ancianos;* y *La Enfermería Gerontológica.* Vivir la pandemia presenta la experiencia de una enfermera especialista en enfermería gerontogeriátrica y muestra cómo asistir a la pandemia, su proceso de contagio, así como la vuelta a los cuidados en una necesaria reinvención. En el impacto a los ancianos tiene que las cuestiones del aislamiento y distanciamiento, los ancianos vulnerables, la solidaridad, la importancia de la iniciativa privada, la mirada sobre las instituciones de larga estancia y las experiencias de ancianos en la pandemia. En la Enfermería Gerontológica son necesarios el conocimiento y la actualización, así como la reafirmación de la especialidad en Enfermería, y que el cuidado es un acto significativamente personal que incluye asumir la importancia de la existencia del otro.
Descriptores: Pandemias; Covid-19; Anciano; Enfermería.

1. Nurse. Specialist in Gerencia em Salud para Personas Mayores. Specialist in Social Gerontology. Master and PhD in Nursing. CNPQ Productivity Scholarship. Associate Professor, School of Nursing and Faculty of Public Health, Universidade de São Paulo (USP), São Paulo, SP, Brazil. ORCID: 0000-0003-3933-2179 E-mail: yedaenf@usp.br
2. Nurse. Specialist in Geronto-Geriatric Nursing. Master in Health Care. PhD Student in Collective Health Nursing, School of Nursing (EE) at USP, São Paulo, SP, Brazil. ORCID: 0000-0002-9342-7454 E-mail: lucianamsn@usp.br
3. Nurse. Specialist in Adult and Elderly Health. PhD Student in Health Sciences by the Inter-unit Nursing Program at the Universidade de São Paulo School of Nursing, Ribeirão Preto, SP, Brazil.ORCID: 0000-0003-3661-3290 E-mail: pamella_lucas@usp.br
4. Nurse. Technologist in Human Resources Management. Specialist in Gerontological Nursing. Specialist in Clinical and Surgical Nursing. Assistant Nurse at Hospital Sírio Libanês - Bela Vista Unit, São Paulo, SP, Brazil. ORCID: 0000-0003-2640-9114 E-mail: lima.carla@hotmail.com
5. Nurse. Specialist in Gerontological and Geriatric Nursing. Specialist in Teaching in the field of Health. Specialist in Planning, Implementation and Management of Open and Distance Learning (ODL). Coordinator of Nursing Projects at the State Center for Technological Education Paula Souza - Parque da Juventude State Technical School, São Paulo, SP, Brazil. ORCID: 0000-0003-1824-0451 E-mail: shafonso@yahoo.com.br

INTRODUCTION

On March 11, 2020, the World Health Organization decreed the highest alert level of the International Health Regulation: the Covid-19 pandemic, due to its wide spread throughout the world. The disease is caused by a new Coronavirus, called SARS-CoV-2, which presents clinical manifestations ranging from asymptomatic infections to severe conditions[1].

The main symptoms of the disease can range from a simple cold to a flu-like illness and even severe pneumonia. They are: cough, fever, runny nose, sore throat, difficulty breathing, anosmia, ageusia, gastrointestinal disorders, asthenia, hyporexia and dyspnea[2]. In the elderly, it can lead to syncope, mental confusion, excessive sleepiness, irritability and inappetence[2].

The virus is transmitted by droplets and direct, indirect (contaminated surfaces or objects) or close contact (1 meter range). The diagnosis of COVID-19 can be: 1) clinical, 2) clinical-epidemiological, 3) clinical-imaging and 4) laboratory[1,2].

Risk groups are those with chronic diseases such as heart disease, diabetes, lung diseases, neurological diseases, obesity, immunosuppression, asthma and others, and also people over 60 years, old due to physiology of aging with decrease in effectiveness of the immune system and decreased functional reserve[2,3].

To prevent the spread of the virus, hygiene measures were proposed, such as washing hands with soap and water or 70% isopropyl alcohol hand sanitizer, wearing face masks, cough etiquette, keeping a distance of one meter (~3 feet) between people, not sharing personal objects, keep the environment clean and well-ventilated, avoid unnecessary circulation of people on the streets and social distance[1,2].

These factors have changed the lives of everyone on the planet. The new normal requires proper compliance with hygienic measures and social distancing. Although the disease affects all ages and social classes, the pandemic exposed several established social problems such as: social inequality, economic crisis, lack of access to health services, lack of political union and transparency and information.

On the other hand, the pandemic showed the value of essential professionals, including those in nursing; it brought visibility to the elderly, who are often forgotten by society; and it spread solidarity throughout Brazil.

People have lost relatives and friends to the disease. Others, no longer able to stand the distance and without any intention, felt guilty for taking the virus to their loved ones. Many survived the pandemic and gave a new meaning to their lives, others survived and had sequelae, but all live in fear. There are still those who have not been contaminated and are still in their homes waiting for the vaccine, others who are terrified and depressed, and still those who believe it to be just a slight cold and even others who deny the existence of the pandemic. Given the above, this text intends to reflect on what we have learned from the COVID-19 pandemic.

METHODS

This is a reflective study based on national and international literature and on the authors' experience. The text discusses lessons brought by the pandemic and makes considerations about how to deal with it.

RESULTS

This reflection is based on three thematic areas: ***Experiencing COVID-19***; ***The impact for the elderly***; and ***Gerontological Nursing***. It is also supported six publications, three of which are from public agencies such as the Pan American Health Organization and the Brazilian Ministry of Health.

DISCUSSION

Experiencing COVID-19

In 2020, the world without borders was confined in a way no one could have imagined. On February 26, 2020, Brazil notified its first case of COVID-19[2], more specifically in the city of São Paulo and in a large hospital in the supplementary health network. The Brazilian health system is on alert for new cases, mayors and governos initiated protocols of social isolation and closing of non-essential trade in an attempt to prevent community transmission of the virus, which in a short time becomes difficult to control and the curve of contagion starts an ascending curve every epidemiological week[1-3].

The report of a nurse specialist in gerontology who experienced (and still experiences) daily care scenario, and who was contaminated and recovered from COVID-19 in April 2020, shows that:

Since the first cases of the novel Coronavirus, still in Asia and Europe, we have observed in the service in which I am part a different posture from managers regarding rational use of personal protective equipment and the possibility of acquiring more beds ever before. However, until the first patient is diagnosed, everything seems so remote and distant that it bordered on overzealous.

In less than a month, emergency care began to receive several suspected cases, people who had contact with confirmed cases and diagnoses of COVID-19. Then everything became real and that distant wave becomes a tsunami, and a race begins against time to adapt routines and create safe care protocols for patients and staff. The public and private dichotomy is broken to join forces to train professionals, carry out studies to seek treatment and expand the service capacity of hospitals.

In a constant attempt to 'fix the machine' in full operation, access flows were changed, employees in risk groups were directed to 'clean' areas, early vacations, non-assistance sectors adopt a home office system and 12x36 day shifts proposal for employees to be less exposed during commute between home and work. All care and non-care sectors relearned how to perform their tasks in a very short time.

Even with full support of the service management and collaborators' adherence to the proposed protocols, many of us were contaminated and it was impossible to identify the origin, since community transmission was already presented in a very short time. At that moment, my team and I experienced constant fear of being the next one to contract the virus or transmit it to our family members. And the feeling of impotence when fighting with something we didn't really known how it evolved and that even taking all the precautions seemed to overwhelm over.

Elective procedures were rearranged and the demand for beds to treat severe cases of the novel Coronavirus inversely grew, the supply of employees who were absent for at least 15 days until the viral condition was resolved, we learned to work more with less and that we needed to support each other. The worker's health sector played a fundamental role in cases of infected colleagues, both in diagnosis and follow-up of treatment. And I was one of the collaborators who needed this service.

At the entrance of the employees, one by one, when everyone had their temperature checked, they were asked if they had any suggestive symptoms, and in one of these screenings I noticed that I had a runny nose, which I associated with an allergic condition at first. I was instructed that if the symptom persisted, I should immediately seek the collaborator's health clinic. Following the guidance, I was tested and received a positive diagnosis for COVID-19.

Immediately I was removed from my activities and I kept revisiting memories, trying to find where I possibly failed in the protective barriers, if I washed all the packaging of products purchased in the market, if I accidentally touched my eyes with my hand, anyway, in a vain search that was soon replaced by 'how am I going to go home and not contaminate my family? It was a 15-day confinement to my room, weak, tachycardic, without the sense of smell or taste, using medications to control symptoms, in a daily fight against the virus and my own mind that knew exactly each pathophysiological mechanism that was occurring in my body.

At that moment I learned that I should filter avalanche of information I received daily in the news and official notes and took away my hope in a few minutes. And as my immune system responded to the aggression I suffered, I began to slowly resume my academic activities, helping to prepare guidance materials about COVID-19 for the elderly, thus keeping my mind active and focused on good thoughts.

At the end of my leave, still in the recovery process, I resumed my care activities and realized how much the 'scars' of the infection were still in my body and mind. It was only after about two months that I felt truly recovered and at the same status as prior to the novel Coronavirus. I return to my sector, which was reformulated with new work processes and a significant change in the pattern of patients under my care.

The chronically "complicated post-covid" elderly were even more fragile, with more invasive devices and more psychologically shaken, as well as family members who had their access restricted. At that time, the Nosocomial Infection Control Commission was instrumental in leading the 'new normal', and helping to raise awareness, that while the family has the role of supporting the elderly hospitalized by COVID-19 or not, it can be a vector for contamination of the patient and the care team.

The experience with COVID-19 allowed me to move through different roles, from the assisting professional, the family member who accompanies her loved one at a distance by video call, the patient in home isolation, the friend who loses a sister by profession who was also in daily combat. You may not understand why this virus appeared, but in honor of all this war fought and those who fell on the battlefield, it is our obligation to learn something from all this, at least to be more supportive. And that a few years from now, the face mask will not be just another habit that we incorporate into our daily lives like hand sanitiers, but a symbol of the care we have for each other.

The impact for the elderly

In the face of the pandemic, eyes were directed towards protecting the risk groups, including the elderly. The first repercussion was social distancing that seemed more like an imprisonment. Many prejudiced actions and attitudes against the elderly emerged at the time, from prohibiting entry into supermarkets to the dissemination of false information such as that elderly people on the streets would have their benefits (retirement, pension and BPC) canceled.

Many elderly people who took care of their grandchildren were separated and transferred to another residence, causing sadness and homesickness.

Isolation caused a feeling of loneliness and abandonment for the elderly who lived alone or in Long-Term Institutions for the Elderly (LTIE). The lack of information about who, how many and how elderly people live in LTIE in Brazil and the lack of policies and an action plan in the face of the pandemic caused alarm for a possible genocide of the elderly.

However, the pandemic taught us to think of creating support nerwortks and fronts in favor of life for the elderly. Professionals from different areas of knowledge got together and formed the National LTIE Front on behalf of the elderly with training courses for professionals working in the area.

The billion-dollar action of the "*Todos pela Saúde*" Project, an initiative by Banco Itaú Unibanco to fight the pandemic on several fronts, one of them – and perhaps the biggest and most urgent – supporting the country's LTIEs, is an example. With a team of public health experts from different sectors, the project is structured around four main pillars of action and its main objective is to fight the coronavirus and support the country's public health initiatives.

In its pillars, actions are being worked on that enable the care of those involved in each assisted unit. Namely, the four pillers are: a) Inform (provide clarification to the population about COVID-19 and guide the correct and opportune use of protective masks); b) Protect (offer personal protective equipment and guide care and prevention actions); c) Care (provide hospital equipment and test the population, in addition to supporting the construction of Reception Centers), and d) Resume (support epidemiological research for the treatment of COVID-19 and instruct local managers about the resumption of activities).

Certainly the greatest financial and instrumental help that the LTIEs had at that time, the support of "*Todos pela Saúde*" has been fundamental so that the Brazilian scenario is not as devastating as seen abroad.

The actions, based on protocols recommended by the National Front for Combating Coronavirus in LTIEs (another successful civil society initiative, consisting of a team of experts who developed, among other various activities, care and care protocols for LTIEs), helped LTIE managers to organize assistance to face the spread of the COVID-19 pandemic and reduce mortality risk due to social and physical vulnerability of institutionalized elderly.

These noble initiatives made the difference between living and dying in the Brazilian LTIEs during the pandemic. They will not be forgotten by those who need it most and who, most likely, are still here because of the sympathetic and considerate gaze of a society that still cares about their own.

Elderly people who live alone or with other elderly people have gained visibility in digital commerce. Markets, pharmacies, butchers favored delivery to the elderly. Solidarity networks were formed across the country in an attempt to help these elderly people.

In times of distancing, it was learned that the elderly are fully capable of using technology and it was noticed that the technological world is not prepared for the elderly. Therefore, they should take into account the physiological changes of aging to compose their products, especially adjusting font size, adjustment to touchscreen, and others.

Still on technology, new forms of communication were learned, such as video calls between family and friends and online health monitoring, which were an achievement. Many innovations occurred in an attempt to invest the elderly's time in health and well-being as the active brain game to exercise neurological functions with games, online activities proposed by day centers to reduce loneliness and promote socialization.

It was another learning experience to see the elderly on the streets and that it was necessary to ensure that they are cared for by the State and when faced with this reality, it was seen that many policies are still not implemented and the time has passed for the State to put them into practice.

Gerontological Nursing

When considering the population aging process, it is important to develop educational and assistance strategies and adjustments that meet the perspective of promoting the elderly's social autonomy and citizenship. Therefore, the State has a great responsibility to organize strategic teaching and education plans that meet the fundamental rights of society[4].

These are plans aimed at the functionality of the elderly, integrating health care with the maintenance of functional capacity, in addition to preventing disabilities. Strategic actions must also foresee the financial impact that surrounds the aging person and, at times, away from the labor market.

From this perspective, there is a perception of the importance of building specific care systems for this portion of the population. It is estimated that these systems can generate challenges and opportunities for adaptation, both for institutions and the elderly.

It is necessary to understand that aging is dynamic and multidimensional and is influenced by collective and individual factors responsible for defining the way people age and, therefore, it is important to promote resulting actions for an evolutionary process of the individual inserted in society[4,5].

Aging is a natural and foreseen process in living beings and, therefore, it is necessary to consider the functional totality to ensure quality of life, whether in disabling situations resulting from degenerative diseases such as prevention, recovery and rehabilitation.

These are strategic actions, based on this consideration, that require the development of practical knowledge capable of supporting observation, identification and decision-making stages to understand and meet the human needs of this portion of the population.

Thus, the concern with the aging population gives rise to new professional spaces and specific functional occupations that require adequate training and specialized social behavior[4-6]. A specialized care practice can promote problem-solving services for the elderly population.

The development of the labor market needs to break down the barriers that stigmatize the elderly population. There is a need to acquire specific knowledge for the service, both health and social; build and transform the forms of communication and coexistence.

In this sense, health services need to specialize and build fundamental guidelines to ensure collective and individual health care, centered on aging, and contribute with strategic actions to preserve autonomy and promote the individuality of the elderly.

Professional training requires specific accreditation, with defined and targeted skills and abilities[4-6]. The circumstance of gerontological nursing education, then, must establish its own control for the execution of the targeted work.

Nursing education for elderly care should focus on specialized qualification, encouraging the development of specific theoretical scientific knowledge in the aging process and including specificities of nursing care for the elderly.

Nursing courses need to describe in their disciplinary topics integrated care for the elderly and point out the transition of the aging process. It is essential to discuss and correlate theoretical concepts about human aging with nursing practice, structuring and characterizing specialized care.

It is necessary to establish and relate the necessary knowledge of the nursing professional and the appropriate gerontological work, aiming at the construction of an autonomous and essential nursing professional identity for the care of the elderly.

The specialization of the occupation of care for the elderly is crucial for the job market in gerontological nursing, with the pretension of exclusivity for qualified nursing care[6]. This reserved interest is suitable for discussing the occupation of the specialized work space, establishing a specific identity recognized and valued by society.

The qualification of nursing for specialized care in the aging process cannot renounce the institutionalization and systematization of knowledge acquisition, because the way in which knowledge about the aging process is acquired and how professional behaviors are prepared need to reflect on aspects significant factors for nursing practice.

The role of Gerontological Nursing in elderly care prioritizes promotion, protection and recovery, with the participation of the family and, therefore, it needs to develop educational practices to guide and inform the family and the person responsible for the daily care of the elderly. It should value the participation of the family for the development of autonomy and decision-making in the care of the needs of this elderly person, observing and directing the actions taken.

It is essential for Gerontological Nursing to understand its competence to act in the promotion, maintenance and recovery of the elderly's health, respecting the contextual aspects of the elderly's daily life and involving family members and responsible persons in the daily care of the elderly. For the care of the elderly involves a complex process of actions structured in the defining dimensions of the elderly's life.

The care actions represent the direction on the degree of concern to provide comfort, relief and satisfaction and, therefore, require responsibility, cooperation and solidarity from everyone involved in supporting the elderly[4,5]. In this sense, caring is a significantly personal act and includes assuming the importance of the other's existence.

CONCLUSION

As one of the most perverse humanitarian crises in history, the COVID-19 pandemic gave hope when it revealed a more solidary and organized society for its people. Amidst a scenario of total helplessness, mainly provided by the government, there are several initiatives, to a greater or lesser extent, coming from civil society with the aim of offering quick and effective responses against this tragedy.

Experiencing the disease as a nurse was a unique experience and there was an opportunity to give new meaning to and thank each moment experienced and for each obstacle overcome.

Bringing visibility to the elderly with expressions of compassion from society brought the possibility of people being better, altruistic and with vision, which needs to be broadly worked on, of the longevity that awaits. Policies must be in effect as soon as possible and actually be put into good use.

In the year of nursing, this was essential, especially geriatric nursing as the main victims of COVID-19 are the elderly. Provocations by fellow nurses about what to do to prevent the genocide of institutionalized elderly people boosted the formation of the National LTIE Front.

The Scientific Department of Gerontological Nursing mobilized the entire country to build educational materials for the elderly and for fellow nurses from other specialties. One could not fail to mention the nursing colleagues who fell on the battlefield in the relentless war against the pandemic.

The pandemic will pass and the lessons will certainly make humans and health professionals stronger, given new meanings and with the certainty of having done the best for the elderly, society and nursing.

REFERENCES

1. Organização Pan-Americana de Saúde. Folha informativa COVID-19 – Escritório da OPAS e da OMS no Brasil [Internet]. Brasília, DF: OPAS; 2020 [cited in 26 Aug 2020]. Available from: https://www.paho.org/pt/covid19

2. Ministério da Saúde (Brasil). Sobre a doença [Internet]. Brasília, DF: Ministério da Saúde; 2020 [cited in 25 Aug 2020]. Available from: https://coronavirus.saude.gov.br/sobre-a-doenca#o-que-e-covid

3. Ministério da Saúde (Brasil). Ministério da Saúde declara transmissão comunitária nacional [Internet]. Brasília, DF: Ministério da Saúde; 2020 [cited in 25 Aug 2020]. Available from: https://www.saude.gov.br/noticias/agencia-saude/46568-ministerio-da-saude-declara-transmissao-comunitaria-nacional

4. Rodrigues RAP, Bueno AA, Silva LM, Kusumota L, Almeida VC, Giacomini SBL, et al. O ensino de enfermagem gerontológica nas instituições públicas brasileiras de ensino superior. Acta Paul Enferm. [Internet]. 2018 [cited on 2020 Aug 17]; 31(3):313-20. Available from: https://www.scielo.br/pdf/ape/v31n3/1982-0194-ape-31-03-0313.pdf. DOI: https://doi.org/10.1590/1982-0194201800044

5. Gil H. Educação gerontológica na contemporaneidade: a gerontagogia, as universidades de terceira idade e os nativos digitais. RBCEH [Internet]. 2015 [cited in 17 Aug 2020]; 12(3):212-33. Available from: http://seer.upf.br/index.php/rbceh/article/view/6005/pdf

6. Kletemberg DF, Padilha MI, Maliska IA, Villarinho MV, Cosa R. O mercado de trabalho em enfermagem gerontológica no Brasil. Rev Bras Enferm. [Internet]. 2019 [cited in 17 Aug 2020]; 72(Supl2):97-103. Available from: https://www.scielo.br/pdf/reben/v72s2/pt_0034-7167-reben-72-s2-0097.pdf. DOI: http://dx.doi.org/10.1590/0034-7167-2018-0178

Associated Publisher: Heloísa Cristina Figueiredo Frizzo

CONTRIBUTIONS
Yeda Aparecida de Oliveira Duarte worked on writing and reviewing. **Luciana Mitsue Sakano Niwa**, **Pamella Cristina de Carvalho Lucas** and **Carla de Lima Silva** participated in the design, collection and analysis of data and writing. **Shirley da Rocha Afonso** contributed to the design, data analysis and writing.

How to cite this article (Vancouver)
Duarte YAO, Niwa LMS, Lucas PCC, Silva CL, Afonso SR. What we learned from the COVID-19 pandemic: reflections and experiences of a nurse. REFACS [Internet]. 2021 [cited in *insert day, month and year of access*]; 9(4):1023-30. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)
DUARTE, Y. A. O.; NIWA, L. M. S.; LUCAS, P. C. C.; SILVA, C. L.; AFONSO, S. R. What we learned from the COVID-19 pandemic: reflections and experiences of a nurse. **REFACS**, Uberaba, MG, v. 9, n. 4, p. 1023-30, 2021. Available from: *insert access link*. Access in: *insert day, month and year of access*. DOI: *insert DOI link*.

How to cite this article (APA)
Duarte, Y.A.O., Niwa, L.M.S., Lucas, P.C.C., Silva, C.L., & Afonso, S.R. (2021). What we learned from the COVID-19 pandemic: reflections and experiences of a nurse. *REFACS*, *9*(4), 1023-30. Retrieved in: *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.