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Dignity and respect for the older adult with COVID-19 in intensive care from the nursing perspective

Dignidad y respeto al adulto mayor con COVID-19 en Cuidados Intensivos desde la perspectiva enfermera

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ABSTRACT

Introduction: To describe nurses' perception of dignity and respect for older adults with COVID-19 during their care in intensive care units.
Material and methods: Qualitative approach study of phenomenological design, with a sample of 15 nurses from intensive care units of public and private institutions in Ecuador, obtained through convenience sampling, to whom semi-structured interviews were applied, for their analysis the Colaizzi model was followed and complemented with the implementation of the Atlas software. Ti.
Results: 5 categories emerged: 1. Lack of care for the elderly during COVID-19; 2. Dignity and respect for the elderly during the pandemic; 3. Separation of the family link to the critical patient during the health emergency; 4. Ethical and bioethical principles violated during the care of the elderly during the health crisis; and 5. Negative effects on the mental health of nursing personnel in critical services.
Conclusions: From the nurse's point of view, the limited therapeutic margin suffered by this age group in the health emergency stands out, presenting bioethical conflicts and human rights violations; in addition, humanized care had to be adapted through strategies to guarantee family closeness and their ontological dignity during the pandemic.

Keywords: Aged; Bioethics; Critical Care; Nursing; Pandemic; Respect.

RESUMEN

Introducción: Describir la percepción de las enfermeras frente a la dignidad y respeto al adulto mayor con COVID-19 durante su atención en las unidades de cuidados intensivos.

Material y métodos: Estudio de enfoque cualitativo de diseño fenomenológico, con muestra de 15 enfermeros de unidades de cuidados intensivos de instituciones públicas y privadas del Ecuador, obtenidos mediante muestreo por conveniencia, a quienes se aplicaron entrevistas semiestructuradas, para su análisis se siguió el modelo de Colaizzi y complementó con la implementación del software Atlas. Ti.

Resultados: Emergieron 5 categorías: 1. Carencia de la atención al adulto mayor en tiempos de COVID-19; 2. Dignidad y respeto al adulto mayor durante la pandemia; 3. Separación del vínculo familiar al paciente crítico durante la emergencia sanitaria; 4. Principios éticos y bioéticos vulnerados durante el cuidado al adulto mayor durante la crisis sanitaria; y 5. Efectos negativos en la salud mental del personal de enfermería de servicios críticos.

Conclusiones: Desde la percepción enfermera, se destaca el limitado margen terapéutico que sufrió este grupo etario en la emergencia sanitaria, presentándose conflictos bioéticos y vulneración de derechos humanos; además el cuidado humanizado tuvo que adaptarse, mediante estrategias para garantizar el acercamiento familiar y su dignidad ontológica durante pandemia.

Palabras clave: Adulto mayor; Bioética; Cuidados Críticos; Enfermería; Pandemia; Respeto.

INTRODUCTION

The COVID-19 pandemic was one of the emerging health problems in recent years, which caused a high mortality rate due to its high contagion, mainly affecting priority groups such as the elderly. (1) It should be noted that the World Health Organization reported a 2.3% global mortality rate in adults between 30 and 79 years of age, distributed in 14.8% in patients older than 80 years, 8% between 70-79 years and 0.5% in patients younger than 50 years. (2)

In this sense, the health emergency generated a significant change in the dynamics of the different age groups, due to the increased predisposition to the risk of contagion that led to vulnerabilities, as well as the morbimortality rate in the elderly, a population group relegated in society. Therefore, the Pan American Health Organization emphasized the need to ensure the protection of this group against isolation and stigmatization derived from the disease, focusing on comprehensive care policies in health systems within a framework of human rights, the ontological dignity of the person and humanized care. (3,4)

However, it had a negative impact on the health of the elderly, due to the presence of comorbidities that increased susceptibility to infection, as well as the incidence of confirmed cases. As a consequence, the limitations of the health systems on the lack of resources and the high demand for hospitalizations in critical services; in addition, decision making focused on survival scales that generated conflicts of interest and bioethical dilemmas in its application among the different population groups. (5)

Therefore, this situation has placed the elderly with a higher incidence of mortality, which means that nursing staff must be at the forefront in the face of changes in the patient's state of health, considering the scarcity of drugs and treatments. In this context, continuous evaluation and follow-up are essential to prevent possible complications and adverse events. (6)

Similarly, during the pandemic there were several aspects of bioethical relevance in the care of the elderly, focused on dignity in the midst of technological and social

progress. In this line, ethical dilemmas emerged due to situations of isolation, abandonment due to exclusion and stigma in critical care services regarding accessibility and availability of beds. [7]

Likewise, in Santo Domingo of the Tsáchilas, Ecuador, 13,769 confirmed cases of COVID-19 were reported, with a mortality rate of 7,163 in adults over 65 years of age, this group experienced a decrease in their autonomy due to confinement, as well as an increase in negative emotions due to the loss of recreational activities. [8]

It should be noted that it is the role of the health professional and especially of nurses to watch over the rights and fight against injustices in the act of care. This is based on the ethical commitment of the nurse to guarantee the rights of sick people, especially in vulnerable contexts. Thus, the pandemic was an invaluable lesson, revealing the importance of care, adapting its practice in scenarios of limitations and high emotional burden. In the study situation, although the nursing staff tried to fulfill this mission, the limitations of the health system, such as lack of supplies and exhaustion, complicated their ability to ensure comprehensive and respectful care. [9]

Therefore, despite these adversities, the nursing professionals made significant efforts to maintain the patient's dignity, communicating with the families and providing emotional support, which demonstrates their commitment, although it was not always possible to guarantee optimal care; therefore, the objective was to describe the nurses' perception of the dignity and respect for the older adult with COVID-19 during their care in intensive care units.

MATERIAL AND METHODS

The qualitative approach with phenomenological design was used, (10) which allows people to narrate the meaning of their lived experience, as well as to visualize the characteristics of their experiences through the perceptive content of the participants on the care provided in the critical areas; a semi-structured interview guide was used as an instrument. [11] In addition, this was articulated with the Consolidated Criteria for the Elaboration of Qualitative Research Reports (COREQ). [12]

The participants were nursing professionals with work experience in an Intensive Care Unit, working in public and private hospitals in the province of Santo Domingo of the Tsáchilas, Ecuador, who were sentinel institutions in the region during the pandemic, and who authorized the study from the teaching department; In this sense, the sample consisted of 15 professionals obtained by convenience and information saturation; thus, the selection of the subjects was carried out by explaining the purpose and methods of the study, both verbally and in writing, and obtaining their informed consent, as well as the assignment of codes to maintain confidentiality and privacy, these as ethical criteria of the study, as well as the approval of the ethics committee of the institution. [13]

Therefore, face-to-face meetings were organized in the participants' homes and virtual meetings through the ZOOM platform, which were recorded with an average duration of 35 minutes; participants provided demographic information on an interview sheet that included gender, age, level of education, area of work and sector. The interviews, conducted in a semi-structured manner, focused on the northern questions that were validated through a pilot test, which allowed a pre-test to 3 people for verification,

verification and validity of the questions with the relevance of the study: What aspects stood out about the care received by the older adult with COVID-19 during the pandemic?, What conflicts of interest and ethics were presented when caring for the older adult with COVID-19?, How did the nursing staff approach humanized care, guaranteeing dignity and respect for the older adult with COVID-19?

The interviews were conducted by four masters in Care Management with mention in Emergency and Intensive Care Units (3 women), under the supervision of a physician and two doctors in Nursing Sciences (1 woman and 1 man). Their commitment is focused on ethical dilemmas and the imperative need to humanize care; this allowed the transcripts to be made available to the participants for their authorization.

The information collected was transcribed into text using Microsoft Word Office version 2016, for in-depth reading through the use of EMIC/ETIC language that facilitated an interpretative analysis of the information derived from the participants in relation to similarities and differences, [14] in the same way the Colaizzi method was used for coding, [15] extracting convergent statements among the participants through a color code, which gave them a meaning for their grouping in relation to the nexuses.

As well as the integration of the Atlas. Ti version 2022 software to complement the analysis, this facilitated the organization and representation of the meaning of the units, which allowed the development of a system of analytical nodes for coding and interpretation, considering both the critical thinking of the researchers and the positions of the participants on the subject. [16]

RESULTS

Most of the participants were female (10) and male (5), with an age range between 27 and 40 years, coming from the intensive care units of public and private health institutions, with third level (8 bachelor's degrees) and fourth level (7 master's degrees) training, as shown in Table 1.

Table 1. Sociodemographic data of the participants.

Participants	Sex	Age	Level of training	Area of work	Sector
E1	Male	28	Bachelor of Science in Nursing	ICU	Public
E2	Female	32	Master's Degree	ICU	Private
E3	Female	29	Master's Degree	ICU	Public
E4	Male	35	Bachelor of Science in Nursing	ICU	Public
E5	Female	36	Master's Degree	ICU	Private
E6	Female	30	Bachelor of Science in Nursing	ICU	Public
E7	Female	27	Master's Degree	ICU	Public
E8	Male	39	Bachelor of Science in Nursing	ICU	Private
E9	Female	31	Bachelor of Science in Nursing	ICU	Public
E10	Female	40	Master's Degree	ICU	Private
E11	Female	39	Master's Degree	ICU	Public
E12	Male	27	Bachelor of Science in Nursing	ICU	Public
E13	Male	39	Bachelor of Science in Nursing	ICU	Public
E14	Female	34	Master's Degree	ICU	Private
E15	Female	33	Bachelor of Science in Nursing	ICU	Private

Source: Authors' own elaboration.

We obtained 2 thematic units declared as categories that group the convergences of the participants, according to their relationship and grouping; on the other hand, 3 emerging categories were obtained from the narratives, as shown in Table 2.

Table 2. Coding in categorization and subcategorization.

Subcategory	Category
Lack of assertive communication during the health-disease process.	Lack of care for the elderly during COVID-19
Therapeutic limitation to the elderly during the pandemic.	
Resource shortfalls and breach of care management during Coronavirus.	
Reflection on integrated care in times of COVID-19	Humanized care and attention to the critical older adult during health emergencies.
Aspects of nurse-patient care during the health crisis.	
Dignified and humanized care in the context of the COVID-19 crisis.	
	Separation of the family link to the critically ill patient during the pandemic.
	Ethical and bioethical principles violated during the care of the elderly in the health crisis.
	Impact on the mental health of critical care nurses.

Source: Authors' own elaboration.

On the other hand, the following responses expressed by the study participants, estimated in units of meaning, are shown:

Category 1. Lack of care for the elderly during COVID-19

The following testimonies stand out from the statements made by the participants in relation to the health policies implemented by the systems on the use of medical equipment, in relation to the limited availability of this equipment focused on the use of scales for its assignment centered on age groups, as well as the comorbidities to determine their admission to critical care hospitalization:

“During the pandemic, it was a very difficult process because the demand for patients with COVID-19 warranted more attention to young people than to older adults”. **E1**

“Patients needed hospitalization, priority was given for medical attention, who needed more a mechanical ventilator or a bed in intensive care, if young or a sick older adult.” **E7**

“Older adults as they did not have much capacity to survive then there were choices, for me it was not dignified care.” **E9**

Subcategory 1. Lack of assertive communication during the health-illness process

Care was limited by different factors and situations during the pandemic, mainly restrictions in the affective and assertive communication between health personnel and relatives of the hospitalized elderly, this evidenced the lack of timely information on the clinical evolution of these, which generated uncertainty about their survival and increased the suffering of the family due to the lack of knowledge of the reality of the health of their patient, according to the following narratives:

“One was the lack of information to the relatives about what the disease was, there was no way to contact them in the beginning” **E10**

“Well, in reality, everyone was altered in all aspects, no one talked to the relatives, no attention was paid to them” **E12**

“There was no direct communication with the relative, the biosecurity restrictions did not facilitate, besides they did not know how to tell them if their relative was going to live or die” **E14**

Subcategory 2. Therapeutic limitation to the elderly during the pandemic

The health professional who worked in critical services COVID-19 evidenced that older adult patients with comorbidities were left vulnerable in the accessibility to interventions that guarantee their recovery, under the context of scarcity of supplies and resources, as shown in the following answers:

“There was the need to choose who to provide all available resources to, the pandemic forced to prioritize who to save, whether the young person or the adult” **E2**

"It was necessary to decide many times between who to ventilate, which patient to ventilate between a young person who had a better chance of living than an older adult. " **E4**

"A pandemic that affected the whole country could not give the priority needed to the elderly" **E11**

"It was necessary to prioritize between a young person who was more viable to live among an elderly person and this one was left aside, priority was given to a young person, this was the major dilemma that arose during the COVID-19 stage" **E15**

Subcategory 3. Resource shortfalls and breach of care management during Coronavirus

The following addresses the scenario of scarcity of resources in the health emergency, which caused difficulties and dilemmas in care, increasing the risk of contagion and morbimortality rate, according to the following:

“It was not possible to provide adequate care to all because there was not enough physical space or medical supplies to provide personalized care...”. **E1**

“They had a lot of deficits even of personnel, supplies, medication, many of them had to see the relatives where they got the medication because everything was a chaos and we tried to work with what we had...” **E3**

“Lack of economic resources, medical equipment, lack of health personnel, lack of resources to avoid adverse events, lack of drugs and lack of adequate physical space in this type of pandemic.” **E7**

Category 2. Humanized care and attention to the critical older adult during health emergencies

Care centered on the ontological dignity of the person was visualized in the context of the pandemic that violated the human rights of this population group at the social and health level, which makes it necessary to deepen the commitment of professionals to the act of care, ethical and bioethical principles in decision-making on therapeutic follow-up, according to the reports:

“As professionals we did everything, we could provide dignified care, even in the shortage in which the hospital found itself” **E9**

“Everyone was treated well; the best was done to guarantee dignified and timely care to the elderly” **E11**

Subcategory 1. Reflection on comprehensive care in times of COVID-19

It addresses the awareness of nursing care, adapting it to human responses, to strengthen the capacity to care during the dying process and family separation. This approach should overcome situations such as health crises with their respective challenges. The objective is to create strategies that favor filial love as an act of empathy. In this way, it is possible to provide dignity to the patient in the dying process. The participants support this vision with their testimonies:

“Care was provided so that the family member could die with dignity and without pain, so that the family member would be immersed in the possible restrictions of the pandemic” **E2**

“Yes, all patients, regardless of the age group they belong to, were treated in a comprehensive manner, we sought to involve the family member, even with the limitations of the COVID-19, to be treated from an ontological viewpoint, as a human being, as a person, as a human being, as a person, as a family member, as a human being, as a person” **E13**

“Respect and dignity of the patient's life, of the family was always put first, especially as children of God, as someone who fought to the end” **E14**

“The care provided to the elderly during the pandemic was personalized care, from the moment of admission, stay and discharge, or until their post mortem care” **E15**

Subcategory 2. Aspects of nurse-patient care during the health crisis

The good nursing practices implemented during the COVID-19 pandemic, despite the limitations present in health institutions. These actions sought to preserve a close relationship with patients, ensuring respectful care for the elderly in critical areas, as shown in the following narratives:

“I believe that 70% of the care provided did promote respect and dignity and 30% did not, because of the arduous work presented by the health personnel, which did not allow them to develop in their full role, due to the patient/nurse relationship, it was not possible to provide adequate and optimal care.... the nurse/patient relationship has not been optimal for an adequate and human quality management of patients at this age; however, we used the few supplies we had to take care of them” **E5**

“On the part of the health personnel, we gave everything we could with what we had at our disposal, we innovated with what we had, we tried, even by video calls, to keep them in contact with their family member” **E8**

Subcategory 3. Dignified and humanized care in the context of the COVID-19 crisis

This subcategory emerges from the participants' accounts of the care provided to patients during the health crisis caused by the coronavirus. In this context, health professionals ensured care based on ontological principles, without incurring in discrimination, despite the limitations and dilemmas present in health decision-making, as reflected in the following statements:

“Care was provided so that the patient could die with dignity and without pain”. **E3**

“Well always as health professionals we promote respect and dignity first and foremost in this case it was a little difficult, but respect and dignity of the patient's life was always put first.” **E4**

“As I told you before the theme of values and the gift of service to others, I believe that we use it and humanize all patients” **E9**

Category 3. Separation of the family link to the critically ill patient during the pandemic

In this category, nursing professionals relate the forced abandonment caused by the policies and restrictions imposed during the health emergency on COVID-19 patients. This situation generated uncertainty about reuniting with their families, increasing emotional stress and negatively affecting patients' recovery, as reflected in the narratives:

"The patient, being infected and admitted, was isolated from his family and being admitted to an intensive care unit was even more isolated, he could not receive visitors, but sometimes they received a call or video call; however, this could not be done with all the patients, they felt alone even more with the fear of the disease and the fear that their family members would be infected”. **E10**

“The patients when they entered intensive care were left alone and many times, they were not seen again by their family members.” **E11**

“A patient who had COVID-19 older adult was super sensitive, they fell into depression much more than a young adult, then we had to be that emotional support, as a support since their family was not there.” **E14**

Category 4. Ethical and bioethical principles violated during the care of the elderly in the health crisis

In the care of the elderly during the pandemic, the principles of bioethics were violated. The lack of medical devices, the saturation of hospitalization areas and insufficient knowledge led to errors in therapeutic decisions, resulting in age discrimination based on scales of probability of survival. These broke paradigms related to respect for human rights and ontological dignity, as evidenced in the following statements:

"In this case the most violated were justice and autonomy; justice in this case because they all had the right to a chance to live, to be connected to a ventilator, which was what they needed at the time, and autonomy because once they were in intensive care they no longer had the ability to decide whether to have an arterial line, a central line, or a bladder catheterization, so they were totally without autonomy and it was up to the health professional to decide” **E4**

"I think the main dilemma was that of non-maleficence, because there was a poor management of these patients, where the lack of family members was seen as the main problem, the contact that the patients needed during their hospitalization period." **E5**

“That of justice could be said, since the right to health is for everyone, within the care given at COVID, priority was always given to younger patients over those who had other comorbidity that complicated or who were patients who were not going to leave.” **E6**

“Well I consider that within these principles justice was violated, many of the patients were not, I mean that the care was not fair because we as health personnel who were here on the front line, we had to choose between an older adult and a young person, who had more possibilities and the same fact there were no ventilators, there was no capacity, so for me that was unfair” **E8**

Category 5. Impact on the mental health of critical care nurses

This section reflects the experiences of nurses on the biopsychosocial impact of providing care in critical areas during the health emergency. Loneliness, abandonment, lack of resources, hospital overcrowding, uncertainty, fear of contagion and the need to prioritize care were factors that deteriorated their mental health. Despite these difficulties, the professionals reaffirmed their commitment to the patients' needs, guided by an ontological approach that promotes comprehensive, quality and warmth care, based on a humanized vision, as described:

Therefore, implying the professional commitment of health professionals to the needs of people, this under an ontological framework focused on comprehensive care, with quality and warmth from a humanizing vision, as detailed below:

“Work stress due to PPE and the disease, excessive workload due to lack of personnel, feeling far from my family” **E9**

“We wanted to give 100% better care, we could not first it was a new disease, fear of catching it ourselves too, and not having all the protective equipment did not give 100% care.” **E13**

“We were trying to do our best because we had to take care of them, they were suffering and we had to understand that because not only they were suffering, but also we were suffering when we saw them and lived what they were going through.” **E15**

DISCUSSION

The SARS-CoV-2 pandemic represented a significant challenge for health systems, revealing pre-existing failures and causing a disarticulation of services in the face of clinical needs and scarcity of resources, which had a negative impact on the clinical evolution of patients. [17] This scenario required complex decisions based on bioethical principles, rights and medical scales, which came to compromise the equity in the distribution of resources and the dignity of individuals. [18]

In this sense, health personnel were faced with a lack of resources to adequately care for critically ill patients, which resulted in difficult decisions as to who would have the best chance of survival. Since this problem was global, protocols were implemented based on criteria such as age, presence of comorbidities and general condition of the patient, thus establishing limits of access to intensive care to extend the available resources to the greatest possible number of people. [19,20]

However, this violates the human rights and bioethical principles that oppose the identity, commitment and feelings of the health personnel as visualized by the testimonies of the participants. [21] This poses challenges to the prejudices and stigmatizations that are generated in the professional commitment to provide humanized care, having the need to strengthen actions and the creation of policies that enable decision making from a person-centered vision, as well as a new hopeful vision to geriatric nursing to ensure human dignity. [22, 23]

On the other hand, bidirectional communication between family members and professionals was limited due to biosecurity restrictions, which made it necessary to develop alternatives to maintain the link. In the absence of visitors and social isolation, telephone calls and video calls became the means to transmit information on the patients' condition, evidencing the need to reinforce communication skills to achieve assertive and effective communication. [24,25]

It should be noted that health care faced ethical dilemmas at the therapeutic level, mainly focused on decision making, although advances in knowledge about the disease made it possible to implement protective measures with professional

responsibility centered on comprehensive care, which guaranteed the patient's dignity according to the severity of his condition and the service's response capacity. [26,27]

In this context, care had to adapt to the reality imposed by the pandemic, transforming the intensive care units from open-door spaces to restricted environments; therefore, it became necessary to promote other forms of emotional connection, such as accompaniment through calls, video calls or letter reading, with the aim of reducing emotional distancing, transmitting support and closeness to people. [28]

The pandemic affected the entire population without distinction, regardless of social status, age, gender, disability or origin. However, lack of resources, staff stress, uncertainty and lack of knowledge especially impacted older adults, whose clinical decisions were more vulnerable due to their higher risk status. [29,30]

It should be noted that this research showed how a health problem can diversify the treatment and care of age groups, as well as the loss of human dignity focused on the violation of human rights, being a need to reformulate regulations to ensure care with quality and warmth, as well as the professional commitment of nurses to ensure respect and preservation of justice in health care.

Therefore, it is evident the need to transform higher education in nursing and health, guiding professional training from the academy with a solid ethical and bioethical basis. This is why this research had limitations, since it focused only on one of the many vulnerable groups prioritized during the pandemic, which restricts the understanding of the global impact of this health crisis and the role of nursing in the face of the challenges derived from working in an environment of scarcity, fear and lack of information.

CONCLUSIONS

Nursing personnel who worked in critical areas during the pandemic showed insufficient attention to the elderly population. The prioritization of resources based on criteria such as advanced age and the presence of chronic diseases led, in many cases, to a clinical exclusion that could be interpreted as a form of institutional abandonment. This phenomenon developed in a context of uncertainty, operational limitations and social isolation, which exposed significant gaps in the health system's response. Given this reality, it is imperative to design and implement strategies that ensure comprehensive, timely and humanized care, based on respect for human rights and an ontological understanding of care, to prevent discriminatory and stigmatizing practices towards vulnerable age groups.

For practice, it is recommended to develop specific protocols for the care of the elderly in health crisis situations, to provide continuous training in ethics and human rights, and to promote the humanization of care in daily practice.

In the same way, this global problem has bent the commitment to care for and defend life on the part of health professionals, in which the context of therapeutic limitation due to the deficit of resources, lack of knowledge and the increase in mortality, evidenced emerging ethical and bioethical conflicts, in which decision making by these broke the human rights of the elderly, impacting on their mental wellbeing.

Therefore, this demonstrated the need for changes at the formative level to face this type of situation, in addition to the implementation of committees for therapeutic management. For research, it is suggested to conduct studies on the impact of the pandemic on the mental and physical health of older adults, to evaluate the effectiveness of family outreach strategies, and to promote the development of new strategies for care in health emergencies.

However, the nurse's perception on the humanized care of the elderly during the pandemic had to be adapted, leaving aside the inclusion of families in the ICU; this led to the development of strategies to guarantee the family approach, providing emotional support, an integral care according to the needs presented by the families, the patient and users in a context of limitations such as the health emergency; in addition, to vindicate the important role of the nurse in the humanization of care with an integral, ontological vision in the face of the new health challenges. With regard to nursing management, the creation of ethics committees, improvement of resource management in ICUs, and the development of inclusive policies to ensure comprehensive and dignified care for the elderly are recommended.

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