Adapting WOC Nursing Practice to the COVID-19 Pandemic

A View From Here

Vicky Pontieri-Lewis

INTRODUCTION

The COVID-19 pandemic impacts all healthcare providers in all practice settings. As a healthcare provider, specializing in WOC nursing, the “daily routine” of how I provide care to patients, families, and other healthcare providers has been profoundly affected. I find myself focusing not only on pressure injury prevention strategies for my patients but also on skin care for colleagues providing care to our patients. Among the most apparent changes in my practice include the need to educate staff on skin care in patients who require prolonged placement in a prone position and teaching providers to use telehealth for routine WOC care consultations. Lastly, with a decrease in elective surgeries, I was tasked to develop a plan on how to refocus the medical department’s various roles and responsibilities during this pandemic.

I work in a level 1 Trauma, Academic Medical Center, in central New Jersey. I have been a nurse for 36 years and a WOC nurse for over 30 years. During my tenure, I have endured a strike, hurricanes (including Hurricane Sandy), outbreaks of severe acute respiratory syndrome (SARS), Ebola virus, and the terroristic acts of September 11, 2001. In my environment, we strive to handle such crises as a unified team. I write this View From Here to share my personal views and experience thus far during the COVID-19 pandemic. As a WOC nurse, I also want to share how I believe my education and experience have prepared me to perform the tasks, roles, and responsibilities I have assumed as the pandemic evolves.

When I first heard about this novel form of coronavirus infection (COVID-19), I thought it similar to other viruses resulting in regional outbreaks. However, as the virus began to spread across the globe and in my region, my inner instincts about the threat it represented to my community, and my patients, began to change. My perception was also influenced through discussion with my husband, a public health epidemiologist. I began to see the influx of COVID-19 patients into our hospital and noticed how ill they were upon admission and how quickly their condition deteriorated. As an experienced nurse and a WOC nurse, I assumed I was reasonably prepared

for every likely scenario, but this situation proved different as I suspect it has proved for you. Nevertheless, I was heartened to realize that my WOC nursing education and experience, along with the education tools, best practice documents, the Journal (*JWOCN*), and algorithms that the WOCN Society has developed over the years prepared me for even the unprecedented challenges posed by COVID-19. In addition, networking with my WOC nurse colleagues across the country and the WOCN Society COVID-19 forum has also helped me through this national pandemic. At this time, if someone was to ask me what is the most rewarding role that I have played, it would be the initiative that I implemented for preventing pressure injuries for our healthcare providers. While this represents an unforeseen shift from my typical WOC nurse practice, adding colleagues to my broad community of “patients” is especially rewarding.

PREPARING FOR AN INFLUX OF PATIENTS

The first call related to the pandemic I participated in came on a Monday night at 10:00 PM. Our Pulmonary intensive care unit (ICU) intensivist was requesting pulmonary beds, asking how many beds we possessed, and where are they located. The following morning, I went into action. With the assistance of our ICU leadership, beds were deployed to the appropriate ICUs. We already had a protocol for patients requiring prolonged placement in a prone position, but this practice was seldom employed in some of our ICUs and I realized that education was urgently needed on how to operate the pulmonary beds and prevent pressure injury or other forms of skin damage in these high-risk patients. I provided education to the nursing staff, along with prone position pressure injury prevention strategies. Our protocol consisted of placing a soft silicone prophylactic foam dressing to all bony prominences (eg, face, ears, chest, iliac crest, knees) and under all medical devices. During the education, I noticed staff were using a donut-like foam cushion to off-load the face/head on patients placed in a prone position. Using my expertise as a WOC nurse, we quickly switched from the foam pillow to a silicone cushion, which allows molding and contouring of the head to redistribute pressure. Pictures were used to illustrate how the head should be positioned on the silicone pillow while protecting the endotracheal tube.

As the number of patients with symptomatic COVID-19 virus infections began to explode, we observed that many required care in an ICU setting and I realized the need to expand our ICU bed capacity. Identifying these patients at high

Vicky Pontieri-Lewis, MS, RN, ACNS-BC, CWOCN, Robert Wood Johnson University Hospital, RWJ Barnabas Health System, New Brunswick, New Jersey. The author declares no conflicts of interest.

Correspondence: Vicky Pontieri-Lewis, MS, RN, ACNS-BC, CWOCN, Robert Wood Johnson University Hospital, RWJ Barnabas Health System, 48 French St, New Brunswick, NJ 08901 (Vicky.Pontieri-Lewis@rwjbh.org).

DOI: 10.1097/WON.0000000000000667

risk for pressure injuries, I reached out to our bed vendor for the availability of ICU beds with microclimate mattress or if we could convert a percentage of our medical-surgical beds to encompass microclimate air mattresses. I wanted to be proactive and prepared for the influx of ICU patients. I also realized that that more and more hospitals were likely to request beds, potentially leading to nationwide shortages.

CARING FOR COLLEAGUES

While providing the education and discussion about pressure injury prevention, one of the ICU nurses asked, "Vicky, please help." She removed her N-95 mask off, revealing a pressure injury to her nose from the prolonged use of the mask. This was the moment I realized that my patient population had expanded to take care of nurses and other care providers wearing these masks for prolonged periods of time while caring for our patients. Who would have thought that my WOC nursing expertise would shift from patient pressure injury prevention to now protecting fellow nurses from developing pressure injuries? I ultimately examined multiple colleagues with similar skin damage and made recommendations for skin care. I explained to the nurses I would not jeopardize the protective properties of their masks in any way but would provide recommendations for protecting their skin while ensuring the efficacy of their mask. I reviewed the literature and could not find any research evaluating placement of a dressing under the N-95 mask without being refitted. I then reached out to the manufacturers of the masks. I also communicated with the mask manufacturers to see if applying any type of dressing to the face would interfere with the proper seal of the mask. As I suspected, the manufacturers that I contacted had no science to support the use of a dressing under the N-95 mask. With that in mind I educated the RNs in 2 ICUs to avoid placing a dressing of any type under the N-95 mask. We implemented a trial in these 2 ICUs, for all staff members to apply an alcohol-free cyanoacrylate polymer barrier to the face. This practice was trialed for 10 days with no reports of any new pressure injuries.

I subsequently developed a 1-page education poster, titled "Maintaining Healthy Skin Under Masks." The education was reviewed and approved by our Senior Nursing Leadership, Infection Prevention, and Senior Vice President for Organizational Effectiveness. The education was rolled out house-wide for all healthcare providers (eg, RN, respiratory therapist, physicians). The practice was also included in our CEO daily COVID-19 report. Since the implementation of this practice, there have been no reports of healthcare provider pressure injuries. I round on the units routinely; in addition, I send out an e-mail to Nursing Directors to notify me if any staff develops a pressure injury related to the N-95 mask. The staff have been very thankful.

ADAPTING ROUTINE PRACTICE IN A TIME OF PANDEMIC

Another impact to my practice was the need to provide consultations for WOC care during the pandemic. While I remain dedicated to the nurse as therapeutic agent delivering care at the bedside, I realized that our routine when consulted for WOC specialty practice services must change. I further realized that the process that provides, including advanced practice RNs such as myself, to ambulatory and inpatients

must change. I was also asked to assist our hospital to develop a system for delivering care via telemedicine by our COVID-19 physician lead. The Centers for Disease Control and Prevention has made recommendations for the use of telemedicine during this pandemic, and we found its guidance particularly helpful. The Center for Connected Health Care Policy/Public Health Institute reacted promptly to the COVID-19 pandemic by releasing a document "COVID-19 Telehealth Coverage Policies."¹ The document summarizes what is covered by various public and private payers when providing telehealth services. Coverage for advanced practice providers delivering telehealth services is also included in this useful document.

Having a prior collaborative professional relationship with the now lead hospitalist of our COVID-19 teams, his first concern was to try and limit the number of healthcare providers who enter patient rooms, to preserve personal protective equipment and avoid the spread of the virus. We discussed developing guidelines for WOC nurse consults using telemedicine (eg, digital photography or laptops). The guidelines were developed and implemented and have been well received by all of the COVID-19 teams/physicians.

Lastly, with the decrease in elective surgical procedures, the patient volume of the WOC nurse department changed. Some members of the WOC nurse department took a refresher course to work as a "buddy" in our ICUs or as a primary nurse. As the lead advanced practice nurse in the department, I maintained availability for telehealth consultations via secured technology. In addition, I work with the COVID-19 team physicians as one of the COVID-19 nurse navigators. The role encompasses attending the multidisciplinary COVID-19 rounds each day where individual patients, different treatment modalities, and clinical trials available for these patients are discussed. Based on the insightful discussions arising from this multidisciplinary group, I hypothesize that the skin damage seen in some patients with COVID-19 are not traditional pressure injuries. Instead, I believe they may be multifactorial and related to abnormal blood serum levels. Many patients with COVID-19 infections present with elevated D-dimer levels and some experience thrombocytopenia. Some of the skin damage that I am seeing presents with bruising (purpura) appearance and or reddish/purple in color (petechiae), very similar to the characteristics we commonly see with deep tissue injuries; however, some of the skin damage on COVID-19 patients may or may not present on a bony prominence or under a medical device. In addition, some of the skin changes may be related to what my colleagues and I refer to as "throwing" microemboli to the lower extremities due to clotting disorders. At this time, since the true etiology of the skin damage is sometimes unknown and most likely multifactorial, treatment is based on clinical assessment.

As one of the COVID-19 nurse navigators, I am also responsible for maintaining a COVID-19 database. This electronic database serves as a registry for our patient admissions. In addition, we work with the hospital bed management department and COVID-19 physician teams to ensure, based on patient acuity, patients are assigned to the appropriate COVID-19 physician team for the level of care that is needed. Recently, our hospital implemented a house-wide chime playing "Here Comes the Sun" each time a patient is discharged from the hospital.

As the pandemic continues, I am increasingly confident of my ability to contribute knowledge and expertise to patient

care and our hospital's role as an essential center for acute and critical care in this time of crisis. In addition, as a member of the WOCN Society's Board of Directors, I am anxious to report that we continue to hold regular (and virtual) meetings regarding the pandemic and how it has affected our WOC practice and our colleagues. We have collectively developed a Clinical Practice Alert, "Guidance for Maintaining Skin Health When Utilizing Protective Masks for Prolonged Time Intervals," and a new WOCN Society COVID-19 forum on our Web site to

provide our members with an avenue to discuss their challenges/experiences during this time. I believe we are WOC Nursing STRONG and as we continue to support each other across the country we will get through this difficult time.

REFERENCE

1. COVID-19 telehealth coverage policies. <https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies>. Accessed April 15, 2020.