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Editorial

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Covid-19 lessons learned from the voices of our geriatric nurses: Leadership, resilience, and heroism

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We have heard much about the nurses working in acute care and the recognition of those nurses as heroes. My grandchildren often call me at 7 pm to let me hear the accolades and shout outs for nurses occurring every evening in New York City. We are not hearing the same shout outs for those of us working in long term care. Conversely, what we hear about is the large number of older adults dying in our long term care facilities. Driven by my own practice and talking with others practicing in long term care across the country I wanted to share the stories of nursing working in long term care in the fight against Covid-19. Twenty nurses from our readership affiliated with nursing organizations focused on care of older adults shared their experiences around preparation and management of Covid-19 outbreaks within their settings, care related experiences with residents and personal thoughts and feelings in terms of dealing with this work. Responses were kept anonymous and include experiences from licensed practical nurses, registered nurses and advanced practice nurses, across a variety of settings and serving in a variety of roles. Experiences are personal and yet consistent for so many.

I anticipate that many of you reading these may have had or are having the same experiences and feelings. It helps to not feel so alone in this. Personally, one of the things that has kept me going has been my pride in being a nurse and in the nursing profession. In contrast to acute care nursing, for those of us in long term care we are caring for individuals we have known for a long time, for me it is sometimes as long as 20 plus years. Depending on our roles and responsibilities within these settings we also may have had differing opportunities to influence the planning and management for the influx of Covid-19. This then influences not only the care of residents we have known for some time but staff as well.

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Nursing Perspective on Prevention and Management of Outbreaks of Covid-19

To varying degrees and at varying times in terms of whether it was prior to having a Covid positive resident or in response to having a Covid positive resident, facilities initiated the wearing of PPE for all staff, at least masks, and in some cases residents also had to wear masks (particularly in continuing care retirement communities). Visitors were limited to compassionate care at the end of life, and this included the limiting of non-staff providers such as podiatrists, nurse practitioners and attending physicians. All services (e.g., hairdressers), activities, and meals were stopped or provided in small groups with physical distancing in place and residents, particularly those in nursing home settings, were isolated in their rooms.

There was some variability between settings in terms of whether or not the facility cohorted residents that were positive. Assisted living settings generally responded differently than nursing homes. For those working in assisted living setting there was consensus that it was quite difficult to cohort Covid positive patients as the rooms and set up of the facilities were not conducive to a separate unit. Moreover, some settings maintained a strong philosophy that the residents' room was their home and it was not appropriate to relocate them to facilitate cohorting. When relocation did occur it was noted to be difficult for residents and families. As noted above, most assisted living settings allowed residents to eat meals out of their rooms in small groups or in some if there was space isolated tables. Further the residents could gather with physical distancing maintained for activities or to sit outside. Unless they transitioned to Hospice, generally residents in assisted living were sent to the hospital or to a nursing facility if they were positive for Covid.

The nurses were acutely aware of the impact of the quarantine on residents. The majority of the nurses indicated that residents generally demonstrated fewer behavioral symptoms associated with dementia, specifically less agitation, aggression and resistiveness to care but that they were noticing more falls. Falls were anticipated to be due to less physical activity and residents being alone in their rooms. Many of the nurses noted that the residents were depressed, lonely and for some this even impacted appetite. Residents were described as... “eating less, talking less, and moving less”. Also the nurses reported that it was difficult to keep some residents quarantined. As one nurse stated, “We have residents who do not... or cannot maintain quarantine” and another reported that... “My memory care facility is unable to control the wandering and they are less restrictive in their quarantine procedures”.

With the decrease in family and resident interaction and resident to resident interaction, the nurses described the development of even stronger bonds between staff and residents. This was articulated by one nurse noting that... “The bond between staff and residents has grown, which has been beautiful. We are one big family we are all here for each other during this difficult time”.

The nurses described some interventions they implemented to help with resident depression and isolation. Some had transportation aides helping to deliver meals and spend some time with residents, others encouraged residents to sit outside on nice days, some did outside concerts for the residents viewing these from balconies, others increased the use of music and television and special treats like ice cream and popcorn. Everyone utilized ipads, phones or tablets of some type to connect families with residents or residents with other residents.

Emotional impact on nurses

The nurses commonly expressed feelings of exhaustion, feeling helpless, sad and somber. Others reported that they were hopeful, grateful and supported by their teams. One nurse said it beautifully:

... “I feel better than yesterday. I have learned to allow the ebb and flow of my spirit to go where it needs. Whether a time of reflection and thankfulness that I did not receive a bad outcome phone call or a time where I was angry because a husband could not be with his wife who was declining in health. I allow myself a moment or two to experience and move forward. I am learning to pour into others more joy, laughter, or an opportunity for them to vent, and also allow myself to be filled by others kind gestures, phone calls, prayers, check ins, etc. I know I am not alone in this upside-down chapter of our lives”.

Other nurses described feeling sad during this period for what was happening to residents and the changes in how we are able to provide care as noted in the following sentiment... “I am so sad for the lives lost. I have spent my entire 38 year career making sure that residents feel the same value/love as they leave this world as they did when they entered it. During this time with the isolation restrictions this hasn't happened and I don't feel good about that”.

Many of the nurses expressed multiple feelings that changed moment to moment and day by day... “I feel anxious, uncertain, angry, unsafe, but also safe. Grateful and full of purpose but also lost and fretful”. Another nurse expressed this mixture of emotions as... “Proud to take care of patients during this pandemic. Feeling isolated from family and friends due to being exposed. And I feel scared of being sick”. There were many nurses who experienced feelings of guilt if they were not on the “frontlines” directly seeing patients but at home doing telehealth or other types of indirect care activities. Others felt guilty or worried about bringing coronavirus home to their families... “At first I actually had panic attacks. I was so worried I would get coronavirus and bring it home to my family. Or worse I could be an asymptomatic carrier and infect other staff or residents. I was freaked out by the guilt”.

Recommendations from the nurses

Not surprisingly, there was a consistent request among all those who responded for more personal protective equipment (PPE). For some this request was more passionate and urgent than others. One individual shared that a family member complained about the difficulty managing her tears and running nose at the bedside of a dying relative and was told to take home their wet and snotty masks to wear them again the next day. In addition to having equipment, many of the nurses felt that more education on how to use PPE and the value of the PPE in terms of protection was needed for all staff. This was to overcome myths and misconceptions and hopefully decrease fear and anxiety.

Most of the nurses indicated that they did not have administrative input to plans around prevention or management of Coronavirus within the facility that they worked. Some of the nurse practitioners particularly tried to influence planning and prevention procedures indirectly through the medical director or talking with administration. Others initiated activities to help address issues that might occur if a large number of residents became Covid positive such as updating advanced directives and talking with residents and families about care preferences and goals in the event of Covid-19. Although the nurse practitioners acknowledged that having these discussions over the phone versus face-to-face was not ideal, it was extremely valuable to have them ahead of time. Others tried to help with encouraging the use of PPE. The nurses all strongly recommended following guidelines from the state and national organizations such as the Centers for Disease Control, despite the daily changes that might occur in those recommendations.

Another common recommendation was for higher pay for bedside staff and increased staffing, increased testing for staff and residents and contact tracing mechanisms. One nurse requested that “... leadership within the state and nationally need to continue to support nursing homes and the staff by letting families know why the precautions have to be taken to give grace to the leaders in these nursing homes. The decisions that the nursing homes are having to make are not easy and the best thing people can do is support their local nursing home with positive encouragement and love.”

There were some differences of opinions among the nurses with regard to maintaining physical distancing. Some thought it was in the best interest of the residents to allow them to socialize in small groups with physical distancing while others felt that strict isolation was critical. Some nurses requested increased “technology” and training with the technology to help residents connect with family.

Specific nursing challenges or barriers to care

In addition to lack of sufficient PPE, the nurses described some other clinical challenges during this period. While many of the nurse practitioners appreciated the ability to provide telehealth they all recognized that this is not perfect. As stated by one nurse practitioner... “Telehealth IS hard! I can't wait to lay a stethoscope on someone!” Others described feeling badly that they have to pull nurses in to help them do these visits.

Particularly for nurses in administrative roles the impact of Covid-19 on staff and staff being out sick, being out scared, or being out due to comorbid conditions was a major challenge. Further decreasing the use of any private duty nursing assistants or staff that were working in other settings also limited options for care. Helping to decrease staff fear and build resilience was also challenging.

Another commonly expressed challenge by nurse practitioners was trying to take care of problems that were not related to Coronavirus. This might be as simple as cerumen impactions or long toenails or more complicated such as decisions about bone healing following a fracture, repeat scanning following cancer treatment, or

management of acute exacerbations of heart failure. Working through with the resident and/or his or her family how to best manage the risk/ benefit in each of these situations required much more time than would otherwise be the case. The logistics of each follow up to an outside provider needed to be carefully considered and evaluated. Often these situations were managed by coordinating a combined telehealth visit to prevent a transfer of the resident to another setting or testing site which could put the individual at risk for exposure to the virus.

Nurses self-care recommendations

When asked what types of activities the nurses were doing to help support and care for themselves the majority turned to physical activity, connections with family (either family within the home or via zoom), prayer, and music. One individual described an innovative approach which involved meeting with and talking to a friend who was not in health care "...I talk to a friend of mine who is not in the field. We drive through for coffee and sit in our own cars but with the windows facing and chat about the news, etc.-it helps unload". Family support has been critical for many. One nurse stated "...My family has been superb and caring for me. After working I am all but ushered into the shower and my dinner is ready and waiting. All of my household chores are being kept up by my husband and children as the shutdown has given them more time to help out."

As nurses we know that self-care does not always take precedence. One nurses noted that in stating that there was simply no

time for self-care. Another nurses nicely articulated "...As a nurse I am not good at self-care. But especially through this crisis, I am realizing I need to work on this. Now I am making a list of self-care activities to try to tend to because I realize I am no use if I am depleted, scared or hopeless. It is hard. I need to take care of myself." Lastly one nurse reported that focusing on resilience and building resilience through this experience was critical. This was done by "... forcing myself to be optimistic, find a moment of joy in each day, connect with others, and remember ways in which other challenges in life were overcome in the past."

The front page of every newspaper has stories about the horrors of long term care settings and the number of deaths and the lack of care and adherence to infection control procedures that occur in these settings. I write about the experiences of our nurses in geriatrics to show that in fact in so many settings we are doing our best with the resources that we have to protect a very vulnerable group of individuals from a disease that is silent and invisible but impacts our residents hard and rapidly. Please take a moment to shout out a cheer for these nurses, nursing assistants, therapists, social workers and other supportive care staff (e.g. housekeeping, dietary staff, and activities) working in these settings. They are truly heroes and deserve to be recognized as such. Please share with your state officials, newspapers and other public media the wonderful things that are being done in your settings to prevent Covid-19 outbreaks, to manage them when they occur and to deal with the daily issues we still deal with when taking care of older individuals, the majority of whom have some cognitive impairment and multiple chronic medical conditions.