NNJ NEPHROLOGY NURSING JOURNAL

COVID-19 Pandemic: Nephrology Experiences – Voices from the Frontlines: Part 3

Beth Ulrich, EdD, RN, FACHE, FAONL, FAAN (Editor)

Over the first months of the COVID-19 pandemic, the *Nephrology Nursing Journal* began a project to capture the COVID-19 pandemic experiences of nephrology nurses and other nephrology health care experiences. This is Part 3 of those experiences – examples of the responses to the questions: "What are your organization's best practices regarding patient care during the pandemic?" What are your organization's best practices regarding caring for staff members during the pandemic?

What are your organization's best practices regarding patient care during the pandemic?

In order to contain, protect, and ensure capacity, our organization set up the Incident Command Center (ICC) at the system and local levels. The ICC allowed for centralized information sharing and communication on all COVID-19-related questions and gave staff guidance navigating the ongoing changes associated with pandemic. It also allowed the system to allocate resources to areas of targeted need. The ICC was an integral part in redeploying staff to the dialysis unit assisting us in getting patients the dialysis treatments they needed. In addition to the ICC, the system demonstrated an authentic commitment to the free flow of communication. During the beginning stages of the pandemic through the peak and as it slowed, the leadership was present and available to staff to help clarify and disseminate information. Standardized messaging went out twice per day (and continues to present). Resource documents were warehoused on Intranet and updated constantly. Communication cascaded through unit huddles, where feedback was given from team members to leadership and vice versa. This forum allowed for key information to be given to leadership so they could support our unit. Some topics covered at these huddles included PPE conservation, visitor restrictions, isolation requirements, support for staff, and education to staff on most updated COVID-19 information. There was a highly visible presence of the executive leadership team – in-person, rounding, with podcasts, in media, and internal communication. The emergency department set up a prescreening station on arrival for all patients, and any patients suspected of COVID-19 were diverted to other triage areas, minimizing potential exposures. Though the operating rooms were not closed, elective surgeries were paused. The infection prevention team played a large role in translating the ever-evolving CDC recommendations and best practice to internal and external stakeholders. In addition, our health care system took a leadership role in reaching out to the community, supporting a 24/7 public hotline, testing structure and telehealth support.

Gave every patient a chance. Maintained safety in caring for patients by ensuring adequate supplies, equipment, and human resources. Infection control was at its best to help prevent the spread.

Masks in the hospital. Screening every employee everyday coming into work, PPE, and letting staff know there is enough by reporting stock every day, wear gown,

Beth Ulrich, EdD, RN, FACHE, FAONL, FAAN, is a Professor at the Cizik School of Nursing, the University of Texas Health Science Center at Houston; the Editor-in-Chief of the *Nephrology Nursing Journal*; and a Past President of the American Nephrology Nurses Association. She is a member of ANNA's Gulf Coast Chapter.

Editor-in-Chief's Note: These experiences are presented as they were submitted. Names of all respondents in this article have been withheld.

Ulrich, B. (Ed.). (2020). COVID-19 pandemic: Nephrology experiences – Voices from the frontlines: Part 3. *Nephrology Nursing Journal, 47*(6), 523-528. https://doi.org/10.37526/1526-744X.2020.47.6.523

N95 covered with surgical mask, TIDI shield, bouffon, gloves, and the training to go with the PPE on proper donning and doffing.

We were all fitted for N95 respirators, and our facility had enough available.

Utilizing specialists to provide patient-centric education virtually. Utilizing specialists to provide guidelines of care around COVID-19 and re-entry into the community for glomerular disease patients who are immune-compromised. Providing mental health and wellness education to patient and caregiver community during the COVID-19 pandemic.

COVID-19 infection guidelines are strictly implemented, COVID team, COVID wards created, RIST at all entrance of the hospital, distancing is strictly implemented, webinars, continuous education of staff, HCW online, RIST before going to work every day for nurses, non-punitive off duty for staff if they are not feeling well or if there's a family member who is sick, patient education and staff training.

TRIAGE = Identifying infected, PUIs, and clean patients timely and appropriately. Assigning them to units and beds that can best care for them. SUPPLIES = Providing adequate PPEs to all health care workers and keeping steady supply of equipment and workforce. EXPANDING BED CAPACITY = Converting underutilized units in the hospital to an intensive care or step-down units and training procedural nurses with the acute nurses to work hand-in-hand. EDUCATION = Staff training and patient education of Infection Control Practices. Giving out masks to whoever enters the hospital. Purell stations at entrances and high-traffic areas in the hospital. PRESENCE of MEDICAL and NURSING staff at bedside at all times.

Working closely with our nephrologist, primary team, and organizational stakeholders in dealing with our daily census. Evaluating lab results on a daily basis to assess need for either HD or CRRT. Opening of dedicated COVID floors, staffing, PPE, infection control guidelines, and resources to ensure preparation for overflow.

We are part of a large health care system. The hospital and organization went to tremendous lengths to create appropriate patient rooms by converting some units to ICU/IMC beds to accommodate a surge. Departments such as the operating room that were stalled during this time cross trained and redeployed personnel to cover various areas. This included physicians, nurses, techs, etc. Surge staffing plans for all units were developed. A back up emergency department was set up for the surge so COVID patients and the general population could be separated, if need. The emergency department as well as several units in a critical care tower were created to be 100% negative pressure. Supply Chain worked tirelessly to assure an adequate supply of PPE and other supplies that were needed. Various types of masks, goggles, shields, some homemade and donated have shown up for associates. This included CVVH equipment/supplies, as well as hemodialysis supplies. CVVH solution is still is difficult to obtain, so pharmacy collaboration with Nephrology to identify other means of producing CVVH replacement fluid alternative and creating new order sets was done. The organization implemented a process to recycle and disinfect N95 masks, disposable stethoscopes, and thermometers. In the dialysis unit, equipment was dedicated for COVID+ use only and separated from the general equipment to prevent cross-contamination. The department was UV Light treated each night. Infection prevention practices that are standard in dialysis units were reinforced. All staff and patients wear masks. There were days that we had double our usual off unit/bedside volume to manage. Treatment times for COVID+ patients were lessened during the surge so all patients could be treated as needed. Now that testing is more fluid and available, certain patient populations are routinely tested as a precaution for admission and procedures. This includes patients with ESRD. This has allowed for a PUI patient to be identified sooner as to whether precautions are needed or if they can be removed. The area hospitals held a joint 2x/day COVID-19 meeting. Patients were transferred among facilities to decompress volume if needed and also to provide the appropriate level of care that a patient may have required. Local dialysis centers became clean or COVID+ units. Patients were reassigned as necessary despite national dialysis provider which involved case management to assisting in relocating those being discharged. The hospital was closed to general visitors, with limited exceptions being granted

with approval. Clinics implemented telemedicine, and in the hospital, electronic pad devices are being utilized for communication with patients and patients' families to limit exposure. Our hospital system has now established a convalescent plasma program, and several IRB studies have been developed to assist with the studying the disease, immunity, and treatments.

ICU managers support their nurses with iPads to take into the patient's room so they can Facetime with their family. They have also advocated for families of those non-COVID patients whose condition is digressing to try to let their significant other in to see them during those last hours. I've seen the charge nurses help out their nurses and to make sure they get their breaks.

They had a COVID response team that met 24/7. For the most part, they did good planning for PPE except inadequate surgical masks and N95. The hospital CEO is an ED doctor and worked in the ED during the surge. He also does a daily video to explain what is going on in the hospital. It is distributed via email at 5 pm every day. It was so helpful to our staff.

Education of staff on evidence regarding their PPE and duties to not compromise patient safety or discriminate based on diagnosis.

Patients who are able must wear masks when an RN enters room. Patients are not allowed in the inpatient HD unit unless they test negative for COVID. All COVID-positive patients are dialyzed in their rooms. Most are on vents.

Following all precautions completely. Supporting all employees/teammates.

Our best practices were dialyzing all COVID patients [at the] bedside. This may have increased our workload, but it allowed us to decrease contamination and adhere to infection control practices.

Patients are in the individual, negative pressure rooms, proper PPEs provided for staff for each room, a checker or spotter available to help coach for donning and doffing PPE, lend staff uniforms to wear while working, PPEs are stocked all the time, designated COVID floors for ICU and general care, no families or visitors allowed.

Anticoagulation for patients in cytokine storm on CRRT, otherwise they clot every 3 to 5 hours. We ordered the M150 filter to possibly implement intermittent CRRT; if we get too busy to manage all the patients, they may have to share machines and get more dialysis in shorter bursts rather than 24 hours a day.

The staff conduct initial screening and masking as soon as the patients enter the building. If symptomatic, they are kept away from other patients until we can send them to hospital. Staff members are also responsible for hourly disinfecting of frequently touched surfaces and door handles.

Screening patients by calling them the day before their dialysis to know if they have concerning symptoms before they arrive in dialysis. All patients are required to wear masks in the HD unit.

Care Conferencing – bringing the Team together decisions are made together. Video conferencing with the patient's family, visitor restriction.

We followed all CDC recommendations, making sure they wear mask, taking temperature. Try not to bring positive patients with negative. All positive patients kept second shift. All staff followed infection control practices policy. Using proper PPE while taking care of patients.

Maintaining PPE, encouraging staff to practice correct use, and having minimal staff and patients convert to positive status of the COVID 19 virus.

Prescreening patients for symptoms and not allowing visitors to decrease risk for exposure.

We started having patients wear masks walking into the unit and during treatment at all times. We also have a no visitor policy in place to protect the staff and patients.

Masks for all patients in dialysis. N95 for staff with suspected or documented COVID-19. Now have plexiglass partitions separating all patients.

We have good infection control. Our company started using masks and taking temps on everyone weeks before the rest of the public was doing it.

Cohorting of failed screened patients to droplet/contact precautions. Telephone screening for symptoms one day ahead of each dialysis treatment to enable planning for cohorted areas, swabbing, isolation, etc. Pre-printed orders for those who fail screen, then also are de-escalated from the isolation areas.

What are your organization's best practices regarding caring for staff members during the pandemic?

The hospital developed a "Colleague Support Center" day one during the pandemic and promoted it daily with all COVID-19 updates. Colleague support included emotional, financial, housing, eldercare, and childcare supports. Examples of opportunities for help were repeatedly offered. Stories of community "hero gratitude" were featured. Gifts of employee meals and community donations were generously distributed to all units, all shifts. Special bulletin boards in the lobby featured expressions of support from our community. Special campus flyovers and visiting dignitaries provided recognition for our work. Daily media updates kept the community and health care workers appraised of changes. On the Intranet, educational podcasts on COVID-19 clinical issues were offered – with call-in questions and answers. Social Work, behavioral health counselors and chaplains were available to provide one on one support if needed. There was a multitude of resources offered for support for all colleagues. Most importantly, the expression "Colleagues" in this institution was genuine. We are fortunate to work in an organization that had a pre-pandemic commitment to employee wellness and communication.

Providing all our needs despite occasional supply shortages. Effective management of supply and demand either with staffing or equipment. Provided multiple incentives to staff across the board.

Lots of options! Mental health counseling available. Help with childcare. Expanded parking. Hotel accommodations for long shifts. Reallocation of staff to help busy areas. Skin care products to prevent skin problems with N95s. And a grant available for those struggling financially.

Staff symptom screening if taking care of COVID patients. Wellness emails every day. Occ health support.

Our organization immediately implemented employee health practices for employee screening and time off when ill.

Three times a week, we have virtual check-ins via Zoom. These check-ins are fun, last about 15 to 20 minutes, and the lead staff member has a fun question for everyone to answer. It is a great way to get to know each other better and deepen relationships virtually.

Being mindful of the added stress on staff during the pandemic. Offering counseling services, hazard pay, etc.

Staff who are exposed are quarantined in a designated hospital housing, provision of PPEs while at work, free hospitalization even to immediate member of the family, and continuously received their salaries even the staff are locked down in their countries.

Providing adequate and steady supply of PPEs to all health care workers. Providing everyday meals, housing, transportation, health care, and financial incentives during the pandemic. Having dialogues with the staff to voice out concerns and hear suggestions to improve patient care. Recognizing efforts with unit-to-unit rounds. Appreciating individual staff efforts with descaled awards and recognition. No group gatherings yet to maintain social distancing. Having a separate pay for COVID-19-related illness or when we fall ill during the pandemic. Lately, we have free Antibody and PCR testing for all staff.

Providing adequate PPE to staff, in-service, and spotters to support staff running COVID patients. Staff were provided in-house scrubs to wear when treating COVID patients. Minimal exposure by keeping HD treatments to 2 to 3 hours when appropriate. Hazard pay provided to staff. Daily update/communication/resources from organization on Intranet.

Associates were very scared in the beginning to be around these patients because of the lack of knowledge and media information being expressed. Our organization has always had tremendous support for the associates, but during this time, they as well as the community have gone above and beyond to support us. Over 25,000 meals from the community and local restaurants have been donated to the hospital. Local and major businesses have donated handmade masks, water bottles, spirit t-shirts, grocery food items – just to name a few. Our employee assistance program, care for the caregiver response team, and psychiatry department have been available to staff. An associate emergency fund was set up for those with financial difficulties. Various webinars and informational resources job aids have been provided to staff. Early on, the census was down, staff were flexed to preserve financial resources but also to maintain their mental and physical health so they could handle the surge when it happened. Senior Leadership Daily updates, staff huddles, and rounding have been done. Transparency in information was a key element, especially in the beginning as information was constantly changing. Paid leave policies were relaxed to allow for advance leave if needed. Transportation and childcare options were provided, and flexibility with staff schedule was allowed as school closures created challenges for parents. Leadership was provided with more frequent support meetings via Webex to provide information and resource to share with the associates.

This is a tough one. As we all feel we have to push for what we need and there is a hostile relationship with them. It is hard to feel like there is a "best practice" at this point. For example, we found out the community was giving the hospital money to provide meals to the nurses. We saw nurses from the ICU posting pictures of the nice meals they were getting. We had not received any of them for the dialysis staff, and when discussing this with other floors, they too had not received them. Even though they had COVID patients on their floors, and we are in those COVID rooms for hours at a time. When we asked our team leader about it, she checked on it, and they had not even put us on the list of units rotated to get meals. The hospital was getting money for lots of meals but not providing them to all of the nurses caring for COVID patients. So where was the money going? We are told they made permanent routine face masks for us because they were not going to be ordering any more surgical masks for us. Yet on the hospital's website, they are requesting the community help by donating money for masks. Once again, where is that money going? It is hard not to feel like they are taking advantage of this situation with the nurses being the ones left out.

They sent out information on the availability of the Employee Assistance Program for counseling. The community did a better job of supporting staff than the hospital. There should have been formal debriefing for staff.

Education to negate social media and news sensationalism. Also, some compromises in PPE sparing and outside room monitoring.

We have warm units, COVID only. We wear N95 or CAPR when dealing with all COVID pts during HD. Full PPE. Neg pressure rooms when available. Double glove.

Our organization's best practices in caring for staff were making sure they had the proper PPE as well as multiple breaks, especially in between dialyzing patients. We made sure they had food and drinks. We also had social work available for anyone that needed emotional support.

Screening checks for all staff at the entrances and providing masks to wear all the time while at work, weekly updates on policies, changes, reports, news, etc., via virtual townhalls where staff can submit questions and be answered, daily emails, uniforms provided while working. Since we don't have many patients, we are allowed to go home early and get paid for our whole shift without using PTO.

We cut all COVID treatments to 3 hours and requested that doctors do not run patients everyday if possible; this helps us with exposure time and burnout. The also told us we are to always wear N95 even when they just have droplet precautions because we are in the room so long. I have felt supported by my company, but still find the lack of PPE training astonishing.

From what I've seen, any staff member showing symptoms, or even simply worried, is able to self-quarantine. My private practice has been great in this regard.

Dialysis staff know how to wear PPE and CLEAN properly! Relaxation stations. Grab N Go Meals. Take home healthy meals to share with your family 3 times a week. No layoffs

They provided all the support and informing CDC and DOH recommendations on a timely manner. Education for how to deal with COVID-19, including infection control practices and proper mask and PPE

My organization has gone above and beyond by making sure employee families are well cared for by paying an extra amount of hourly salary through this trying time.

We have trialed many ways to protect ourselves. The hospital and unit manager are very nice about making us safe and comfortable at the same time with PPE.

We all received a pay increase, and staff members who are off for quarantine are paid by the company.

Huddles: we commenced these at the beginning with twice daily (0700 hours and 1400 hours) as information was changing so quickly. Corporately, we have a Learning Hub with meditations, mindfulness, and links to resources with themes of emotional agility, emotional intelligence, and resilience. Each week, our renal social workers across our citywide program send out emails to staff on other resources that have been received by staff very well.