Carl V. Tyler Jr, MD, MSc, CAQ-Geriatrics, CMD
Cleveland Clinic Family Medicine Residency, Lakewood, OH

We *are* all in this together: Lessons learned on a COVID-19 unit

Like most family medicine residencies, our teaching nursing home was struck with a COVID-19 outbreak. Within 10 days, I was the sole physician responsible for 15 patients with varying degrees of illness, quarantined behind the fire doors of a wing of a Memory Support Unit. My daily work there over the course of the next month prompted me to reflect on some of the core principles of family medicine, and health care, that are vital to effective patient care during a pandemic. My experience provided the following reminders:

I began asking for the names of everyone I was working with that day and I observed, first-hand, the great finesse that nurses display in their efforts to de-escalate disruptive behaviors.

Work as a team. Gowned, gloved, and masked behind the fire doors, our world shrank to our patients and a 4-person team comprised of a nurse, 2 nursing assistants, and me. For the first time in the 10+ years I've worked at that facility, I actually asked for and memorized the names of everyone I was working with that day. Without an intercom or other telecommunications system, it became important for me to be able to call for my team members by name for immediate help. We had to depend on one another to make sure all patients were hydrated and fed, to avert falls whenever possible, to intervene early when dementia-associated behaviors were escalating, and to recognize when patients were crashing.

We also had to depend on each other to ensure that our personal protective equipment remained properly placed, to combat the psychological sense of isolation that quarantine environments engender, and to placate a gnawing undercurrent of unease while working around a potentially deadly pathogen.

Develop clinical routines. Having listened to other medical directors whose nursing homes were affected by the pandemic earlier than we were, and hearing about potentially avoidable complications, we developed clinical routines. This began with identifying any patients with diabetes whose poor appetites while acutely ill could send them into hypoglycemia. We devised a daily clinical report sheet that included vital signs, date of positive COVID-19 test, global clinical status, and advance directives. Unlike the usual mode of working almost in parallel, I began my workday with a "sign-out" from the nurse, *then* started examining each patient.

Under the strain of this unusual environment and novel circumstances, we communicated *more* and more *often*. This allowed us to quickly recognize and communicate emerging changes in the clinical status of a patient by sharing our observations of subtle, nonspecific "sub-threshold" indicators.

Clarify the goals of care. Since most of the patients in the COVID-19 unit were

under the long-term care of other attending physicians, it was important for me to understand the wishes of the patient or surrogate decision maker, should life-threatening complications occur. While all affected patients were long-term residents of a memory support unit, some had full-code advance directives. I quickly realized that what was first necessary was to develop rapport and trust with the families who didn't know me, then discuss goals of care, and finally assure that the advance directives were in congruence with their stated goals. What helped families gain trust in me was knowing that I was seeing their loved one daily, that I was committed to helping the patient survive this infection, and that I was willing to come back to the facility if a crisis occurred—even at night, if necessary.

Appreciate the daily work of team members. One of my greatest worries was dehydration. When elders were acutely ill and eating and drinking poorly, I would assist with feeding and offering liquids. I quickly came to appreciate how complex and subtle this seemingly mundane task can be. Learning the proper pace and portion size, even choosing the right conversation topic and tone, could make the difference between a patient "shutting down" and refusing all nourishment and successfully drinking a 360-cc cup of a high-nutrient shake.

In the disrupted routines and altered physical environments of the COVID-19 unit, the psychological and behavioral complications of dementia intensified for some patients. I observed first-hand the great patience, kindness, and finesse that nurses and nursing assistants display in their efforts to de-escalate and prevent disruptive behaviors.

Empathize with (and appreciate) families. Families tearfully reminded me that they had been suffering from the absence of contact with their loved ones for months; COVID-19 added to that trauma for many of them. They talked about the missed graduations, birthdays, and other precious times together that were lost because of the quarantine.

Families also prevented me from making mistakes. When I ordered nitrofurantoin for a patient with a urinary tract infection, her son called me and respectfully requested I "just check and make sure" it would not cause a problem, given her G6PD deficiency. He prevented me from prescribing an antibiotic contraindicated in that condition.

Bring forward the lessons learned. The COVID-19 outbreak has passed through our nursing home—at least for now. I perceive a subtle shift in how we continue to interact with one another. Behind the masks, we make a little more eye contact; we more often address each other by name; and we acknowledge a greater mutual respect.

The shared experience of COVID-19 has brought us all a little closer together, and in the end, our patients have benefitted. JFP

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