COMMENTARY

A Day in the Life during COVID-19: Long-term Care Providers in Durham, North Carolina

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Perm J 2020;24:20.165

E-pub: 08/05/2020

https://doi.org/10.7812/TPP/20.165

INTRODUCTION

As parts of America slowly start reopening during the recovery phases of the coronavirus disease 2019 (COVID-19) pandemic, our national focus is too often on the people who are flooding the streets, shops, and beaches. Meanwhile, we are not giving enough attention to the people we *cannot* see, who are most at risk to be seriously affected by COVID-19. More than 8 million Americans use long-term care (LTC) such as home health agencies, nursing homes, and hospices.[1] What is more is that those Americans are being cared for by a large number of health care workers, who are risking their own health as well as their families' health as essential workers.

People in LTC are the epitome of high risk of COVID-19; they are overwhelmingly above the age of 65 years, chronically ill, and/or immunocompromised.[1] Furthermore, they use LTC because they need hands-on assistance from another person, meaning they are in close contact with 1 if not multiple care providers.

The following day-in-the-life amalgam is based on the recently reported experiences of 6 health care providers working in LTC who responded to an online question and answer session; we coupled this with evidence from news sources and reports in March and April 2020. All responding care providers are currently dealing with COVID-19 in LTC settings in Durham, NC. Notably absent from this day-in-the-life scenario are the family and friend caregivers who have not been able to visit the facilities because of policies restricting visitors. This narrative is a breakdown of life inside some of the most emotionally and physically perilous places to be in America right now.

LIFE INSIDE LONG-TERM CARE

6 am: I wake up in the morning and try not to disturb my kids and partner as they sleep. I'm up earlier than anyone else in the house. Even if my family members were awake, I would try my hardest to keep away. They've been socially distancing, but given how common asymptomatic coronavirus cases are[2] and how vulnerable my patients are, I can't take chances. It's hard to make some space in my house, but it's even harder at the nursing home, where the close quarters of living circumstances and shared rooms can make social distancing almost impossible.[3] This close living situation is one of the many reasons the residents are so vulnerable to infection, and their vulnerability is one of the many reasons I no longer hug my children.

7 am: Once I get to the nursing home, the first thing I do is put on my personal protective equipment, which has been in the news a lot lately, referred to as PPE. Much like every health care center in America, my workplace is in dire need of PPE, and the way I'm forced to use and reuse my PPE puts myself, my family, and my patients at risk.[4] Our facility has an infection control specialist, but the limiting factor is protective gear. There aren't nearly enough masks to follow the approved protocol, and I've started to bring masks I've made at home[5] rather than contaminate my patients by wearing the same manufactured mask all day. My homemade mask isn't nearly as effective as ones designed for healthcare use,[6] and I know nursing home workers have died after making the switch.[5] But knowing the death rates due to COVID-19 in LTC residents,[7] I've decided to take the risk for my residents. After I am dressed in protective gear, I make the rounds to examine each patient for symptoms to ensure there aren't any new cases of COVID-19. I do this every day, without fail, even though it feels like a fool's errand given how often coronavirus is asymptomatic. Still, some of my residents seem to enjoy me checking on them. For some of them, without communal meals or family visits allowed currently, it is some of the only human contact they get all day.

12 pm: We try to make the facility as social and homelike as possible, but we are limited by the need for social distancing. At lunch, everyone eats alone in their rooms. It's heartbreaking to see how the residents react to having much less community time.[8] It isn't like quarantining at home with your family. Most of the residents aren't whipping out Zoom for virtual cocktail hour, and they're so vulnerable to COVID-19, there truly is no wiggle room allowed for unnecessary contact. My patients are not only bored but also cripplingly lonely, and I'm forced to watch their mental health plummet because I don't have the time or physical ability to make sure their emotional needs are met. Social distancing is not only mentally dangerous but also physically dangerous. First, the residents are likely not moving around as much given the restrictions, so they could be losing strength gradually. More immediately, we have several residents who struggle to eat without choking, yet we try to be [1.8 m] 6 ft away from them as they painstakingly eat.[8]

3 pm: We've started to transition into telecommunications for our medical appointments. It's definitely safer for both the health care providers and the patients to limit actual contact, but we don't have the kind of telehealth access we need.[9] Our Wi-Fi is unreliable, and telehealth can't take a patient's temperature. We risk everyone's health to get a good patient assessment. Also, regulations

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Keywords: clinicians, coronavirus, long-term care, nursing homes

stipulate that new patients aren't allowed to use telehealth services, meaning that the patients who are the most likely to be harboring COVID-19 are the patients we are mandated to physically examine.[9] Hospitals are looking to move patients to our facility, but we worry about taking care of the high-need residents we currently have. Communication between our facility and the hospital and the state were strained early on but have moderately improved.

5 pm: We have individualized goals-of-care conversations with each resident and his/her health care power of attorney to determine the resident's wishes in the event of terminal illness due to COVID-19. We want to make sure that the residents receive the desired care and that we do not transfer people to the hospital who would rather receive supportive care as they die at our facility. Luckily, our health care providers also see patients at the local academic medical center, so there are resources to keep up to date on changing COVID-19 requirements, and LTC advocacy can occur with medical center leaders. I am not sure it is the same at all facilities; some may not be well equipped to handle a patient who has COVID-19.

7 pm: When I finally get home, I don't embrace my kids. I desperately want to, but it's not safe. They're too young to understand why I won't play with them anymore, or why they can't go outside and see their friends. I try to feel thankful for the chance to even see my family; none of my residents have been allowed visitors for months.[10] For so many of them, the best things in their lives have been taken away, and I know so many of them don't understand fully why their loved ones haven't been to see them in so long. I don't hug my children, and the nursing home residents cannot hug theirs.[10] I cannot even tell them how long it will be until they will next get the chance.

9 pm: As I wind down, I watch the nightly news and brace myself for the latest piece of horrifying information. I mourn for all the health care workers across America whose lives have been cut short by COVID-19, and I can't help but ponder if I will be next. I wonder if hospital workers are more hopeful, compared with those of us who work in LTC. I wonder why all the news cameras seem to be focused on big-city hospitals, when nearly half of all COVID-19-related deaths have happened in nursing homes.[11,12] I wonder if my nursing home will be the next to lose a quarter of its residents.[13] My mind doesn't stop racing with questions like these until I finally fall asleep, hoping to get enough rest to face another day.❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgments

We thank the following clinical leaders for sharing their experiences (unlisted clinicians wished to remain anonymous): Gwen Buhr, MD, MHS; Liza Genao, MD; Milta Little, DO, CMD; Dev Sangvai, MD; Holly Wenger, GNP; and Heidi White, MD.

Kathleen Louden, ELS, of Louden Health Communications performed a primary copy edit.

Authors' Contributions

Nathan A Boucher, DrPH, PA, MS, MPA, CPHQ, and Courtney H Van Houtven, PhD, MSPH, handled data collection and writing of the manuscript. Both authors have given final approval to the manuscript.

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