Nursing Home ECHO

COVID-19 Action Network

Virginia Nursing Homes * VCU Department of Gerontology
VCU Division of Geriatric Medicine * Virginia Center on Aging

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Agency for Healthcare Research and Quality

Institute for Healthcare Improvement

Session 12

Best Practices Briefing :

Ethics and Managing Social Isolation During COVID-19

Quality Improvement:

Asking and Action on What Matters

CE/CME Disclosures and Statements

Disclosure of Financial Relationships:

The following planners, moderators or speakers have the following financial relationship(s) with commercial interests to disclose:
Christian Bergman, MD – none; Dan Bluestein, MD – none; Joanne Coleman, FNP-none; Laura Finch, GNP - none; Tara Rouse, MA, CPHQ, CPXP, BCPA – none; Sharon Sheets-none;

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Session agenda

- Acknowledgements and announcements
- Social Isolation - Management
- Ethical Dilemmas and Moral Distress
- Quality Improvement - “What Matters”
- Community forum - Sharing challenge, successes & solutions

- Next week’s topic is about CNAs. Try to bring a few CNAs to the session.

ECHO is All Teach, All Learn

Session 12 Learning Objectives

Best Practices Briefing:

By the end of the session, participants will:

1. Define social isolation and loneliness
2. Discuss the impact of social isolation and moral distress on residents and staff
3. Appraise ethical considerations engendered by social isolation

Quality Assurance-Performance Improvement:

By the end of the session, participants will:

1. Identify ways to incorporate the voices of residents and caregivers into improvement activities

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Social Isolation During a Pandemic, and After

Slides courtesy of Paige Hector, LMSW
Professional Speaker and Clinical Educator
Paige Ahead Healthcare Education & Consulting, LLC

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Social isolation or Loneliness?

Social isolation is the **objective** physical separation from other people

Loneliness is the **subjective** distressed feeling of being alone or separated

They are different and can exist independently from each other

Losing sense of connection and community changes a person's perception of the world - may feel threatened, mistrustful – which can trigger the biological defense mechanism

"Social isolation, loneliness in older people pose health risks", National Institute on Aging 2019, https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks

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Risks Associated with Isolation and Loneliness

1. Functional Loss
    a. pressure ulcers
    b. malnutrition
    c. increased ADL dependence
    d. falls
2. Depression/Anxiety
3. Behaviors associated with cognitive dysfunction

Touch Starvation (skin hunger)

- Physical contact is limited or eliminated
- Instinctively, we want to touch someone, but we can’t do it because of the fear associated with the pandemic
- Touch starvation increases stress, depression and anxiety, triggering a cascade of negative physiological effects
- Can increase heart rate, blood pressure, respiration and muscle tension, and suppress the digestive system and immune system leading to increased risk of infection
- Can lead to PTSD

Touch starvation is a consequence of COVID-19’s physical distancing, https://www.tmc.edu/news/2020/05/touch-starvation/

Social Isolation as Emotional and Psychological Trauma

Think about Trauma-Informed Care

"Result of **extraordinarily stressful events** that shatter your (one's) sense of security, making you feel **helpless** in a dangerous world. Often involve a threat to life or safety, but any situation that leaves you **feeling overwhelmed** and **isolated** can result in trauma, even if it doesn't involve physical harm. The more **frightened and helpless** you feel, the more likely you are to be traumatized."

(emphasis added)

Emotional and Psychological Trauma
https://www.helpguide.org/articles/ptsd-trauma/coping-with-emotional-and-psychological-trauma.htm

Dr. Van der Kolk
Psychiatrist, trauma researcher, and author of *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*

Social Isolation and The Virus

1. **Immobilization** – cannot move (quarantine, shelter-in-place)
2. **Unpredictability** – not knowing what is going to happen next, cannot say tomorrow will be a different day or the day after
3. **Fear** (death)

When the world is unpredictable and you cannot move, then the vulnerability to become traumatized is very great.

Resultant Defense Mechanisms and Resident Behavior

- **FIGHT** may appear as “non-compliant or combative” but maybe it’s the person struggling to regain or hold onto control.
- **FLIGHT** may appear as “resistance and uncooperativeness” but it could be disengaging or withdrawing.
- **FREEZE** may appear as “passive or unmotivated” but it could be giving in/giving up.

A framework for response

Individual resident/family level

- Staff to screen for trauma
- Providers to screen for trauma
- Refer for assessment and treatment when necessary

Facility level

- Facility commitment to operationalize trauma-informed care principles
- Train, mentor and coach staff on TIC (trauma informed care) practices
- Collaborate with community professionals/experts to provide TIC assessment and treatment
- Affect sustainable culture change

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Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), applicable to other healthcare settings

In the past month, have you …

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?	YES	NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	YES	NO
3. been constantly on guard, watchful, or easily startled?	YES	NO
4. felt numb or detached from people, activities, or your surroundings?	YES	NO
5. felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the events may have caused?	YES	NO
Total score is sum of "YES" responses in items 1-5.	**TOTAL SCORE**	

https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf

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Supplement to the PC-PTSD-5

For Nursing Homes

- Inform care plan
- Assist in staff wellness efforts

Box 3.9 **DELAYED REACTION TO TRAUMA**

Signs & Symptoms of Posttraumatic Stress

Possible Delayed Emotional Reactions **YES/ NO** source_____

Irritability; Aggression; Negative affect; Distress at trauma reminderes; Fear of trauma happening again; Negative thoughts about self; Detachment; Feelings of vulnerability; Mood swings; Grief reactions.

Possible Delayed Physical Reactions **YES/ NO** source_____

Nightmares; sleep disturbance; Hypervigilance/Heightened startle; Persistent fatigue; Changes in appetite or digestion or cortisol levels; Lowered immune function/more colds and infections; Focus on aches and pains

Possible Delayed Cognitive Reactions **YES/ NO** source_____

Intrusive memories; Flashbacks; Exaggerated self-blame or blame of others about the event(s); Difficulty concentrating; Belief that avoidance or other behaviors will protect them from trauma; Avoidance of trauma-related feelings or memories or preoccupation with the event; Panic & phobia-like behavior in response to trauma triggers; Inability to remember key features of the trauma

Possible Delayed Behavioral Reactions **YES/ NO** source_____

Avoidance of event reminders ; Decreased interest in activities; Risky or destructive behavior; Isolation/withdrawal; Disrupted social relationships; History of abuse of alcohol or drugs

Possible Delayed Existential Reactions **YES/ NO** source_____

Questioning ("why me"), disillusionment, cynicism; Loss of purpose or faith; Hopelessness; Also potential adaptive responses such as re-establishing priorities, redefiniting meaning and importance of life, reviewing life assumptions to accommodate trauma.

Adapted from HHS (2014). *TIP-57*, pp. 61-62.

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Provided courtesy of Barbara Ganzel PhD, LMSW
Director, Gerontology Institute Ithaca College

Social Isolation Needs to be Included in Ongoing Disaster Planning

- Emotional, psychological and physical distress will continue, even when the pandemic “ends”
- Adopting and sustaining a culture of trauma informed care (TIC) is crucial
- What issues/challenges can we anticipate as we begin re-entry into “usual” community life?
- What do we need to be prepared for?

Process Improvement Project (PIP) Ideas

Video calls and other technology

- What is the process in your facility? Scheduling? Oversight? Devices? Infection control?
- What are the barriers?
- What works?
- Conversation starters to help facilitate a rewarding experience (name the grief *and* elicit smiles, laughter, new shared experiences)
- What to do if the resident becomes distressed or confused?

Segue: An Ethical Conundrum

How do we balance stopping the spread of the virus from the psychological and emotional trauma of social isolation?

- **Autonomy**: People have the right to control what happens to their bodies.
- **Nonmaleficence**: "First, do no harm" is the bedrock of medical ethics
- **Beneficence**: All healthcare providers must strive to improve their patient's health, to do the most good for the patient.
- **Justice**: be as fair as possible when offering treatments to patients and allocating scarce medical resources

Ethical Conflicts During COVID-19

- Public mandates vs. individual clinical judgement
- Resident autonomy regarding decision making
- Testing mandates (staff, residents)
- Public health policy heavily focused on ALL (collective) but less flexible for individuals
- Mandatory vaccination policies

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Case 1

- Ms. F is a 90 year old nursing home resident. When interviewed, she has the following concerns:
  - Lockdown is pretty bad and has been very hard on me.
  - Can’t see my daughter, just by appointment and via window.
  - I cry easily now. I never used struggle with depression
  - This is not right. I have a right to leave this place whenever I want and then come back.
  - How come you all are doing this to me?
- Her PHQ-9 score is 20 (high)
- Diagnosed with major depression

What are the Ethical Principles involved here?

- Autonomy
- Non-maleficence
- Beneficence
- Justice

Ethical Principles

Autonomy vs. Nonmaleficence

- How do we balance facility need for isolation/quarantine with individual rights?

Justice

- All residents are treated equal so if one is allowed to have visits, go outside, go to lunch with family, then others should as well. Enforces need for strict observance of rules/protocols at expense of individual autonomy

Case 1 Discussion

- Resident mandated to isolate. Now declining, both clinically and psychologically
- Isolation is for benefit of facility staff and other residents
- Positive interventions that can be done:
  - Allow reflection and discussion
  - Develop facility strategies to mitigate loneliness
  - Short term medical treatment
  - Virtual visits
- Ok to remind resident of intent of policies but may not make it easier.

Interventions

Psychosocial Interventions:

- Music, robotic pets, lavender, snacking with staff at distance, favorite TV shows on tape, facetime with family, walking program (inside building), reading poems, watering plants, art, puzzles, bright light therapy)

Nursing Interventions:

- Encourage fluid intake, prevention and treatment of constipation, dry skin, nail care, dental care.

Staff Interventions:

- Emotional support (praise, validation), education, empowerment of staff to take initiatives (singing), and mindfulness

Case 2

Mrs. Jones is a 92 year old female with advanced dementia who prior to COVID19 was faithfully cared for by her husband. He would spend 3-4 hours at the facility daily and assist with care, read to her, and feed her lunch. When COVID happened, her husband was no longer allowed in. He tried window visits but found it too frustrating to not be able to help. He hasn't been able to navigate the virtual visits and calls the nursing station every day at 3 PM to ask how Mrs. Jones is doing.

Case 2, continued

- She has lost 20 lbs over 2 months, decreased eating and due to escalating behaviors was admitted to the hospital last week and new medications were started. He is worried about her and is allowed brief compassionate care visits but is unable to help her with much and she seem more agitated and non-cooperative with him.
- Her behaviors continue, she has 3 falls over the next 2 months, has had a functional decline. She developed a pressure ulcer on her sacrum that would not heal and eventually was transitioned to hospice and died 1 month later.
- Mr. Jones is upset and feels that he could have spent more time with her at the end. He was allowed compassionate care visits at the end but blames himself for her quick decline. On speaking to the hospice agency SW, he has regrets and struggles with complicated grief.

What are the Ethical Principles involved here?

- Autonomy
- Non-maleficence
- Beneficence
- Justice

Ethical Principles

Beneficence, Justice

- Balancing the need of the individual with safety of others in the facility
- You have two obligations, which one takes priority?
- How do you justify your choice?
- Can you safely expand capability for compassionate visits?

Case 3

- Mrs. Smith is a 95 year old female who has a history of severe dementia and requires assistance with all activities of daily living. She has multiple care aides in her room throughout the day to help with bathing, dressing, eating, and toileting.
- Her family have been unable to come into the facility to help
- She has not contracted COVID-19 but the family worries as there were several staff members on her unit who got COVID in December and January. Mrs. Smith had to be quarantined one time late December due to a high risk exposure.
- With the arrival of the COVID-19 vaccine, the family is requesting that her care aides all be vaccinated. The are asking the facility to provide a log of who has contact with Mrs. Smith and their vaccination status.
- The facility struggles with how to respond.

What are the Ethical Principles involved here?

- Autonomy
- Non-maleficence
- Beneficence
- Justice

Case 3 Discussion

Ethical Questions

- Can we mandate COVID-19 vaccination for LTCF staff.
- Does the resident (or family) have a right to deny services if vaccination status of the staff is not disclosed?
- How does the facility respect staff rights to medical confidentiality vs. rights of residents to refuse care?

Case 4

- Judy is a CNA who works at nursing home A. She has been trying to comply with COVID safety in her work and personal life. She only works at one nursing home, has been complying with all PPE requirements. When she comes home, she leaves her shoes in her car, showers, and has only been around her immediate family. In fact, she gave up hosting Thanksgiving and Christmas this year as she wanted her family to be safe.
- Judy overhears another staff member Linda who is also a CNA. She is younger and is talking about all her travels over the last 6 month and how she went to NY to help as a CNA in the Spring, “made tons of money”, and vacationed in Mexico for a month over the summer. She then took a job as a travel agency nurse and has been up and down the East Coast. She enjoys her new travel and has made many new friends. She shows pictures of her eating indoors at extravagant restaurants, and hanging around at a bar with her friends.
- Judy is a seasoned CNA with >20 years of experience and knows that Linda is a great CNA. She is always on time and has been doing great work. **Judy is concerned about Linda’s behavior and does not feel comfortable being around Linda. She approaches the administrator and asks why Linda is “allowed” to do all these things. Isn’t she putting our residents at risk?**

What are the Ethical Principles involved here?

- Autonomy
- Non-maleficence
- Beneficence
- Justice

Case 4 Discussion

Ethical Questions

- What do we tell staff about COVID-19 safety outside of work?
- Can we put limits on off-duty activities?
- Does the facility have ethical obligations to place expectations and consequences on off-duty employees behavior?
- How do we respond to staff who are uncomfortable being around other staff members due to perceived increased risk-taking behavior outside work (travel, indoor dining, not wearing a mask, etc.)?

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Let’s Poll It Up!

Asking and Acting on ‘What Matters’

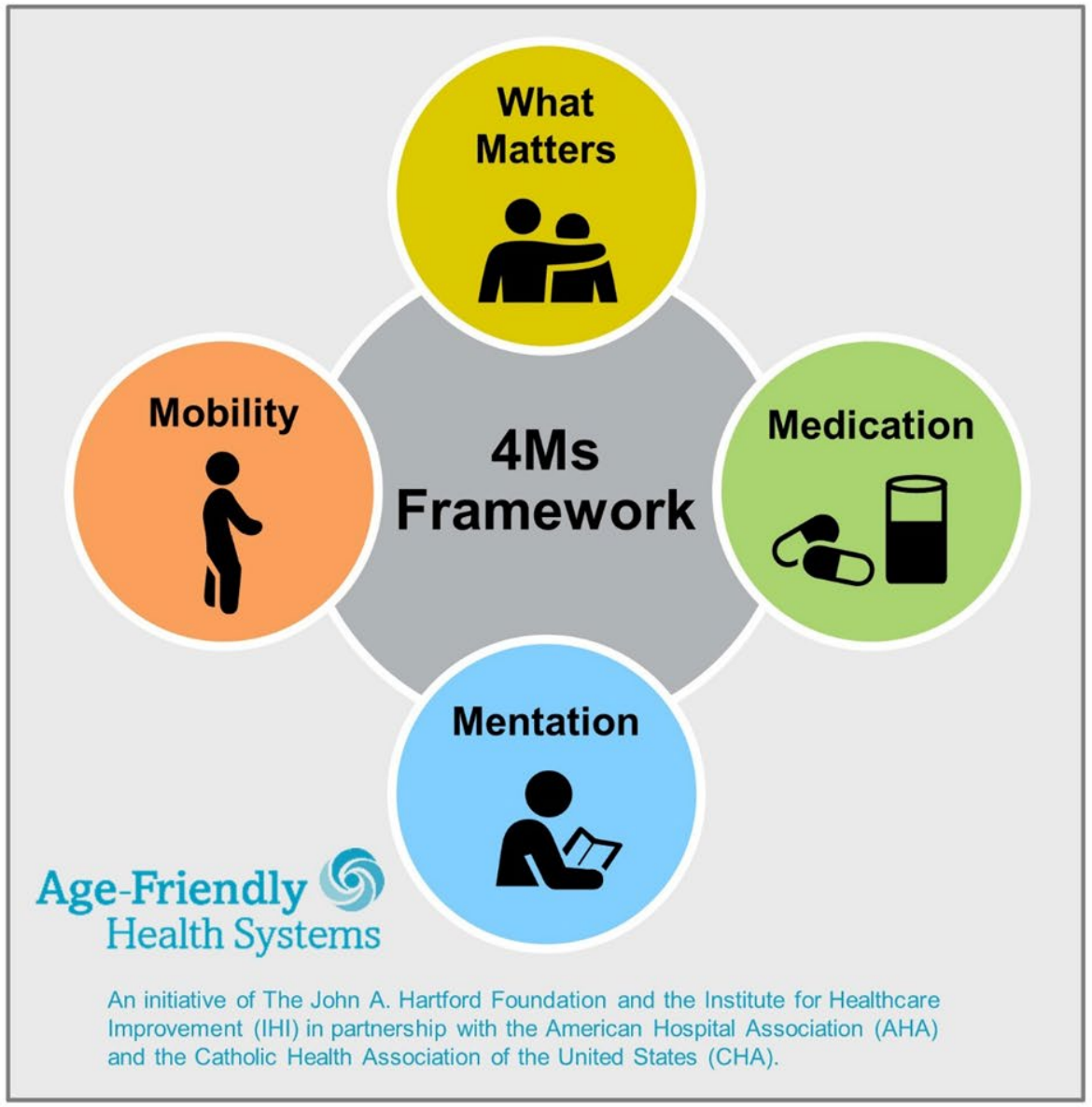
AHRQ ECHO National Nursing Home COVID-19 Action Network

HEALTH SCIENCES | Project ECHO

AHRQ Agency for Healthcare Research and Quality

Institute for Healthcare Improvement

The 4Ms Framework



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Why Ask and Action on What Matters?

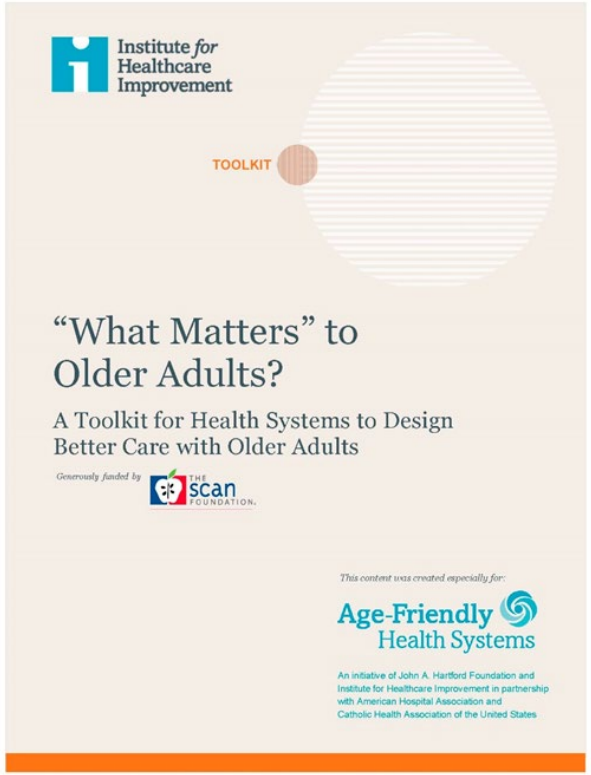
- For older adults
  - Vary in What Matters most (it will include more than just “end of life” issues!)
  - Feel more engaged, listened to
  - Avoid unwanted care & receive care that is desired
- For everyone (residents, care partners, clinicians)
  - Everyone on same page
  - Improved relationships
  - It is the basis of everything else

Tips On How to Ask What Matters Most

- Agree on what information important
- Involve residents, families, staff
- Feasible (time, format)
- How documented, transmitted, shared
- Consider culture, cognition, etc.
- Reliable, specific, actionable (preferably vette and tested)
- AFHS What Matters toolkit

Getting to Know the Person & What's Important: Commonly Used & Vetted Questions

- What is important to you today?
- What brings you joy? What makes life worth living?
- What do you worry about?
- What are goals you hope to achieve in the next six months, one year?
- What do we need to know about you to take better care of you?
- What else would you like us to know about you?



Leave in Action

- Test asking a ‘What Matters’ question from the list provided (or your own version) on 2-3 residents during the next week

- Note if anything surprising comes up or how it might impact the daily or weekly activities or care of the resident

Let’s Poll It Up Again!

Break slide

NEXT UP – WRAP UP & NEXT STEPS

Announcements

Next Week: **The Role of Certified Nursing Assistants (CNAs) in Managing and Supporting Residents and Families during COVID-19**

CE Activity Code

Within 7 days of this meeting, **text the attendance code to (804)625-4041.**

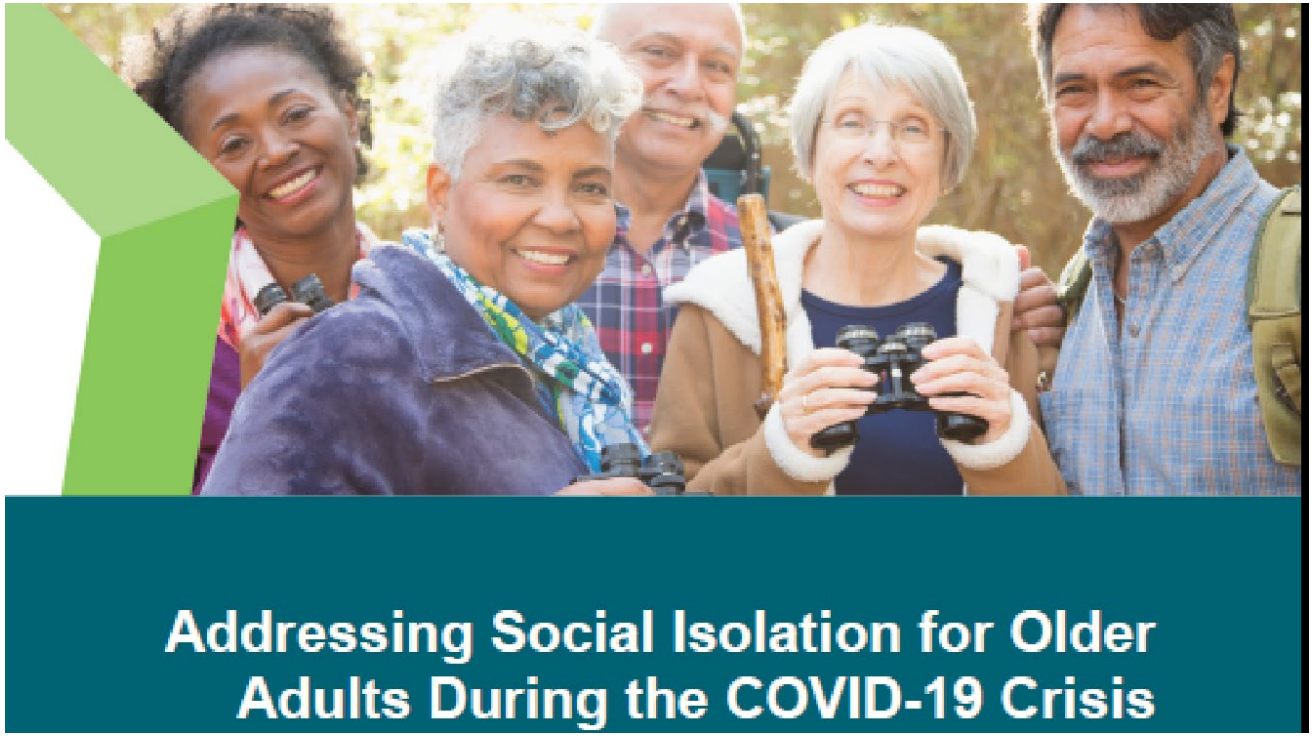
Questions? email ceinfo@vcuhealth.org

Attendance

Because attendance rewards and CE credit are dependent upon your ECHO attendance, contact us at nursinghome-echo@vcu.edu if you have a conflict.

Social Isolation

https://www.challenge.gov/assets/netlify-uploads/social-isolation-resource_08042020.pdf



A supportive reframe for counselling patients, families, & staff re. “loss of safety”

Micky ScottBey Jones
“The Justice Doula”

Invitation to Brave Space

by Micky ScottBey Jones

Together we will create *brave space*
Because there is no such thing as a “safe space”
We exist in the real world
We all carry scars and we have all caused wounds.
In this space
We seek to turn down the volume of the outside world,
We amplify voices that fight to be heard elsewhere,
We call each other to more truth and love
We have the right to start somewhere and continue to grow.
We have the responsibility to examine what we think we know.
We will not be perfect.
This space will not be perfect.
It will not always be what we wish it to be
but
It will be our brave space together,
and
We will work on it side by side

Needs

Physical well-being
air
food
water
shelter
protection
(emotional) safety
movement
rest
sleep
touch
sexual expression
health
comfort
warmth

Harmony
peace
tranquility
relaxation
beauty
order
ease
predictability
familiarity
stability
balance
completion
wholeness

Autonomy
choice
freedom
time
space
independence

Power
self-esteem
confidence
dignity
inner power
empowerment
competence
effectiveness

Pleasure
to celebrate
to mourn
flow
humor
laughter
vitality
challenge
stimulation

Connection
collaboration
reciprocity
communication
company
to belong
durability
continuity
to give
to receive
to see / to be seen
to hear / to be heard
to understand
to be understood

Liveliness
to discover
adventure
passion
spontaneity
play

Authenticity
honesty
integrity
transparency
openness
self-expression

Meaning
to learn
growth
to contribute
to enrich life
hope
creativity
inspiration
purpose
clarity
awareness
liberation
transformation
to matter
participate
to be present
simplicity

Love and attention
love
compassion
care
attention
acceptance
appreciation
reassurance
affection
trust
involvement
respect
care
support
nearness
intimacy
tenderness
softness
sensitivity
friendliness

Important to identify and address Unmet Needs

www.cupofempathy.com

https://cupofempathy.com/get-the-empathy-toolkit/

What Matters to Older adults

http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHI_Age_Friendly_What_Matters_to_Older_Adults_Toolkit.pdf

Measuring Loneliness in Residents

De Jong Gierveld Scale

https://mvda.info/sites/default/files/field/resources/De%20Jong%20Gierveld%20Lonliness%20Scale.pdf