

COVID-19 Pandemic: Nephrology Experiences – Voices from the Frontlines: Part 1

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 1 of those experiences – examples of the responses to the request to “please tell us about your experiences with caring for patients during the pandemic.” In subsequent articles, we will report experiences of successes, challenges, best practices, and ethical issues.

Please tell us about your experiences with caring for patients during the pandemic.

It’s here, and it’s real. It’s now lurking in our neighborhood. New York City hospitals geared up for the onslaught of COVID-19 as the first case in New York City was confirmed on Sunday, March 1, 2020. The patient was a 39-year old woman who is a health care worker and believed to have contracted the disease while traveling in Iran (<https://www.nbcnewyork.com/news/coronavirus/person-in-nyc-tests-positive-for-covid-19-officials/2308155/>). She uses mass transit as I do, and she is also a health care worker like I am. Did I go to work with this person? Have I sat beside her or near her on the trains and buses? The questions kept coming as we faced the reality that we would be caring for these patients in the coming days. In silence, I started to pray more as fear and anxiety gripped me.

The hospital leaders cautioned us on what [was] yet to come. Dialysis preparedness was put into gear and strategies to maximize patient-centered care put in place. We got instructions to make use of our personal protective equipment (PPE) judiciously and conserve accordingly. We needed to ensure that we have enough for everyone when COVID-19 patients arrive at our doors. The anticipation was nerve-racking. We can barely handle the number of dialysis treatments we provide to our patients admitted to the hospital. The thought of getting more cases due to one of the possible sequelae of the virus rendering kidneys to fail acutely was frightening. How are we going to handle this? Do we have enough machines and staff?

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.

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The virus, thought to be airborne at first, was concerning because we only had a handful of negative pressure rooms available. Would that be enough to keep the virus contained? How are we going to protect ourselves and prevent the spread of this disease? Why is testing limited only to those who have a cluster of symptoms and predispositions? We were drowning in apprehension. We found a glimmer of hope when the transmission of the COVID-19 virus was said to be through droplet and contact. It can only be rendered airborne through aerosolizing procedures. Negative pressure rooms were not required but preferred. Depending on the doctor’s order, we can now dialyze infected patients in rooms with doors for three to four hours at a time. At the time, when testing was limited, only patients with clustered symptoms got tested. Patients with mild or no symptoms were not. COVID-19 patients were dialyzed in their rooms while the stable, non-infected patients had dialysis treatments in the central Dialysis Unit, which has five patient stations. We performed bedside dialysis treatments in intensive care units (ICUs), select treatment rooms, and step-down units. We felt reassured that we can somehow handle the influx of patients who need hemodialysis.

The first three COVID-19 patients needing dialysis came to us in the second week of March. How are we going to decide who will take care of these patients? The goal is to minimize sustained exposure time and contact with infected patients, but we provide this life-saving treatment for 3 to 4 hours each time we are at our patient’s bedside. Should we ask for volunteers or schedule staff rotations? We decided on doing our COVID-19 dialysis patients by rotation, taking care of one infected patient per nurse per day. Unfortunately, we were not able to keep this pace as the number of our infected patients quadrupled the following week. We were riddled with COVID-19 dialysis patients day in and day out. It was daunting as we were left to care for them during our entire 10-hour shift or more.

Forget about minimizing exposure and clustering patient care. Our patients need us in their rooms at all times. In an instant, we became the provider of a life-saving procedure, and the de facto companions to our patients as the hospital

restricted visitors to come to their loved one's bedside at this unprecedented time. We conversed with our patients while still conscious, gasping for air through their nasal cannulas and non-rebreather masks. In their weakened state, we encouraged them to eat and rest to strengthen their bodies to fight off the virus. We told stories about each other and shared opinions on what was going on around us. The nurses and the health care team in general were all the patients had as their families stayed home while we cared for them. Witnessing their isolation and anticipation was unbearable.

It was heart-wrenching to see every room in the ICU filled with critically ill and dying patients. These patients were surrounded by multiple intravenous (IV) drips, ventilators, feeding pumps, warming and cooling blankets, and dialysis machines to help them recover from the debilitating disease. We cheered them on and held their hands as they lay sedated, unresponsive, and intubated while we dialyzed them, hoping that we will see them again in the next hemodialysis session. That hope got doused when the patients we cared for the previous week were no longer on the list the following week. We had a new set of patients every week and found little time to mourn for missing names on our list. It was devastating and surreal as this went on for weeks. The staggering number of dialysis needs made us go into regular rooms previously unequipped with dialysis set-up. We learned to convert these rooms to become dialysis-capable as we plumbed the sinks with dialysis connectors. Suddenly, the whole hospital became our battleground as we pushed our machines in the hallways, elevators, and into the rooms of our patients. We stayed in the room with the patient for hours on end dressed with layers of gowns, gloves, caps, shoe covers, and masks, with sweat trickling down our spines as we felt inadequate in helping our patients despite our best efforts. Tears were flowing down our cheeks as we thought of the uncertainties after being exposed to the virus. It was taking a physical and emotional toll on us as some of our dialysis staff contracted the disease, became symptomatic, were quarantined, and one devastatingly succumbed to the virus's ultimate wickedness. We were weakened physically, emotionally, and mentally. It was utterly unnerving. We relied on our excellent health, mental strength, resilience, and spiritual beliefs to continue working, praying that we will get over this and will soon see the end of it. Our hospital's unwavering support encouraged us by providing us with adequate PPE, kind words, housing, affordable parking, meals, hospital-laundered scrubs, shower rooms, health care, and financial incentives. Our leader appreciated our heroic efforts every day as she sent us messages of gratitude and hope.

These acts of kindness and assistance urged us to continue and endure the work that we do as dialysis nurses with honor and grace under pressure. We learned to accept the uncertainties comfortably and bravely came to work as scheduled. We put patients first with care, and we make amazing things happen with creativity and resourcefulness. We convinced ourselves that with wisdom and compassion, we would triumph over this COVID-19 pandemic. We are

exceptional in many ways as we provide patient-centered care to everyone who comes through our doors, proving that we are New York Presbyterian strong. As we put on our masks and don our gowns and gloves in this unforgettable fight, we are beyond grateful to God for giving us the opportunity to use our lives to protect and save other people's lives. And for every smile you see behind the mask is a silent prayer to stay healthy and resilient in the face of an invisible foe.

*Maricel Lim-Sibbaluca Calagui, MPA, BSN, RN, CNN
Name and identifiers used with permission*

When the COVID-19 pandemic mandated that our nephrology clinic limit face-to-face contact with patients, I was presented the opportunity to answer the hospital-wide call for volunteers to work in other areas. I agreed to work on an extended care floor, located within the main hospital. Little did I know how impactful and life-changing this experience would be. The assignment was an excellent fit for my nephrology skill set. I would be providing one-on-one care to an elderly nun with CKD Stage 5. Sister was 89 years old and had recently been admitted to the extended care unit for symptom management of kidney disease. However, because of the pandemic, she had to complete a 14-day quarantine before allowed out of her room. I became her day-time nurse during these two weeks.

I quickly realized that my nephrology nursing knowledge would guide the care Sister required. She was mentally sharp and comprehended what was occurring because of her kidney disease, and had chosen to let nature take its course, refusing renal replacement therapy. As stated in the ANNA core values, nephrology nurses have the responsibility to enhance the quality of care delivered to people with kidney disease. Sometimes, that means providing a good death, and I knew Sister's care was a hospice situation.

I gave Sister as much symptom relief as I could. For the edema in her legs, I wrapped and rewrapped her lower legs with clean compression bandages daily. The edema was incredible. For the uremic taste in her mouth, I found mint flavored oral swabs. This was a hit! She very much enjoyed them. Sister refused pain medication, but I convinced her to take ondansetron for her nausea. The dry heaves were endless, especially when she moved. She felt short of breath even though her oxygen saturation on room air was in the low 90s. To relieve the shortness of breath, she was most comfortable either sitting in her wheelchair or recliner, something that allowed elevation of her head, and she wanted to sleep sitting up. Perhaps the most impressive symptom was the constant pruritis. She was delighted, both physically and mentally, in a hot shower with particular attention to her back and feet. As a nurse, I've given many showers, but this was perhaps the best one ever, and my scrubs were soaked! Sister loved it!

The most profound part of caring for Sister were the talks we had. No subject was off limits. She shared with me stories about her life as a nun and expressed how fulfilled and lucky she was to have had the life she did. There were no regrets. Because she had so openly shared her beliefs, I was able to tell her about my own faith journey, and we bonded over this deep conversation about life, love, and what we held sacred.

As the uremia progressed, her condition worsened day by day, and Sister barely ate or drank. The nephrologist told her she would only live a week or two more at most, but this news did not alarm or frighten her. Sister knew what was happening. Thirty-six hours before her quarantine ended, I had my last shift with her. When I left her that night, I kissed her on top of her head (through my mask) and told her I loved her – and if I didn't see her at my next shift, I knew where she would be. Sister smiled and nodded.

Sister passed away the morning of my next shift.

As a CKD instructor, I have now seen the progression of the disease first-hand. Before Sister, I had only read about it. Like a checklist, Sister's symptoms were textbook for uremia. I knew she felt awful but was stoic and truly never complained. I knew the questions to ask, and depending on her response, I attempted to minimize the symptoms. I believe as a nun, she was comfortable being alone. We talked about her love of solitude and comfort, and her never-ending faith. She had no fear, and I had the privilege of delivering her to a peaceful death. I will remember and love her forever.

Peggy Freeman, BA, LPN
(Name used with permission)

Over the last two decades dialyzing patients and then transplanting patients, luckily my experience with dying patients has been relatively low. Only one person passed on dialysis in my care, and he was known to be dying and on hospice. Three weeks ago, I dialyzed an older Native American lady about 76 years old. She was COVID-19 positive, and the room set up mandated I stay in her room for the whole 4-hour treatment (no windows). She was on a lot of O₂ but stable. She spoke about her family between naps. I fed her lunch as we would in the older days, when there was more time to assist patients. It felt good actually connecting with a patient and feel more useful and caring towards her. No visitors. She was alone. I love the long-term relationships built in the care of nephrology patients. How I love seeing their color change after a transplant. I feel like I have a good "gut" monitor when someone doesn't look right or may pass on, so coming back the following week, I was blown away to learn my patient had passed on. It was a shock. So surprising and sad. That is what this virus can do in an instant, and unfortunately, we are sometimes helpless to fight it.

Jonathan D Duggan, MSN, RN, CDN
(Name used with permission)

I practice in a medium-sized midwestern community. Out of our 100 patients, six were found to be COVID-positive. Of those six patients, five of them were persons of color. The disparity of this disease has been a lot to grapple with.

Mara Zobrist, RN, CDN
(Name used with permission)

At first I was scared because you don't know who is a carrier or not. When my two staff got a positive result and other staff who [are] doing bedside dialysis were quarantined due to exposure to positive cases, as a head nurse I remained calm and always reminded my staff to take care of themselves and strictly adhere to infection prevention guidelines. I always advised them to think positive. Every time my staff are swabbed, my heart is beating so fast waiting for their results. But thank God so far after my two positive staff, nobody has gotten a positive result.

Name withheld by request

COVID-19 introduced a lot of unknowns into our service line. It has changed how our department functions and validated our team mission. Rather than falter under increased utilization, the team adapted under pressure. We accomplished what felt like an insurmountable feat. Each day presented unique challenges to deliver care as the number of COVID-19 positive patients increased. During the pandemic, we saw the proportion of unit-based versus bedside treatments change. The number of dialysis unit treatments decreased to 40 per day. However, bedside treatments grew to 90 treatments per week, which is a 260% increase from the typical weekly volume. Apheresis treatments remained steady at three per week. This increased demand for bedside dialysis treatments created the need for rapid innovation.

Susanne Yeakel, MSN, RN, NEA-BC, CNML, Alex Ilchenko, BSN, RN, and Jarrett Lautier, MSN, RN
(Names used with permission)

I had to advocate for my fellow acute dialysis nurses to have proper PPE. On March 14, 2020, the CDC included airborne precautions for both PUI and positive COVID-19 patients as there had been several studies showing the virus can stay airborne for up to 3 hours. Even after showing our infection control team this CDC PPE update, they still kept positive COVID-19 patients not on a ventilator on only droplet precautions. Fortunately, after showing this update to our team leader, she was concerned for our safety and

has provided PPE for us to go into those rooms with our N95s, face shields, and feet and head coverings. This is so very frustrating. We have the supplies we need and are able to get more, though not in large quantities. Yet at this time, they are choosing not to use them in order to conserve them in case we run out. This puts our nurses at incredible risk and increases the chance it could be spread throughout the hospital. I also had to show them where the ASN recommendations stated acute dialysis nurses should stand outside the room as much as possible. I am disappointed the management didn't research this information for themselves. I've made sure the other nurses know this so they aren't bullied into staying in the rooms if it is not necessary. Some hospitals have even told their acute staff they can't have their fellow staff members relieve them while running the COVID-19 patients. This is brutal, and in my opinion, a form of bullying and workplace violence. I can at least be glad my management team hasn't chosen that approach.

Name withheld by request

Our staff were very frightened at the beginning. The hospital administration was telling them that they should not be masking for non COVID patients. Staff was aware that the Boston and NYC hospitals were all masking. It took Gov. Cuomo to issue a directive to mandate masking when in contact with all patients. In addition, N95 masks were not available when dialyzing patients. We had to argue and plead to get them. After a couple weeks and a recycling program, the N95 masks were more available. But it was frightening enough for them when COVID had just begun. Without the proper PPE, it was a much bigger issue.

Name withheld by request

Doing the treatments has been no issue for me. I don the PPE and stay in the room 4 to 5 hours feeling perfectly safe. I go home to my wife and kids, taking care to strip and isolate the clothing and then shower. The experience with caring for patients with COVID-19 is more about communication to the patient's family or support people. That is lost with visitation restrictions. Nurses relied on these personal visits to make personal contact. Now it's virtual and more difficult to plan times that work for the nurse and the family. That lack of communication and personal contact has eroded trust and increased anxiety and frustration in patients' families. It also weighs heavily on the patient to not have that support in the same way.

Name withheld by request

Not able to be fit tested due to allergy. I wear a CAPR when caring for COVID-19 patients. When dialyzing, we must stay in the room from set up to break down and all the time in between. No breaks due to short staffing. Late nights. Wearing the CAPR so many hours, I sustained burns to my face. Every nurse is working on COVID-19 units. Feeling left out of the "all in this together." We are not recognized at all. No public support because no one knows we are here. No one understands that every one of these patients goes into renal failure. They look at us as "just dialysis nurses." Not feeling appreciated and feeling resentful. I know I need thicker skin, but I feel very much left out.

Name withheld by request

Caring for patients with COVID-19 in the acute setting is an experience you will never forget. It's a picture etched in your mind that you won't be able to get out. Walking into a cath lab turned ICU to dialyze a patient was daunting. All the patients were prone on ventilators, with multiple pressors for BP support, arrhythmias alarming on the cardiac monitors, people running for defibrillators. And as a nephrology nurse, you walk around and see empty Foley bags, and you get chills. All you hear is "Call a Nephrology consult." These patients were not allowed to have visitors, so they were alone. It brought a lot of sadness.

*Faith Lynch, MSN, RN
(Name used with permission)*

Our state was one of the last states to have a confirmed case of COVID-19. We knew the pandemic would eventually spread into the state, and as such, the state government had started taking steps for the day the first COVID-19 cases were detected. It was really interesting and wonderful how many people took the threat of COVID-19 seriously. However, this wasn't the case for all. During the early days of the pandemic, before the first cases in the state were found, I walked into one of the dialysis clinics I round at to hear one of the nurses declaring loudly to the patients that the whole thing was a conspiracy. That it was propaganda designed to impact the next national elections as how many other "pandemics" such as SARs and Ebola had occurred in an election year. To say I was shocked at this is a bit of an understatement, and I knew this was upsetting for the patients. I made sure to talk with the patients and the nurse about what we currently knew about COVID-19 as the need to educate is such a key component to slowing the spread of this virus. Patients look to us for guidance and expertise, and we have to take this responsibility seriously. Two weeks later, COVID-19 cases had been confirmed in the state. I was in this unit when this nurse got the call that

the unit would be dialyzing its first patient with COVID-19. Now there were fear and tears, but I was and am proud of how the staff rose to this challenge of overcoming their fears utilizing expertise and knowledge.

Name withheld by request

Caring for dialysis patients will require skills as you have to prepare yourself mentally, taking into account the supplies needed, PPEs to protect you, your machine, etc. So it will take more time than what we do for a non-COVID patient. We have to learn the donning and doffing of PPEs the proper way. We become cautious and will feel the scare of contacting the virus even with using the PPE. We have less patients admitted since most surgeries were cancelled, but I am also being cautious of too much exposure, so I lessen/cut my hours to work. And yet I empathize with the patients' well-being and feeling of isolation. No families, friends, or visitors allowed to visit them. They are by themselves in the room, and they felt people are scared of them from contracting what they have.

Name withheld by request

The PPE has been a challenge. As a guest contractor in 12 different hospitals in the metro area, each hospital expected us to bring our own PPE. We are a small company of less than 100 employees, so it was hard for us to get what we needed at first. I felt untrained and unsafe to care for these patients. It came on so fast, the N-95 supply was changing daily, and we hadn't been fit-tested to some of the N95 they were giving us. I wore a PAPR in that case but hadn't been trained on it properly, and the PAPR was over-stretched, so I wasn't sure if I had a good seal. For a while we used the brown paper sack to reuse our N95, but then they handed it back to us in the same dirty sack. I also wondered why we didn't have full coveralls like we see in other countries. The patients were dying quickly on CRRT. We had 1, then 3, then 5, until we hit 11 patients needing CRRT in one day, which was the highest I had seen in my 10 years.

Name withheld by request

It has been heart-breaking seeing the most critical patients on dialysis. Alone and sedated. Those were the ones who most likely did not go home to family. But also encouraging to see COVID-positive patients who did improve. The majority of those have gotten better and gone home.

Name withheld by request

We had a few patients who were under investigation at that time and had symptoms. I knew the risk for exposure was very high since the patients were symptomatic, yet we were not provided adequate and appropriate PPE. When we asked if we could have N95 masks, we were told that we didn't have them. I was scared and anxious knowing that I could end up getting sick and bring it home, but I did it anyway because I had to take care of the patients.

Name withheld by request

As a nurse practitioner in a hemodialysis outpatient unit, I was involved as a key leader with pandemic planning at the beginning of the planning. At our facility, three of our four formal leaders (coordinators, managers, and program director) were in quarantine. Hence, there were gaps that needed to be filled and done so quickly. As such, my clinical role (unchanged) also morphed into program planner and pandemic planning stakeholder.

*Julie Ann Lawrence, MScN, RN(EC), CNeph(c), NP
(Name used with permission)*

The outpatient areas were difficult to manage and required adaptive, innovative ways to revise unit function and flow to keep patients and staff safe. In the early stages of the pandemic, the guidelines for PPE were not as supportive of outpatient dialysis staff working with COVID-19 positive patients as they could/should have been, but did ultimately update with time.

Name withheld by request

At first, we did not get hospital issued scrubs – this made us worried because we had to be in the room for so long. The second week we were allowed to get the hospital-issued scrubs. At first, we had to bring rule outs to the Dialysis Unit at the end of day, alone or put in isolation room; then we were able to coordinate with our Facilities team to make accommodations for the dialysis equipment to go to atypical rooms. Coordination of care, practitioner/nurse/tech, communication, and administration all had to work together in order to provide for the success of situation.

Name withheld by request