INTERDISCIPLINARY TEAM CASE STUDIES

By Barbara Resnick, PhD, CRNP, and Paige Hector, LMSW

A Younger Adult With Rheumatoid Arthritis and COVID-19 Isolation

Mrs. R is a 47-year-old White woman who moved into the long-term care facility in 2018 when she needed more assistance than could be provided in her adult-care home. Her medical history is long and complicated: rheumatoid arthritis with multiple joint replacements, seizure disorder, right hemiparesis due to cerebrovascular accident, coronary artery disease with iron deficiency anemia, and rheumatic heart disease with atrial and mitral valve replacements.

Her medications include Zofran at 4 mg every 8 hours as needed; aspirin at 81 mg daily; vitamin D at 1,000 units daily; gabapentin at 200 mg at night; ferrous sulfate at 325 mg daily; enetercept solution autoinjector at 50 mg once weekly; and Coumadin at 4 mg daily. She also receives milk of magnesia, a Fleet enema, and Tylenol as needed. Mrs. R has full decision-making capacity and is involved with all aspects of her care. She is independent with her electric wheelchair.

She had tested positive for COVID-19 on rapid antigen testing — not once but also on a repeat test — on a wing where others had also tested positive. On Monday, after she was exposed to a staff member who was COVID-19 positive, she was moved into isolation the same day. Her COVID-19 PCR confirmatory test is pending, and the facility has been told it could be several days to get the result. Mrs. R is completely asymptomatic. She is eager to return to her usual room and be near her friends, and she expressed frustration at being quarantined for two weeks. Mrs. R sums up her current situation as “there is nothing simple.”

Attending Provider
Mervin Hector, MD, FAAP, CAQ Geriatrics, CMD
Dr. Hector is a Tucson-based physician with over 30 years of medical director experience.

Although false-negative results with rapid antigen testing (i.e., failing to identify COVID-19 infection in someone who has it) have been reported to range from 2% to 37%, the incidence of false-positive results (i.e., identifying an infection in someone who doesn’t actually have it) is only about 1%. Despite her lack of symptoms, the odds are that Mrs. R was indeed infected at some point.

With her presumed immune suppression, things are even less clear. It is imperative to isolate her for a period with full precautions — preferentially keeping her in a single-occupancy room in her own unit so she can return to her usual long-term care room if her PCR test result is negative. Being in the COVID-19 unit would expose her to even more risk while she awaits the result of her PCR testing, and she would be committed to at least 7 to 14 days of quarantine before being able to return.

Activities Director
Diane Mockbee, BS, AC-BC
Ms. Mockbee is an Activity Consultant/Educator — Board Certified through the National Association of Activity Professionals Credentialing Center. She had worked as an activity director and dementia trainer in long-term care for over 28 years until retiring in 2018. She currently consults and speaks in a variety of settings. Being isolated can be daunting and discouraging. The staff can help support Mrs. R by ensuring that she has items from her LTC room such as electronic devices and supplies (such as hobby materials) that she could use to occupy her time. These items can be disinfected when she returns to her own room. The activity staff can provide daily visits and assist with facilitating video visits (such as FaceTime calls) with her family and friends, if needed. Consider using the free resources from the TimeSlips website, such as the Beautiful Questions, to stimulate creativity and conversation (www.timeslips.org/resources).

Perhaps Mrs. R would be interested in paper games such as word finds, Sudoku, and crossword puzzles. Given her arthritis, the activity staff can provide her with adaptive equipment (grips for writing utensils and a stylus if she uses one for her electronic devices) to help facilitate her independence and enjoyment with her daily leisure pursuits.

To facilitate communication that follows COVID-19 protocols, the staff can use door hangers that convey her requests. Even in isolation, she can still enjoy special snacks like root beer floats or other treats when special days or events are honored.

Pharmacist
Nicole Brands, PHARM D, MBA
Dr. Brands is a professor and the executive director of the Lamy Center on Drug Therapy and Aging at the University of Maryland School of Pharmacy. Mrs. R’s complicated scenario is one that many of us have experienced — the balance of resident wishes and risk reduction. As such, it may be necessary to stop her etanercept treatment. Per the American College of Rheumatology guidance, if the person has documented or presumptive COVID 19, regardless of COVID 19 severity, hydroxychloroquine/chloroquine, sulfasalazine, methotrexate, leflunomide, immunosuppressants, non-interleukin-6 biologics, and Janus kinase (JAK) inhibitors should be stopped or withheld.

With respect to reintroducing treatment after COVID-19, for COVID-positive residents who have no or mild pneumonia, restarting therapy for rheumatic disease with immunosuppressants, biologics, and JAK inhibitors may be recommended within 7 to 14 days of symptom resolution. For asymptomatic PCR-confirmed COVID-19 cases, rheumatic disease therapy may be restarted 10 to 17 days after the PCR test result is reported as positive.

Director of Nursing
Judi Kalus, MSN, MAT, RN, NHA
Ms. Kalus is Chief Nursing Executive at Lantis Enterprises

According to the Centers for Disease Control and Prevention, Mrs. R should not be moved to the COVID-19 unit until her confirmatory PCR test returns a positive result. She may remain in her current unit in a private room with the door shut and on droplet precautions and aerosol precautions if the staff are required to perform any aerosol-generating procedures (e.g., nebulizer treatment). If her PCR test comes back positive, then she must be moved to the COVID-19 unit for continued isolation and close monitoring.

While Mrs. R continues to be asymptomatic she should be monitored for fever, reduced oxygen saturation, and the signs and symptoms of COVID-19 at least every shift. Once her COVID-19 status is confirmed by a PCR test, the likelihood of developing symptoms three to five days after exposure remains high. With her complicated health status, Mrs. R has a high probability of rapid decline

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have psychiatric training or background (nurses, social workers, etc.). Staff who have the appropriate experience are more comfortable working with residents who have high psychiatric needs.

6. Tap into the strengths of the younger resident. Identify ways in which he or she may be helpful to the other residents. For example, many older residents whose family members are not active in their life may enjoy interacting with someone the age of their own children. Pairing younger and older adults as roommates can be mutually beneficial, and it may decrease potential behavioral issues (which can occur when roommates have similar emotional or behavioral functioning).

7. Offer activities that target younger adults. Although some younger adults enjoy the traditionally offered activities such as bingo, many do not. Identifying age-appropriate opportunities for positive interactions can help, such as incorporating technology into activities.

8. Provide a list of available resources to the resident that are specific to his or her individual needs. Residents’ sense of perceived social disconnection can be decreased by access to social support with individuals of similar life experiences. For example, if the resident has multiple sclerosis, ensuring access to an online support group may be beneficial. If the resident is in recovery from alcohol use disorder, providing information on local Alcoholics Anonymous anonymous meetings could help (or arranging for meetings at the facility if a large number of residents would benefit).

Refer to The Younger Adults in the Long-Term Care Setting (R.L. Ferrini et al., 2013; https://bit.ly/3s7hUM), a tool kit from AMDA – The Society for PAsusters and Long-Term Care Medicine, for more information on best practices when dealing with younger adults.

The tool kit includes guidance on:
- Identifying individual perspectives that inform needs and wants.
- Facilitating appropriate relationships between residents and staff.
- Anticipating cognitive problems.
- Making facility policies and behavioral management practical.
- Preparing staff to care for younger residents.
- Advocating for the value of a long-term perspective.

Dr. Lind is a Licensed Psychologist and the Chief of Quality Assurance for Deer Oaks, a national behavioral health company serving the behavioral health needs of residents in LTC and AL settings. She is a member of PALTC’s Behavioral Health Council.

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Rationale for isolation, validating her
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Understandably, Mrs. R is frustrated.
Ms. Hector is a social work expert and a Social Worker
Paige Hector, LMSW
Social Worker
To assist Mrs. R with her frustration at not being close to her friends while on isolation, it is important to facilitate virtual interaction with her friends and family as well as support her in finding creative ways to engage in hobbies and self-care. To uphold person-centered care, encourage her to voice any feelings of depression, fear, and loneliness. Review her advance care plans to talk with her about the risks associated with COVID-19, including death. Determine whether she would want to be transferred to the hospital, and talk with her about the risks of hospitalization.

Social Worker
Paige Hector, LMSW
Ms. Hector is a social work expert and a coeditor of this column. Understandably, Mrs. R is frustrated. Although she seems to appreciate the rationale for isolation, validating her feelings with expressions of empathy is important. She may also be feeling bored, irritation, and uncertainty about her situation and her belongings. The staff can help support her well-being by acknowledging these feelings and needs. The usual communication habits may lead some staff to offer well-intended but hollow comments such as “Don’t worry, you’ll be back in your room soon enough.” Or “You know we have to follow isolation protocols to keep everyone as safe as possible.” While both of those statements are true, they come across as uncaring and do not convey empathy or compassion.

Using the principles of nonviolent communication, the staff can validate her feelings and connect them to unmet needs. For example, her frustration at having been moved into isolation may be related to an unmet need for continuity or familiarity with her routine in her usual long-term care neighborhood. The staff can say, “Are you frustrated (feeling) because you miss the people (need for connection) and routine (need) that you had in your long-term care neighborhood?” Or, “Are you bored (feeling) without your usual items from your room and would like to have something meaningful (need) to do?” Or, “Are you angry (feeling) because you would like more choice in your plan of care (need)?” By identifying her feelings and needs, the staff connects with Mrs. R, by offering empathy and compassion. They cannot change the current situation or the fact that she may be in isolation for at least two weeks, but they can validate her feelings and do what is possible to help meet her needs in appropriate ways.

Summary
The interdisciplinary team is in agreement about balancing Mrs. R’s exposure to COVID-19 with supporting her emotional well-being. They plan to help her engage in meaningful activities during her time in isolation while closely monitoring for signs of COVID-19. The review of her medications indicates the possible need to hold or discontinue at least one medication in the event she has contracted COVID-19.

KEY POINTS
• Isolate the resident while awaiting the results of the PRC COVID-19 test.
• Facilitate meaningful leisure activities, and use door hangers to enhance communication between the resident and staff.
• Discuss possible temporary discontinuation of the etanercept.
• Monitor for symptoms of COVID-19.
• Encourage the resident to voice feelings of depression, fear, and loneliness.
• Review the resident’s advance care plans and treatment goals in the event of a positive COVID-19 PCR test result.
• Use the principles of nonviolent communication to validate the resident’s feelings and connect them to unmet needs.

Dr. Resnick is the Sonya Ziporkin Gershowitz Chair in Gerontology at the University of Maryland School of Nursing in Baltimore. She is also a member of the Editorial Advisory Board for Caring for the Ages.

Ms. Hector is a clinical educator and professional speaker specializing in clinical operations for the interdisciplinary team, process improvement and statistical theory, risk management and end-of-life care, palliative care, among other topics. She is a member of the Editorial Advisory Board for Caring for the Ages.

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