Nursing and Palliative Care

Case Study ISSN: 2397-9623

# A case study from a nursing home – Lack of human touch

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**Abstract**

This article illustrates how the corona pandemic affected the residents' quality of life in a nursing home setting. Neither the politicians nor the health care staff had experiences with pandemics. News from China suggested that older people were in the risk group, the elderly had to be isolated. Strict rules reduced human touch and contact. This article illustrates the balance between human touch and infection prevention measures.

## Introduction

In this article, I would like to illustrate how the corona pandemic affected the residents' quality of life in a nursing home setting. In March 2020, health workers all over the world started to fight against an invisible enemy. Older people are seriously at risk for infection. Chronic obstructive pulmonary disease (COPD) and lower respiratory infections are the third and fourth crucial reasons for death [1]. Lung problems combined with COVID-19 and high age is challenging for the patients and the medical staff [2].

One year has passed since I learned about Covid-19 for the first time. I participated in a conference in Belgium (www.interrai.org). We received daily news about how quickly a new unknown virus in China was spreading. I became acquainted with some representatives from Asia. They were worried about this new virus and considered whether they should stay in Europe or dare to go home. When I arrived at the international airport in Brussel a couple of days later, I wondered why everything seemed chaotic. The virus has to reach Norway.

A few weeks later, on March 15, my sister (71 years) and I went skiing not far away from our family cabin. The weather was fantastic; this was our second day in the mountain. The next day, our older sister (76 years) would join us. In the meantime, we enjoyed the magnificent scenery around us. We passed a cabin, and an older man shouted out through a window. "Do you know about the lock-down? We all have to leave our cabins, the "plow truck" is stopping to drive, and the news tells that more snow is coming." Shortly after, a new regulation law ticked in on the phone: In regulations of March 15, 2020, no. 294 on quarantine, isolation, and prohibition of residence on leisure properties, etc. due to the outbreak of Covid-19, the following changes are made:

The SARS-CoV-2 was soon in all news channels. No existing vaccines could save us. We needed isolation to slow the virus from spreading. The children have always been a threatened group. The number of child-deaths reduced due to modern medicine and childhood vaccination (https://www.historyofvaccines.org/ content/articles/different-types-vaccines). When the medical elite feel they have control, a new variant of the virus is developed. COVID-19, however, has proved that this time children are not in focus, but their grandparents. Guo [2] states that older adults can easily ignore the early symptoms of COVID19 and will miss the best time to seek medical advice. China experienced a lack of treatment conditions and guidelines in the face of the new disease. China has relatively few nursing home beds, and the residents are frail [3]. All over the world, people were scared. Political disagreement and lack of pandemic strategies made the situation difficult.

### New routines

The COVID pandemic started a new style of living. The health personnel learned to use basic routines because all body fluids and non-intact skin and mucous membranes could contain infectious agents. In the first months of the pandemic, the government, health personal, and the general population were shocked. It seemed hopeless to fight an invisible enemy. The Norwegian Institute of Public Health updated every day the number of infected or dead. The health minister ordered the schools to lock down, and traveling becomes forbidden. In the first months, the health sector had strict rules for visiting, especially nursing homes. In the newspapers, we could read tear-dripping stories about dying persons without their relatives at the bedside.

The best palliative care for residents at the end of life should usually be given in the nursing home, without transferring to a hospital. The staff should allow the next of kin to be present in the final phase of life.

Norway is a pioneering country when it comes to public care and adapts living conditions for the elderly. The Norwegian nursing homes have a good reputation. All older people in need of 24 hours follow-up may have their room in a nursing home. About half of Norwegian inhabitants, on average, spend their two last years of life in nursing homes. Their old age pension administrated by the Government covered the expenses. Those with a private fortune may pay an additional fee [4].

### Long-time care institution: A home or a prison?

I have had the privilege to follow a non-profit 70 beds nursing home in Oslo annually from the spring of 2013. We evaluated the residents using the international assessment tool interRAI for long time care facilities (www.interrai.org). The analysis tool generated statistics and algorithms (www.raisoft.fi). The residents' primary nurse and one researcher filled out the assessment, which included physical and

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**Received:** March 13, 2021; **Accepted:** March 25, 2021; **Published:** March 31, 2021

cognitive performance, social involvement, diagnoses (WHO-10), and use of medication Anatomical Therapeutic Chemical (ATC) [5,6]. The data program automatically generated Scales that tell abilities and risk factors. These tools identify areas where a resident has a higher than expected decline rate and increased potential to improve (www.interrai.org/protocols). The project followed ethical guidelines for social sciences, humanities, law, and theology [7] (www.forskningsetikk.no) /en/guidelines/ social-sciences-humanities-law-and-theology/guidelines-for-research-ethics-in-the-social-sciences-humanities-law-and-theology/). A nurse informed the resident or the next of kin about the project and signed a written informed consent form.

## Case

Mrs. N was 91 years old when she moved to the nursing home. She had a diagnosis of light dementia with a depressive symptom (F0023), arthritic (M139), and Osteoporosis (F0023). Her main medication was antidepressives (N06AB10) and analgesic (N02AA59). She communicated well with both the staff and with fellow residents. She needed comprehensive help to take care of daily activities due to previous fractures due to osteoporosis and joint pain. She joined the other residents in the dining room and participated in various activities. Gradually she withdrew from social settings. She preferred to be in her room listening to music. Mrs. N appreciated that someone came into her room and talked to her. She often expressed that she was depressed and complained about her poor health (Table 1).

She expressed a sad mood last year. During the first assessment, she was functioning relatively well. After one year's stay, she had become depressed and lost weight, and her body mass index reduced from 27 to 22. She had a close relationship with her family, and they visited her regularly.

In March 2020, everything changed. Mrs. N felt increasingly anxious as various COVID-19 restrictions tightened. The family was visiting her only after individual appointments with the responsible nurse.

The next of kin had to prove that they understood and oblige to follow the national routines and restrictions.

Mrs. N had earlier enjoyed eating with her fellow residents. She gradually became increasingly helpless in daily life functioning. Eventually, she would rather be in her room, listen to music on the radio.

The day the nurses started wearing infection suits, visors, and gloves, there was a marked deterioration in Mrs. N. Eye contact became difficult. She also had problems with hearing, and the visor made it impossible to read on the lips. She gradually lost all zest for life. The primary nurse wished she could spend more time with Mrs. N. The nurse knew that the patient relaxed when giving her massage. She especially enjoyed that the nurse stroked along her back without the infection control gloves. The patient calmed down - the tense muscles relaxed when skin-to-skin was meeting. After this massage, Mrs. N fell into a quiet sleep. The nurse washed her hands and quietly slipped out of the room. The last days she did not want to eat, and she was drinking very little. Her mouth was dry, but she only wanted gently lubricate the lips.

**Table 1.** Scales and CAPs

| Scales and CAPs | First assessment | Second assessment | Last three days of life |
|---|---|---|---|
| Risk for decubitus (0-8) | 1 | 3 | 4 |
| Cognitive function (0-6) | 3 | 3 | 3 |
| Depression risk (14) ≥ 3 | 2 | 7 | 4 |
| Pain (0-4) | 0 | 2 | 2 |
| Communication (0-8) ≥ 4 | 0 | 0 | 3 |
| Activity of daily living (0-28) | 9 | 18 | 27 |
| Body mass index | 26.9 | 21.8 | 20.3 |
| Stability in health status (0-5) | 0 | 4 | 5 |
| Mood (0-2) | 1 | 2 | 2 |
| Dehydration | 0 | 2 | 2 |
| Pain (0-2) | 0 | 1 | 1 |

In her last week's, Mrs. N seemed less depressed, changing from "7" to "4" on the depression scale. She expressed that she was not afraid to die. The patient now received palliative care. The physician had delegated medication to the responsible nurse. Following medication could be give if needed: Midazolam - N05C D08, 5 mg / ml subcutaneous, Morphine - N02A A01, 5 mg / 1/2 ml. subcutaneous and Paracetamol (N02BE01), 500 mg rectally.

The daughters were at the bedside with her for her last two days and were present when she stopped breathing peacefully and calmly. The relatives expressed that they were grateful for the care the mother had received at the nursing home.

## Reflection

Older people who are isolated across the country have been in a difficult situation [8,9]. It does not help with television, radio, and newspapers if you have no human contact. Young people are good at digital media, while older people struggle more.

Depriving the elderly of the opportunity to meet grandchildren and great-grandchildren hurts. Children and young people miss getting to know their grandparents. The young people have a long life ahead of them. The elderly may die without having their loved ones around them [10].

Strict infection control is necessary to limit the pandemic. The staff has problems explaining the situation to the residents. The older may be restless and scared. The nurses are dressed up in infection coats, gloves, and face masks. We call it nursing homes. However, the residents' homes are changing from a place for social contact to a place for isolation. The solution may not be to isolate one by one. Responsible authorities must arrange for relatives to take care of their loved ones. In Norway, we have become experts in the home office but less skilled in facilitating death in our nursing homes. We need more knowledge for ordinary praxis care in extraordinary times [8].

**A few positive facts:** It is our oldest people who are hardest hit by COVID-19. The serious respiratory problems that some people experience have frightened both health professionals and relatives. Especially in older women, this has led to lifestyle changes. This may explain the fact that we in Norway have reduced mortality by 3.5% in the last year [11]. In some municipalities, funeral homes complained that they had too little to do.

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