Not Infected by COVID-19, but Affected All the Same

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Esther is a feisty, petite 99-year-old woman who's been a client of my geriatric care management agency for the past couple of years. Until recently, Esther was living at a lovely assisted living facility in her own tidy little one-bedroom apartment. Like her apartment, her life was also rather tidy; tied to her daily routine.

Esther got exercise each day when she walked to the dining room for breakfast, lunch, and dinner. She was nervous on elevators and chose to take the stairs instead. She went slowly and carefully and always with one of the facility's caregivers next to her for safety. She participated in activities offered and enjoyed the camaraderie, socialization, and opportunities for creativity and mental stimulation.

Esther also was regularly visited by Suzanne, her primary care manager from my firm. Suzanne, a Registered Nurse and professional advocate, is responsible for overseeing Esther's care to ensure that all of her needs are being met and that nothing is missed. She met with Esther on a weekly basis at the assisted living facility and, as part of her overall assessment, engaged with her in discussions of whatever was on Esther's mind. These in-person visits gave Esther opportunities to have meaningful conversations, face-to-face and helped her to feel connected with the goings-on in the world outside her home.

Although surely showing signs of dementia-related short-term memory loss, Esther maintained her keen interest in current events. She loved to talk about politics and was strong in her conservative leanings. She liked to guess her visitors' political party alliances as well (Suzanne never told!).

COVID-19 began its ugly fog-like descent on facilities like Esther's about eight or so weeks ago, in early March. It quickly became referred to as the, "Invisible Enemy." For the safety of its vulnerable residents, and like every other long-term care facility in our area, Esther's facility heeded our Governor's directive that all residents isolate in their rooms to avoid potential exposure.

Rather than the daily walks to the dining room, meals were delivered to each resident's room three times a day. Instead of Esther's trips to the Wellness Office for her medications, nursing staff brought her medications to her. Group activities halted and individual activity sessions were very limited or non-existent. Outside visitors were prohibited.

At first, Esther took the changes to her routine in (reasonable) stride. Instead of weekly in-person visits with Suzanne, the two spoke daily by phone. But as the weeks went by, Suzanne noticed Esther was losing her orientation. Like many of us affected by the new routines and

isolation brought about by the pandemic, Esther had difficulty remembering what day it was. Sometimes it would take Suzanne almost thirty minutes on the phone to help Esther regain her orientation, to remember where she was and what was happening in the world.

Unfortunately, the re-orientation Suzanne helped Esther achieve during her calls didn't last, and soon her disorientation expanded. Most of the time, Esther wasn't sure where she was living. She often thought she was living in her childhood home or at a hotel. Sometimes she would tell Suzanne she was waiting for her mother to visit. She didn't recognize her long-time caregivers and became afraid when "strangers" came into her room and tried to help her with personal care. "They are going through my dresser drawers! They are trying to help me undress! Who do they think they are?!"

Esther began resisting personal care assistance and yelling at the staff who came into her room. She sometimes refused to take her medications. She descended into deeper confusion which eventually brought with it depression, and a complete disconnection from reality. Although Suzanne's calls continued, on most days she wasn't able to bring Esther back from beyond. It was heartbreaking.

And then, probably related to a lack of exercise, seven weeks into the isolation, Esther lost her balance and fell in her apartment. She shattered her hip.

At the hospital, the orthopedic surgeon did not recommend going ahead with a major surgical repair for Esther's badly broken hip, partly because the surgery would have to be extensive, and partly because he was concerned that general anesthesia for a 99-year-old woman would be a dangerous, and perhaps fatal, endeavor.

Suzanne was able to coordinate Esther's transfer out of the hospital and into a nursing home where the care and rehabilitation services are excellent. In this new calm and supportive environment, Esther has been slowly coming back to herself. Time will tell if she will return to her cognitive baseline, but at least she is beginning to feel comfortable and familiar with her new surroundings. The compassionate staff have been patiently re-orienting her and helping her to adjust. She is not quite as isolated as she was at her assisted living apartment, mostly because the nursing home offers the higher level of care and attention she needs right now.

Esther has a phone again, and Suzanne has resumed her daily check-in calls and conversations. Esther is responding positively and has told Suzanne she doesn't have a good memory for events of the past number of weeks but that she is feeling better, "in my brain." She seems to understand that she will need a wheelchair from now on and laments that she never expected to live out the end of her life this way.

Esther has been tested for COVID several times in the last several weeks. Her test results have been consistently negative; no evidence of virus. Although her neighbors at the assisted living were testing positive in the dozens in March and April, the social distancing and room-isolation

served Esther well in that respect. But even without a positive result, Esther's life has been undoubtedly and, most certainly, permanently affected by COVID-19.

We know that Esther is not alone. There are many elderly, disabled and mentally ill people who are alone in their homes or in care facilities, and who are experiencing the very same effect from the prolonged social isolation.

Predictions are that COVID-19 will make a second round in our community this fall. We have the next few months to address ways in which to limit the spread of the virus and prepare for any surges that might once again fill up our hospitals.

As important as that preparation is, there also needs to be a plan in place to limit the impact of the mass isolation that is very likely going to accompany those efforts. We must prioritize the needs of those affected by the very real secondary level of impact: those who don't contract the virus but suffer its effects anyway.