

Caring for Nephrology Patients and Staff During the COVID-19 Pandemic: Experiences of the Northwest Kidney Centers

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CE 0.9 contact hours

The following is a transcript of the *NNJ Extra* interview, "Caring for Nephrology Patients and Staff During the COVID-19 Pandemic: Experiences of the Northwest Kidney Centers." Listen to the interview in ANNA's Online Library and earn additional CNE contact hour credit: <https://library.annanurse.org/anna/sessions/7448/view>



Beth Ulrich: Hello and welcome to *NNJ Extra*. I'm Beth Ulrich, the Editor-in-Chief of the *Nephrology Nursing Journal*. Today, I'm privileged to have as my guests Liz McNamara and Suzanne Watnick, the Chief Nursing Officer and the Chief Medical Officer of Northwest Kidney Centers in

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Note: Additional statements of disclosure and instructions for CNE evaluation can be found on page 126.

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The Northwest Kidney Center (NWC) in Seattle, Washington, has been a leader in nephrology care for almost 60 years, opening the first hemodialysis unit in the United States in 1962. In February 2020, one of their patients was the first reported death from COVID-19 in the United States. On April 6, 2020, as a part of NNJ Extra – the *Nephrology Nursing Journal's* podcast series, Beth Ulrich, EdD, RN, FACHE, FAONL, FAAN, Editor-in-Chief of the *Nephrology Nursing Journal*, talked with the leaders of the Northwest Kidney Centers – Suzanne Watnick, MD, the Chief Medical Officer, and Liz McNamara, MN, RN, Vice President of Patient Care Services and the Chief Nursing Officer, who discussed dealing with the onset of COVID-19 at NWC, how their team worked together to provide care for their patients and support for their staff members, and the lessons they learned that can benefit others.

Key Words:

COVID-19, nephrology nurses, coronavirus, dialysis, peritoneal dialysis, home hemodialysis, hemodialysis, collaboration, infectious disease.

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Washington State, who are going to share with us their recent experiences with COVID-19. Welcome to you both.

Suzanne Watnick: Thank you so much, Beth.

Beth Ulrich: Let's start by having you both tell us a little bit about your background and your current positions. Liz, do you want to go first?

Liz McNamara: Thanks, Beth. My name is Liz McNamara, and I became the Chief Nursing Officer here at Northwest Kidney Centers in June of 2018. I actually started nursing in 1987. I like to joke that I was five when I started in case people are doing the math. I came from the hospital world, and most of my bedside years were spent in the medical ICU at a Level 1 Safety Net Trauma Center. So I knew hemodialysis from the in-patient side of the house. I was super excited and privileged to join the birthplace of hemodialysis as part of an amazing executive leadership team. And that's where I met Dr. Watnick, my dyad partner, Suzanne.

Suzanne Watnick: Yes, I'm Suzanne Watnick. I started in this position in January of 2017. Prior to that, I had been practicing nephrology for well over a decade – I'll just leave it at that – in the Oregon region; but had also practiced in various other areas in New Haven and San Francisco. I was so excited to join Northwest Kidney Centers because it really aligned with some of my basic principles – to improve the life of people with kidney disease at both the micro- and the macro-level through patient care and education, and research. And I was really lucky to have Liz join us because the two of us have been working really hard no matter the challenge, including this particular situation which really came to us first in nation.

Beth Ulrich: Walk us through how that happened. How did your experience with the coronavirus and COVID-19 begin?

Liz McNamara: Thanks, Beth. This is Liz, I'll take the first stab at that. As part of my previous role, I ran a Local Infections Prevention and Control Department, so I kept in touch with folks. We had been following the whole COVID-19 thing since Washington State had its first positive patient right after the first of the year. But then my phone rang on Friday night, February 28th, and it was Suzanne calling to let me know that one of our outpatient dialysis patients who had been in the hospital for a week had just died and he had tested positive for COVID-19.

Needless to say, I was shocked until I realized that, oh, that's right, we just had our state test approved. And the CDC just opened up testing so that you didn't have to have travel history. So we were shocked initially, and then we're like, okay. We called our local King County Public Health,

I think the partnership with the physicians can't be spoken to enough. This isn't a dialysis disease, right. We don't need dialysis-specific acumen. But this is an operational disease; it takes the both of us together to be a united front, and that's really powerful. Even from the hospital world, nurses can't change things by themselves, and neither can docs, but we are incredibly powerful when we work together.

— Liz McNamara, MN, RN

who've been great partners, I have to say. We let them know that the patient was one of our patients. We stood up; we started our Emergency Operations Command center. We were onsite Saturday morning.

The particular clinic that this patient ran in was closed on Saturday – they do a Tuesday-Thursday-Sunday schedule along with Monday-Wednesday-Friday. We thought we had a little bit of time. We deep-cleaned the unit. We were in constant communication with the King County Public Health, and we started our exposure list. We started to list the patients who were dialyzed next to the source patient. We listed all the staff who had taken care of the source patient. We furloughed all that staff, which was the recommendation then, but which has since changed.

The other complicating factor is that we provide acute care services to this particular hospital as well. We had a list of acute care staff that we also had to furlough. All in all, we probably furloughed around 14 staff members.

Suzanne and I, really as we worked through that Saturday, developed some guiding principles that I think have really driven us. The first being, we're obligated to provide outpatient dialysis care for our patients.

We knew that this was a respiratory illness transmitted primarily by droplets. We felt pretty confident that we knew that our hospitals were set to be overwhelmed. We knew we could safely take care of these patients, our patients, and their home unit with the right PPE.

Second, we wanted to follow the science and again, really listen to the World Health Organization. We had a very strong alliance with our local hospital partners as well. And then the third principle is that we knew we had to provide leadership – leadership for the community that needed to be transparent, it needed to be timely, it needed to be supportive.

Given that third guiding principle, we actually went to the unit Sunday at 4:45 in the morning. I did not want patients to hear about this in the media. I had no idea when it would hit the media that this was in Northwest Kidney Center stations, so we sat chairside with each of the patients telling them that the death actually had been one of our patients and it happened here. We had the unit deep-cleaned, although we know now that our normal cleaning protocols are fine with the virus. That's how we started. We also huddled with the staff. The staff [were] fearful, of course; anxious. This was something new. We taught people how to don and doff gowns where we never had donned and doffed gowns before – thinking about droplet transmission; so a lot of information really quickly.

Then Sunday night, we thought we were getting things in place, and then we got the call about the second death, who was also one of our patients. Suzanne, do you want to comment about those initial 24/48 hours?

Suzanne Watnick: So just as Liz described, it was quite a sprint upfront. And even though this has become a marathon, it still feels like a sprint at times. But the bottom line is, we worked on this together. And I think that can't be emphasized enough. I think the strength of having the nursing leader and physician leader in any dialysis organization working closely together to make sure that not only general staff but also the physicians and other medical staff are informed in the same way is really important.

That first 48 hours, we were making sure that, in addition to providing deep education to our patients and our staff in the facility, we were making sure we brought in the medical staff, informing them what we are doing, when we're doing it, and why we're doing it. I think the piece about education is critical to mention. We did a number of things upfront, but one of the things that was recognized within the first week was the need for very specific uniform education for all of our facilities. We have 19 facilities; all of the policies and procedures that were implemented at the one facility where the initial patient who had died were implemented at all of our facilities because as we know, COVID-19 has no bounds for roll-out. So we felt that we needed to roll this out as well.

In addition to all of this, we very quickly recognized that some of the challenges were not only making sure we teach people about the science, but also to address the concerns, fear, and anxiety. So Liz and I both hold calls on a regular basis. She has a daily call that was initiated back within the first week or two. Now it's turned into two daily calls with staff. And I do a daily call with all the medical staff. And by really providing a forum for everybody to have questions answered, it has helped significantly.

With that, Liz, do you want to add on some of the additional things that we've done to support the patients and the staff members?

Liz McNamara: Yes. Thank you, Suzanne. So we worked – the CDC local team landed on that Sunday, and we spent two weeks with them from March 1st through the 14th. We had multiple calls with the CDC team every day. We were giving them data multiple times a day. They really helped us stand-up our policies. They really helped us think about when is the highest risk when we take care of the patients given our PPE allocations and how do we think about preserving that PPE. So that was super helpful, and they were really great.

I have to say that the calls have been crucial; staff feel heard. Staff like getting updates, and so we start our calls with what are the local numbers, what are the hospital numbers. We talk about how many patients of ours have been tested, how many are positive. We talk about how many staff have been tested, and how many are positive. Just giving people information really helped.

We have a staff person who worked in New Orleans who said that one of the things that they did during Hurricane Katrina was to help the staff get things that they weren't able to get, like supplies. So it's going to sound tongue-in-cheek, but we sourced toilet paper that we put in the break room so people will be able to take it home with them. We have hand gel. We actually worked with a compounding pharmacy to make hand gel, give that to our staff, give that to our transportation people because they are key in all of this as well.

We made Northwest Kidney Center colored bandannas knowing that in a mask shortage situation, we could give those kinds of things to our patients who are outside the clinic and to the transportation drivers to wear outside the clinic. Any little thing that we can do, we try to do to for the staff so that they feel appreciated, knowing that it wasn't just them, but it was their families who were helping support them to be able to come to work.

I think the partnership with the physicians can't be spoken to enough. This isn't a dialysis disease, right. We don't need dialysis-specific acumen. But this is an operational disease; it takes the both of us together to be a united front, and that's really powerful. Even from the hospital world, nurses can't change things by themselves, and neither can docs, but we are incredibly powerful when we work together. Those are some of the highlights.

I will also say that one of the biggest challenges to the staff anxiety is the media. We talked to a local newspaper, and I said that's our biggest challenge because you can't get away from it. And we've really tried to message to our staff, get away from it. Don't watch the news tonight. Play a game. Do something different. Take a walk. Because this is going to take us a long time, and this is going to change the way we practice.

As difficult as this has been, as challenging a time as this has been, there are some items that we're able to implement to benefit our patients that hopefully will stay here and that we'll be able to partner with the various national groups such as CMS to allow some of these regulations to persist afterwards.

— *Suzanne Watnick, MD*

One of the other things that I think too, and Suzanne and I have also talked about this, is a lot of the things that we've implemented are things that in an ongoing way are just going to benefit dialysis. Thinking about how we approach flu season in the future, thinking about using modified contact droplets, thinking about masking – it's just best practice. We also implemented routine cleaning of all of our shared surfaces; wheelchair handles, rails of the scales, common areas both for staff and for patients – those are things that we won't just drop off when we have a low in the COVID-19. Suzanne?

Suzanne Watnick: It's really important to think about all those additional items that I hate to say it, but sometimes, a crisis allows for opportunities to be innovative and implement something more rapidly than you might otherwise. I think in addition to all of the additional infection prevention and control interventions, we've seen a number of waivers from Medicare on the 1135 Waiver Abilities. And items such as telehealth waivers, so allowing our physicians and other medical staff to be able to have more frequent interventions and interactions with the patients I think is an important thing that we're in the process of implementing right now.

In addition to this, we haven't talked too much yet about the home dialysis environment, but we've rolled out all of our screening for patients, as well as screening for staff in the home environment, too. We've even thought about, hey, these patients specifically are home dialysis stay patients, they want to be home. How can we provide additional quick visits?

And there've been great ideas throughout the entire country; things such as drive-through testing. But for us, we're able to implement some rapid visits, what we're calling "quick visits" so that patients can come very expeditiously to get their blood drawn, as well as gather supplies, and then be able to have interaction via telehealth with the facilities. As difficult as this has been, as challenging a time as this has been, there are some items that we're able to implement to benefit our patients that hopefully will stay here and that we'll be able to partner with the various national groups such as CMS to allow some of these regulations to persist afterwards.

Beth Ulrich: So, like you, I have a bias towards home dialysis. You all started home dialysis. The first job I ever had in nephrology nursing was to open a home dialysis center. So long-term, I'm wondering, do you all think this pandemic could have an influence on more patients wanting to go home or organizations more willing and facile at sending them home?

Suzanne Watnick: I think there's no question that it will have an impact. Also, this summer, the Advancing American Kidney Health Initiative was put forth, and many dialysis organizations are aiming for 25%, even 50%, as a goal long-term. I think that for so many reasons, a number of people around the country have not been able to consider home dialysis to the same degree that they might be able to in different environments. But I think that this in particular is going to help patients to consider very strongly what the best option is for them; dialyze at home or dialyze not in their home. I do think that it's going to impact this. That's part of a national conversation right now. Most of the dialysis organizations do feel that this will have a positive impact in getting a higher number of patients to do home dialysis. Liz, do you have any additional thoughts?

Liz McNamara: Yes, I agree with you. And I also think that doesn't or hasn't changed our message for the NKC because we have always been really pro-home.

Suzanne Watnick: Exactly.

Liz McNamara: I think, for us, it's just doing more of the same. I think having these telehealth visits is just going to help us make it that much more easy for patients and their families.

Beth Ulrich: You had said a little bit about education before. Your staff knows how to dialyze patients, but not deal how to deal with a pandemic. What kind of things did you do to educate the staff – the medical staff, the nursing staff, the care technicians – to get them going on this with obviously no notice when you started?

Liz McNamara: A lot of this wasn't written down at first. We had all of our policies actually stood up within a week, which is fast – I was shocked. But we made a video on how to put on a gown and how to take off a gown. We launched that. We actually did the just-in-time physical donning and doffing demos at every clinic. I took my core group of clinical directors and showed them how to do it. Then they went out and they showed other people how to do it. We had a checklist. We have an infection control nurse as well who was key, being out there, talking both to the patients and to the staff, so that was a huge help.

We used the CDC donning and doffing because there's no reason to reinvent the wheel. We really wanted to use what was out there. We also used hospital partners' infectious

disease expertise as well. Whenever they would write something, we would share that with our staff so they didn't think it was just us sitting here making this stuff up, right; because that's what it can feel like sometimes. So we really wanted to use the science and use the expertise.

We're incredibly fortunate here in this city, we're a little bit the birthplace of infectious disease as well, so we have a lot of expertise that we were able to draw from. And I think from the physician side as well, I think it was helpful for the physicians to also hear from other expert physicians. And knowing that Suzanne and I were saying pretty much the same thing to whichever group we were talking to, was very reassuring, I think, to the staff.

Suzanne Watnick: Yes, I just have to second that. Not only were we able to do this in the local region, but this was a definite partnership with our public health partners' entire community here as well as the national community. We're a nonprofit and we've been working really closely with a number of other non-profit dialysis organizations to try to come up with best practices.

We're not doing this in a vacuum. We're trying to work with CDC, with the WHO principals. I think it really is important so that people do understand that even though this is an evolving situation – and things are changing sometimes week-to-week – we're doing this as we learn to try to follow best practice. I think that's a really important message because it's not just the 'what,' it's the 'why.' And I think both staff, patients, and all of the medical staff involved really can understand and work with us together if they understand that 'why.'

Again, leaning back on those three main principles – providing dialysis, leaning into the science, and making sure we're providing appropriate leadership through communication and transparency and support – it's really seeming to pay off for us.

Beth Ulrich: You all talked about supporting patients and staff; tell us what you did specifically to support your patients and then also to support your staff mentally, physically, and psychologically. What kind of programs did you put in place? What did you do?

Liz McNamara: I think for the patients, it was transparent communication. We have probably four versions of a patient letter that we sent to all patients, being honest about what they could do to keep themselves healthy. We adapted our online website so it's very clear, COVID-19. And what we told them is that first and foremost, you need to come to dialysis.

Our registered dietitians have put together some tip sheets for them because we don't want our patients going and just stocking up on all these canned goods. And a list of what

goods can they have at home. Our social workers normally call patients who miss their treatments. But we have a new focus of that – reassuring them it's safe to come to dialysis. It took the IDT [interdisciplinary] team, I think. And it's an ongoing conversation.

For staff, again, I think it's the multiple-times-a-day phone calls. I think it's the ability for them to know that we're there. We want to balance being visible and not hurting their work in the unit. So we think about how we round and how often we round physically.

We also provided a childcare stipend for people who need help with that because a lot of our staff have a lot of kids. And those have been the main things that we've done. Suzanne, is there anything I missed?

Suzanne Watnick: No, I don't think so. We talked about the forum that we've been providing. To be honest, I think that's probably the most valuable thing that we've done. I have a feeling that given how much success we've felt with that, that may be something that's long-lasting for the organization. Perhaps if it's even just once or twice a month to have open forums like that.

But really, the support for patients and staff, it's the communication that we've been providing. We didn't mention that we're actually crafting a communication for the entire NKC community both internally for Northwest Kidney Centers staff as well as for medical staff – updates that go out every morning. It's not just the calls, but it's written communication that I think has really been helpful.

Beth Ulrich: I also saw in your website that you've established a COVID-19 Emergency Response Fund for your patients and staff.

Suzanne Watnick: Yes, we have.

Liz McNamara: We had a huge outpouring from folks saying, "What can we do to help?" So it's been really nice because we're not completely sure what, but we know we're going to need some help.

People have wanted to do the hand-sewn masks. We're actually accepting those, but we're giving those to the patients who are outside the clinic. We really want our patients to have the medical grade mask while they're here with us.

A staff member from one of our more outlying clinics drove into work the other day with a hand painted sign that was put in their yard that said, "Thank you so much, health care workers, NKC." That was really heart-warming. A lot of the practice is in the ICUs, in the acute care, and places like that. But we feel that if weren't doing our part, that it would really hinder our hospital partners. And so we know that we're making a difference that way.

Beth Ulrich: It occurs to me that one of the questions I didn't ask you earlier and probably some of our listeners don't know is, tell us how many patients and about how many staff you have at the Northwest Kidney Centers in total.

Suzanne Watnick: We currently have a little over 1,850 patients. Approximately 270 of them are on home dialysis – peritoneal dialysis and home hemodialysis. And we have just under 800 staff members. We have over 100 medical staff members. Of that, about 40-plus of them are active medical staff. We really have a lot of folks that we try to interact with. It's always a challenge to make sure you're getting the right message to the right people at the right time.

And not everybody is going to see all of the initiatives that we're taking as necessarily the right ones. But nonetheless, we're open to feedback. Not only do we announce and communicate, but we also have been really taking the feedback at the level of our Emergency Operations Center so that we can hear what's going on, and to potentially change what we're doing, to make sure we're doing the best we can for our patients and our staff, that's the point.

Liz, do you have anything else you want to add?

Liz McNamara: Yes, I think the only other thing is that we have our Emergency Operations Center meeting daily. For the first two weeks, we had it twice a day. But now we still have that daily. I think we're launching week six of our response.

Beth Ulrich: Suzanne, you had mentioned earlier the strong working relationship that you and Liz have. That's obviously helped you succeed in this and be pretty quick and agile in your responses. How did that come to be? How did you make that happen?

Suzanne Watnick: There's no easy simple answer to that aside from the fact that first of all, Liz is wonderful. [Laughs] So that goes without saying, she brings tremendous strength from a nursing leadership perspective. And I think both of us have worked very hard to make sure that we're doing that we can to work together.

I think a very defining moment was a little less than a year into Liz's tenure here as Chief Nursing Officer, we joined together to attend a Chief Nursing Officer and Chief Medical Officer National Meeting. It was interesting. The two of us were the only two initially to sit together at the same table. [Laughs] We rented a car together (ended up getting a little convertible) and took it out. We're really partnering, talking about what we're doing. We talked about it as a *Thelma and Louise* moment, to some degree. Although I think we have had a better outcome than that particular movie.

Success is not final. Failure is not fatal. It's the courage to continue that counts.

— Winston Churchill

Liz McNamara: So far, yeah, so far. [Laughs]

Suzanne Watnick: I'm certainly a glass-half-full kind of person. And I think that our collaboration has been incredibly powerful as leaders – and we don't always succeed, and we point out – look, even though the two of us miss some things, for the most part, we're really on-point together. I think it's important for people in the organization to see the nursing and the physician component of the organization come together closely. Liz, what else do you want to add to that?

Liz McNamara: Well, that's good, you gave us away – *Thelma and Louise*. I think the only thing that I would add to that is that we've been doing this intentionally. We've actually been partnering with NTDS [Nephrologists Transforming Dialysis Safety] to grow leadership within the dialysis world. We actually had a full-day conference education session with our dyad partners of our nurse managers and our medical directors of each of the clinics. We did some leadership work and they took some tests. It was a great day.

In fact, we're going to launch a WebEx discussion. It was supposed to be, I think, next week. But of course, it's been pushed back. But we've really taken a very methodical approach to this work because learning how to lead, knowing how to lead, is just as important as knowing how to order dialysis or put needles in. Or run a machine. And it's that piece of work that sometimes gets missed both in our nursing and in our physician training. So we're just kind of a case-in-point of what we've been trying to accomplish.

Beth Ulrich: Well, it's good to see. Based on your experience and what you've learned, what advice would you have for other dialysis centers in general and nephrology nurses in particular?

Suzanne Watnick: I'll start off really briefly, and I'd love Liz to finish this up. I'm going to go back to the three basic principles. So if you're talking about what do we think about... First and foremost, we should be providing dialysis. We have an obligation to provide dialysis for our patients in the safest and most effective way that we can. Secondly, we should be doing the best that we can to use the understanding and the science behind what's going on to make sure we're providing the right kind of treatment, for the right patients, at the right time.

And then lastly, the leadership piece that we both alluded to in your prior question, making sure that we're providing that with appropriate communication, lots of transparency, and really support at every level so that people can hear us and have the opportunity to give us feedback; and with that, making sure that patients and staff understand that we're the humblest of their servants to try to do this well. Liz, what would you like to – please, add to that?

Liz McNamara: I think that's exactly right, Suzanne. I can't say enough that this is a marathon, this is long-term. We have to take steps away, we have to take a break even if it's an hour to walk your dog or as I say jokingly, to people, walk my dog.

I sent an email to my staff actually when we got some feedback that was a little bit hard to hear about how our staff was feeling, and it came from outside the nursing world. And as I noodled about that, I realized that it's not about where we hear the feedback from, it's not about not listening to it, but we have to attend to it. We have to hear it. As hard as it is, because that helps us do the right thing for both our patients and our staff. And I ended that email with this quote by Winston Churchill, who said, "Success is not final. Failure is not fatal. It's the courage to continue that counts." And I really think that speaks to our times right now.

Beth Ulrich: That's a great quote. So how are things going now? You're six weeks in, you said?

Suzanne Watnick: Yeah, we are. [Laughs]

Liz McNamara: Yes, we're six weeks in.

Suzanne Watnick: But you know what? The nice thing about where we are now is that we never get bored. [Laughs] And there's something new every day, there really is. I think the important thing to give advice to folks who are listening is to make sure that you're taking care of yourself. Self-care is really important along with Liz's comment about, "This is

a marathon, not a sprint;" we need to be resilient. We need to be resilient for our patients and for our staff. And there is going to be something new every day, so whatever you can do to take care of yourself so that you can come to work ready, mildly refreshed, to be able to carry through as we move through probably the next month or two.

Liz McNamara: Yes, absolutely.

Beth Ulrich: Any other final thoughts, Liz?

Liz McNamara: I'm appreciative of the partnership and the ability to chat with the ANNA community. When we first heard that there were guidelines around airborne isolation, I picked up the phone and I called Tammie [Tammie Kear, ANNA Executive Director]. And she called me right back. And we had a joint meeting. It's been great seeing the ASN WebEx spill-over the nursing world as well so we could join together and hear the same information. I think when we come out of this, at least to get a bit of a breather, we're going to be much better off and our patients are going to be much better off. So I'm just so thankful that we had the opportunity to share our experience with folks. And I look forward to being able to hear from others once the dust settles as well.

Beth Ulrich: Liz and Suzanne, I want to thank you both for taking the time to share your experiences and your valuable insights with us. Just as the Northwest Kidney Center was the leader at the beginning of nephrology care, being the first chronic hemodialysis unit in the United States almost 60 years ago, your leadership and experience clearly continues as we face this pandemic. Thank you very much. Take care and stay safe!

Addendum: COVID-19 is a rapidly evolving situation, and knowledge about the coronavirus based on new data changes almost daily. This interview predated the CDC's identification, on April 21, 2020, of two deaths due to COVID-19 in California on February 6 and 17, 2020.

ANNA 2020 National Symposium – Session on COVID-19

Wednesday, September 2, 2020

7:30 am-8:30 am

COVID-19: Looking in the Rearview Mirror and Moving Forward

Presented by: Elizabeth McNamara, MN, RN

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