Telenursing (TN) has become increasingly common in the delivery of care among various populations and for various health conditions. TN has been used in the treatment of heart failure (Radhakrishnan et al., 2012), pain management, and wound care, as well as for physical examinations (Cleveland Clinic, 2018) and care for children and adolescents (Ray et al., 2020). Bashir and Bastola (2018) assessed the satisfaction of home care agency telenurses who monitored chronic illness in older adults with chronic obstructive pulmonary disease and heart disease. Although their study did not include electronic health records (EHRs) and videoconferencing, they planned to include it in the future. Findings showed that nurses perceived the achievement of quality of care via TN and the provision of peace of mind to clients. The most frequent negative outcome perceived by nurses was the difficulty in technical areas, including equipment inconsistency and malfunction. The functional use of empathy was also a perceived difficulty (Bashir & Bastola, 2018). Thus, the therapeutic relationship between nurse and client in TN is unclear and requires further research (Jackson, 2020).

Advanced Practice Telenursing Through a Pandemic

Less than 1 day was available to prepare for treatment via TN. My employment agency provided a confidential communication and collaboration platform. The pandemic created record high levels of telephone calls to the agency Help Desk; therefore, they could not assist me in setting up the platform. With telephone assistance from an agency secretary and a priority request from an agency administrator, I was eventually able to set up the available platform and virtual private network for the EHR. It was necessary to use three computers: one for the EHR, one for collaborative information not yet filed in the EHR, and one to use the platform. Using multiple computers allowed me to view the EHR without interrupting the visual of participants (i.e., clients and their family members). The third computer was helpful to view rating scales simultaneously.

I began TN medication checks and support the first day with previously established clients who were already in the working phase (Peplau, 1952) of the therapeutic relationship. Due to the global emergency, Initial Psychiatric Evaluations were added the next day. As mental health issues following the start of the pandemic include increased violence, anxiety, insomnia, depression, and posttraumatic stress disorder (Rajkumar, 2020), provisions of Initial Psychiatric Evaluations were necessary to prevent mental health crises. As the weeks continued, the frequency of follow-up sessions with stable clients decreased to allow for increased frequency of Initial Psychiatric Evaluations.

As expected, technical challenges presented themselves. I was able to physically see my first client, but my client and his mother had difficulty connecting to the platform and were unable to see me. I observed other clients just awakening from sleeping on living room couches, including a client who just waved and refused to speak. It was beneficial to observe clients’ sleep and waking process and to observe them in their residential setting.

It became apparent that TN with clients who have specific diagnostic features and symptomatology may require periodic in-person sessions as they advance through orientation, identification, exploitation, and resolution stages of the nurse–client therapeutic relationship. A client I diagnosed with autism spectrum disorder was stable. Our established therapeutic relationship in the working phase (which includes the identification and exploitation stages) was apparent as he was able to maintain continuity between the in-person and TN sessions. My recognizable voice helped him identify and remain calm. I was able to use knowledge of his intense interest in computers to provide client ease to the TN process. Previous in-person sessions with development
of a working relationship were highly beneficial. It would have been difficult building initial rapport with this client via TN sessions.

Parents/guardians were required to attend their child’s appointment. During in-person sessions, I routinely encouraged a team approach and appreciated attendance and collaboration with client case managers, therapists, juvenile court staff, school counselors, and employees from ancillary behavioral health programs. During TN, it was difficult to have client support staff attend as they frequently spoke simultaneously. Each member who joined the session decreased the size of the client visual, thus increasing the difficulty of observational assessment. Visual limitations were extremely difficult because I was accustomed to acutely observing clients in the waiting area, as they walked with me to the office, and throughout the session to assess for various side effects and to complete rating scales for issues (e.g., involuntary movements related to antipsychotic medications). Therapeutic techniques, especially kinesthetic, were much more difficult to implement. For example, during in-person sessions, I frequently intervene with pacing and leading to lower client anxiety without their conscious awareness of the process. Pacing my breathing to their breathing then gradually leading them to a relaxed breathing process was difficult due to visual restrictions and the inability to assess if they were observing and connecting with me. Certain techniques, such as therapeutic posturing, seemed less potent with TN.

Within each 30-minute TN session, I discuss prescribed medications with clients and parents/guardians followed by routine completion of a medication consent form. I am unable to obtain written consent during TN, but I document verbal consent. Parents are observed writing the date and time of the next appointment prior to conclusion of the session. Following completion, I transport prescriptions for controlled substances to the pharmacy or office for parent pick up.

RECOMMENDATIONS

Radhakrishnan et al. (2012) included lack of a client guide as a barrier to TN. My future prerequisites would include a clear, written description of operating instructions for clients (e.g., equipment and limitations, bandwidth requirements, 3G, 5G, rural areas, phone and Wi-Fi access, assistance/contact for help). Guidelines for clients should include basic information, such as being awake and dressed prior to their session.

I recommend choosing a platform as the first step. Multiple platforms are available with detailed descriptions via the American Telemedicine Association (ATA) COVID-19 Response Webinar Series. The ATA (2020) series provides excellent resources and practical tips that would have been highly advantageous to know prior to starting TN. Specific platforms allow providers more control of the client environment, resulting in less time needed to teach clientele operating instructions. When selecting a platform, the ATA (2020) advises that any platform requiring clientele to download a program is going to be a barrier for care. A direct link is always preferable over a required download.

Additional time should be allocated to allow for TN challenges. I also recommend advance set up with assistance, as technical issues have been a frequent challenge (Bashir & Bastola, 2018; Radhakrishnan et al., 2012). A trial run with 3G Wi-Fi resulted in screen lag; therefore, 5G Wi-Fi was necessary.

Client medication consent forms could be mailed to clients for completion prior to the next appointment. The ATA (2020) also emphasizes the necessity to obtain and document clients’ consent to use TN and to have an established place where clients can receive in-person care.

Providers should have resources readily available at their TN site, including rating scales, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, prescriptions, dictation guide, and Initial Psychiatric Evaluation guideline. Preparation prior to sessions would be helpful, including prior completion of rating scales by clients, parents, and teachers, especially when there is decreased visual assessment. Depending on platform and number of participants, consider a brief consult with team members and collaborators prior to meeting with clientele, followed by team members joining auditorily without visual to allow for improved visualization of the client. This is also a prime time to discuss intake forms that are completed by clientele prior to Initial Psychiatric Evaluations. Secretarial support can assist with scanning information ahead of time, such as the appointment schedule and history not available in the EHR, and assisting clients with joining the platform prior to each session.

Providers should assess legalities. The COVID-19 pandemic was an ideal time to begin TN due to the urgent need and the dramatic changes that were made to the rules and regulations governing telemedicine (Brauser, 2020). Changes include relaxed licensure during COVID-19 through a new waiver issued by the Centers for Medicare & Medicaid Services (2020) and Emergency Orders that addressed telecare and greater flexibility for health care providers (Wisconsin Department of Safety and Professional Services, 2020). In addition, on March 16, 2020, due to the public health emergency, the Drug Enforcement Administration Division Control Division (2020) issued exceptions to increase the use of TN and to loosen restrictions in prescribing schedule II-V controlled substances. However, during times of less flexibility, license requirements may vary by state based on where the client resides and where the provider is licensed. For example, the Cleveland Clinic (2018) TN site includes an advanced practice nurse who is licensed in 13 states. Federal agencies, such as the Department of Veterans Affairs, may continue re-
requirement of licensure in only one state while allowing TN treatment in another state.

I recommend providers who begin in TN start with preestablished clients and occasionally continue to have in-person appointments. The nurse–client relationship is perhaps the most crucial component to TN as described by Peplau (1952). TN with previously established clients, especially those who were already in the working phase of the therapeutic relationship, were a much easier population with whom to start and to use therapeutic strategies that have been successfully used in the past.

CONCLUSION

As I self-reflect, I yearn for TN strategies that foster forward movement of clients through use of the nurse–client relationship during an era that will redefine our future. Innovative in-person strategies must be transformed to manage stress and anxiety that have increased with the pandemic. TN strategies to assist clients with severe and persistent mental illness are needed more than ever. I am optimistic that nurses can learn new innovative strategies for use with TN and translate the strategies we already have to the new TN environment. Although the COVID-19 pandemic thrust TN into broader prominence under less than ideal circumstances and with little preparation, the advances in the field of TN during this time will undoubtedly have a lasting positive impact long after the pandemic.

REFERENCES


Laurie Schaumberg, DNP, APNP
Advanced Practice Nurse Prescriber
Brown County Child and Adolescent Behavior Unit
Green Bay, Wisconsin

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Address correspondence to Laurie Schaumberg, DNP, APNP, Advanced Practice Nurse Prescriber, Brown County Child and Adolescent Behavior Unit, 2232 Balsam Way, Green Bay, WI 54313; e-mail: APNP21@gmail.com.

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