When Weather Rages, How to Keep Calm and Continue Caring

By Joanne Kaldy

Just about every week there are headlines about some weather-related disaster — a flood, tornado, hurricane, wildfire, or something else — somewhere. Although these events are becoming increasingly common, this doesn’t mean that they’re easier to manage, less dangerous, or less psychologically damaging. More than ever, your disaster preparations need to address different scenarios, the lessons learned, and ways to protect your residents’ and staff’s emotional well-being before, during, and after a weather-related event.

A Delicate Balance

“Situations that we feel we can do something about are far less stressful than those we can’t, and so it’s important to prepare for disasters. However, talking about disaster planning could increase anxiety, so it has to be done carefully,” said David Smith, MD, CMD, president of Geriatric Consultants in Brownwood, TX. For residents, especially those with neurocognitive disorders, less may be more. “You might simply reassure them that the facility and their family have things taken care of and not to worry. This is just one tactic, of course. It might be different in a setting where more residents are cognitively intact,” he said.

Discussing the science of weather and what experts are saying might be helpful for some staff and maybe a few residents. However, it is best to use this kind of information sparingly. Patricia

The Aspirin Controversy Continues Despite New Guidelines Regarding Aspirin Usage in Older Adults

By Angela M. Sanford, MD, CMD, and Milta O. Little, DO, CMD

For many years, it was thought that an aspirin a day may keep the doctor away. This age-old sentiment has been put to the test in the past decade. In October 2021, the U.S. Preventive Services Task Force (USPSTF) released a draft of their recommendation regarding the role of aspirin in primary prevention against cardiovascular disease (CVD) in adults aged 60 and older (“Aspirin Use to Prevent Cardiovascular Disease: Preventive Medication,” https://bit.ly/3GWm0Ey). The draft does not recommend initiating low-dose aspirin as primary prevention for CVD in older adults because the risk of harm outweighs the potential benefits. This recommendation mirrors the 2019 guidelines released by the American College of Cardiology and the American Heart Association based on high-quality evidence from several large trials (J Am Coll Cardiol 2019;74:1376–1414). Interestingly, the release of these new recommendations by the USPSTF is an
Within the aging population, people are living longer with chronic and severe illnesses. At times over the course of disease progression, patients with severe illnesses may lose decision-making capacity. In those situations, the decision-making process may become more challenging if the health care proxy (HCP) also lacks the capacity to make decisions.

**Case Description**

Mr. X was a 75-year-old with severe amyotrophic lateral sclerosis (ALS) causing severe dysphagia, aspiration, aphasia, inability to follow any commands, and neurogenic bowel and bladder. In addition, his ALS had also caused restrictive lung disease, leading to chronic hypoxia requiring 40% oxygen via tracheostomy. Mr. X had a feeding tube for nutrition, tracheostomy with 40% oxygen, and a Foley catheter. He was bed-bound and required a mechanical lift for transfer. Mr. X was totally dependent for all his activities of daily living and was unable to make his needs known. He experienced frequent hospitalizations due to aspiration pneumonia, so a focus of care discussion was initiated.

Mr. X lacked the capacity to make any healthcare and safety decisions, including decisions regarding his treatment preferences and living arrangements. He lived at home with his wife and had four children who were supportive of their parents and involved with the care of Mr. X. His wife was his duly appointed HCP, and a daughter was his duly appointed alternate HCP.

During a focus of care discussion, Mrs. X agreed with the recommendations of the treatment team to forgo life-prolonging and life-sustaining treatments and to let nature take its course. However, in those discussions it became apparent that Mrs. X was emotionally overwhelmed, and her own mental health was affecting her decision-making. She demonstrated a lack of understanding of her husband’s serious condition as well as its impact on his life expectancy with and without life-sustaining measures. In short, Mrs. X also lacked decision-making capacity to make decisions on behalf of her husband.

Mrs. X’s lack of decision-making capacity was discussed with her children, who agreed that this was the case. Their daughter (the alternate HCP) was willing to make decisions on behalf of her father and consented to hospice care. However, the children requested that their mother not be told that she could not make decisions for her husband because it would upset her and likely to further mental health decompensation.

**How to Approach This Case**

Autonomy is a well-established ethical principle. Health care providers are obligated to follow a patient’s decisions as long as he or she has the capacity to make these decisions. However, if patients lack decision-making capacity, then their autonomy is still honored via their surrogate decision-maker. In this case, a challenge arose when Mr. X’s appropriate surrogate decision-maker also lacked decision-making capacity. When a HCP also lacks decision-making capacity, health care providers proceed to the next person in the hierarchy of surrogate decision-makers. In this case, the alternate HCP, his daughter, became the decision-maker. This aspect of the case demonstrates that health care providers should not assume that a person has decision-making capacity just because she or he agrees with the recommendations of treatment team.

Mr. X’s daughter asked us not to tell her mother that she would make decisions for her father. However, ethical principles also require health care providers to tell the truth and not to compromise the ethical principle of nonmaleficence (do no harm). Beneficence and nonmaleficence principles are mostly used in reference to patients; however, there is also a moral obligation to do no harm toward the general population, including the family members of a patient.

Even if the care team withheld information from Mrs. X about the change, she would likely come to know of it when the hospice election form required her signature. In this case, the children believed that telling Mrs. X of this change in HCP would decompensate her mental health as it was apparent that her mental health was already very frail. The health care providers needed to develop a way to address the need to uphold the ethical principles of care while also addressing the needs of the family.

**Outcome of Case**

A family meeting was held which was attended by Mrs. X, all the children, and the health care team (including the palliative care attending physician, palliative care coordinator, and primary team social worker). Mr. X’s condition was reviewed as well as prior discussions with the family. Risks versus benefits of interventions and focus of care were revisited. The health care team encouraged the family to consider enrollment in hospice.

All family members agreed that enrollment in hospice care was in the best interest of Mr. X. The health care team also discussed with Mrs. X how her husband’s situation may be overwhelming for her. They suggested treatment for her own mental health and suggested that her daughter make decisions for her husband, including signing the hospice enrollment form. Mrs. X agreed with the assessment that her husband’s declining condition had been stressful for her and had caused mental health decompensation. She also agreed to see a counselor and expressed that she would let her daughter make future decisions for her husband. Subsequently, Mr. X was enrolled in hospice care with the consent for hospice election form signed by his daughter.

**Conclusion**

This case illustrates a feasible approach that may be used when a patient and his or her primary HCP both lack decision-making capacity. With this approach, the health care team was able to gain consent from the previous HCP without further decompensation in her mental health. The team was also able to honor the autonomy of Mr. X (via a surrogate decision-maker) while also practicing beneficence to him and nonmaleficence to his wife.

Dr. Iraqi is a geriatric and palliative medicine physician at Syracuse Department of Veterans Affairs (VA), a professor of geriatric medicine at Upstate Medical University, Syracuse, NY, and CMD and attending physician at a VA nursing home.

**When a Health Care Proxy Also Lacks Decision-Making Capacity**

By Abid Iraqi, MD

**Medical Ethics**

**Weather from page 1**

Bach, PsyD, RN, a California-based clinical geri/neuropsychologist, said, “Being knowledgeable and staying on top of current predictions and expert guidance is helpful.” She suggested signing up to receive real-time alerts from local weather agencies and other sources. “These can be helpful for facility leaders and others in decision-making roles, and they can help family members stay on top of the situation.”

Ensuring that staff have the resources and confidence to deal with a disaster is essential, Dr. Smith stressed. “There absolutely needs to be teamwork. During pre-planning, it’s the ideal time to give staff a sense of participation and empowerment that will benefit their response and, hopefully, reduce their stress and anxiety.” Ultimately, he said, “Pre-planning is almost a laboratory for improving one’s culture. Take advantage of this opportunity.”

Drills and tabletop exercises can help increase everyone’s confidence about handling a disaster. They also present a chance to identify the residents and staff who may need extra support during an actual disaster. Observe people for signs of anxiety, fear, confusion, indecision, or other emotions or behaviors. “These might give you a clue about people whose mental health or well-being are more likely to suffer during a disaster,” said Dr. Smith. “You then can discuss what their particular fears or concerns are and address these in advance.”

Ultimately, there is no one-size-fits-all model for how people will respond to a disaster. “My experience is that some people for whom weather-related disasters are part of life are more resilient. They’ve been through such horrible things; they have strong internal coping resources,” said Dr. Bach. Others who’ve never experienced a tornado or other disaster only know what they’ve seen on the news or in movies, which is often terrifying. They may also need reassurance.

**How Experience Impacts Perceptions**

Discussions around disaster response are necessary, and it’s important to listen to different viewpoints. For instance, Anna Fisher, PhD, director of quality and education at Hillcrest Health Services in Nebraska, recalled, “We recently had severe high winds. Under citywide protocol, sirens sounded. This was upsetting and confusing to some residents and communities, as they associate such sounds with a tornado.” The result was questions asked by some providers in the area about whether sirens are appropriate for high winds or if they cause more worry than good.

When Hurricane Ida was threatening New Orleans last year, many in the area — including nursing home residents and staff — couldn’t help but think back to Hurricane Katrina and the devastation that storm caused. Hearing that Ida could be worse surely made it challenging to keep people calm, Dr. Fisher
Dr. Fisher suggested, “If we can equip people with the knowledge of what a weather-related disaster is and what we might expect, they are better prepared from a psychological standpoint.” Justin Watson, MPA, healthcare coordinator for the Omaha Metropolitan Healthcare Coalition, added, “When it comes to the psychological effects of a disaster, we can prepare with partnerships, building relationships with behavioral health organizations and practitioners, and training for psychological first aid” (see the sidebar).

Focus on Lessons Learned, Not Shoulda, Woulda, Coulda
“Despite all your planning and best efforts, you absolutely cannot preplan for all possible contingencies. Each disaster is extremely nuanced, and a lot of issues go into decision-making,” Dr. Smith observed. Although it is important to learn lessons from each and every disaster, he said, it’s important not to second-guess and dwell on regrets or what could have been done differently.

“Invoking all the stakeholders in pre-planning is the best tactic to help prevent people from dwelling on regrets,” Dr. Smith said. There may be some contingencies that you would have had to be clairvoyant to anticipate, he offered. Instead of torturing yourself over these, focus on what you could do to anticipate, address, and even prevent such surprises in the future.

While you’re assessing your disaster response and planning for the future, take time to recognize your staff for their efforts. “Staff often make a lot of sacrifices before, during, and after a disaster to keep their residents safe and comfortable. They do this for the benefit of the residents and often at great personal expense. They need to be rewarded and thanked for their efforts,” Dr. Smith said.

Reflecting back on lessons learned can and should be a positive effort. As Dr. Fisher said, “With each disaster, we further our understanding of our environment and the weather. What we learn will help us better prepare for the next one, even though every disaster is different.”

Mr. Watson stressed, “We are learning from each disaster how to be better prepared and to expect and prepare for the unexpected. And we can and should do a better job of communicating to the public what we’ve learned from these events.” He added, “Not only does this help those outside of facilities prepare for disaster. It also helps them feel confident that their loved ones are safe with us, and this helps their psychological well-being before, during, and after a disaster.”

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