Supporting Nurses to Ease the Workforce Crisis

By Joanne Kaldy

"Get out of here! Take that thing off your face! I was a nurse, I know what that thing is. I’m not going to the operating room! Where is my daughter?" Mary Knapp, RN, MSN/GNP, NHA, FAAN, director of health services at Foulkeways at Gwynedd in Pennsylvania, took to the stage at PALTC22’s opening general session with a frank impression of what nurses and other staff have heard from residents during the pandemic. For months, she observed, they’ve had to deal with issues and challenges they couldn’t have imagined two years ago. All this has taken its toll, and rebuilding the nursing workforce will include supporting the physical and emotional health of these individuals.

Nursing varies from setting to setting to some degree, Ms. Knapp observed. For example, she said, “in personal care and assisted living, you really have to hunt out who is a licensed, trained nurse. Nursing homes are different. The nurse staffing requirements in nursing facilities are governed by states, and each has different requirements.” However, she noted that patients and families don’t necessarily know this, which can lead to unrealistic expectations. “All they know is that there are nurses when they enter the facility.” They don’t know that the facility may be short-staffed and that a nurse or certified nursing assistant (CNA) is caring for twice as many residents because their colleagues are out sick or taking on tasks and responsibilities that take time from direct patient care.

Often, Ms. Knapp said, “licensed nurses are stuck on the med cart administering..."
CARING COLLABORATIVE

By Elizabeth Galik, PhD, CRNP

The Power of Social Relationships With Peers and Staff in Post-Acute and Long-Term Care

Throughout the COVID-19 pandemic, we have witnessed the deleterious effects of social isolation on older adults in home settings and in post-acute and long-term care. Although the use of technology and telephone calls has helped buffer the impact of social isolation, we have learned that they are no substitute for face-to-face interpersonal interactions.

As the older adults that we care for and the staff in PALTC are re-engaging with their social networks, I am reflecting on the power of positive social relationships and how they are vital components to well-being and quality of life (Aging Ment Health 2017;21:910–916).

Peer Relationships

I have always enjoyed observing how many older adults in PALTC are able to forge new and satisfying relationships with their peers, despite the stresses of declining health, functional disability, and often cognitive impairment. For instance, there were three gentlemen who were residents in a newly opened assisted living community where I once worked. All had been admitted around the same time, and they included a retired attorney, an accountant, and an FBI agent. All three had severe cognitive impairment, and their ability to communicate verbally with one another was limited.

Fortunately, they were all able to ambulate independently. Despite the communication challenges, they located one another every morning during their walks around the unit. They always greeted one another with smiles, handshakes, and incomprehensible verbal banter. They ate meals together, walked together, and observed structured activities from a distance. On two occasions, they combined resources for failed elopement attempts — once by cutting a window screen with a butter knife and pushing a heavy bench closer to the outdoor fencing. When redirected from these “activities,” they smiled, laughed, and patted one another on the back in a friendly way.

Patient and Staff Relationships

We all have been fortunate to experience or witness a strong relational bond between a resident and a staff member. One of my favorites involves a resident, “Gloria,” and a nursing assistant, “June.” June was one of the few staff members who could assist Gloria with bathing and toileting without Gloria screaming loudly and hitting her caregiver. The other staff tried to model their own care approaches on June’s strategies, but there was just something about the two of them that truly clicked.

June’s daughter was getting married, so she was scheduled to be off from work for two weeks; Gloria and the remaining staff were quite concerned. For one month before the wedding, June would regularly bring other nursing assistants into Gloria’s room to get them acquainted with Gloria’s care routines and her likes and dislikes. Because Gloria was anxious about June’s departure, they made a large calendar that hung on Gloria’s wall to mark the days until her return. June also made brief recordings of herself giving words of encouragement to Gloria that the other staff would play when Gloria would become upset or resistant.

On the day of the wedding, one of the nursing assistants helped Gloria get dressed in her best outfit and took pictures of her to share with June. It wasn’t easy, but everyone survived, and Gloria managed to build improved relationships during June’s absence.

Like peer relationships, the staff can try several evidence-based strategies to promote the development of positive relationships between patients and staff (J Clin Nurs 2018;27:4361–4372):

• Introduce newly admitted residents to peers with similar interests, hobbies, and life experiences. Introductions can be made during recreational activities and require the staff to have good knowledge of the residents.

• Optimize the residents’ ability to maintain their mobility for as long as possible. Physical proximity is key for the development of friendly peer relationships. Mobility also helps residents remove themselves from the company of others whom they may find stressful or overstimulating.

• Match residents with similar communication and cognitive capacities. This minimizes the chance of frustration when there is a significant discrepancy between peers’ ability to converse and remember.

Medication

Testimony at Ms. Vaught’s trial revealed that the error was made possible by the nurse being able to “override” an automated dispensing cabinet (ADC). She initially typed the letters “VE” to obtain the ordered Versed, but when the ADC did not dispense Versed, she overrode the system, retyped “VE,” and the ADC dispensed the fatal dose of vecuronium. Trial testimony revealed that the nurses at Vanderbilt “routinely” override the medication carts when attempting to obtain a prescribed medication.

Whether Vanderbilt needs to reconsider its medication delivery system is beyond the scope of this article. However, it points to the salient issue: medication errors are virtually always flawed system problems rather than an aberrant nurse, physician, advanced practice provider, or pharmacist.

Systemic Flaws

The entire medical community (as well as all others) was stunned by the landmark Institute of Medicine (IOM) report, To Err Is Human: Building a Safer Health System (National Academies Press, 2000). In large measure, this IOM report paved the way for the patient safety movement at both the federal and state levels. Perhaps the most important takeaway from the IOM report is that the estimated 44,000 to 98,000 deaths per year from medical errors (not just

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By the time many patients with severe dementia require long-term nursing care, medications such as cholinesterase inhibitors may be safely deprescribed to minimize the potential adverse events that outweigh the limited long-term benefits.

Now a controversial new drug to treat Alzheimer’s disease is garnering a tremendous amount of attention and raising big questions for patients and families: Is this a game changer? Should people with dementia be prescribed aducanumab (Aduhelm), a monoclonal antibody that targets the buildup of beta amyloid in the brain?

Aducanumab – The Society for Post-Acute and Long-Term Care Medicine, other medical organizations, and many experts are uniting behind a simple message: there are insufficient data to support prescribing aducanumab to older adults living with dementia despite its recent approval by the U.S. Food and Drug Administration. (Read the Society’s position statement on aducanumab: J Am Med Dir Assoc 2021;22:1777. https://bit.ly/3uF94PR.) Medicare has weighed in too, announcing that it won’t cover the drug outside of clinical trials, a decision that will greatly limit its use.

Still, medical professionals are likely to get questions from patients, families, and colleagues about the current state of dementia treatment and whether aducanumab is an advance worth considering.

Existing Treatments for Dementia

The first thing to know is that existing dementia drugs, the ones that have been around for years, have limited effectiveness at best. These medications include the cholinesterase inhibitors — donepezil (Aricept), rivastigmine (Exelon), and galantamine (Razadyne) — and an NMDA (N-methyl-D-aspartate) receptor antagonist, memantine (Namenda). Each works by boosting or regulating the levels of chemical messengers (acetylcholine for cholinesterase inhibitors or glutamate for memantine) that are involved in learning, memory, and judgment (Mayo Clinic Staff, “Dementia: Diagnosis and Treatment,” Mayo Clinic, updated July 21, 2021, https://mayo.in/3FCh3hp). “To the way that think about [cholinesterase inhibitors] is they slow down the decline from dementia by about three months compared to people who don’t take them,” said Lea C. Watson, MD, MPH, a geriatric psychiatrist in Denver and co-chair of the Society’s Behavioral & Mental Health Advisory Council, in an interview with Caring. “They don’t make things better.” Well-meaning outpatient clinicians in the community may prescribe the drugs thinking they can keep patients on them indefinitely, she said, but “they’re not benign.” Their significant side effects include insomnia, diarrhea, weight loss, and arthralgias.

All these dementia drugs are candidates for deprescribing in the nursing home setting, where medication management decline is common. “When people come to live in a nursing home, it’s usually a sign that dementia has progressed and the medications would not be helpful,” Dr. Watson said.

FDA Approves Aducanumab and Faces Immediate Outrage


The FDA’s decision on the approval of aducanumab has been widely criticized. Concerns include the effectiveness of the drug, its potential side effects, the scientific merit of the underlying studies, and the controversial FDA approval process itself. As the authors of a commentary in Nature Reviews Neurology (2021;17:715–722) wrote, “a broader concern is that the FDA has inadvertently been co-opted to serve the interests of special groups over the general interest of the public,” in part because “legislative changes intended to speed up the approval process … have potentially increased the FDA’s reliance on industry funding, undermined its regulatory independence and weakened regulatory standards.” These authors and others have further questioned the role of patient groups like the Alzheimer’s Association, who were also recipients of Biogen funds, in lobbying for the approval of the drug.

Mark H. Ebell, MD, MS, a family physician and professor of epidemiology at the University of Georgia, said in an interview that aducanumab “was approved based on its ability to change how scans look, and that it has not been shown to improve memory or function.” And, he added, it has “potentially serious side effects,” including vasogenic edema.

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medication) were typically a result of flawed systems.

If a system is flawed to the point where it permits medication errors, is it fair or just to punish a single health care practitioner? Why not fix the system and incorporate fail-safe measures and redundancies learned from human factors engineering?

The medical community could learn from the Federal Aviation Administration’s Aviation Safety Reporting System (ASRS), which is a confidential and nonpunitive voluntary reporting system of adverse occurrences and near misses. Not having actionable data because a practitioner chose not to disclose a medication error due to a fear of loss of a license, a job, and possible criminal conviction is a missed opportunity to correct a system in need of repair.

Adverse Effects

High-profile criminal charges and convictions likely have an adverse effect on practitioners and health care facilities making voluntary disclosures when adverse events, especially patient deaths, occur.

According to an internationally recognized pioneer in the area of medication safety, Michael Cohen, RPh, MS, ScD (hon), president emeritus and founder of the Institute for Safe Medication Practices (ISMP), “Information about the cause and nature of medication errors is important. Yet even when no patient harm occurs after a medication error, health care practitioners won’t want to risk disciplinary action for their involvement, and may just choose to hide an incident under the rug.” Consequently, valuable information is forever lost that could prevent future adverse events.

Dr. Cohen’s sentiments are echoed by the American Nurses Association (ANA) in a statement responding to Vaught’s criminal conviction: “ANA believes that the criminalization of medical errors could have a chilling effect on reporting and process improvement” (Nursing World, Mar. 23, 2022, https://bit.ly/3KcHHjJ). One of the witnesses at Vaught’s trial, Ramona Smith, an investigator with the Tennessee Bureau of Investigation, testified that “Vanderbilt Medical Center carried a heavy burden of responsibility in this matter.” Yet interestingly no charges were brought against Vanderbilt even though it failed to report the fatal medication error to the Tennessee Department of Health and the Centers for Medicare & Medicaid Services. Additionally, a physician at Vanderbilt listed the cause of death as “natural.” (Vanderbilt settled with the former patient’s family for an undisclosed amount.)

Past Prosecutions

Unfortunately, Ms. Vaught’s case is not the first time that medication errors have occurred. By Randy Dotinga

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