Innovation to Transform Nursing Home Care

RESEARCH PAPER

Heather Riley, MA
Executive Director and Chief Spiritual Officer

SOULrapha
Holistic Wellness for Aging Communities

EXECUTIVE SUMMARY

COVID-19 has struck our nation's nursing homes with terrifying force. No one group of persons have been more affected than the frail and infirmed elderly in our local nursing homes. Since the pandemic hit the shores of the United States, the virus has swept over one facility after another, leaping between patients and staff. Nursing homes have locked their doors. Outside visitors are banned and it appears the homes will remain on lockdown for an extended period.

The result is even greater social isolation and desperation among these highly vulnerable persons and frontline staff.

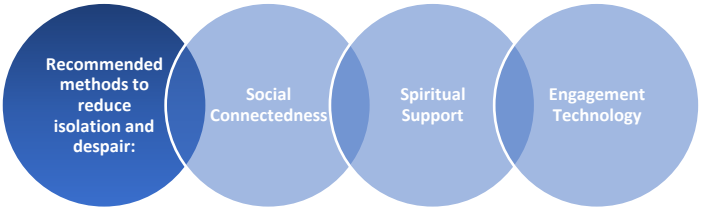
> "This is institutionalized isolation. Some call it a form of solitary confinement. It's become inhumane and cruel." states Anthony Chicotel, Esq., California Advocates for Nursing Home Reform

The heartbreaking stories emerging from many nursing homes are indicative of dwindling staffs being left to navigate this disaster on their own, often without sufficient resources and expertise. A cough now sends a ripple of fear; stress is rising to impactful levels never before seen among fearful healthcare workers, anxious residents, and frantic families. Residents are losing their will to live and dying of broken hearts.[1]

As coronavirus morphs into heightened feelings of loneliness, "failure to thrive" and "social isolation" are being listed as current causes of death according to Robyn Grant, National Consumer Voice for Quality Long-Term Care.

Isolation and loneliness have negative effects on mental health with worsening depression, anxiety, and mood disorders. Impact on physical health is higher rates of cardiovascular impairment, chronic pain, and fatigue. Additional studies found that loneliness is a risk factor for accelerating the progression of cognitive decline, Dementia, and Alzheimer's disease.[2]

Spiritual, relational, and practical challenges of Covid-19 imperils the lives of our nations' nursing home residents and staff. Lockdown demands lasting innovative transformation for care.



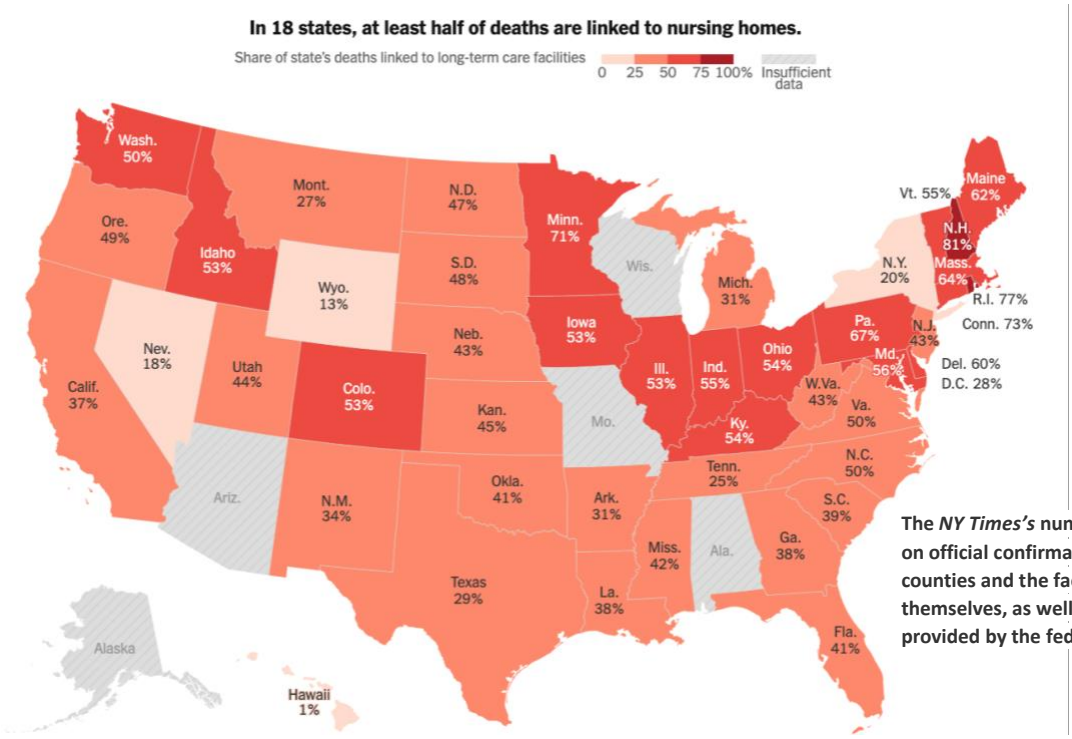
Social connectedness, spiritual support and engagement technology play an essential role in the overall well-being of individuals. These means enhance mental, emotional, spiritual and physical health. Engagement technology and smart devices boost an older adult's relationships with peers, family, friends and caregivers. Integrated, holistic approaches increase the quality of life and care for seniors and lowers the risk of nursing home abuse.[3]

Holistic care includes assessing and meeting both spiritual and religious needs. During transitional crisis moments, people have many deep questions about the spiritual dimension of life and are looking for resources to support them.[4] Spiritual care is necessary to achieve a positive impact on the well-being of patients, families, health care professionals, and health institutions. Care providers need training in research based, evidence-informed psychological insights from field study. **Introducing spiritual care to nursing promotes best practices in patient care and elicits greater job satisfaction among providers**.[5]

Using remote tools and virtual media, practical presence can be achieved and valuable resources for managing the devastating effects of social isolation can be disseminated. Practical presence is possible because it is about making and/or maintaining an emotional and spiritual connection. An innovative pivot in services brings a scalable business model, more consistent and efficient. The result is a healthier, happier, and safer nursing home community using contemporary technology.

This paper promotes integration of social, emotional, and spiritual support for nursing home residents and the staff who care for them. The creation of a Spiritual Care Institute will provide the infrastructure and support to ensure these needed services are provided in a timely and sustainable manner. Launching the institute into a social enterprise can create a vital revenue stream.

TABLE OF CONTENTS



The *NY Times's* numbers are based on official confirmations from states, counties and the facilities themselves, as well as some data provided by the federal government[9]

INTRODUCTION

The longstanding challenges to achieve high quality nursing home care is colliding with the nation's recent failure to respond effectively to COVID-19 in communal living environments. Implementing resilient environments via practical presence, social connections, and spiritual care to reduce stress and increase positive outcomes is imperitive.[6 7]

- **Orange County Health Care Agency logged 2,651 confirmed cases of COVID-19 in long-term care residents**
- **45% of deaths from COVID-19 in OC have been reported in nursing homes**
- **77,000 residents and workers have died from COVID-19 in nursing homes nationwide**
- **479,000 people at 19,000 care facilities nationally have been infected with COVID-19**

*Numbers Updated 12/5/20 [8 9]

To limit the spread of COVID-19 in nursing homes, the Centers for Medicare and Medicaid Services (CMS) restricted outside visitation by anyone other than essential healthcare personnel. Group activities have been canceled and residents are eating alone in their rooms, as all communal dining has been stopped. These steps were essential to protect residents, however, the repercussions of these actions are substantial and carry separate harms of their own.

COVID-19 allows only employees to enter nursing facilities, forcing them to unfairly carry the full stress burden of residents that are experiencing emotional and spiritual distress, along with the horrific effects of social isolation. It is also likely that nursing home clinicians and other staff, many of whom are disproportionately impacted by the pandemic personally, are likely experiencing thier own isolation, depression, and anxiety. While 7% of the country's cases have occurred in long-term care facilities, deaths related to COVID-19 in these facilities account for about 40% of the country's pandemic fatalities.[9] The common "cost of caring" for others in emotional and physical pain is burnout and Secondary Traumatic Stress Disorder (STSD) or compassion fatigue.[10]

PROBLEM

Prohibiting group activities decreases the risk of spreading the COVID-19 infection, but it significantly increases isolation which is a risk factor for developing loneliness.[11] Social isolation is consistently associated with reduced well-being, health, and quality of life, as well as negative psychological outcomes such as depression and anxiety. It can even be life threatening; "Loneliness is as lethal as smoking 15 cigarettes a day," says researcher Julianne Holt-Lunstad.[16] Subjective feelings of loneliness can increase the risk of death by anywhere from 26% to 45%.[17]

Many people feel lonely under the best of circumstances. When a crisis like the COVID-19 pandemic looms out of control, our capacity to deal with it is quickly overwhelmed. Individuals may struggle to find a way through the confusion, fear, and painful losses that come with this crisis. The sudden loss of connections to family, friends, and volunteers along with the new barriers to health and social services staff limit the provision of what we have come to define and expect as high quality nursing home care. Loneliness is a common source of distress, suffering, and impaired quality of life in older persons.[15]

Prior to the pandemic, The National Academy of Sciences, Engineering, and Medicine book, "Social Isolation and Loneliness in Older Adults," published in 2020 reports approximately one-quarter (24%) of community-dwelling Americans aged 65 and older are considered to be socially isolated, and a significant proportion of adults in the United States report feeling lonely (35% of adults aged 45 and older and 43% of adults aged 60 and older).[12] Loneliness is even more common in long-term care institutions. The prevalence of severe loneliness among older people living in care homes is at least double that of community-dwelling populations: 22% to 42% for the resident population compared with 10% for the community population.[13] One study found that more than half of nursing home residents without cognitive impairment reported feeling lonely.[14]

Although it is hard to measure social isolation and loneliness precisely, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk. Recent studies found that:[12]

- Social isolation significantly increased a person's risk of premature death from all causes, a risk that may rival those of smoking, obesity, and physical inactivity.
- Social isolation was associated with about a 50% percent increased risk of dementia.
- Poor social relationships (characterized by social isolation or loneliness) was associated with a 29% increased risk of heart disease and a 32% increased risk of stroke.
- Loneliness among heart failure patients was associated with a nearly four times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits.

KEY DEFINITIONS:

Social Isolation: While researchers recognize a variety of definitions for social isolation, it is accepted to define social isolation as: An experienced or perceived lack of personal relationships with family, friends, and acquaintances on which people can rely in case of need.

Spiritual Distress: Spiritual distress can be defined as the impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself.

Spirituality: Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.

Resilience: Resilience is the ability to withstand, recover, and sometimes grow when faced with adversity; it is an active process of enduring and successfully coping. Resilience is bouncing back after a crisis. It is also bouncing forward to adjust to a "new normal."

As in hospitals, clinicians and staff in nursing homes have worked long hours in incredibly challenging conditions during the pandemic. Unlike in hospitals, though, these individuals have worked in relative obscurity to meet the needs of residents and protect them from harm, often without adequate guidance or support.[15]

Dr. Vee voices the hardship of remaining isolated from his family due to the risk of infection for his wife and small children. His kids do not understand why "daddy" has been away from home for so many months.

Meghan, RN, shares of how she spends hours scrubbing herself after her days working in nursing homes afflicted by COVID-19 for fear she may unwittingly infect her immunocompromised mother living with her and the guilt that would ensue.

Jennifer, RN, weeps emotionally, "Each day is a battle! It's facing my worst nightmare and wondering, Will I be next? Fighting daily intrusive thoughts like, Did I sanitize well enough? Or, Was my PPE on properly?"

These added mental burdens are taxing facility caregivers and contributing to high levels of burnout. Healthcare providers are most often helper-type personalities, willing and able to go the extra mile to help those in need. Many nurses will articulate that they chose the field of nursing to be able to help people, often motivated by their personal religious or spiritual values.[18-19] Difficulty arises when caregrivers provide a higher level of care for those being served than for themselves. Compassion fatigue, burnout, vicarious traumatization, moral distress, and spiritual distress are the unintended results.[20]

Burnout and Compassion Fatigue

"Frequent environmental stress associated with human pain and distress in the workplace can impact the physical and mental wellbeing of health professionals and result in burnout and, in some cases, traumatic stress-like symptoms. These negative stress incidences can impact, not only the well-being of health professionals, but also their ability to care effectively for others" (McCann et al. 2013, p.60).[21]

Administrator Alex describes the extreme angst of informing family members they cannot enter the facility. The grief and distress of loved ones unable to be together, even as they are actively dying, due to the lockdown is unbearable! The forced separation of individuals during such a sacred time is now the norm.

Spirituality is often studied on a spectrum of well-being, from spiritual well-being (also referred to as resilience) on the healthy end through spiritual concerns and spiritual distress/struggle to spiritual despair at the unhealthy end. Spiritual distress can be defined as "the impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself."[22 23 24]

Spiritual distress can directly impair health. Studies show that people with relatively higher levels of spiritual distress are more likely to have pain, more likely to be depressed, suffer from anxiety, and be at higher suicide risk. Research indicates that spiritual struggles are associated with greater psychological distress and diminished levels of well-being.[25 26 27 28]

When a resident/patient, family, or healthcare professional is experiencing spiritual distress, his or her ability to make meaning or positively cope during this intense experience is compromised. A person's well-being and overall health is severly jeopardozed.

Skills Gap

Nursing has long been associated with spirituality and meaning making, alleviating suffering, and bringing about healing.[29] However, nurses often feel underequipped to provide spiritual care, are uncertain about what constitutes spiritual care, and struggle to articulate an actionable definition of spirituality.[30 31] Contributing factors are a lack of standardization and no agreed definition of what is meant by "spiritual," "spiritual need," and "spiritual care"; moreover, there are few guidelines for spiritual caring in nursing practice.[32]

Staff require knowledge and resources on how to meet patient's spiritual needs without increasing their workload. Healthcare professionals neglect spiritual needs due to a perceived lack of time. Additionally, they often feel unqualified and ill-equipped to tend to the emotional and spiritual needs of others since they lack formal training, which translates to a gap in care.

Historically, facilities and clinicians only address physical needs which creates a gap where there would otherwise be an opportunity to improve resident's well-being by treating holistically – body, mind, soul. Though every healthcare professional should provide some basic levels of spiritual care, most are not aware of suitable curriculum, and even fewer are comfortable engaging patients spirituality.[33 34]

SOLUTIONS

Maintaining Connections Mitigates Isolation and Loneliness

Connecting with others is a powerful way to promote life. Social connections provide people with the emotional support, material help, and intellectual connection they need to thrive. Social connectedness — both the sum of individual relationships and a sense of belonging — is crucial to overall health and well-being. Connection can be measured by the strength of the older person's existing social network and the characteristics of the individuals and institutions providing support to him or her through this network.[35] Social support is described as various kinds of help or assistance from family, friends, and others.

Resilience is also reported to be closely associated with social support. Researchers, who define resilience as a dynamic process changing over time and contexts, have emphasized the importance of social support for resilience. An increasing body of research has revealed that resilience is influenced by environmental factors which concentrate particularly on social support, including relations with professionals, social connectedness, and community/ family/friend support .[36 37 38] Research in women aged 85 and over revealed that the accessibility of care and family support were two environmental factors underpinning resilience.[39] Among older adults who received long-term community care, Janssen and his colleagues conducted 29 in-depth interviews and found that social support, positive social interaction with others, access to health services, and a supportive social policy, could give rise to resilience.[37] A cross-sectional survey of 162 community-dwelling Chinese elders in Singapore confirmed the contribution of social support to resilience.[40]

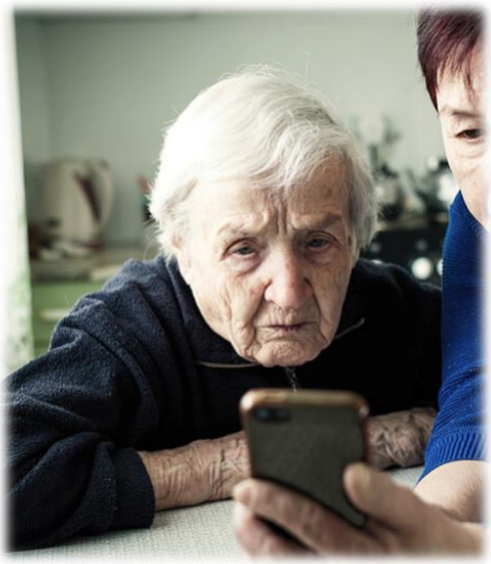
A basic human need, as identified by Maslow, is love and belonging where one experiences a sense of connection. Since spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, **community**, society, nature, and the significant or sacred, programs should offer both non-religious content and traditional religious services, including Christ-centric material. It is imperative to develop content that is inclusive of all persons represented at nursing homes. Contemporary tools create a healthier and safer nursing home community which is scalable to a national level. Virtual delivery is more efficient, consistent, and equal, if not stronger, in efficacy.

Maslow's Hierarchy of Needs

Engagement Technologies are Required

To minimize some of the unintended harms of social distancing measures for residents and staff, nursing homes must look to mechanisms like those that many people in the community have used to cope during their stays at home. Practical presence requires a shift in delivery of social, emotional, and spiritual support. The critical component to ensure success is a move to a virtual delivery system of historically proven in-person interventions. Practical presence is possible because it is about making and/or maintaining an emotional and spiritual connection.[41] The purchase of technologies such as enhanced internet access and tablet computers to facilitate these types of exchanges in nursing homes is a necessity. Smart devices allow residents access to social networks, digital content, and emotional/spiritual support.

During this social-distancing season, it is important to make sure that the elderly can have social connectedness. The benefits of social connectedness and engagement technologies include increasing an older adult's social network and reducing loneliness and social isolation; increasing resident/client engagement and satisfaction; improving health and quality of life and reducing depression; and reducing health care costs. Innovative technology keeps those on the outside of the lockdown connected with the isolated elderly. Every student has been provided with an opportunity to remain connected during distance learning, how much more should our society care for those at the end of the spectrum. Through technology, we get to monitor resident's well-being, their needs, and their health.[42]



Physical distancing co-existing with social connectedness

Holistic Care

Spirituality and faith continually encounter moments of growth and trial. Today, the pandemic has thrust them to the forefront. When we witness things beyond our comprehension or beyond our control, we search for the deeper meanings in life. Holism assumes that the mind, body, and spirit are inextricably linked, and that influence in one will lead to a change in the other. A holistic approach to restoring the harmonious balance between these three components of humanity is paramount as individuals are increasingly being treated as integrated systems that reflect body, mind, and spirit

An international team of interprofessional thought leaders on spiritual care developed the following statements identifying what healthcare professionals should know about spiritual care:[43]

1. Spiritual care should be integral to any compassionate and patient [and family] centered healthcare system model of care.
2. Spiritual care models should be based on honoring the dignity of all people and on providing compassionate care.
3. Spiritual distress or religious struggle should be treated with the same intent and urgency as treatment for pain or any other medical or social problem.
4. Spirituality should be considered a patient vital sign. Just as pain is screened routinely, so should spiritual issues be a part of routine care. Institutional policies for spiritual history and screening must be integrated into intake policies and ongoing assessment of care.

Reservoirs of Resilience

Spirituality can be a healthy and constructive reservoir of resilience for healthcare providers. Practicing disciplines of meditation, prayer, and religious ritual, as well as the relationships many create and maintain in their faith community, propels hope. There are many studies looking at religious and spiritual practices and the potential positive impact these can have on care providers in helping to mitigate compassion fatigue and creating positive coping strategies around issues of self-care.[44] [45] [46]

COVID-19 invites us to an expanded idea of community, recognizing the whole world is in this together. Pain and sorrow are felt together globally and locally. We hold the joy and responsibility of creating and recreating the kind of compassionate community we need.

Access to one caring individual increases an individual's resilience. Longer life, lower instances of depression, and better overall aging is linked with resilience. Emotional exhaustion and depersonalization lessen with spiritual well-being. Spirituality as a coping resource increases resilience and protects against burnout.[47] [48]

Since spiritual care contributes positively to healthy workplace environments, combatting compassion fatigue, and preventing provider burnout, it opens the door for strategic leadership in healthcare administration. Resilience can reduce provider turnover rates and lessen absenteeism, which affects the overall fiscal bottom line.

Spirituality as Self-Care

Innovating to transform nursing home support uplifts frontline care providers with intentional resources and training. Staff should strive to be intentional about their own self-care. Functioning as a spiritual reservoir, sustaining others resilience from their own excess rather than from a place of depletion. People find ways of coping with the intensity and stress of their daily work. It may be in eating, drinking, exercising, sexual activity, smoking or drugs, music, yoga, art, or other "outlets" that function as coping strategies.[49] The key is intentionality, finding constructive and healthy coping strategies. Many options arise from within the spiritual and religious disciplines that may prove helpful. Care providers spiritual health has a positive effect on professional commitment and caring. Spiritual and faith-based practices are both individual and communal. Self-care can pivot to peer support as healthcare providers hold an openness for what brings meaning to themselves and co-workers. Flexing to find new practices from new pools of healing can drive wholeness.

California Surgeon General Playbook recommends these six stress busters during COVID-19

Mindfulness and Meditation

Spiritual interventions can protect our brains and bodies from the harmful effects of stress and adversity. UCLA Mindful Awareness Research Center (MARC) exists to disseminate information on education and research.[50] Mindfulness is the practice of training the mind to be present through moment-to-moment awareness of our thoughts, feelings, body sensations and environment. As individuals strive to hear themselves in their communications with others and their own self-talk, notice their breathing, and acknowledge difficult emotions that arise throughout the day, they allow themselves to validate the emotions and then process them, which assists in alleviating additional stress.

- Scientific research shows mindfulness can help manage stress-related physical conditions, reduce anxiety and depression, cultivate positive emotions, and help improve overall physical health and well-being.
- Mindfulness promotes an attitude of openness, curiosity, and a willingness to accept our reality and experiences.

Spiritual Care Strengthens Connection Bonds

Frank connected with Chaplain Dave via video visits during lockdown. Frank lives in a nursing home infected with COVID -19. Over 50 residents and two healthcare providers died during the months of their bedside virtual visits, facilitated by staff. Once COVID-free, the chaplain entered his friends room only to find the man shrinking behind his blanket, desperately desiring to make the chaplain disappear, and shouting "GET OUT!"

Fear reigns in residents hearts as outsiders represent death. Familiar clinicians have access and appeal to support residents emotional and spiritual well-being. Social and spiritual support helps people find meaning, hope, and comfort in times of crisis. Captured caregiver commentary expresses, "What is spiritual is basic, because it is fundamental to life, like breathing." "Spirituality is something that human beings need in order to live." "Each person is unique, a complete whole."[51]

The authentic presence of the healthcare professional with a senior resident is characterized by generous companionship, responding to the call for help and being available to others, which result in mutual benefit and satisfaction.[52] Clinicians entering the area of spiritual care can be grouped into two categories: religious and nonreligious interventions. Religious interventions include treating patients' religious beliefs without prejudice, providing them with opportunities for connecting with God and expressing their values and beliefs, helping them practice their religion, and referring them to clerical and religious leaders. Nonreligious interventions include care providers' presence for patients and their families, making direct eye contact when communicating with patients, sympathizing with patients and their families, listening to patients and their families attentively, and showing love and enthusiasm for patients.[53]

Emotional support is born out of authenticity and discovered in relationships. Harnessing the ability to show genuine concern, empathy, and compassion for another person accelerates supportive stability and emotional well-being. Individuals that feel unconditionally accepted and cared for live healthier lives with less morbidity and mortality.[54] [55] Active listening, engaged body language, physical touch, and validation are all components of emotional support. Daily, individuals grapple with all kinds of emotions. Upset, scared, worried, grieving, or happy people benefit from others willing to authentically engage them. Emotional support is not having an answer to every issue or offering advice. Emotional support is providing non-judgmental love, reassurance, acceptance, and encouragement. One of our most basic needs as human beings is meaningful connections with other people.[56] [57] Research released in 2020 by the Humanitarian Disaster Institute of Wheaton College has shown that helping people address five core unmet needs in the wake of disasters like COVID-19 can help them gain a sense of meaning, feel connected, and improve resilience:[41]

Humanitarian Disaster Institute "BLESS"

- **Belonging** Needs

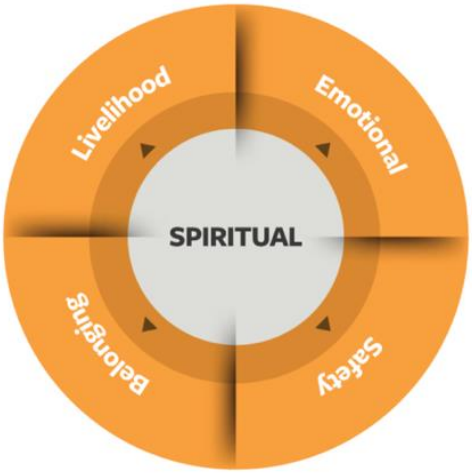
  (relationships)
- **Livelihood** Needs

  (health, finances, resources, employment)
- **Emotional** Needs

  (mental health)
- **Safety** Needs

  (suicide, harm to self, threat to others, domestic violence)
- **Spiritual** Needs

  (faith, spiritual struggles, meaning making, purpose)



Spiritual Care Institute

Incorporating programs to target holistic well-being is what is most effective in supporting the residents, families, and frontline care providers. Integrating spiritual care into nursing curricula could meet that need during the nurse formation process.[58] Educators have an important role in the learning process; the teaching of this dimension of care is necessary at both faculty and clinical practice. Reflective teaching methodology including group discussions, critical incident analysis, keeping diaries, role-play, online discussions to allow ongoing mentoring of students beyond class hours, and self-reflection are recommended. A Training Institute will transfer learning into clinical practice and minimize the divergence between the theory and practice of spiritual care. Healthcare professionals would have timely access to critical tools.

How to Use the BLESS Method to Assess Unmet Core Needs and Intervene

The 5 Core Needs	Assess Core Needs		Intervene to Address Primary Unmet Core Needs	
	Attend (*What to Observe*)	**Ask** (*What to Explore and Prioritize*)	**Act** (*What to Do*)	**And Repeat** (*if Warranted/ Possible*)
B = Belonging	Relationships	Social Questions	Provide Spiritual Support	Address Secondary Unmet Core Needs
L = Livelihood	Health and Finances	Resource Questions	Connect to Faith-based, Community, and Healthcare Resources	Address Secondary Unmet Core Needs
E = Emotional	Mental Health	Well-Being Questions	Facilitate Lament	Address Secondary Unmet Core Needs
S = Safety	"Red Flags" (hints they are experiencing violence, self-harm, or suicide thoughts/ behavior)	Threat and Harm Assessment Questions	Refer and Report	Address Secondary Unmet Core Needs
S = Spiritual	Meaning-Making and Religious Behaviors	Spiritual Struggles, and Ultimate Questions (e.g., about life and death)	Encourage Spiritual Coping	Address Secondary Unmet Core Needs

The Institute will offer research-based, evidence-informed psychological insights from field study and best practice resources in providing emotional and spiritual care. In addition to being a valuable part of total patient care, spiritual care interventions promote a sense of well-being for healthcare providers.

The Institute will train care providers to perform basic emotional and spiritual assessments utilizing five criteria identified as critical in the genre study **Spirituality in Patient Care**.[59] HOPE,[60] SPIRIT,[61] FACT[62] approaches will be used along with the developed tool by Christina Puchalski, M.D., at the George Washington Institute for Spirituality and Health (GWISH), called FICA, which has become one of the most utilized:[63]

F – Faith and belief: "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" If the patient responds with "No," the history-taker might ask, "What gives your life meaning?" Sometimes patients respond with answers such as family, career, or nature.

I – Importance: "What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?"

C – Community: "Are you a part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?" Communities such as churches, temples and mosques, or a group of like-minded friends can serve as strong support systems for some patients.

A – Address in care: "How would you like me, and the entire medical care team, to address these issues in your health care?"

Over the past four years, Wheaton College Graduate School has released curriculum targeting disaster and crisis events. Their Spiritual First-Aid Manual can be used with almost anyone regardless of faith background. It offers a step-by-step approach to learning and providing spiritual and emotional care for others through Spiritual First Aid's BLESS Method. The basic helping skills they teach in their BLESS Method target five common identified core needs to reduce distress and promote better mental health. BLESS stands for the core needs: Belonging, Livelihood, Emotional, Safety, Spiritual. Taking the guesswork out of spiritual and emotional care makes humble helping and practical presence more concrete. Spiritual First Aid helps people positively engage their faith in ways that research has shown to reduce distress during times of adversity. Specifically, this method helps reduce distress by identifying and providing for an individuals five core needs.[41]

KEY FINDINGS

Turnover in Nursing Homes

It is fiscally wise to invest in retention of this critical frontline workforce. "Simply put, frontline turnover in long-term care can be expensive, and when it does become costly, it becomes a business problem, a quality-of-care problem, and a public resource problem" (A Better Jobs Better Care Practice & Policy Report, 2004).

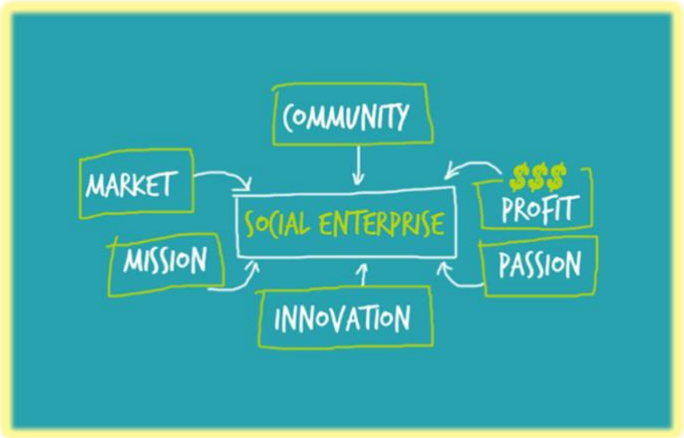
Turnover in this industry has been an issue for decades. In the year 2000, the economic burden of depression was estimated at $83.1 billion, of which $26.1 billion was incurred by direct medical costs and nearly twice that amount ($51.5 billion) was associated with costs incurred in the workplace.[64] Other research on depression-related costs in the workplace has shown that depressed workers who underperform as a result of their depression incur $35.7 billion in costs with another $8.3 billion incurred as a result of absenteeism among depressed workers.[65] In 2017, nursing home turnover rates for aides and nurses were 55%–75%, costing $7,000 per employee.[66] Whole, resilient, and truly healthy individuals bring creativity and productivity to their work. Addressing emotional and spiritual health and well-being of employees fosters a healthy workplace environment through trust, unity, relationship, and community.[67] [68] Overall wholeness translates to greater productivity, a better bottom line, and lower workplace risk.[69] [70]

Creating a Social Enterprise

The development of commercial sources of revenue allows traditional nonprofit organizations (NPOs) to improve financial certainty in response to the reduction of established funding sources from governments, grants, and individual donors. It further insulates the NPO from the increased competition for these limited funds. “A social enterprise (SE) is a cause-driven business whose primary reason for being is to improve social objectives and serve the common good.”[71] Although profits are not the primary motivation behind an SE, revenue still plays an essential role in the sustainability of the venture. The COVID-19 pandemic has exposed the systemic inequalities of our economic system. Vulnerable populations, which are most at risk to the impacts of COVID-19 are being excluded because of market and government failures to anticipate and address known problems.

The Institute can become an SE that feeds the nonprofit by charging a service fee. A strategic advantage in the marketplace is creating a solution to the staffing crisis plague in facilities. One study of 902 nursing homes in CA found that even a 10% reduction of turnover could save nearly 3% of total costs (upwards of $165,000 per facility).[66] Launching an institute to train care providers, administrators, and directors in mindfulness practices and other evidence-based spiritual interventions to facilitate self-care during COVID-19 and beyond can become a game changer for the nursing home industry.

This type of SE proposed is called **The Innovation Model**. The proposed Institute would be an example of a company that directly addresses a social need through innovative products and services. The company would bring mental wellness to all nursing home teams using contemporary technology. When nursing homes invest in their worker’s wellbeing a **win-win-win** scenario is created. The private nursing home staff feel cared for and loved leading to long-term employee commitment. The nursing home business profits from lower turnover and onboarding expense of new employees. Finally, the nursing home resident benefits from consistent frontline staff trained in social, emotional, and spiritual care that they interact with daily.



Implementation of self-care and peer support training will decrease stress levels, increase employee morale and engagement, increase employee retention and productivity, and increase empathy and respect.[72]

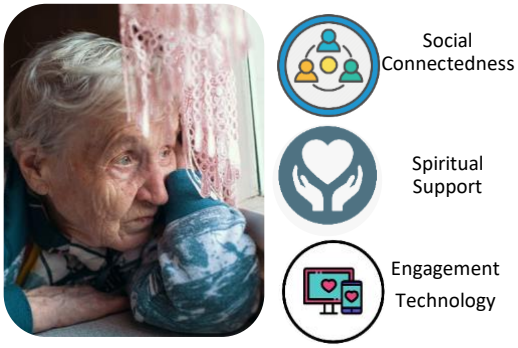
CONCLUSION

Social connection, spiritual care, and engagement technoly counters negative effects of social isolation and loneliness by improving people's quality of life, spiritual well-being, and performance. Like other caring activities and procedures, spiritual care has positive effects on individuals' interpersonal relationships, sense of integrity and excellence, and stress responses. A large and growing volume of research suggests that religious or spiritual beliefs and practices are used to cope with or adapt to stressful life circumstances.[73]

While in-person communication and interactions continue to be critical, contemporary technology offers a new stream into nursing homes. On-demand virtual content removes geographic and time constraints that often limit our connectivity. Smart devices unlock the value of social connectedness for millions of seniors in nursing homes.

High quality nursing home care should treat the whole patient and engage them holistically; including the emotional element around the patient and family experience. Emotions attached to interactions and everyday encounters can surface existential questions. Equipping care providers to address patient values, beliefs, and how they make sense of life implements best practice standards since spirituality and religion is a preferred coping strategy for most people, especially at the end of life.[74]

Recommended methods to reduce isolation and despair:



Meeting social-emotional needs and supporting spirituality impacts patient experience, medical outcomes, and cost savings. Healthy workplace environments produce increased trust levels, prevent provider burnout, and decrease turnover. Collaborative efforts in our choices to achieve greater values in life and for the pursuit of truth define a resilient community. Uniting to help one another, to show care and compassion for those who are vulnerable, and to each do our part in service of the greater good is essential. Innovative transformation offers a better model for social, emotional, and spiritual care in nursing home communities.

REFERENCES

1. Is Extended Isolation Killing Older Adults in Long-Term Care? https://www.aarp.org/caregiving/health/info-2020/covid-isolation-killing-nursing-home-residents.html
2. Cacioppo S, Grippo AJ, London S, et al. Loneliness: Clinical imports and interventions. Perspect Psychol Sci 2015; 10:238e249. https://www.jamda.com/article/S1525-8610(20)30373-X/pdf
3. Coyle N. Introduction to palliative nursing care. In: Ferrell BR, Coyle N, Paice JA, eds. Oxford Textbook of Palliative Nursing. 4th ed. New York, NY: Oxford University Press; 2015:3-10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6343956/#:~:text=Compassion%20fatigue%20is%20medically%20defined,caring%20for%20sick%20or%20traumatized
4. Balboni, M. J., Puchalski, C. M., & Peteet, J. R. (2014). The relationship between medicine, spirituality and religion: Three models for integration. Journal of Religion and Health, 53(5), 1586–1598. https://doi.org/10.1007/s10943-014-9901-8
5. Cockell, N., & McSherry, W. (2012). Spiritual care in nursing: An overview of published international research. Journal of Nursing Management, 20, 958-969. doi:10.1111/ j.1365-2834.2012.01450.x https://www.researchgate.net/profile/Monica_Veloza/publication/294423989_The_Importance_of_Spiritual_Care_in_Nursing_Practice/links/5a09c557a6fdcc1b976cc744/The-Importance-of-Spiritual-Care-in-Nursing-Practice.pdf page 11
6. Bonanno, G. A. (2008). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? Psychological Trauma: Theory, Research, Practice, and Policy, S(1), 101–113. https://doi.org/10.1037/1942-9681.S.1.101
7. Salmoirago-Blotcher, E., Fitchett, G., Leung, K., Volturo, G., Boudreaux, E., Crawford, S., Curlin, F. (2016). An exploration of the role of religion/spirituality in the promotion of physicians' wellbeing in emergency medicine. Preventive Medicine Reports, 3, 189–195. https://doi.org/10.1016/j.pmedr.2016.01.009
8. COVID-19 Case Counts and Testing Figures https://occovid19.ochealthinfo.com/coronavirus-in-oc
9. The New York Times database https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html
10. Rushton, C. H., Batcheller, J., Schroeder, K., & Donohue, P. (2015). Burnout and resilience among nurses practicing in high-intensity settings. American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses, 24(5), 412–420. https://doi.org/10.4037/ajcc2015291
11. Span P. Just What older people didn't need: More isolation. https://www.nytimes.com/2020/04/13/health/coronavirus-elderly-isolation-loneliness.html https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7205644/#bib13
12. Blazer D.G. National Academies of Sciences, Engineering, and Medicine. 2020. Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System. Washington, DC: The National Academies Press. https://doi.org/10.17226/25663.
13. Victor C.R. Loneliness in care homes: A neglected area of research? Aging Health. 2012; 8:637–646. [Google Scholar] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7205644/#bib13
14. Drageset J., Kirkevold M., Espehaug B. Loneliness and social support among nursing home residents without cognitive impairment: A questionnaire survey. Int J Nurs Stud. 2011; 48:611–619. [PubMed] [Google Scholar] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7205644/#bib13
15. Health Affairs, The Importance Of Nursing Home Transparency And Oversight, Even In The Midst Of A Pandemic https://www.healthaffairs.org/do/10.1377/hblog20200511.431267/full/
16. Julianne Holt-Lunstad, PhD, The Potential Public Health Relevance of Social Isolation and Loneliness: Prevalence, Epidemiology, and Risk Factors, Public Policy & Aging Report, Volume 27, Issue 4, 2017, Pages 127–130, https://doi.org/10.1093/ppar/prx030
17. Andrew Steptoe, Aparna Shankar, Panayotes Demakakos, Jane Wardle Social isolation, loneliness, and mortality Proceedings of the National Academy of Sciences Apr 2013, 110 (15) 5797-5801; DOI: 10.1073/pnas.1219686110 https://www.cdc.gov/aging/publications/features/lonely-older-adults.html
18. Mamier, Iris, et al. "Nurse Religiosity and the Provision of Spiritual Care." (2015). http://www.nursinglibrary.org/vhl/bitstream/10755/602820/1/Mamier_STTI_2015_76398.pdf
19. Raingruber, Bonnie, and Terri Wolf. "Nurse perspectives regarding the meaningfulness of oncology nursing practice." Clinical journal of oncology nursing 19.3 (2015).
20. Spiritual Care Association, Spiritual Care and Nursing: A Nurse's Contribution and Practice https://www.healthcarechaplaincy.org/docs/about/nurses_spiritual_care_white_paper_3_3_2017.pdf
21. McCann, C. M., Beddoe, E., Mccormick, K., Huggard, P., Kedge, S., Adamson, C., & Huggard, J. (2013). Resilience in the health professions: A review of recent literature. International Journal of Wellbeing, 3(1), 60–81. https://doi.org/10.5502/ijw.v3i1.4
22. Peterman, Amy H., et al. "Measuring spiritual well-being in people with cancer: the functional assessment of chronic illness therapy—Spiritual Well-being Scale (FACIT-SP)." Annals of behavioral medicine 24.1 (2002): 49-58. Monod, Stefanie M., et al. "The spiritual distress assessment tool: an instrument to assess spiritual distress in hospitalized elderly persons." BMC geriatrics 10.1 (2010): 1.

23. NANDA International, Defining characteristics of spiritual distress: an integrative review http://kb.nanda.org/article/AA-00657/0/Defining-characteristics-of-spiritual-distress%3A-an-integrative-review.html
24. Monod, Stefanie M., et al. "The spiritual distress assessment tool: an instrument to assess spiritual distress in hospitalized elderly persons." BMC geriatrics 10.1 (2010): 1. https://bmcgeriatr.biomedcentral.com/articles/10.1186/1471-2318-10-88
25. Koenig HG. Religion and remission of depression in medical in patients with heart failure/pulmonary disease. Journal of Nervous and Mental Disease. 2007;195(5):389–395. [PubMed] [Google Scholar]
26. Cohen S, Underwood LG, Gottlieb BH. Social Support Measurement and Intervention. New York, NY, USA: Oxford University Press; 2000. [Google Scholar]
27. Broadhead WE, Kaplan BH, James SA. The epidemiologic evidence for a relationship between social support and health. American Journal of Epidemiology. 1983;117(5):521–537. [PubMed] [Google Scholar]
28. Braam AW, Delespaul P, Beekman AT, Deeg DJ, Peres K, Dewey M. National context of healthcare, economy and religion, and the association between disability and depressive symptoms in older Europeans: results from the EURODEP concerted action. European Journal of Ageing. 2004;1(1):26–36. [PMC free article] [PubMed] [Google Scholar]
29. Berenguer, S. M. A. C., & Pinto, S. M. D. O. "The competence for the spiritual care in nursing." Journal of Nursing UFPE on line, 10.6 (2016): 4974-4975. http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/9871/pdf_2065
30. Chew, Brendan WK, Lay Hwa Tiew, and Debra K. Creedy. "Acute care nurses' perceptions of spirituality and spiritual care: an exploratory study in Singapore." Journal of Clinical Nursing 25.17-18 (2016): 2520-2527.
31. Selby, Debbie, et al. "Patient versus health care provider perspectives on spirituality and spiritual care: the potential to miss the moment." Annals of Palliative Medicine (2017). http://apm.amegroups.com/article/download/13171/13547
32. Ross L, van Leeuwen R, Baldacchino D, Giske T, McSherry W, Narayanasamy A, et al. Student nurses perceptions of spirituality and competence in delivering spiritual care: a European pilot study. Nurse Educ Today. 2014;34(5):697–702. doi: 10.1016/j.nedt.2013.09.014. [PubMed] [CrossRef] [Google Scholar]
33. Ruder, Shirley. "Spirituality in nursing: nurses' perceptions about providing spiritual care." Home Healthcare Now 31.7 (2013): 356-367. http://bit.ly/2o1qdP7
34. Balboni, Michael J., et al. "Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training." Journal of Clinical Oncology 31.4 (2012): 461-467. http://ascopubs.org/doi/pdf/10.1200/JCO.2012.44.6443
35. Wu, M., Yang, Y., Zhang, D. et al. Association between social support and health-related quality of life among Chinese rural elders in nursing homes: the mediating role of resilience. Qual Life Res 27, 783–792 (2018). https://doi.org/10.1007/s11136-017-1730-2
36. van Kessel, G. (2013). The ability of older people to overcome adversity: A review of the resilience concept. Geriatric Nursing, 34(2), 122–127. doi:10.1016/j.gerinurse.2012.12.011.
37. Janssen, B. M., Van Regenmortel, T., & Abma, T. A. (2011). Identifying sources of strength: Resilience from the perspective of older people receiving long-term community care. European Journal of Ageing, 8(3), 145–156. doi:10.1007/s10433-011-0190-8.
38. van der Leeuw, S., Costanza, R., Aulenbach, S., Brewer, S., Burek, M., & Cornell, S., et al. (2011). Toward an integrated history to guide the future. Ecology and Society. doi:10.5751/ES-04341-160402.
39. Felten, B. S., & Hall, J. M. (2001). Conceptualizing resilience in women older than 85: Overcoming adversity from illness or loss. Journal of Gerontological Nursing, 27(11), 46–53.
40. Li, J., Theng, Y., & Foo, S. (2015). Does psychological resilience mediate the impact of social support on geriatric depression? An exploratory study among Chinese older adults in Singapore. Asian Journal of Psychiatry, 14, 22–27. doi:10.1016/j.ajp.2015.01.011.
41. Humanitarian Disaster Institute, Spiritual First Aid, A Step-By-Step Spiritual & Emotional Care Manual. https://www.nohcob.org/upload/documents/disaster_response/spiritual_first_aid_manual_l_r4_5-13-20_1.pdf
42. Leading Age - Social Connectedness and Engagement Technology for Long-Term and Post-Acute Care: A Primer and Provider Selection Guide https://www.leadingage.org/white-papers/social-connectedness-and-engagement-technology-long-term-and-post-acute-care-primer-and
43. Puchalski, Christina M., et al. "Improving the spiritual dimension of whole person care: Reaching national and international consensus." Journal of Palliative Medicine 17.6 (2014): 642-656, page 6. http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1429&context=smhs_medicine_facpubs
44. Ross, Linda, et al. "Student nurses perceptions of spirituality and competence in delivering spiritual care: a European pilot study." Nurse Education Today 34.5 (2014): 697-702. http://bit.ly/2nPjk44
45. White, Mary L. "Spirituality Self-Care Practices as a Mediator between Quality of Life and Depression." Religions 7.5 (2016): 54. http://www.mdpi.com/2077-1444/7/5/54/htm
46. Pembroke, Neil. "Contributions from Christian ethics and Buddhist philosophy to the management of compassion fatigue in nurses." Nursing & health sciences (2015).
47. Duggleby, W., Cooper, D., & Penz, K. (2009). Hope, self-efficacy, spiritual well-being and job satisfaction. Journal of Advanced Nursing, 65(11), 2376–2385. https://doi.org/10.1111/j.1365-2648.2009.05094.x
48. Taylor, J. J., Hodgson, J. L., Kolobova, I., Lamson, A. L., Sira, N., & Musick, D. (2015). Exploring the phenomenon of spiritual care between hospital chaplains and hospital based healthcare providers. Journal of Health Care Chaplaincy, 21(3), 91–107. https://doi.org/10.1080/08854726.2015.1015302

49. Chiang, Yi-Chien, et al. “The impact of nurses’ spiritual health on their attitudes toward spiritual care, professional commitment, and caring.” Nursing outlook 64.3 (2016): 215-224. http://bit.ly/2mRvmZN
50. UCLA Mindful Awareness Research Center https://www.uclahealth.org/marc/
51. Journal of Holistic Nursing - The Importance of Spiritual Care in Nursing Practice, page 4 https://www.researchgate.net/profile/Monica_Veloza/publication/294423989_The_Importance_of_Spiritual_Care_in_Nursing_Practice/links/5a09c557a6fdcc1b976cc744/The-Importance-of-Spiritual-Care-in-Nursing-Practice.pdf
52. McBrien B. Nurses' provision of spiritual care in the emergency setting--an Irish perspective. Int Emerg Nurs. 2010;18(3):119–26. doi: 10.1016/j.ienj.2009.09.004. [PubMed] [CrossRef] [Google Scholar]
53. Zehtab S, Adib-Hajbaghery M., The importance of spiritual care in nursing. Nurs Midwifery Stud. 2014 Sep;3(3):e22261. doi: 10.17795/nmsjournal22261. Epub 2014 Sep 20. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4332997/
54. Reblin, M., & Uchino, B. N. (2008). Social and emotional support and its implication for health. Current opinion in psychiatry, 21(2), 201–205. https://doi.org/10.1097/YCO.0b013e3282f3ad89
55. Morelli, S. A., Lee, I. A., Arnn, M. E., & Zaki, J. (2015). Emotional and instrumental support provision interact to predict well-being. Emotion (Washington, D.C.), 15(4), 484–493. https://doi.org/10.1037/emo0000084
56. Stewart-Brown S. (1998). Emotional wellbeing and its relation to health. Physical disease may well result from emotional distress. BMJ (Clinical research ed.), 317(7173), 1608–1609. https://doi.org/10.1136/bmj.317.7173.1608
57. Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan, C. A., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: from neurobiology to clinical practice. Psychiatry (Edgmont (Pa. : Township)), 4(5), 35–40.
58. Burkhart L, Schmidt W. Measuring effectiveness of a spiritual care pedagogy in nursing education. J Prof Nurs. 2012;28(5):315–21. doi: 10.1016/j.profnurs.2012.03.003. [PubMed] [CrossRef] [Google Scholar]
59. Koenig, H. G. (2002). Spirituality in patient care: Why, how, when, and what. Philadelphia: Templeton Foundation Press.
60. G. Anandarajah and E. Hight, "Spirituality and Medical Practice: Using the HOPE questions as a practical tool for spiritual assessment," American Family Practice 63 (2001): 81-88.
61. T. A. Maugans, "The Spiritual History," Archive of Family Medicine 5 (1997): 11-16; Ambuel and D. E. Weissman, "Discussing spiritual issues and maintaining hope," in eds., D. E. Weissman and B. Ambuel, Improving End-Of-Life Care: A Resource Guide for Physician Education, 2nd ed. (Milwaukee, WI: Medical College of Wisconsin, 1999).
62. LaRocca-Pitts. (2015)Four FACTs Spiritual Assessment Tool FACT: “Taking a spiritual history.”
63. Puchalski, Christina, and Anna L. Romer. “Taking a spiritual history allows clinicians to understand patients more fully.” Journal of Palliative Medicine 3.1 (2000): 129-137.
64. Greenberg P.E., Kessler R.C., Birnbaum H.G, Leong S.A., Lowe S.W., Berglund P.A., Corey-Lisle P.K. (2003). The economic burden of depression in the United States: how did it change between 1990 and 2000? Journal of Clinical Psychology, 64(12), 1465-1475.
65. Stewart W.F., Ricci J.A., Chee E., Hahn S.R., Morganstein D. (2003). Cost of lost productive work time among U.S. workers with depression. Journal of the American Medical Association, 289(23), 3135-3144.
66. Med Care, The Costs of Turnover in Nursing Homes https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761533/
67. Karakas, F. (2010). Spirituality and performance in organizations: A literature review. Journal of Business Ethics, 94(1), 89–106. https://doi.org/10.1007/s10551-009-0251-5
68. Watkins, L. (2014). Should emergency nurses attempt to meet patients’ spiritual needs? Emergency Nurse, 22(6), 36–38. https://doi.org/10.7748/en.22.6.36.e1333
69. Holt-Ashley, M. (2000). Nurses pray: Use of prayer and spirituality as a complementary therapy in the intensive care setting. AACN Clinical Issues, 11(1), 60–7.
70. Lo, R. (2003). The use of prayer in spiritual care. The Australian Journal of Holistic Nursing, 10(1), 22–9.
71. The Good Trade, What Is A Social Enterprise? https://www.thegoodtrade.com/features/what-is-a-social-enterprise
72. Pereira, S. M., Fonseca, A. M., & Carvalho, A. S. (2011). Burnout in palliative care: A systematic review. Nursing Ethics, 18(1), 317–326. https://doi.org/10.1177/0969733011398092
73. Bonelli, R., Dew, R. E., Koenig, H. G., Rosmarin, D. H., & Vasegh, S. (2012). Religious and spiritual factors in depression: review and integration of the research. Depression research and treatment, 2012, 962860. https://doi.org/10.1155/2012/962860
74. Balboni, T. A., L. C. Vanderwerker, S. D. Block, M. E. Paulk, C. S. Lathan, J. R. Peteet, and H. G. Prigerson. (2007) “Religiousness and Spiritual Support Among Advanced Cancer Patients and Associations With End-of-Life Treatment Preferences and Quality of Life.” Journal of Clinical Oncology 25.5 : 555-60. https://pubmed.ncbi.nlm.nih.gov/17290065/