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Geropsychiatric Nursing Leadership in Long-Term Care

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KEYWORDS

• Nursing homes • Geropsychiatric nursing • Leadership • Dementia

KEY POINTS

- Geropsychiatric nursing (GPN) is a subspecialty.
- GPN leaders are essential to high-quality nursing home care.
- Initiatives to infuse GPN into undergraduate and graduate curricula, research and policy will prepare the next generation of GPN leaders.
- GPN leaders improve the care of older adults.

INTRODUCTION AND DEFINITION

Geropsychiatric nursing (GPN) has been defined by the GPN Collaborative[1,2] as the *holistic support for the care of older adults and their families as they anticipate and/or experience developmental and cognitive challenges, mental health concerns, and psychiatric/substance misuse disorders across a variety of health and mental health care settings*.[1] The GPN Collaborative was started by a group of leaders in GPN, Drs Cornelia Beck, Kitty Buckwalter and Lois Evans funded by the John A Hartford Foundation to enhance the cognitive and mental health of older adults through Geropsychiatric Nurses.[3] This definition of GPN is purposively broad to encompass the integration of geropsychiatric care across the continuum of care.

The integration of GPN leadership into education, practice, research, and policy is essential to improve the quality of life of older adults living in long-term care settings. This has become gravely evident during the coronavirus disease-2019 (COVID-19) pandemic whereby older adults in long-term care were not only at

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risk physically from the virus but also at risk for several geropsychiatric conditions including depression, isolation, loneliness, exacerbation of the behavioral symptoms of dementia, psychosis, and suicide.[4] Geropsychiatric leadership in long-term care requires expert communication, motivation, and persuasion skills to improve the therapeutic environment and the uptake of evidence-based interventions for geropsychiatric conditions. Expert geropsychiatric assessments lead to evidence-based interventions that can improve the care and quality of life of older adults in long-term care. GPN leaders impact policy decisions and drive the long-term care research agenda.

History of Geropsychiatric Nursing Leadership

GPN leadership is needed in all settings but never more important than in the long-term care arena. Unfortunately, the workforce in long-term care is unprepared to meet the growing population of older adults with mental health conditions, especially in the nursing home.[5] To understand leadership in GPN in the nursing home, it is important to start at the beginning.

Dr Mary Starke Harper was the first geropsychiatric nurse and is considered the pioneer of GPN. Through her national and international leadership, she overcame many personal and professional obstacles to improve the quality of care for older adults with mental health disparities.[6] Dr Harper was born in 1919 in Alabama and was the first black woman to graduate from the University of Minnesota. She published many books and articles, became the first woman, black social scientist, established the Mary Starke Harper Geriatric Psychiatry Center, and mentored countless students. She was the first to call attention to mental health disparities for minority older adults and directed the National Institute of Mental Health Minority Fellowship program. Four United States Presidents looked to Dr Harper for advice on mental health and aging. She served on the Advisory Board for the National Institute of Aging and continued to work every day of her life until her death at 87 years old.[6]

GPN evolved rapidly under the leadership of Dr Mary Starke Harper. In the 1970s, GPN was a blended subspecialty shared between gerontological and psychiatric nurses. Clinical nurse specialists in gerontological or psychiatric mental health nursing took the first step toward blending the specialties in GPN.[7] During this same time frame, nurses certified in gerontological nursing also paved the way for future generations of geropsychiatric nurses by convening the first State of the Future Geropsychiatric Nursing Conference in 2005 took place in Philadelphia.[8] The National Invitational Geropsychiatric Nursing State of the Future Conference resulted in a series of white papers were published on GPN in the *Journal of the American Psychiatric Nursing* Association,[9] including a state of the science paper on GPN.[10]

Before her death in 2006, Dr Harper collaborated with geropsychiatric nurse leaders Jacqueline Stolley and Kathleen Buckwalter (1994) to publish results of a survey of geropsychiatric nurses.[11] The survey reported that geropsychiatric nurses held certifications in gerontological or psychiatric mental health nursing or both. The survey emphasized unity in the diversity within GPN. This survey identified problems that continue today such as lack of integrated or stand-alone curriculum in GPN, limited programs with courses in GPN focus. The survey showed that geropsychiatric nurses demonstrate “a diverse blend of skills” and recognized interprofessional roles of the geropsychiatric nurse. The survey respondents reported that their most important concern was the “recognition of the population…. that we serve.” Geropsychiatric nurses strongly identified with persons living with dementia as the primary population with whom they worked, and they were very concerned about the quality of care in long-term care settings. The 1994 survey reported that GPN leaders prioritized

recruitment and hiring of adequate nursing staff in long-term care, education of physicians, certification of staff, and the education and leadership training of staff.

Ten years later, in 2004, another survey by Kurlowicz and colleagues[12] (2007) concluded that there were few GPN programs and little integration of GPN content across graduate nursing specialties. In 2015, investigators conducted a follow-up national survey[13,14] and compared the results to earlier findings. They found little change in GPN content in graduate nursing education. Although there were more psychiatric nursing programs, GPN content continued to be embedded in the primary care curriculum, rather than psychiatric mental health curriculum.

In 2008, the Geropsychiatric Nursing Collaborative (GPNC) was led by Drs Cornelia Beck, Kathleen Buckwalter, and Lois Evans. The GPNC was housed in the American Academy of Nursing and funded by the John A Hartford Foundation. The purpose of the GPNC was to improve the cognitive and mental health of older adults by developing Geropsychiatric Nursing Competency Enhancements across all levels of nursing and to adapt, develop, and disseminate GPN curricula.[3,15]

In 2015, another Geropsychiatric Nursing State of the Future Conference was held in San Francisco. This conference used an interprofessional approach.[16] A series of white papers were published in a special issue of the *Journal of the American Geriatrics Society*.[17] The participants identified the need for a cadre of GPN leaders to define GPN, create curriculum, and enhance and grow the pipeline of geropsychiatric nurses, advanced practice nurses, and scientists. These geropsychiatric nurse leaders are positioned to: (1) engage professional organizations in addressing the lack of a certification examination for GPN, (2) form a leadership group for knowledge development, translation, and dissemination to improve quality of life for all older adults.[18]

In 2020, GPN leaders again supported the 1994 call for a wide range of specialties to include GPN within their scope of practice but most importantly for those who routinely care for older adults. The Gerontological Advanced Practice Nurses Association (GAPNA) Position Paper *Supporting Evidence for Geropsychiatric Nursing as a Subspecialty of Gerontological Advanced Practice Nursing*[19] *supports* within the discipline and interdisciplinary engagement in geropsychiatric care. Similar to the early survey of geropsychiatric nurses, the authors state the work of the diverse group of advanced practice nurses echoes the same passion to reflect “the highest respect and sensitivity for older adults and their families.” The authors also used an interprofessional approach and continued a remarkable similarity in the recommendations of their predecessors to prioritize education and certification while making additional recommendations to improve the quality of life for diverse older adult populations.

Scope of Geropsychiatric Nursing Practice

GPN is a blend of many overlapping nursing roles.[20,21] Because, it is impossible to separate the mind from the body, at some point, it is likely that most nurses caring for older adults serve as geropsychiatric nurses, and those working in nursing homes do so daily. The overlapping of disciplines is very evident in the field of dementia care. For example, the Diagnostic and Statistical Manual of Mental Disorders[21] identify dementia as a psychiatric diagnosis. Yet according to the Centers for Disease Control and Prevention (CDC),[22] dementia is a term to describe memory loss. Alzheimer’s disease-related dementia and vascular dementia are characterized as medical illnesses with discrete pathologic findings. In addition to depression and anxiety, a person living with dementia may also have a comorbid diagnosis of a severe and persistent mental illness such as schizophrenia or bipolar disorder.

Therefore, nurses who specialize in multiple disciplines, such as neurology, psychiatry, gerontology, and family practice, contribute to the care of persons living with

dementia. Psychiatric mental health, family practice, adult-gerontology primary care, adult-gerontology acute care, and other gerontological advanced practice nurses may all practice, conduct research, and lead in long-term care settings. It is, therefore, critical that all nurses in long-term care receive training in GPN.[4]

Geropsychiatric Nursing Education

Despite the extraordinary efforts to improve the GPN curriculum, little is known about individual nurse practitioners', registered nurses', and licensed practical nurses' expertise and preparation to practice GPN in nursing homes. Although, more than 60% of the almost 1.5 million nursing employee FTEs are dedicated to employment in nursing homes,[23] only 11.9% of these employee FTEs are registered nurses.[23] This is a small number considering that the registered nurses are dispersed to more than 15,600 nursing homes and 1.3 million nursing home residents.[23] The COVID-19 pandemic highlighted the need for the 24-h presence of registered nurses in nursing homes to meet the psychosocial and physical needs of the older adults.[24]

Although there is no certification for GPN or long-term care for advanced practice registered nurses or registered nurses, GPN is a necessary subspecialty at the top of the Advanced Practice Registered Nursing Consensus Model[19] and best represents nursing leadership in the nursing home. Because of the nature of caring for older adults, the interprofessional team approach is not new to nursing homes and remains a foundational model of care for older adults.[24] Geropsychiatric nurses are well-positioned to lead interprofessional teams in US nursing homes.

GAPNA supports the subspecialty of GPN. Recommendations from the GAPNA position paper[19] for strengthening the subspecialty and GPN leaders include developing nursing competencies, integrating interprofessional education, removing scope of practice barriers, and endorsing a variety of strategies such as portfolio and educational development to support credibility for the scope of practice for this subspecialty.

Geropsychiatric Nursing Leadership

Meeting the health care needs of older adults in Nursing homes who live with dementia, psychiatric and substance use conditions poses challenges for GPN leadership. Recent data show that almost half (45%) of nursing home residents have a dementia diagnosis, while almost one-third (32%) have other psychiatric disorders such as schizophrenia, mood disorders, or other psychiatric diagnoses.[25] Of those with dementia, 61.4% had moderate to severe cognitive impairment.[26] Prevalence rates for Depression (46.3%) and delirium (15%–70%) provide further evidence for the pressing need for GPN expertise.[22,27] GPN leaders have the expertise to distinguish between these conditions, and this is exceedingly important because treatment plans for these conditions differ. Access to services and support for mental health needs, however, is often inadequate, especially for minority older adults in nursing homes who represent a growing proportion of that population.[28–30]

GPN leadership is particularly necessary when caring for older adults with dementia. Person-centered, evidence-based, nonpharmacological interventions are the front-line approaches for the treatment of behavioral and psychological symptoms of dementia. If nursing home clinicians are untrained, inconsistent, and unprepared to provide nonpharmacological interventions, antipsychotics may be prescribed. Therefore, the high turnover of certified nursing assistants and inadequate RN staffing pose significant barriers to reducing inappropriate use of antipsychotic medications putting residents at risk for adverse health outcomes.

Geropsychiatric nurse leaders must continue to engage in concerted efforts to influence evidence-based nursing practices and policy to improve the quality of care in nursing homes. The recognition and support of GPN as a subspecialty of gerontological advanced practice nursing is critical to filling the gap in the provision of comprehensive on-site geropsychiatric services and consultation in nursing homes, especially in rural and medically underserved areas whereby the demand for mental health providers exceeds the supply.[30] Moreover, advanced practice nurses specifically educated in GPN could play a key role in reducing the risk of potentially avoidable psychiatric hospitalizations, while supporting person-centered care planning and education and training of staff in dementia-related behavioral management approaches. An example of evidence-based strategies to support GPN leaders is the Nursing Home Toolkit (www.nursinghometoolkit.com/).[31] This web-based toolkit was funded by The Commonwealth Fund and The John A Hartford Foundation and provides evidence-based strategies to provide person-centered care for individuals exhibiting behaviors of psychological distress.

Although federal legislation has been proposed to amend titles XVIII (Medicare) and XIX (Medicaid) direct care to residents, including assessments, facilities are still only required to have one RN on site for 8 hours a day, regardless of the acuity and complexity of nursing home residents.[32,33] A group of 22 nursing gerontology and GPN experts recently called up the CMS Coronavirus Commission for Safety and Quality in Nursing Homes to enact policies to ensure appropriate 24-h RN coverage to guide the care provided to all older adults who reside in nursing homes.[24] “CMS oversight and more regulations cannot replace on the ground expert care and supervision provided by RNs.”[24,26]

Exemplar of Geropsychiatric Nursing Leadership

Robust engagement of GPN leaders at local, state, and national levels is critical to improving LTC care. An example of proactive GPN leadership is the work of Dr Wanda Spurlock.

Dr Spurlock, through her past participation and leadership in the Louisiana Enhancing Aging with Dignity through Empowerment and Respect (LEADER), played a key role in Louisiana’s reduction in antipsychotic medications in nursing homes. Dr Spurlock also served on the Louisiana Dementia Partnership, chaired the Advancing Excellence in America’s Nursing Homes Special Interest Group, and was the contact to the CMS National Dementia Partnership.

In 2012, CMS established the *National Partnership to Improve Dementia Care in Nursing Homes*[33] in response to a report issued by the Office of the Inspector General highlighting the widespread “off-label use of atypical antipsychotic medication among nursing home residents, despite FDA warnings of increased risk of death when used to treat behavioral symptoms of distress in older adults with dementia.” The initial overarching goal of this national partnership was to reduce the inappropriate use of antipsychotic drugs in long-stay nursing home residents through the use of person-centered, nonpharmacological interventions as the front-line approach to managing behavioral symptoms of dementia. At the start of the national partnership, Louisiana ranked 50th in the nation for the use of antipsychotics in long-stay residents, with a statewide prevalence of 29.7%.

To gain an understanding of factors that were contributing to this high use, Dr Spurlock was instrumental in the design of a survey to collect statewide data from nursing home staff on the perceived barriers to the reduction in the use of antipsychotics, perceived reasons for the initiation and/or the continued use of antipsychotics, and knowledge of person-centered nonpharmacological interventions. Nurses also

responded to specific items on the survey that assessed their knowledge regarding the potential adverse effects of antipsychotics in older adults.

Based on findings from the survey, barriers that identified were lack of knowledge of nondrug interventions to manage behavioral symptoms of dementia, and the lack of physician and family support to reduce antipsychotic medications. Using the findings from the survey, Dr Spurlock led efforts to tailor a statewide educational outreach aimed to reduce the use of antipsychotics in Louisiana's nursing homes. Dr Spurlock's main role was to educate nursing home staff on person-centered, nonpharmacological interventions as the front-line approach in managing behavioral and psychological symptoms of dementia. This was accomplished in workshops conducted across the state and attended by staff representing 150 different nursing homes. On-site training was also conducted at nursing homes with the highest use of antipsychotics. This on-site strategy increased the participation of direct care staff, such as certified nursing assistants, who provide the most direct care for residents. In addition, nurses attended an educational session: "Antipsychotic Medications and Older Adults: What Every Nurse Should Know." Content included information on the impact of normal age-related physiologic changes on pharmacokinetics, side effects of antipsychotics, inappropriate behavioral target symptoms for use of antipsychotics (ie, wandering and resistance to care), and evaluation of the resident's response to antipsychotic medications based on target symptoms. Additional resources were also shared with the staff such as the American Geriatrics Society *Beers Criteria for Potentially Inappropriate Medication Use in Older Adults*.[34]

Success in reducing the use of antipsychotic medications in nursing homes also requires the support of family members/consumers. To garner their support, Dr Spurlock planned and conducted educational sessions in public places (ie, conference rooms in libraries) on nonpharmacological approaches and potential dangers in using antipsychotics to treat behavioral symptoms of dementia. Finally, she engaged consultant pharmacists and prescribers of antipsychotics, including physicians and advanced practice nurses. Existing tools such as the Minimum Data Set (MDS), the Certification and Survey Provider Enhanced Reporting (CASPER), and the consultant pharmacist reports were used as pragmatic measures for tracking potentially inappropriate use of antipsychotics.

The official measure of the National Partnership is the percentage of long-stay residents who are receiving an antipsychotic medication, excluding those with diagnoses of schizophrenia, Huntington's Disease, or Tourette's Syndrome. According to the most recent CMS quarterly prevalence report on antipsychotic use for long-stay residents (2020 quarter 2), 15.4% of Louisiana's long-stay residents were receiving an antipsychotic medication, a significant decrease from the initial 29.7%. Although gains have been made, on-going interdisciplinary collaboration and regular monitoring through a continuous quality improvement process are necessary to continue this positive trend. More importantly, the reduction in antipsychotic medications contributes to positive resident, clinician, and family outcomes such as improved quality of life for residents with dementia, an improved work environment for the clinicians, and enhanced family satisfaction.

Gaps in Care for Older Adults in Long-Term Care

Dementia, depression, delirium, and anxiety disorders are the most prevalent psychiatric disorders among older adults in long-term care.[35] Despite the plethora of regulations governing long-term care facilities, there are still gaps and room for improvement in caring for older adults in nursing homes with significant mental health disorders. Geropsychiatric nurses can help bridge these gaps.

Gaps in clinical care include the limited evidence base on the efficacy of nonpharmacological interventions for neuropsychiatric symptoms such as sleep disturbances and aggression, and insufficient evidence on the effectiveness, side effects, and interactions of psychoactive and other medications. Older adults often have a higher prevalence of comorbid chronic health conditions, in addition to psychiatric disorders. Multiple comorbid health conditions add to the risk of overprescribing, drug interactions, and treatment complications. While regulatory pressures have reduced the use of psychotropic medications in nursing homes, the absence of a strong evidence base underlying other medications for older adults, who are often frail and have multiple comorbid health conditions, is disturbing. This problem is especially evident for medications used off-label, such as some antidepressants. Even when medications are prescribed for therapeutic purposes rather than for chemical restraint, possible toxicities and dangerous interactions may be underestimated. Identifying the potential for aggression (before it occurs) in older adults in nursing homes with a diagnosis of dementia and effectively managing aggressive symptoms remains a crucial challenge. Aggression poses a danger to other vulnerable older adults in the nursing home and caregivers. Better ways to identify triggers and defuse them are urgently needed.

The COVID-19 pandemic has created unique challenges and opportunities for geropsychiatric nurses at the bedside, those in nursing home leadership, and advanced practice nurses. One of the COVID-19-related challenges is new or worsening mental health symptoms. Many older adults, families, caregivers, and providers experienced mental health consequences, such as depression, anxiety, grief, and fear during the pandemic, and these consequences may linger. Current evidence indicates resurgence in cases as social distancing restrictions were lifted. Evidence is needed on how to best preserve and protect the short- and long-term well-being of older adult residents, families, caregivers, and providers. Although the pandemic continues to negatively affect the well-being of many, social distancing restrictions have positively influenced the adoption of telehealth and other technologies in long-term care. Additional data are needed to better understand the efficacy, adoption, and costs of providing geropsychiatric care using different technologies.[36]

CLINICAL RESEARCH PRIORITIES

The authors recognize that there are many clinical research studies needed to address gaps in care for older adults residing in long-term care who have mental health disorders. While the scope of this article prevents an exhaustive list, we present several priorities for future research.

1. Where we do have sufficient evidence, conduct embedded pragmatic trials to enhance the uptake of EBP (see Collaborative Care of Depression IMPACT trial)[37]
2. Determine how to promote social interaction while balancing safety with respect to infection control
3. Develop and test person-centered outcomes that matter to older adults living with mental health problems (see Alzheimer's Association practice guidelines)[38]
4. Rigorous, adequately powered, placebo-controlled, randomized, double-blind controlled clinical trials are needed to determine the most effective nonpharmacological interventions for sleep, agitation, aggression, and other common neuropsychiatric symptoms.[38]
5. Existing large databases and new databases should be created to analyze the effectiveness, side effects, and interactions of medications commonly prescribed for older long-term care residents. These studies should be adequately powered to examine multiple correlations.

6. Determine how best to mitigate the short and long-term mental health effects of the 2020 to 21 COVID-19 pandemic and the ongoing resurgence. Outcomes of importance include the mental health of residents, families, caregivers, and providers, and the economic impact on nursing homes.
7. As the demands for providing complex GPN care and improving business efficiency in nursing home settings increase, rigorous experimental research evaluating the efficacy, adoption, and costs of telemedicine (synchronized video communications between a provider and a patient) and telehealth (video conferencing, remote patient monitoring, store and forward technologies, and mobile health applications) is needed. Telemedicine and telehealth may help address the lack of on-site expertise and communication challenges.
8. Assess the psychometric properties of aggression scales in diverse populations, and to develop and validate instruments that predict aggression. Almost all (96%) persons with dementia display severe aggression at least once during their illness.[38]

As previous surveys[8–10] have shown, there is minimal education provided across the curriculum in GPN neither at the baccalaureate level nor advanced practice level. One of the important outcomes from the Geropsychiatric Nurse Collaborative was the development of GPN competencies across nursing curriculums particularly in advanced practice nursing. These recommended competencies are freely available on the Portal of Geriatric Online Education (www.Pogoe.com/).[2] Stephens and colleagues[39] provided a robust list of educational and practice resources for GPN (p. 282). There is also an effort underway to develop a certificate recognition through GAPNA for the top of the APRN pyramid.[40] The top of the pyramid is focused on specialty certifications, typically identified and provided by professional organizations. These recognitions are focused on a health care need.[40] Expertise in geropsychiatric advanced practice nursing fits well within the top of the pyramid.

SUMMARY

GPN leaders have the expertise to address common psychiatric conditions in long-term care settings, from ADRD, anxiety, depression, delirium, and delirium superimposed on dementia to substance misuse issues and serious mental illnesses including bipolar disorders, schizophrenia, and schizoaffective disorder. Expertise in evidence-based medication and nonpharmacological treatments of these disorders is an expectation of geropsychiatric nurses. Consultation with and education of colleagues on the evidence-based interventions is provided by GPN leaders in long-term care to improve interprofessional care.

Professional organizations are recognizing the importance of GPN. The Geropsychiatric Nursing Collaborative is an extension of the work started by Drs Evans, Beck, and Buckwalter initially housed with the American Academy of Nursing and funded through the John A. Hartford Foundation[2,3] The Geropsychiatric Nurse Collaborative is currently a special interest group within the National Hartford Center of Gerontological Nursing Excellence.[39] In addition, GAPNA has a very active special interest group in GPN. As mentioned earlier members of this special interest group published a position paper supporting GPN as a subspecialty of gerontological advanced practice nursing. The American Psychiatric Nursing Association frequently features professional speakers on geropsychiatric topics. Interprofessional groups also engage advanced practice nurses. The formally named organization the American Medical Directors Association (AMDA), now called AMDA - The Society for Post-Acute and Long-Term Care Medicine, includes advanced practice nurses working in long-term care.

Many of these APRNs are focused on GPN. AMDA recently started a Behavioral Health Work Group to address the mental health issues in long-term and postacute care.[41] The American Association of Geriatric Psychiatry also has an advanced practice nurses' caucus for their APRNs in GPN. As you might imagine, geropsychiatric nurses belong and engage with several of these professional organizations to advance their knowledge and the knowledge of others in GPN leadership.

GPN leaders address essential health care needs from dementia to substance misuse and serious mental illness. Developing new evidence and/or using evidence-based interventions to improve the lives of older adults with psychiatric conditions is rewarding work. We welcome any and all nurses interested to become GPN leaders.

CLINICS CARE POINTS

- Nurses specializing in multiple disciplines contribute to the care of persons living with dementia.
- Person-centered, evidence based, nonpharmacological interventions are first line approaches for the treatment of behavioral and psychological symptoms of dementia.
- Off label use of atypical antipsychotic medications in persons with dementia continue despite FDA warnings of increased risk of stroke or death in persons with dementia.
- A survey in long-term care, found that barriers to reducing antipsychotic medications included lack of knowledge of nonpharmacological interventions and lack of physican and family support to reduce antipsychotic medications.
- Regular monitoring of antipsychotic medication use through continuous quality improvement is necessary to reduce the use of antipsychotic medications and improve the quality of life for nursing home residents with dementia.
- Nursing home residents suffer from multiple chronic conditions increasing the risk of polypharmacy and adverse drug events.

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The authors have nothing to disclose.

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