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Social Isolation and Nursing Leadership in Long-Term Care: Moving Forward After COVID-19



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KEYWORDS

- Long-term care • Nursing leadership • Social isolation • Social engagement
- Residential care • Older adults

KEY POINTS

- Understand the importance of social engagement and connectedness is essential. Critical considerations include avoiding social isolation for those with dementia and planning for activities to increase social engagement for LTC residents.
- Nursing leadership is needed to foster open communication and strategies to prevent social isolation and foster an inclusive environment to build a healthy community.
- Interdisciplinary programs that nurture engagement and connectedness are essential to prevent resident decline and meet the cultural, functional, spiritual, and social needs.
- Collaboration among professional disciplines, nursing, social work, rehabilitation services, medicine, and chaplaincy cannot be overemphasized.
- If/when quarantine is required, plan for continued social engagement and connectedness among residents.

INTRODUCTION

The 2020 to 2021 COVID-19 pandemic shed light on a longstanding problem in long-term care (LTC), the need for nursing leadership compounded by a heightened awareness of the impact of social isolation. Implementing the coronavirus precautions demanded by the pandemic resulted in the unintended consequences of social isolation for many residents, especially those vulnerable individuals with dementia. Moreover, increased

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severity of dementia is associated with increased negative consequences of social isolation, leading to a decrement in cognitive status and increased behavioral symptoms of dementia (BSD).¹ The aim of this paper is to examine the role of nursing leadership to address social isolation in LTC settings through evidence-based practices that protect and enhance the quality of life for residents with dementia. In addition, the paper will explore strategies to prevent social isolation, the importance of spiritual and cultural considerations, and the significance of interdisciplinary collaboration.

It must be noted that the lack of professional nursing leadership in LTC has been and remains a longstanding issue.^{2,3} As noted by Harvath and colleagues,⁴ most directors of nursing in LTC have graduated from a diploma or associate degree program with no leadership or specific gerontological training, rendering them ill equipped for these positions. Moreover, the bulk of care for some of these most complex older adults is provided by paraprofessionals with little targeted education to care for this vulnerable population. Indeed, poor management practices are associated with high staff turnover, creating major barriers to person-centered dementia care.⁵ Lessons highlighted by the coronavirus pandemic include the realization that augmenting person-centered care is essential, as is interdisciplinary collaboration, such that comprehensive holistic care is not compromised. Best practices indicate mandatory activities and socialization, a need to continue these even in difficult circumstances.⁶

The Importance of Social Connectedness

Social connection is key for older adults' well-being. Family and friends are critical. Being socially engaged and connected influences psychological and emotional well-being as well as having a positive effect on physical health⁷ and longevity.⁸ Moreover, a lack of social engagement and connectedness is associated with negative health outcomes such as depression. In addition, actual and perceived social isolation is associated with an increased risk of mortality.⁹ Furthermore, research over the past 15 years has indicated that social isolation is strongly associated with comorbid conditions such as hypertension, cardiovascular disease,^{10,11} cognitive decline,¹² depression,¹³ and early mortality.¹⁴ Because of the impact of isolation on mental health and well-being, the World Health Organization cautioned about the use of the incorrect term "social distancing" that referred to increasing physical space between people. Instead they highlighted the need to refer to these measures as "physical distancing" and to conceptualize policies to avoid disconnection from family and loved ones because there is a pressing need to stay emotionally and socially connected.¹⁵ Although this terminology is important to consider at any point in time, this became crucial during the COVID-19 pandemic. The extent to which an individual is socially connected depends on multiple factors, including structural, functional, and quality components.¹⁶ Not only does one need to have social connections, the perceptions of these relationships are inextricably linked to the risk of developing loneliness and/or social isolation.

The 2020 Report of the Lancet Commission noted brain mechanisms responsible for enhancing or maintaining cognitive reserve and preventing dementia. One of the main factors is maintenance of frequent social contact.¹⁷ Growing evidence indicates that the magnitude of the effect of social isolation on mortality risk is comparable to, or greater than, factors such as smoking, obesity, and physical inactivity.¹⁶ In addition, social isolation not only increases the risk for dementia but is also associated with increased memory decline and increased behavioral symptoms in those with dementia.^{18,19} Social isolation coupled with the sensory impairments associated with aging leads to a synergistic effect of more severe isolation. Social vulnerability, frailty, and mortality are a dangerous triad for older adults, especially those with dementia.²⁰

An animal study completed by Muntsant and Giménez-Llort²¹ highlighted brain changes in rodents that mimic brain changes in those with dementia as a result of social isolation. The study examined the impact of long-term social isolation on male 3xTg-AD mice modeling advanced stages of Alzheimer disease (AD) compared with age-matched counterparts with normal aging. The main findings were an exacerbated (2-fold increase) hyperactivity and emergence of bizarre behaviors in isolated 3xTg-AD mice, worrisome results, as agitation is a challenge in the clinical management of dementia and an important cause of caregiver burden. Asymmetric atrophy of the hippocampus (the area of the brain most associated with memory), recently described in human beings with dementia, was also found to increase with isolation. These results emphasize the negative consequences of isolation, consequences that are not only psychological but also profoundly physiologic. Moreover, they also highlight the relevance of personalized-based interventions tailored to the heterogeneous and complex clinical profile of the individuals with dementia and to consider the implications on caregiver burden.

THE CALL FOR NURSING LEADERSHIP

Where Do We Go from Here?

A post-COVID-19 era implies strong efforts to redesign living conditions and lifestyles, to find new care models, and to provide better management of the social isolation of residents enforced by physical distance; this requires leadership. Much of this isolation could have been prevented with educated and informed nursing leadership such that pandemic regulations could have been implemented while maintaining social engagement and connection.

Shared governance models provide structures and processes that empower front-line engagement in practice and policy decision-making.^{22,23} The effectiveness of shared governance largely depends on supportive nursing leadership, providing an infrastructure that supports and empowers all staff to participate in clinical decision-making and work collaboratively to affect resident outcomes.²⁴ This participation is especially important for those who have been overlooked in LTC, the direct care workers (DCW).

Kanter's theory of structural empowerment²⁵ underscores how organizational performance benefits from leaders sharing power with employees through structures and processes that bolster access to information, resources, support, and professional development and learning opportunities.²⁶ This level of understanding and application requires professional nursing leadership in LTC to implement these principles.

In their narrative review, Zonneveld and Minkman²⁷ explored appropriate leadership in LTC. Overall they found that, although context dependent, relationship-oriented behaviors, where leaders focus on relationship, were significantly associated with the implementation of person-centered care and psychosocial climate. In contrast, high staff turnover and absences were related to less effective nursing leadership, whereas close interpersonal relationships were positively related to leadership. Corazzini and colleagues²⁸ describe adaptive leadership requiring new and innovative solutions, which may also require a change in values or attitudes. In this context, technical challenges refer to issues easily defined and solved with the appropriate expertise or resources. Issues often include both technical and adaptive challenges, in which different leadership behaviors are needed. Professional nursing leadership, those who are registered nurses (RNs), with leadership training at a minimum, can coordinate comprehensive assessment, advocate for resources, and coordinate with the interdisciplinary team to ensure high-quality care. The need for interdisciplinary

collaboration, such as nursing, social work, rehabilitation services, medicine, and chaplaincy cannot be overemphasized. All members of the team can assess and plan to meet resident needs culturally, functionally, spiritually, and socially to prevent impairment during isolation.²⁹ In fact, interdisciplinary collaboration is essential for program success.

SOCIAL ENGAGEMENT PRACTICES

Nursing leadership has proved critical to the implementation of programs that focus on social engagement and connectedness. Using a Delphi consensus approach, Kales and colleagues³⁰ identified 4 targeted nonpharmacological approaches for those with dementia and BSD: caregiver/staff training, adaptation of the environment, person-centered care, and tailored activities, as first-line approaches before any pharmacologic approaches. These targeted approaches highlight the importance and value of nondrug approaches. In addition, the consensus was that DICE (Describe, Investigate, Create, Evaluate) was the preferred nondrug approach followed by music therapy.³⁰

Kolanowski and colleagues² have suggested that affect balance may be used to assess well-being in persons with dementia. The Bradburn Scale of Psychological Well Being (Affect Balance Scale), first developed by Bradburn and Noll,³¹ compares the frequency of positive affect with negative affect over a period of time. However, absence of negative affect does not equate with well-being. The higher the ratio of positive affect, the greater the well-being. Kolanowski and colleagues³² found that modifiable factors such as positive staff interaction, number of RN hours, number of certified nurse assistant hours, and higher resident function were significantly associated with higher positive resident affect balance. Earlier work by Tappen and Williams³³ found an association between positive staff communication and resident mood supporting Kolanowski and colleagues³⁴ findings. In addition, modifiable factors including the built environment, such as light, noise, and seating, can be supportive or provide barriers to optimal independence, physical activity, and well-being. The findings of Kales and colleagues³⁰ and Kolanowski and colleagues³⁵ have major implications for LTC staff education, specifically the importance of staff communication training during caregiving interactions. Communication training is an essential component to ensure the well-being of residents with dementia.

Bethell and colleagues³⁶ reviewed observational and intervention studies on social connections in LTC, finding associations with various mental health impacts. Among 61 studies the reported mental health outcomes included “depression; responsive behaviors; mood, affect, emotions; anxiety; boredom; suicidal thoughts; psychiatric morbidity; and daily crying” (p. 231) acknowledging overlap among categories. Bethell and colleagues³⁶ identified 12 strategies, informed by 72 observational studies that may help residents, families, and staff build on and maintain social connection. Findings included managing pain; addressing sensory needs (vision, hearing); sleep at night (vs daytime); opportunities for creative expression; exercise; maintaining religious and cultural practices; garden (indoor or outdoor); visits with pets; use technology to communicate; laugh together; reminisce about events, people, places; and address communication impairments and communicate nonverbally.³⁶ Critical barriers to successful implementation are chronic understaffing³⁶ and staff turnover that can be as high as 85% within many facilities.^{37,38}

In a recent study with direct care workers (DCW) in LTC, Woods and colleagues found that teaching staff strategies including a method of approach and therapeutic communication increased their confidence in interacting with those with dementia in

a positive manner and decreased their self-reported stress levels (Woods, unpublished data 2021). Moreover, DCW urinary oxytocin, a hormone that measures social bonding and connectedness, increased when DCW administered the CALM (therapeutic communication and therapeutic touch) intervention to residents (Woods, unpublished data 2021). In a 3-group experimental study, this calming intervention, therapeutic touch, showed a significant decrease in agitation for those with BSD.³⁹

An early qualitative study by Thorne and colleagues⁴⁰ asked older adults about what the term “wellness” meant to them. Interviews with 15 older adults residing in LTC found 3 themes: comfort and abilities, connectedness and competence, and sense of meaning. A sense of meaning was found to be the foundation that cements the other dimensions of health and well-being, assertions that support Travelbee’s⁴¹ discussion about the importance of meaning in human experience. Although resident’s spiritual and existential needs are acknowledged, they are frequently left to clergy and not institutionalized into any programming. Taking measures to understand what gives a resident meaning is essential to their health and well-being. The spiritual needs of these patients need to be addressed with appropriate interventions put into action. Spirituality can be defined as the belief in a power greater than self, which may or may not involve membership in a specific religion.⁴² Some of the spiritual needs of older LTC residents during the pandemic were the need or desire to attend church with their family members, to commune with those of the same faith, and to participate in the community activities associated with attendance at religious services such as singing and receiving communion.⁴³

LTC communities attempt to engage residents in stimulating activities and encourage social connections to add to quality of life.⁴⁴ During the pandemic restrictions group activities and person-to-person contact were stopped. Better attempts at continuing modified enrichment activities may have prevented the increase in depression and cognitive decline.^{45,46}

The staff in LTC facilities are entrusted with caring for the most vulnerable at-risk older adults, a challenging mandate. A systematic review conducted by Seitz and colleagues⁴⁷ found that of 74 studies reviewed, the median prevalence for resident dementia was 58%, whereas the median prevalence of behavioral symptoms among those with dementia was 78%. Moreover, the median prevalence of depressive symptoms was 29%. These data were collected years before COVID-19. The restrictions of the pandemic worsened many of these issues, as visits to LTC facilities were banned, group activities ceased, and residents had no face-to-face contact with their families nor interaction with other residents. Residents were socially isolated, lacking the social and environmental enrichment that are key factors to mitigate cognitive decline and increased behavioral symptoms. Redistribution and relocation of rooms also contributed to increased stress and behavioral problems; each new arrangement resulted in residents adjusting to a new environment.^{30,48} Coping with stress and negative and sad emotions has a stronger impact on older adults due to their age-related decrement on immune function and the neuro-immune dysregulation associated with these psychosocial processes.⁴⁹

CULTURAL PERSPECTIVES

Cultural associations as we age are linked to feelings of belonging and mental well-being.⁴³ As we age these associations become an important connection to community and encourage socialization through shared worship, celebrations, and common languages.^{43,50} Statistics on nursing home residents in the United States finds that of those 65 years and older, 81% were non-Hispanic White, 12% were African American,

5% Hispanic, and 2% as Asian/Pacific Islander.⁵¹ Racial and cultural stigmas combined with privacy concerns are barriers to socialization as well as obstructions for health care professional access.⁴³

Acculturation is more difficult later in life, and adjusting to living in a residential facility may be difficult for many.⁵⁰ The loss of social networks or work peers is associated with a higher risk of depression and anxiety in those of advanced years.⁵² Many LTC staff are from different ethnic origins than the residents for whom they care, presenting challenges of communication among ethnically diverse LTC residents.⁵³ In 2015, Kim and colleagues found that culturally congruent communication, including verbal and nonverbal styles, between DCW and residents was associated with a decrease in behavioral symptoms for those with dementia, potentially because culturally congruent communication evoked a sense of familiarity and comfort. Culturally sensitive perspectives are imperative in providing quality of care for a rapidly changing, ethnically diverse aging population, modeled and supported by professional nursing leadership.

Nursing leadership in LTC must be cognizant of the impact that social isolation has not only for residents, but staff as well; caring for those older adults with dementia and those with different cultural backgrounds can be stressful for the LTC facility staff on any given day. Some of the stress that both residents and staff experience is related to divergent staff-resident communication culture, resulting in increased BSD.⁵⁴ Adding social isolation to the equation amplifies staff stress interfering with their ability to adequately provide the needed care for those with dementia, particularly focused on maintaining social connection and social engagement. Communication issues and strategies and education that increase cultural congruency should be key staff educational foci. Some strategies that address barriers to these issues can be incorporated into educational programs, for example, culturally specific verbal and nonverbal ways of greeting older adults, introducing oneself before beginning care, and using simple and familiar words; this is especially important for DCW who provide the bulk of the care, belong to an ethnic group different from the resident, and have little formal education.

Implementing interventions to address and support staff's stress is vital for the mental health of the valuable caregivers who have had to step up and take on multiple roles in providing care to help prevent social isolation, especially with residents with dementia. Cummings and colleagues⁵⁵ found that a higher level of staff job satisfaction corresponded to more effective leadership. Residential facilities that demonstrate adaptability, community approaches to challenges, and productive engagement of residents have been associated with healthier lifestyles.^{56,57}

The multitude of deficits that characterize dementia add to the challenges that LTC facilities face to prevent social isolation. During the pandemic, staff and resident routines were disrupted such that staff, mainly DCW, were less able to provide activities that focused on connectedness and engagement such as socially focused group activities and cognitive stimulation or meet physical and psychosocial needs. Research has found that more health-related education and knowledge leads to increased participation in care and better overall outcomes.⁵⁶ Education on the deleterious effects of social isolation and the positive affect of cultural congruency in those with dementia needs to be disseminated to the staff at all levels.^{58,59} Nursing leadership is essential to develop and implement programs that include this focus.

STAFF EDUCATION: AN ESSENTIAL INGREDIENT

Increasing staff's competencies and supporting and promoting an interdisciplinary collaborative culture among all staff, (DCWs, nurses, therapists, social workers, and

family practitioners at a minimum) are essential in supporting persons living with dementia. Moreover, it is critical to increase staff knowledge and understanding about persons with dementia and their support networks. Interdisciplinary collaboration is essential thus learning how to collaborate within an interdisciplinary team from a person-centered care perspective, for example, is important. Another example of this collaboration involves developing interdisciplinary team meetings to review residents' care plans, especially including staff participation in these teams, especially DCW who may need encouragement to participate.

Fostering an environment that perpetuates open communication between staff and leadership lays the foundation for a healthy work environment. Conversations regarding staff perceptions of their workloads and needed education related to the care of residents with dementia is a starting point. Staff's ability to communicate with those with cognitively impaired residents is fundamental; however, some LTC facilities may be deficient in providing the education to staff about how to effectively connect with residents. Fundamentally, staff gain an understanding that their skills in communication build relationships and healthy interactions among these residents with communication impairments.⁶⁰

In addition to providing ongoing staff education regarding caring for residents with dementia, nursing leadership needs to focus on decreasing staff turnover and improving workflow. Providing opportunities to support consistent staff assignments that create routines and relationships tailored toward individual resident's needs promotes the positive opportunities to be able to have adequate time to engage with residents and prevent their social isolation.

Changing the LTC facility culture to promote strategies to prevent social isolation can take time and effort. Nursing leadership is in a position to model the behaviors that demonstrate approaches to preventing social isolation, as well as supporting staff activities that engage residents in their care.⁶⁰ Setting expectations for the staff to engage in strategies that prevent resident exclusion, actually promoting social inclusion, helps pave the way to success. Doing so builds the relationships between staff and residents beyond attention solely based on clinical care.⁶²

Nurse leaders in LTC must model leadership behaviors. Interacting with residents is important. These interactions can be implemented with daily leadership rounds involving both the resident and staff. Problem behaviors possibly linked to social isolation can be noted during the rounds, and a timely action plan can be developed involving the resident and staff to address the issue (Lehman, 2021). Holding focus groups with staff to identify their perceptions of success in preventing social isolation is a strategy leadership can implement. Who better to describe what is actually occurring than the staff who are with the residents for long periods, especially those with dementia? Involving staff to be a part of the solution to prevent social isolation is vital for success.⁶²

PROGRAM EXEMPLAR ON ENGAGING AND CONNECTING

One program that includes recommendations by Kales and colleagues (2019)³⁰ and Andresen⁶¹ is Nexus, an evidence-based model for memory care, showing a positive impact on cognition through social engagement and connectedness. The word *nexus* is derived from the Latin *nectere*, meaning "to bind or tie." The term often represents the point where different occurrences or ideas come together or intersect, a connection or series of connections linking two or more things. The Nexus program, developed by Andresen,⁶² is an evidence-based program focused on optimizing cognitive functioning. The program includes a variety of activities categorized under 5 pillars of brain health: (1) physical exercise programs (walking clubs, dancing

classes, morning workouts); (2) cognitive exercises (creative writing club, group word games); (3) stress reduction (chair yoga classes, group-guided meditation); (4) purposeful social activities (service club, cooking classes, making floral arrangements for the community), and (5) support groups. Nexus constitutes a model for staff training that increases staff competencies in dementia care through an interdisciplinary and cross-sectional classroom.⁶¹

Andresen⁶² presented data on this innovative program at the Alzheimer Disease International Conference. Findings from 423 residents who scored greater than or equal to 15 on the Folstein Mini Mental State Exam (MMSE)⁶³ were included in the original study of 5 Danish LTC communities. Activities of daily living (ADLs) were measured using the Alzheimer Disease Cooperative Study—Activities of Daily Living (ADCS-ADL) every 6 months between September 1, 2015 and September 1, 2017. Ninety-one residents completed both measures at 6 months, 68 completed at 12 months, and 18 completed at 18 months. Findings indicate that those with the highest MMSE at baseline maintain or increase their cognitive function and ADLs over a period of 2 years lending credence for the use of social engagement and connectedness to not only combat isolation but also optimize cognitive function in adults with mild or major cognitive impairment in LTC.

Recently, Andresen⁶¹ reported that after 6 months of focused workshops using the 5 pillars, staff when interviewed from 3 Danish nursing homes described increased awareness and feelings of being more successful when interviewed. Moreover, Andresen⁶¹ assessed the Nexus Program in one LTC over a period of 2 years, finding that there was a 60% improvement in cognition, for those with an MMSE score greater than or equal to 20 compared with those who did not participate in the program, which supported clinical observations.

Several LTC facilities in the United States have adapted this structured and individualized approach for those with mild-to-moderate dementia in memory care. The Nexus program, planned by the social work and recreational activity staff, works in conjunction with the philosophy of person-centered care promoting optimal function in these specific LTCs. The residents, all of which have some form of cognitive impairment, spend most of the day out of their rooms. The staff help the residents get dressed and ready for the day, guiding them to the common areas. Residents may participate in varied groups, organized and supervised by social work and recreational staff, depending on their interests and cognitive ability. If a resident is socially withdrawing, it is an indicator that they are having difficulty keeping up with the group they are in, and the staff will introduce the resident to try a different group. Residents that are not actively engaged in a planned activity can still sit in common areas with other residents, reading in the library or watching television in the lounge.

Cheston and colleagues⁶⁴ describe dementia as an “existential threat” emphasizing the importance of maintaining a sense of identity and purpose in people with dementia. For this program to be effective, it is important for the staff to help residents to maintain this sense of identity and minimize the loss of self-described by Cohen and Eisdorfer⁶⁵ by understanding the residents as individuals. By knowing their likes and dislikes, staff can encourage their participation accordingly. Staff solicit brief profiles from families. Knowing the resident’s past interests or career can help the resident continue to feel that they have a purpose in society. Shadow boxes outside resident rooms display photos and keepsakes from the resident’s life. These help staff to be familiar with the resident’s life and also act as reminders for the residents themselves. The environment can contribute enormously to a sense of self and connectedness, reflecting a feeling of normalcy and belonging, rather than segregation from society. Nexus LTC facilities often have pets such as dogs, cats, fish, and birds. In

addition, staff and visitors encourage staff and visitors to bring their children to the facility so that they can also engage the residents.

Acquiring nutrition is part of social activity. Volkert and colleagues⁶⁶ provided recommendations about meeting the nutritional needs of individuals with dementia. Nexus program residents eat in a large dining room set up such as a restaurant with silverware and table cloths. Several residents, typically 3 or 4, or just 2 when physical distancing, are seated at each table; this provides the residents with social cues that promote good intake and encouragement to eat.

Another important component of the model of care is music. Baird and Thompson⁶⁷ examined how music helps combat the disruption to one's sense of self that people with dementia often experience. Their work found that music has the capability to engage individuals in a uniquely holistic way. With such a highly stigmatized disease, music has a critical ability to affirm the identity of the individual rather than letting the person being defined simply by their diagnosis. These LTC communities have live musical entertainment on a regular basis. At one LTC, the Director of Resident Engagement is a board-certified music therapist, with music therapy interns working one-to-one with residents as well as playing for the group. The music therapist also leads the resident choir, who practice weekly and perform regularly for the community. Beyond the choir, the musicians routinely encourage the residents to sing along as they play music, which makes music a social activity where residents can enjoy each other's company people and learn they love the same songs.

Focus groups with residents asking what is going well encourages their involvement in strategies that promote social engagement and is another approach to preventing social isolation. Assessing the needs and desires of the LTC resident helps to personalize interactions and can lead to encouraging resident engagement in activities geared toward promoting social inclusion. For those residents with dementia or other cognitive impairments who may not be able to provide this information, asking family and friends can elicit important information specifically individualized for this resident. Gaining this information, in whatever forum, helps leadership develop and secure resources for the facility to enhance greater social engagement.

An LTC facility social worker from Southern California reported that 28 residents were participating in the NEXUS Program in January 2021. From those 28, 19 (68%) remained in the program after 6 months. Six residents (21%) were withdrawn from the program, as they no longer met the MMSE greater than or equal to 20, and the remainder (11%) left the program due to a move from the facility or death (M. Dawson, personal communication, July 9, 2021).

IMPLICATIONS MOVING FORWARD

Nursing leaders have a responsibility to promote and facilitate social engagement and connectedness to mitigate social isolation in LTC. The 2020 to 2021 COVID-19 pandemic emphasized longstanding problems in LTC facilities, such as staff mix, workload, and support. Moreover, the pandemic shed light on the severe deleterious effect of social isolation and the critical importance of maintaining social engagement and connectedness especially in times of crisis or major change. Staff education and ongoing support cannot be overemphasized. Critical nursing leadership and interdisciplinary collaboration engaging all team members is essential in operationalizing non-pharmacological approaches that foster the well-being of residents with dementia.

LTC settings are complex systems with nursing leadership, an essential component for improved resident outcomes, especially those most vulnerable residents with dementia. The presence of nurse leaders in LTC with more experience is associated with

a decreased prevalence of BSD, improved mobility, greater relationship-oriented leadership practices, higher levels of open communication between DSW and management staff⁶⁸ and less staff turnover.⁶⁹ A National Hartford Center of Gerontological Nursing Excellence funded training program, consisting of both leadership and gerontological content was delivered to 14 nurse managers in the Veteran's Health Administration (VHA) Community Living Centers (CLC). Results showed an improvement in quality indicators such as function (78.6%) and decreased antipsychotic medications (76.9%) over a 6-month period (Kolanowski and colleagues,^{3,4} personal communication, July 14, 2021). These results support the development and mandating of specific dedicated programs that address the deficits in nursing leadership and gerontological knowledge in LTC. Staff education and ongoing support cannot be overemphasized. For example, group meetings to talk about staff challenges and find resolutions specifically effective communication. Nursing leadership and interdisciplinary collaboration are critical, engaging all team members to develop coordinated programs to foster dementia well-being is critical.

The strategies delineated earlier that emphasize education, positive interactions and connectedness with residents, and bonding and well-being are associated with decreased staff stress, increased job satisfaction, and decreased staff turnover. Moreover, programs such as Nexus can be expanded to incorporate the national Age-Friendly Health System's initiative including the evidence-based 4 Ms (What Matters, Medication, Mentation, and Mobility)⁷⁰⁻⁷³ with a focus on what matters, an essential component, as Travelbee⁴¹ and Thorne and colleagues⁴⁰ noted several years ago. Now implementation of key nursing leadership strategies is essential to avoid further crises and promote social connectivity in LTC.

CLINICS CARE POINTS

- Incorporate social engagement programs especially for those with dementia to optimize cognitive and physical functioning.
- Establish resident group activities by level of cognitive impairment for optimal resident engagement.
- Educate staff about resident's life, accomplishments, and interests to facilitate connectedness.
- Use meals as a social activity to create opportunities for connection and improve nutritional intake.
- Incorporate music to engage residents in group and individual settings.
- Use shared cultural traditions such as worship, celebrations, and other common languages during times of mandated isolation to increase engagement and connectedness.
- Nursing leadership in LTC is essential to understand and communicate the impact that social isolation has not only for residents but staff as well.

DISCLOSURE

The authors have nothing to disclose.

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