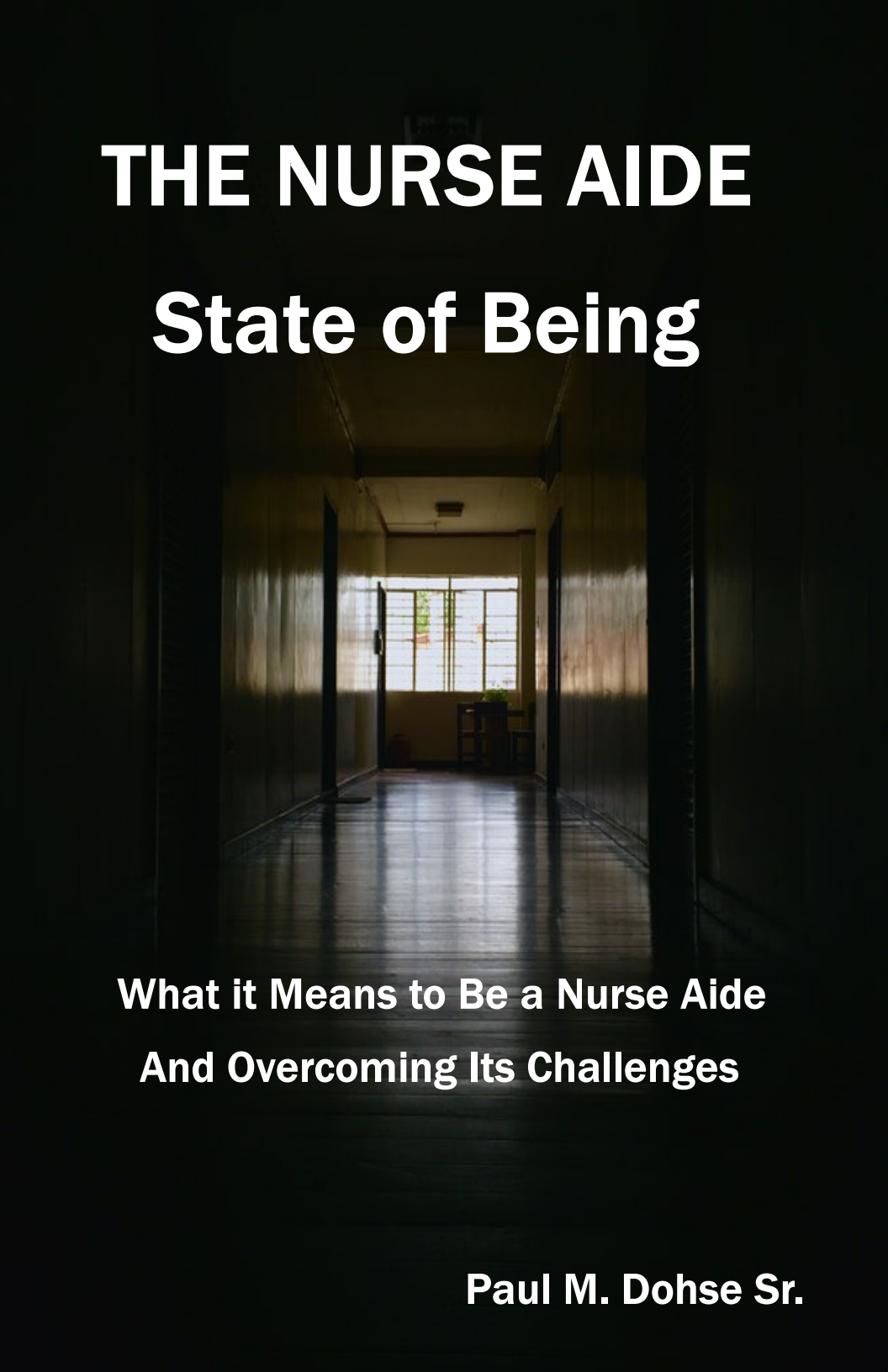
THE NURSE AIDE

State of Being



What it Means to Be a Nurse Aide

And Overcoming Its Challenges

Paul M. Dohse Sr.

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"The greatest act of love is to take care of a sick person. If you take care of him with love and patience, he is saved through you, and you are saved through him."

~ Elder Paisius Olaru of Sihla

Introduction

Welcome to a book about one of the greatest, self-fulfilling careers in the world, the nurse aide. Yet, unless you have been on the moon for the past decade, you know the shortage of nurse aides in the healthcare workplace is severe. And, considering that in the post COVID era nurse aides are finally making respectable wages, how can this be?

The focus of this book answers those questions with an event witnessed at a healthcare facility somewhere in the state of Ohio. It was a conversation between a facility resident and a STNA (state tested nurse aide). After a hearty greeting, the resident asked the aide, "What are you doing today?" The aide answered this way: "I am a certified butt-wiper, and I am doing a lot of it today."

Full stop. The one sentence spoken by the aide encapsulates the core problem with the present-day nurse aide crisis; identity, the problem is an identity crisis. That is the thesis of this book. For the most part, nurse aides have no vision, and have not been given one by the healthcare establishment. To a large degree, nurse aides do not know who they are. An emphasis on what a nurse aide is will solve the problem, as it did with nurses.

Nursing was not always a reputable profession. It is fair to say that nursing of the early 19th century had no vision. Nursing was an occupation, not a profession. Hospitals were referred to as "pesthouses" and were staffed by untrained personnel. Workers loosely referred to as nurses were generally women of ill report, such as prostitutes and prison inmates.[i] Florence Nightingale was the reformer who changed all of that. She gave nursing the identity it needed to fulfill its true calling. She was one of the few in her day who saw nursing for what it really is.

[i] Msn, C. K. R., & Msn, G. K. R. (2018). *Foundations and Adult Health Nursing* (8th ed.). Mosby. p.2

Technically, the identity of nurse aide is a profession, but it is overwhelmingly seen as an occupation. Ironically, the training and state requirements show that it is a profession, but in the field, it is treated like an occupation. Do not misunderstand, there is virtue in all work, but professions are distinguished by levels of training and demands on the individual. The true identity of nurse aide demands much, but in reality, little is expected from nurse aides by those who need their services. After all, for the most part, they are "butt-wipers."

Frankly, there are a lot of people who are dead well before their time because of this aide misidentification, and you might ask yourself the following: What does aide self-image project to those being "cared" for? But these are subjects for later in this book. A nurse aide reformation is needed; nurse aides must find themselves for their own good and the good of those who need them. We can begin there with the true identification; nurse aides are needed by doctors, nurses, patients, and the extended families of patients. In a long-term care setting, hundreds of extended family members are counting on aides to do their jobs. It is a sacred trust before God; it is God's work.

That is only the beginning of the identification. This book will attempt to articulate the identity in depth and supply the necessary vision. But we will hardly stop there. Included in the vision is a new way to think about the nurse aide profession. What it truly is—is astounding, but the challenges are part of that identity. Part of the nurse aide identity follows: nurse aides are not inclined to search for the easy road. Caring for others is not always easy, and quality care is the ultimate goal. Nurse aides will do things they would have never done before they were an aide because the goal of quality care was not on the other side of the task. You may call that "love" if you want to, that is probably apt nomenclature.

It is 0600 somewhere in Dayton, Ohio. A nurse aide pulls up to a drive through window at a local coffee shop about a mile from his assigned facility. The shop manager opens the drive through window and hands the aide an extra-large coffee, black.

The manager notices the scrubs, and asks, "Are you a nurse aide?" After the affirmative answer, the manager states, I saw an aide care for my dad while he was dying, it's a very hard job." After the aide agreed, the manager asked, "What do you have to do to become a nurse aide?"

What was going on there? After all, the manager was already in a career. Apparently, the manager saw something in her father's aide that she wanted to aspire to, even though she knew it was hard. This is because intuitively, we know that hard tasks bring greater self-fulfillment. And in life, there are some jobs that must be done; someone has to do it. Therefore, self-aware aides know they are the ones who stand in the gap. They know they go places and do things others will not do, and they like that about themselves. They do what they do because someone has to; that is their contribution to humanity, and that is honorable.

With all of this said thus far, you are probably assuming there is a type of brotherhood or sisterhood among nurse aides like you see in law enforcement. You would be totally wrong about that. No profession eats their young, so to speak, more than nurse aides, with nurses being a close second. If the profession is so difficult, why is this the case? The answer is easy: no vision. No identity.

Aides who work for staffing agencies are special aides that cover staff shortages on short notice; they stand in the gap, right? Yet, agency call-offs are commonplace, and are an oxymoron of sorts. The agency aide who was supposed to cover a call-off, called off. How could this possibly be commonplace in our day? Same answer. Aides simply do not know who they are.

Why are all kinds of abuses against residents and patients by aides commonplace as well? Is it because aides don't know who they are? It's a rhetorical question. Moreover, if an aide identity was clearer, it would prevent many from obtaining the position who do not belong.

This book will provide the vision, which includes identity, worldview, and mindset necessary to survive the rigors of the profession, and the ability to excel in it. To a much lesser degree, we will discuss execution of tasks.

So, it is the nurse aide state of being; it is who we are, which leads to what we do, and the goals we set for ourselves to realize the full vision. If, we know what all of that is.

Together, we can overcome the nurse aide identity crisis, and do our part to put this sacred trust on full display.

Paul M. Dohse, ADN, LPN, CDP, CMA, CNA

SECTION ONE
IDENTITY

"We didn't open up his chest and look at his heart. We didn't look at that. I don't know if anybody did. What kind of spine he had. And resiliency, and all the things that are making him really great right now."

~ Steve Mariucci on why he didn't draft Tom Brady, 7- time Super Bowl champion.

Chapter One: Nurse Aide Defined

This book is not a *how to* book. It is a book that seeks to define a nurse aide identity. It is a book, perhaps the first one ever, concerning nurse aide theory. People act according to who they think they are. Many nurses will testify to the fact that many people working as nurse aides have no idea what one is, and this also includes administrators. The role is distorted.

Meet Jake—Jake has no experience in health care but arrives at a home health care agency for orientation by the agency's RN. The RN, a foreign national who speaks broken English, introduces herself and places a large stack of papers on the table between her and Jake. Each document is to be signed by the RN and the new employee stating that the new employee has been instructed about basic aide tasks and safety protocols. The RN begins the process: "Jake, do you wash hands?" Jake replies, "Of course I wash my hands." The RN then replies, "Very good, sign here." The RN continues, "Jake, have you ever helped a person get up from floor or chair?" Jake replies, "I am not sure I remember ever doing something like that." The RN replies as she points to the bottom of the page, "Sign here Jake."

Noticing the concern on Jake's face, the RN states, "No worry Jake," and as she closes her hand in a fist while striking her heart up and down softly, states, "You either have nurse aide heart or no, we will see."

Few in health care would condone this method of orientation, yet, the RN states a rock solid fact: real aides have an aide heart. There are only two kinds of aides in the world, those with an aide heart, and those who were looking for a job and found one. Every nurse knows the difference. Every nurse knows the difference between those delivering care and the clock-punching usurpers. Real aides obtain self-satisfaction from helping others; the usurpers are there to grudgingly perform the required tasks and collect a paycheck. The nurses know who they can depend on and who they can't. When nurses talk about "good aides" and "bad aides," unfortunately, some define that

according to tasks. That's not the issue, the issue is identity. Right identity determines the outcomes of action.

There are no good aides or bad aides, only aides with heart or no heart, and the aforementioned RN is right, "We will see." Hereafter, any reference to good aides or bad aides refers to either having the heart of an aide, or not having the aide heart. It doesn't mean that "bad aides" are necessarily bad people in general, it simply means all parties would be better served if bad aides are employed by non-healthcare employers. They don't have the heart. With that said, if a person is educated regarding the right aide identity, could they develop the right mindset and heart? In at least some cases, yes.

Nothing makes the point about *heart* better than what experience taught us during the COVID pandemic. Nurse aides didn't only qualify for unemployment for workplace hazard reasons, but the government added an additional $600.00 per week, plus, in some cases, $500.00 per child. Many nurse aides had the opportunity to make more money than their normal pay rate for staying home, and many did exactly that. However, many didn't, and in addition, few facility staff aides went to work for staffing agencies for more money. Why? The reasons sounded like this: "I could never leave my residents." Aides with the aide heart consider what they do a calling, and feel responsible for the wellbeing of those under their care. Many nurse aides refused to abandon residents under their care out of fear or more money during COVID. The condition of long-term care during COVID was bad enough, but without aides with the aide heart, long-term care in America would have suffered a complete apocalyptic collapse. Nurse aides are not only the foundation of all care, but no hospital or long-term care facility can operate for one day without them.

And, a peculiar thing happened in long-term care facilities during COVID: because fear and greed weeded out inferior aides (the usurpers), workplace environments were demonstrably more positive. Furthermore, due to the positive workplace environment, which enhanced teamwork, levels of care stayed

nearly the same or improved with fewer aides. Much will be said in this book about the importance of aides with heart overcoming workplace toxicity that is common in nursing facilities. Until then, know that the sole cause of such toxicity are aides that are merely drawing a paycheck (clock-punchers) and are not personally invested.

We cannot condemn the usurpers too harshly because the true nurse aide identity is not a facility gateway that decides who will work as an aide; the usurpers do not know they are working in a place where they do not belong. They see it as just another job, and it is a job, but as previously mentioned, it is also a ministry and calling. And here is some strong coffee to drink; they endanger lives. Care-giving and nurse-helping is a ministry that goes the extra mile to improve the lives of people and protect them from any kind of harm. Elderly people and sick people are at risk. A nurse aide stands in the gap to provide foundational care and make the nurses more efficient in the healing process...and that's what they want to do...it's their passion...it's their life purpose...it's what makes them tick.

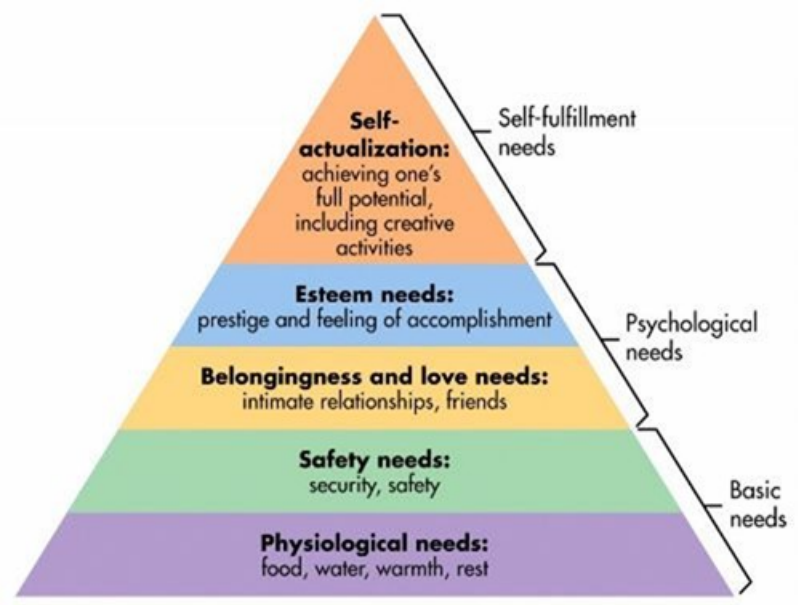
This is the nurse aide state of being, or who a person is intrinsically. Different aspects of this will be peppered throughout this book under different contexts. One of the contexts will be overcoming the challenges the profession presents. After all, most things worth pursuing are not easy. This book is also about how to survive as a nurse aide through right thinking. With that said, the foundational key is knowing who you are and the gravity of being a nurse aide. This will enable you to block out all of the surrounding noise and focus on the task of bettering yourself. In the world we live in, which is inclined towards jealousy, condemnation, disrespect (some due to hierarchical caste), and projection, your success will create a lot of surrounding noise. You must learn to overcome that with the better you. Let's say you are a basketball player and your success creates controversy; you learn to ignore the noise and keep playing ball. One nurse put it this way: "Overcome it with greatness." As an aide, you understand that distractions subtract from care.

In addition, you must make real knowledge your standard and not necessarily what the status quo presents as fact-based care. This brings us to one part of the nurse aide identity, perhaps one of the most important elements: the nurse aide scope of practice is the foundation of all healthcare. If a resident in a long-term care facility is not safe, properly hydrated, receiving sufficient nutrition, and in possession of dignity, care provided by doctors or nurses will make little difference. The foundation of all healthcare is not just any job...it is a sacred calling. There is a special place in heaven for the good nurse aides, and a special place in hell for the ones who fail the sacred trust through ignorance or indifference.

Chapter Two: Nurse Aides Are the Foundation of Healthcare

Fortunately, Abraham Maslow's Hierarchy of Needs is the philosophical standard for care in the U.S. The reality of Maslow's theory has its fingerprints on every aspect of healthcare and is seen everywhere you look. Aides should pay particular attention to this chapter because Maslow's theory will teach you how to think as an aide, which will lead to long term success and survival as an aide.

We will begin this chapter by observing an illustration below of Maslow's theory:



Maslow's theory follows: the wholeness of a person depends on having a succession of needs fulfilled according to priority. Much of this theory is common sense. If one is starving to death, or dangerously dehydrated, little else matters. Under the physiological needs, there is also a sub-hierarchy; you can do without food for weeks, but you can only do without water for a couple of days. Therefore, water is the priority need. In addition, a severe lack of basic needs is not the only issue here, but poor

nutrition, for example, affects the whole person physically and mentally. Poor nutrition, or lack of hydration, hinders the effectiveness of most medical treatments such as medication therapy. The proper treatment of wounds is affected demonstrably by diet and hydration.

This is where we need another full stop to ponder the identity of nurse aides. Through ADLs (activities of daily living), aides supply the foundation that makes all other medical care effective, and for that matter, relevant. Also, effective aide care prevents the need for additional care by other care team members resulting in increased quality of care for the rest of the facility. In other words, nurse aide care has a direct correlation on the overall efficiency of any healthcare facility whether LTC (long-term care) or acute (short-term care). The role of nurse aide is foundational to all other healthcare disciplines.

Another strong emphasis in nurse aide training is safety, and the fact that according to all state laws, the nurse aide is an advocate for patients and residents. Safety needs are the next level of Maslow's theory, and the aide role for this priority is barely less than physiological needs. Nurse aides have a significant role in helping patients and residents feel safe. This is particularly true in LTC. Good aides will be sensitive to the fears of residents and will find ways to assure them that they are safe. Even in nursing school, "safety first" is a constant emphasis. The nurse aide is an additional five senses for the nurse that accomplishes this priority.

Regarding LTC, it is a sad reality that often, the facility and its staff are the primary source of a resident's sense of belonging and receiving love. There are many reasons for this, but in some cases the residents have simply outlived all their relatives and friends. Of all LTC staff, the residents have the most exposure to nurse aides. Making a resident feel like they belong to the community, and also loved, is not a specific required role of a nurse aide, but is an unavoidable natural occurrence if an aide is doing their job properly. Nevertheless, the aide must be careful to keep this natural occurrence within professional

boundaries. With this being said, we would be amiss to not recognize the nurse aide has a substantial role in the first three foundational priorities of healthcare. Does this make the nurse aide position the most important discipline in healthcare? Yes, it does.

But what about the remaining top two needs/priorities of Maslow's hierarchy? That is, self-esteem and self-actualization (being all you can be). Are aides instrumental in assisting people in experiencing those needs? Yes, and more so than other healthcare disciplines. Again, nurse aides have more interrelation time with healthcare recipients than any other healthcare discipline. Though examples are myriad in health-care settings, especially home healthcare, we can use Marvin as an example.

Meet Marvin. Not his real name. He is a resident in a Dementia/behavioral unit somewhere in the United States. The following is what Marvin's life looks like. He awakes early and begins his daily routine. As he wheels down to breakfast he enjoys observing the various activities of the nursing unit and expressing his opinions about them. These opinions create much needed moments of humor for nurses and aides as Marvin's unfiltered opinions lack the kind of honesty that is better veiled to some degree if it could get you fired. They can't fire Marvin.

Marvin enjoys eating and expresses his opinion about the quality of the dinning room meals. The reviews are usually positive. Marvin is a big hit with the kitchen employees. Marvin is dearly loved. Marvin is usually taken to physical therapy after breakfast. His ability to walk long distances with a walker gives him a great sense of accomplishment. This is known because he makes it known verbally.

"Nobody in this place can walk as well as I can, isn't that right?"

The physical therapists smile and agree. Marvin makes everyone smile. We could all use a little of Marvin's confidence as

well. Next, Marvin goes to work. It's a hobby, but he considers it his job. Marvin builds and paints model kits. Not his real hobby, the details here are also modified to protect his privacy. By any standard, the articulation and skill of the construction is very impressive. Marvin then offers the completed models as gifts. Though accepted, they never leave the facility and are on display everywhere. Laws prohibit nurses and aides from accepting any kind of gifts from residents. However, all of them would love to display one of Marvin's completed models in their homes as a reminder of how much they love caring for him.

Marvin eventually leaves work and retires to his room, and will often apologize for being snippy with an aide because he had a "rough day at work" while adding that he "got a lot done." Marvin takes much pride in his work and reminds the aides of the just recognition accordingly; and of course, they are in full agreement. Marvin's work speaks for itself.

Here, we must ask a question: what makes our life better than Marvin's life? If your physiological needs are met; you have safety; you belong; you are loved; you have self-esteem; and self-actualization; you are happy. If you have all of those things. Well, Marvin has them too, only in a different world. Nurse aides enter that world, and supply care. They project Maslow's theory into other worlds and apply it. And those worlds are uniquely different, but the nurse aide learns to adapt accordingly.

Maslow's theory is a priority healthcare standard, and it is the domain of the nurse aide. Its goals for those in need can be applied to every healthcare setting, and the true nurse aide strives to master that setting through the prism of Maslow's theory. The nurse aide can contribute and encourage activity on each level of Maslow's theory, and prioritize tasks accordingly. Ironically, specialty healthcare disciplines are usually limited to one or two of Maslow's priorities, while the nurse aide has opportunity to contribute to every level.

Lastly, a distinction needs to be made between real aides and

the aforementioned usurpers. In another chapter, we will discuss the application of Maslow's theory to the wellbeing of the nurse aide, and how the nurse aide functions. From an inner perspective, the real nurse aide applies Maslow's theory to the inner self and also the outer needs of others. Usurpers only function on the lower level of Maslow's hierarchy. In other words, it is only a job for purposes of meeting physiological needs for themselves. Furthermore, people will rarely do for others what they won't do for themselves. In contrast, a real aide strives for self-actualization, and also wants that for people under their care.

"The story of the human race is the story of men and women selling themselves short."

~ Abraham Maslow

"Be the change that you want to see in the world."

~ Gandhi

Chapter Three: Audience of One

In our present-day healthcare setting, if any aide is looking for leadership, they will not want to hold their breath until they find it. The American healthcare system is notorious for lack of leadership.[i] According to the American Nurses Association, one of the eight primary reasons that nurses are leaving the profession is lack of positive leadership. If nurses cannot find positive leadership, it stands to reason that aides will not find it either. Here is a key element of the successful nurse aide: in our day, you must be self-motivated. The following is not a primary element of the identity, but it will boost your overall experience as an aide: impacting and changing the aide culture is fun. And this book will tell you how to do it, and live to tell about it. You **must** be self-motivated, and motivating others is recommended. Changing the culture through your aide example and wisdom will add to your self-satisfaction and self-actualization.

Again, we must point to Maslow's Hierarchy of Needs to successfully make ourselves the issue. The successful nurse aide must be self-focused. This seems contradictory to all things moral because individual focus is usually referred to as "selfishness," which has negative cultural connotations. But that depends on where the focus is. If the focus is self-actualization per Maslow's hierarchy, we are building a stronger self that makes us more able to care for others. In other words, we must tend to self-needs before we can tend to the needs of others. This is the inside application of Maslow's theory. In fact, burnout, the #1 nemesis in healthcare, is wholly defined by lack of self-actualization. In most cases, advice to overcome burnout are things that do not address Maslow's priorities. Somehow, healthcare workers don't need the same things that are prioritized for healthcare recipients, which doesn't make sense.

Therefore, how do we utilize Maslow's pyramid for true

[i] American Nursing Association. (2023). *Why nurses quit and leave the profession*. ANA. https://www.nursingworld.org/content-hub/resources/nursing-leadership/why-nurses-quit/

self-actualization, rather than interpreting it through altruism (sacrifice of self as the highest moral standard)? To start, we will look at this through our natural bent. Our natural bent is to be people pleasers. Yes, one of our psychological needs according to Maslow is acceptance by others, but this must be kept in balance. We cannot sacrifice self-esteem for the judgement and opinions of others. Perceiving ourselves as a bad person, either factually or erroneously, is not congruent to happiness and sound mental health. We must partake in life building, which is progress on each of Maslow's priority levels (not necessarily in any given order). As we are doing this, we need to be patient with ourselves, knowing we are a work in progress. Hence, we judge ourselves according to our progress towards self-actualization. Maslow's hierarchy, or the same general principles, are the standard (some religious beliefs will be very similar), and we are the judge, because no one knows us better than ourselves. In fact, regardless of the stripe, almost all religions teach that we will stand before God alone in judgement. If you want to invoke religion into this conversation, very well, God is our only judge, not others.

So, the point here follows: we must redirect our goals towards self-care for the sake of others and ourselves, and an overemphasis on pleasing others will always lead to failure. In fact, due to nurses having a cultural tendency towards altruism, almost 20% of newly licensed nurses will leave the profession within one year.[i] Nurses, and their understudies (nurse aides), routinely do too much for too little in order to gain acceptance, job security, and pseudo love/praise when capitulating to the *wants* of others, rather than their own needs. Burnout follows; it's the law of gravity, and by the way, the eight primary reasons for nurses leaving the profession coincides perfectly with Maslow's pyramid. According to the American Nurses Association, the eight reasons are: nurses feel underappreciated by the facility they work for; lack of positive leadership; excessive

[i] American Nursing Association. (2023). *Why nurses quit and leave the profession*. ANA. https://www.nursingworld.org/content-hub/resources/nursing-leadership/why-nurses-quit/

hours; lack of moral support; burnout; patient-to-nurse ratios; incivility in the workplace; and moral injury.[i] And, according to the CDC, feeling unsafe.[ii]

Please note, the reasons are mostly out of the individual nurse aide's control. No nurse aide can control what others think of them. No nurse aide can control how much others accept them and respect them; earning respect can only go so far and doesn't guarantee the desired results. No nurse aide can control the imposition of aide-to-client ratio. No nurse aide can make anybody appreciate them. No nurse aide can make a facility civil or non-toxic. Even if you have earned everything individually by right doing, positive results may be circumvented by jealousy, projection, politics, misunderstandings, the poor work ethic of others, and a myriad of other human tendencies of ill report.

Hence, the nurse aide must focus on what they can control. They need to focus on their own self-actualization. However, this focus will result in leadership by example, which is the only way any change takes place. No facility or healthcare organization will change for the better without positive leadership. In some cases, that might be you alone. The nurse aide must focus on their own self-actualization and let the chips fall where they may. The nurse aide must be satisfied with their own efforts as judged by them alone, and what their conscience tells them about God. This alone results in truthful and positive self-esteem. And, in all cases, this will always yield the most respect by others because it is predicated on a fact-based criteria.

Therefore, the nurse aide will choose the right place of employment to begin with.

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[i] American Nursing Association. (2023). *Why nurses quit and leave the profession*. ANA. https://www.nursingworld.org/content-hub/resources/nursing-leadership/why-nurses-quit/

[ii] CDC. (2020). *Nursing workplace violence: More compelling facts*. The National Institute forOccupational Safety and Health. https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit1_7#

Will the pay enable the aide to meet physiological needs and shelter? Will the aide receive enough rest? Are there any co-workers at the facility or healthcare organization that the aide can trust? Is there some level of respect? Does the organization offer upward mobility and attainment of personal accomplishment? If not, can the job be used to obtain accomplishment by other means? In short, is there enough substance to obtain self-actualization to some degree?

We have examined the inward (self-care) and outward (care of others) application of Maslow's hierarchy, and it begs the question, "Why don't healthcare facilities or organizations make Maslow's pyramid an employment model? In other words, "Does our organization enable our employees to self-actualize? Do our policies facilitate self-actualization? That is a good question, isn't it?

That day may come, but meanwhile, ***audience of one*** is a primary element of the nurse aide identity.

Chapter Four: Types of Nurse Aides; Wider Versus Narrow

As mentioned before, nurse aides provide the foundations for all healthcare. While home healthcare aides (HHA) are the least skilled from a technical perspective, they provide critical preventive care. HHAs provide help with things like housecleaning and companion care. Hence, HHAs prevent injury to clients by providing help with needed activities of daily living (ADLs). When physically or cognitively impaired people attempt to do some ADLs on their own, they are at risk. Regarding mental health, inability to perform ADLs can force individuals into facilities and giving up their homes. A person's home is their well-being sanctuary. In addition, as far as federally and state funded medical assistance, the ability for people to remain in their homes is demonstrably more cost efficient. HHAs save the government more money than any other healthcare discipline. Furthermore, HHAs can promote good health practices that prevent the need for future healthcare because, like no other healthcare discipline, they have a relationship based (companion care) practice.

Furthermore, companion care is crucial because loneliness is a contributor to poor mental health. Loneliness and isolation are major contributors to a plethora of physiological health problems, substance abuse, low self-worth, and suicide.[i] No other discipline treats the whole person more than the nurse aide discipline in general, and the HHA in particular. All HHAs should know this, and equip themselves accordingly. The HHA's scope of practice is very wide, though lacking in technical recognition. However, in healthcare, as so-called "specialty" certification rises, the ability to treat foundational healthcare needs decrease. Hence, no other healthcare discipline lengthens homeostasis and effects preventative care more than the HHA. "Home health," therefore, is a good designation for the HHA.

[i] Cigna Healthcare. (2023). *Signs and Symptoms of Chronic Loneliness*. https://www.cigna.com/knowledge-center/chronic-loneliness

The HHA discipline requires a special temperament and heart because tasks are performed in private homes. The structure of the environment is almost totally on the client's terms, and there are many, many different strokes for different folks, as the saying goes. No other nurse aide disciple requires more flexibility and mental toughness than HHA. Therefore, the HHA must remind themselves concerning who they are, and why they do what they do, and competent agencies will remind them and reward them as well.

In nursing school, withholding judgement while focusing on needed care is a priority teaching, but it is likely that this nursing attribute is required by the successful HHA more than any other nursing discipline. In private homes where people are in their own private sanctuary, all kinds of boundaries can be lacking. HHAs will experience what people are really like more than any other healthcare setting. No other healthcare setting will require more personal compromise than HHA. In addition, because HHA is deemed to be unskilled, no other healthcare discipline will receive more disrespect. In some cases, HHAs will be treated like servants rather than healthcare professionals.

It is at this point that we reach a critical juncture. The primary purpose of this book is to supply a nurse aide vision, a nurse aide theory, and a nurse aide way of thinking that leads to positive outcomes for those who have needs, and the individual nurse aide. Right thinking leads to right doing. Right doing leads to high self-esteem based on the facts, and the only rightful arbiter of those facts is the individual and God. Outside assessment should be considered and weighed as a help for formulating self-assessment, but should not play a large role in the individual's self-esteem. In the vast majority of cases, people's opinions regarding others are distorted by personal agendas like controlling others or attempting to attain self-esteem shortcuts. In other words, regarding the latter, rather than doing the hard work of life building to obtain factual self-esteem, they are attempting to tear others down for purposes of elevating themselves without a climbing effort.

As with all people, happiness determines quality of life, not circumstances, and happiness is obtained through self-actualization; ie., being all the individual is meant to be. Being free is an important element of happiness, and the pursuit of self-actualization is freeing because the individual is only competing with self. Competing against others is bondage on many different levels. You are not trying to prove anything to anybody, only yourself. All of this is being written to make the following point: while home healthcare has a limited skill set as far as training, this also results in less regulation. In other words, there is freedom to fully exploit the opportunity, which is whatever you make it. In home healthcare, the experience can be much more than expected by what you make it, and the sky is the limit. In many respects, the HHA is friend-like to the client, and friendship can have a wide scope of practice. One of the elements of its scope is "companion care."

More than any other healthcare professional, the HHA has freedom to expand treatment of the whole person regarding the physical, emotional, and spiritual. Physically, the HHA can prevent harm by performing tasks that are risky for the client to perform. A clean and orderly environment contributes to well-being. The HHA has unlimited resources to supply unregulated emotional and spiritual support through conversation, encouragement, reading, hobby activities, physical therapy, and if the client wants to, spiritual activities like prayer. In reality, as technical qualifications increase, the opportunity for wholistic care and wholistic outcomes decrease. Specialties limit scope of practice because they are specialties. And, to the degree that specialties are specialized, they treat symptoms and are not preventative. Specialties are narrow scopes of practice. A medical doctor is rarely your friend, but would be much more help to you if he was. This is the difference between Allopathy, a Western cultural approach to medicine focusing on surgery and medications, rather than prevention and treatment of the whole person (Holistic, or Wholistic). In post-surgery situations where the patient returns home, HHAs are crucial and have a much broader scope of practice. Surgeons do not go home with the patient.

The HHA scope of practice is whatever the aide makes it for purposes of self-actualization. To some degree, Maslow's cited need for respect and acceptance should come from the health-care agency management and the client, but is not as important or impactful for purposes of self-assessment. Though a difficult mindset, the aide should learn to make self-appreciation paramount because the aide is in total control of that. However, obtaining deserved appreciation from others is illusive. Yet, it is an element of Maslow's hierarchy that is necessary for self-actualization, but should dictate to a lesser degree where the aide is employed. The HHA may receive ample appreciation, acceptance, and respect from the client to cover agency discrepancies. The source matters little, but the need is required for self-actualization. However, compensation must also be considered due to Maslow's cited need for safety, shelter, food, and other basic physiological needs. Again, we should revisit the idea that Maslow's hierarchy is a tool for deciding where to work. A particular job is either contributing to your self-actualization or depriving you of it, and subsequently, happiness.

In this chapter, the other two levels of nurse aides, Resident Assistant (RA), and Certified Nurse Aide (CNA), are defined through the HHA lens. RAs are aides employed by assisted living facilities (AL) and like HHAs, are not required to be certified. CNAs are required to be certified and can work in skilled nursing facilities (long-term care [LTC]) or hospitals. However, in reality, most AL facilities are now skilled to a lesser degree.

In the case of HHA, RA (AL), and CNA (LTC), the expectations are low. If the aide merely performs enough to remain employed at a facility, the job will offer little in obtaining self-actualization. In all three cases, it's whatever the aide makes it by maximizing the job's potential. In other words, in most cases, the aide must supply leadership for themselves and also set an example for others. The overall strength of a facility or agency is based on the strength of its foundational care, which is the nurse aide discipline, but few facilities or agencies see it that way or function that way, which also contributes to

nurse shortages via stress and burnout. Nurse aides are not taught that their primary focus is to aide nurses. Subpar nurse aide performance increases care needs and causes an additional burden on nurses. Nursing facilities, to a large extent, do not see the aide discipline as foundational to care. In AL facilities, aides are not expected to perform on a CNA level for the skilled residents, leading to an additional burden on nurses. Regarding LTC facilities, aides will only be expected to utilize about 10% of their training leading to the job delivering low self-satisfaction and burnout. However, every aide can choose to make the job what it was meant to be in the world's one acre of reality where they perform. It's a choice.

In contrast, a hospital CNA discipline is different. In acute care, people are readily harmed in the short term if full scope of practice is not performed. Hospital CNAs can also obtain additional certifications that enable them to practice advanced skills in hospital settings. Hospital CNAs need far less self-motivation to obtain self-actualization. However, again, their scope of practice is more regulated and narrow.

"Obviously, the historical core and essence of a nurse aide is to enable fewer nurses to do more without burnout resulting in even more shortages. That's the way it has always been. But today, here we are, paid nurse aides are not seen as the primary tool to cure nurse shortages, and in fact, nurse aides expect nurses to aid them! Again, the present-day nurse shortage is primarily caused by an identity crisis concerning nurse aides. If the healthcare industrial complex doesn't know what a nurse aide is, you can be assured that nurse aides do not know either."

Chapter Five: *Nurse* is a Noun; *Aide* is a Verb

There is a severe shortage of nurses in the American healthcare system, and this is no surprise to anyone who knows what it takes to be a nurse. To begin with, obtaining a nursing diploma and passing state nursing board tests are daunting tasks emotionally, physically, and financially. Regarding LPNs, at least in long-term care, healthcare administrations keep pushing the patient-to-nurse ratio; one nurse for 30 residents is not uncommon enough, even in skilled care facilities. Beyond passing medications to between 20 and 30 residents, nurses are responsible for overseeing aides, administering care in unexpected situations, processing doctor's orders, writing phone orders, charting, and taking phone calls from family members, pharmacies, and a variety of healthcare service companies. And consequently, doing all of the aforementioned, which is hardly a comprehensive list, for many additional hours per week to compensate for staffing shortages. And in the final analysis, nurses are 100% responsible for any mental errors that may result from being overworked, which includes criminal liability. Becoming a nurse is difficult, and persevering as a nurse is even more difficult.

Here, we will get to the point of this chapter: nurse aides are the single most efficient answer to the nurse shortage, IF, they know what their identity is. And here, we should also note the very nomenclature of "nurse aide." In this compound word, *nurse aide*, "nurse" is the noun and subject receiving action from the verb, "aide." In other words, the very title implies that the primary role of a nurse aide is to give aid to the nurse. To the degree that nurse aides fulfill their true role, nurse shortages will decrease.

If you are waiting for healthcare administrations to focus on this fact and reorder the roles of nurse aides accordingly, don't hold your breath while you are waiting. However, nurse aides have the ability and freedom to invest in themselves and offer their skills to nurses within the nurse aide scope of practice.

The scope of practice taught to state tested nurse aides, and what they are actually called on to perform in facilities is a wide gulf, and to the detriment of nurses.

Due to the extreme shortage of nurse aides in America's healthcare system, facility administrators are hesitant to hold nurse aides accountable for not fulfilling their roles and inclined to blame nurses for their "leadership style" if a nurse aide quits for being, "disrespected." Consequently, in reality, nurse aides often, "run the facility," so to speak. Overall, nurses are hesitant to instruct nurse aides, leading to undue burden on nurses, and substandard care. Hence, smart nurses will focus on aides with a nurse aide heart who know their identity and will partner with them to deliver quality care. Be that aide.

State tested nurse aides offer a vast list of services within their scope of practice that assist nurses. Granted, many nurses will not trust an aide to perform some services, but many will. One example is taking vitals on a skilled nursing hall. These vitals, such as blood pressure and heart rate, will sometimes determine whether or not a nurse will administer certain medications. If the vitals are not right, and a medication is administered accordingly, the resident's blood pressure could be lowered to a dangerous level. Glucose monitoring, and the administration of insulin is another example. For certain, if a nurse trusts an aide to help in such areas, it is a compliment and testimony to the aide's professionalism.

Jenny is a nurse on a skilled hall in a LTC (long term care) facility. Further down the hall she sees a call light go on, but the room is close enough to her med cart to hear conversation in the room. An aide answers the light quickly and enters the room saying, "Hi, my name is Susan; I am your nurse aide today, how can I help you?" The resident replies, "I am short of breath." The aide then states the following: "let me raise the HOB (head of bed) 30 degrees (semi-fowlers) and make sure your cannula (oxygen supply that is inserted under the nose) is positioned correctly and patent." While in this process, the aide asks the resident, "Are you upset about anything?" After the resident

answers the question, the aide then states, “I am going to get the vitals cart to check your 02 peripheral saturation, I will be right back.” The aide returns and uses the oximeter part of the cart to check the resident’s 02 saturation. The reading is 92, which is a little low, and Susan tells the resident that she will be back to recheck the saturation level in 15 minutes. The resident is assured and thanks the aide.

The nurse, who can hear all that is going on, then sees Susan coming towards her to report what happened. “Hi Jenny, room 29 states that she is short of breath. I raised the HOB to semi-fowlers, adjusted her cannula, and found an 02 stat of 92. The resident denies being upset or nervous and denies angina. I will follow up in 15 minutes and report back to you.” Susan just saved Jenny 15 minutes. If Susan performs 12 tasks like this in a 12-hour shift, or one per hour, this will put 3 hours back into Jenny’s schedule. This is an aide role that is far too rare. A professional aide should always ask themselves, “How much time can I put back into the nurse’s schedule today?” Putting time back into the nurse’s schedule increases the quality of care, reduces the chances for medication errors, and reduces stress for the nurse.

Unfortunately, a common mentality in aide culture is an expectation that nurses should be available to help aides. While the vast majority of nurses are willing to help aides here and there, so to speak, to expect nurses to fulfill aide work as an additional job description is completely unreasonable. If being an aid to an aide is a nurse role or job description, one must wonder why we would call aides *nurse aides* to begin with. Any so-called nurse aide who thinks nurses are obligated to help aides is misunderstanding the identity of a nurse aide, and the distortion is in a vacuum created by administrative incompetence and lack of vision. And, it contributes to nurse shortages.

We have examined the primary reasons for nurse shortages, and they can be summarized by *over-expectation*. Primarily, research points to eight reasons, and we

want to contribute to the nurse crisis problem by adding a ninth expectation for nurses?

In contrast, nurse aides should be more like nurses rather than nurses being more like aides. Besides, it is why we call them "nurse aides." The nurse aide profession began during WWI to aid nurses in the battlefield. The role was invented and initiated by the American Red Cross. During WWII, the role was reinstated to aid nurses at home because many nurses were called to do nursing in the war theater. In both cases, it was a volunteer position.

Obviously, the historical core and essence of a nurse aide is to enable fewer nurses to do more without burnout resulting in even more shortages. That's the way it has always been. But today, here we are; paid nurse aides are not seen as the primary tool to cure nurse shortages, and in fact, nurse aides expect nurses to aid them! Again, the present-day nurse shortage is primarily caused by an identity crisis concerning nurse aides. If the healthcare industrial complex doesn't know what a nurse aide is, you can be assured that nurse aides do not know either.

Consequently, what should we expect when these kinds of perspectives concerning nurse aides are prevalent in health-care? We should expect what is, in fact, happening. It is not uncommon for nurses to arrive at a shift and find out there are no aides working. And why not if nurses are expected to aid the aides? Isn't that the next step in the downward spiral of health-care?

In addition, it would seem that it would behoove nurse aides to present themselves as more inexpugnable. As it is, our culture has a propensity to expect nurses to do everything while being accountable for the outcomes of everything. At the end of WWI and WW2, the nurse aide programs were quickly terminated. Even when nurse aides were used after WWII, hardly any training was implemented. This ended in disaster, leading to the Omnibus Reconciliation Act of 1987.

Increasing needs of healthcare require nurse and nurse aides to be a healthcare team with well-defined roles. Subjective ideas and confused identities will not achieve the goals of best nursing practice.

Sources regarding nurse aide history:

"Whoever saves one life, saves the world."

~ Jewish Proverb

"Don't believe everything you think"

~ Byron Katie

"Unless people are willing to turn on their minds and challenge their deepest held beliefs, they don't matter. Nothing will change."

~ John Immel

"Insanity is doing the same thing over and over again and expecting different results."

~ Rita Mae Brown

SECTION TWO
NURSE AIDE IDEOLOGY

"Because a true nurse aide has the right worldview of life, that nurse aide is a defender and advocate for life, and in this way, contributes to saving the world. Nurse aides tend to the needs before them and leave the rest to the patient and God. "

Chapter Six: How Nurse Aides Save the World

The Fox News TV personality, Jesse Watters, uses an exaggerated expression of self-confidence as a trademark much like the late conservative pundit, Rush Limbaugh. Accordingly, Watters wrote a book titled, *How I saved The World.* No one really believes he saved the world; but the use of this shtick adds humor to serious truth and creates interest through curiosity. How in the world does Watters think he saved the world? How will he make this absurd notion fit with the points he wants to make in the book?

Regarding nurse aides, it's not a shtick—it's reality, and that's what this chapter is about. This reality begins with examining the notion of, "quality of life." If life has degrees of "quality," life also has degrees or levels of value. This is because quality determines value. Work is virtuous, even when it pays minimum wage. We wouldn't want to determine the virtue or value of work based on wages; work is virtuous, and valuable, in, and of itself. The belief that there is a "quality of life" is a slippery slope; who then determines what defines "quality"? It's subjective and is an opinion that varies greatly among people.

Here is how nurse aides save the world: they believe life has value, in, and of itself. They believe life value is multifaceted; life always has value, and it is a value that is defined in many different ways without a hierarchy of value, which can't be defined anyway. Likewise, there are many different types of work, but work is always valuable. A quality-of-life mentality will always be equal to quality of care, and that is antithetical to an equitable ideology of care. "Quality of life" is a term we hear often in healthcare culture, and that's a huge problem. The term has no rightful place in healthcare; it is wrongheaded, and antithetical to compassion. Be not deceived, in all cases, a value placed on life will always determine the quality of care and how care is delivered. And furthermore, quality is also closely related to purpose, and this is where things can become very dark.

Though a historical cliché, Nazism during World War II is

the best example for the point being made here. The basic ideology of the Adolf Hitler regime married life value, or quality, with purpose. In other words, life value was determined by one's ability to fulfil the purpose for living. In this case, the sole purpose of every individual living under the Nazi regime was defined by ability to support and contribute to the state. A person's value was determined by their ability to contribute to the Nazi regime.

The ideology of collectivism is similar: one's life value is determined by their ability to "contribute to the group." Along the same lines, Altruism, the idea that levels of virtue are defined by the degree that you sacrifice yourself for others, is a pseudo-goodness. Altruism is a naive support for collectivism, which defines life value according to one's ability to contribute to something else. Hence, as history testifies, during the Nazi rein in Germany, the feeble, mentally ill, and handicapped were exterminated. Again, the idea that life has degrees of quality and value is a slippery slope that must be rejected. What constitutes a quality of life is an open question that can only be answered with subjectivism. Worse yet, invariably, the wrong people become the judges for what constitutes a quality life. In addition, the open question of life value is almost always determined by monetary and collectivist ideas. This is because the idea of life quality was given birth by these ideologies. Here is something else to remember: history teaches us that ruling elitist minorities never live by collectivist ideology; these ideologies are always relegated to the lesser classes in caste systems.

Life, as valuable, in, and of itself, is intuitive, or as the founders of Americanism liked to say, "self-evident." An example is the many Hollywood movies, such as Soylent Green and Logan's Run that depict the possible outcomes of labeling life according to quality. An additional thought includes the fact that NASA spends billions every year collecting rocks from other planets in search for life in any form they might find. Life must be very important.

But, what about end-of-life suffering? What about extreme suffering in general? Thankfully, in our day, we have drugs and other therapies that can alleviate pain. But again, the question of suffering is also a slippery slope. How slippery? Even though this book is in no way an argument for or against abortion, it is often advocated to prevent the assumed future suffering of an unwanted child. That's how presumptuous and subjective things can get. Not only that, suffering can come to be defined as one less brewery in the world or one less rock and roll band. According to an article on Salon .com, music superstar Stevie Nicks stated that there wouldn't be a Fleetwood Mac (the band she sings for) if she hadn't had an abortion in 1979. In the same article, another woman stated that she wouldn't have been able to open a brewery that she owns.[i] A rebuttal could be just as presumptuous because someone possibly growing up and finding a cure for cancer would be much more beneficial to humanity than a brewery or a rock and roll band. At any rate, the present-day arguments for abortion are a far cry from the original premise that argued for its legalization. And that's the whole point; the unfortunate consequences of slippery slopes.

Due to the fact that a worldview of life is linked directly to the quality and compassion of care, nurse aides must avoid all ideological slippery slopes. What then, as part of the nurse aide state of being, should be our worldview concerning life? We must believe that all life has equal value, and that all individuals are worthy of our best efforts in delivering care.

When a nurse aide exerts full efforts, as far as it is possible, in caring for an individual in the most hopeless and purposeless circumstances, that aide, is, in effect, defending the principle of life as valuable, in, and of itself. There is really no choice in the matter because anything less will always digress to the slippery slope and begin the inevitable downward slide to greater and lesser care for individuals on the same unit.

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[i] Stine, A. (2022, July 4). *Stevie Nicks' abortion and the freedom to choose you*. Salon.com. https://www.salon.com/2022/07/04/stevie-nicks-abortion-freedom-to-choose-you/

However, something else can be added here. Though so-called "quality of life" and needed care are mutually exclusive from an ideological point of view, one could argue that quality of life should be judged according to one's level of happiness. Apparently, that's how Jesus Christ assessed so-called quality of life in his eight beatitudes. Each one begins with, literally, "Happy are you..." when or if certain things occur. Anyone who has worked any amount of time in a long-term care facility knows that many of the residents are, indeed, happy to various degrees, and they are happy regardless of being unable to contribute anything to anybody or any institution. But, this is not entirely true; they contribute to the livelihoods of aides, nurses, and administrators. In essence, they are employers, and are paying our wages with their past industries. This is even true of many who suffer the affliction of dementia or Alzheimer's, they are not only happy in their own world as it is (remember, for them, perception is their reality), but they are our employers, and employers are important people. In light of this, who are we to judge their so-called quality of life, which may lead to a diminishing of care that is due to them? In many cases, people who need total care spent their whole lives caring for others, and they are owed the best care possible accordingly. There is a sense in which end of life care honors the past life.

There is something else we can consider. Experience tells us that people often compensate for lesser elements in their life by extracting more happiness from whatever is left. How caregivers can add lost elements back into their lives will be discussed in another chapter, but for now we will meet Joe (not his real name), also known as "Milkshake Man" (not the real food either) in a long-term care facility located somewhere in the United States. Joe has dementia, is a paraplegic, and enjoys watching cable TV. He also has an extreme likeness for milkshakes. Every Friday evening after dinner, an aide travels to UDF and buys Joe his favorite handmade milkshake. When the shake is delivered to Joe, it is a celebration enjoyed by everyone working on that unit. Joe enjoys his life. Also, Joe brings joy to those who care for him. Who are we to judge the quality of his life? That's not our venue, our venue is to meet care needs.

There is yet something else to consider. Some residents are not happy, but they are not ready to die for various reasons. Regardless of their condition, which may be severe, they do not want to die, and that is their right. Again, at least for those reading this in the United States, one way or the other, through taxes or direct funds, or both, they have paid to have their needs met. In addition, the United States Constitution establishes the right of every citizen to life and liberty. If a person wants to fight a painful death to the bitter end, that is their right and their decision.

There is an old Jewish proverb that states the following: "He who saves one life, saves the world." What does it mean? It means the following; if you don't value an individual life for one reason or another, you don't really value any life. If one life is expendable, all lives are expendable. Collectivism is the ideology behind every mass grave known by God upon the earth. The purpose of life goes far beyond the ability to contribute to "the group," or "greater cause," or the state. In addition, people are not pets that we put down to prevent suffering.

And if you are a nurse aide, don't fool yourself; if you will compromise care and compassion for one patient because they "aren't going to get better" or "They are actively dying," or "They have a low quality of life" (whatever that means), you will eventually compromise everyone you care for, and your lack of compassion will become plenary.

Because a true nurse aide has the right worldview of life, that nurse aide is a defender and advocate for life, and in this way, contributes to saving the world. Nurse aides tend to the needs before them and leave the rest to the patient and God. Nurse aides serve the desires of the patient within professional and ethical guidelines, and subjectivism belongs to the patient. This is a healthcare standard. What the patient says or states is subjective, unlike objective vital signs. However, we are also told that the patient's pain is whatever they say it is. Likewise for the patient, life is whatever they say it is. Subjectivism belongs to the patient or resident in long-term care, not any

professional, whether in healthcare, religion, politics, or philosophy.

If you think otherwise, you may not want to believe everything you think. Experience teaches many of us that people who had very strong opinions about "quality of life," change their tune when they get bad news from the doctor, or experience the privilege of old age, which many do not experience. This author has firsthand experience concerning people who were advocates for euthanasia to end lives of "low quality," until they were diagnosed with a terminal illness. These people who were once dogmatic about ending lives of "low quality," fought and suffered to the very end for purposes of extending their lives as much as possible.

However, in either case, nurse aides have their role and plan of care. Judging decisions about end-of-life is not within our scope of practice, and the conflation of judgment into the subjective will influence our care discipline.

Again, the subjective realm belongs to the patient, and no one else. Their life is what they say it is.

Chapter Seven: A Deeper Look into Life Value; APA Paper

Presented to Ohio Institute of Allied Health by Paul M. Dohse January 15, 2023.

As nurses, we want to promote health, but what is health? If our goal in nursing is fact-based care, we need to make sure all our defining terms are not merely bumper stickers. Of course, health promotion has different goals throughout our lifespan. Hence, how we promote health will be determined by our definition of life itself, or so-called "quality of life." It cannot be denied that the quality of life idea frames our health promotion process. But what is "quality of life"? Though a term used daily in healthcare, when you ask the user of the term to define it, we see the proverbial deer in the headlights response. This is not surprising since organizations like the NIH state that there is no uniform definition for quality of life (NIH, 2023).

The thesis of this paper follows: the term quality of life is a bumper sticker. What do we mean when we use the term "bumper sticker" in this context? Good bumper stickers are short statements that sound profound, but usually promote an agenda that goes far beyond the short statement. These short statements can be handy shortcuts for dealing with life. When confronted with a difficult situation, we can say "stuff [sic] happens" or "it is what it is" and move on. Usually, however, bumper stickers exhibit a short statement that few people can disagree with on face value, but in fact, represent a larger body of beliefs that may be controversial. In other words, bumper stickers garner widespread support for an idea while those making the bumper stickers have a much broader and deeper agenda.

Furthermore, the *quality of life* bumper sticker is always accompanied by the *right to choose* bumper sticker. Indeed, the NIH states that, for the most part, since the *quality of life* idea is subjective, it should be defined by the individual's perception, or in other words, how the individual determines quality of life for herself or himself (NIH, 2023).

Assumed Definitions

Undefined truisms mean different things to different people while people assume a unified meaning when they hear the truism spoken. When we hear "quality of life," we assume everyone knows what that means and is talking about the same thing. This is the unfortunate power of bumper stickers, which do not take science into consideration. Water happens when you have two atoms of hydrogen and one atom of oxygen or H_2O. The *quality of life* formula should have at least 200 different expressions that look something like this: Nqol. In this formula, quality of life is determined by nihilism. Or you could have a formula that looks something like this: Sqol. This is quality of life determined by socialism, which defines quality of life as a person's sole ability to contribute to the state or the "greater good." When we hear someone speak about quality of life, we have no idea what they mean unless we know their worldview—we have no idea what they mean unless the term is qualified.

By way of example on this point, the World Health Organization defines health promotion as supporting governments and communities for "building healthy public policies" (WHO, 2024). Even though support and education for the individual is interwoven in the statement, "building healthy public policy" is really a soft term for mandating health "choices" through the legislation of laws. This is where we begin to see the fallacy of *right to choose*.

The Right to Choose and Dying Incorrectly

Unfortunately, most people driven by a worldview are zealots—zealots struggle with someone's right to choose because invariably, if the choice does not align with their worldview, it is deemed a choice driven by some inequitable standard based on their opinion. This is a huge problem in healthcare as exemplified by the documentary Death Land narrated by Leah Green, a journalist with The Guardian (Guardian, 2019).

In episode II of the documentary, Green interviewed Dr. Sunita Puri, director of palliative care at Keck Hospital in LA, California, and shadows her during visits with some of her patients. During the interview, Dr. Puri shared her philosophy of palliative care as reflected in her book, *That Good Night: Medicine in the 11th Hour*. The framework that guides her counseling to terminally ill patients follows: "No matter where you are in the dying process you are still living, so what does it mean to live well?" (Guardian, 2019). According to Dr. Puri, that means "respecting the limits that your body imposes" and acknowledging "the limits of biology" (Guardian, 2019). Puri suggests that "prolonging the death process" inflicts harm in the dying process, and therefore violates the principle of dying well and living well while you are still alive. Puri also comments to Green, "it's not really about them, but about the limitations of their body."

Those are not unreasonable suppositions, but clearly, as shown in Green's documentary, Puri is counseling patients to avoid any treatments that may prolong life if the treatments are painful. In other words, rather than supporting the patients in their choice, she overtly counsels them against it while suggesting that they are violating moral principles against self-inflicted pain (and thereby dying incorrectly) and showing disrespect to the limitations of one's body and biology, whatever that means. This is not therapeutic, and borderlines on being confrontational with terminally ill patients because they do not share her wisdom regarding bodily limitations and biology, and our supposed moral obligation to respect such.

The various reasons for fighting death, even in terminal situations, are not unreasonable suppositions as insinuated by Dr. Puri. If a patient is not ready to die, they may attempt to prolong life regardless of the pain. Dr. Puri, like many in our profession today, do not see treatments to prolong life as a process that some people need for their own purposes. Many terminally ill patients fear death far more than they fear the sufferings that may result from treatments. If it is truly their

right to choose, they should be supported in that decision. Many people simply want more time in the process of death to come to terms with it. Whatever those concerns might be, pain may not be at the top of the list.

Defining Quality of Life

The idea of quality of life is useless and non-therapeutic because, as mentioned earlier, in every case, the term must be qualified to determine the version. Again, for example, the socialist would judge quality of life solely on one's ability to contribute to the state or the "common good." Altruism, or an altruist, would determine quality of life based on one's ability to contribute everything they are to others. If a person in a total-care situation can only receive from others and not give, the altruist would deem their quality of life as being very low, but in addition, it is an unavoidable conclusion that this also puts a value on the person's life. Hence, the *quality of life* idea flirts with putting a value on life itself, which historically has never turned out well. We get a sense of this when we consider the words of George Bernard Shaw, awarded the Nobel Prize for Literature in 1925:

> You must all know half a dozen people at least who are no use in this world; who are more trouble than they are worth. Just put them there, and say, now sir or madam, now will you be kind enough to justify your existence? If you can't justify your existence; if you're not pulling your weight in the social boat; if you're not producing as much as you consume or perhaps a little more, then clearly we cannot use the big organization of our society for the purpose of keeping you alive, because your life does not benefit us, and it can't be of very much use to yourself (Rose, 2019).

In addition, we can consider that many philosophers in the world would go much further than Bernard and reject quality of life altogether because they come from an anti-humanity point of view. Here is where we have a perfect example of bumper

stickers. Few are against protecting the environment and most people would agree with the pithy truisms displayed about environmentalism on the bumpers of cars. But that has to be qualified. We may agree with the statement based on face value, but who produced the sticker? Being pro-environment can also mean you believe that humans need to be extinguished from the earth altogether. In other words, humans are destructive earthly usurpers that have invaded the only valid life in metaphysics; e.g., trees, fish, air, water, or the environment in general. Lighter forms of anti-humanity philosophies focus on so-called "overpopulation" and the supposed problem of too much life and too many people.

The quality of life idea is like a cell floating around that has receptors for a myriad of different cells that produce different actions in the one cell. Health promotion is qualified by one's definition of life quality, which determines nurse action. The complexity of the issue is supposedly rectified by "right to choose," but what is that right? Does the aforementioned Dr. Puri think patients have the right to put her in a position where she is violating the Hippocratic oath to "do no harm." Clearly, Puri believes that any kind of suffering in the process of dying is harmful. In her aforementioned book, she decries medical treatments that "prolong the dying process" for the sake of keeping people alive regardless of the suffering and the inevitable end result. In her book, that is not living well or dying well, and clearly, she counsels terminally ill patients accordingly.

But if she is foisting her philosophy into her counseling, is that therapeutic? No, because therapeutic communication establishes rapport through empathy, elicits a list of all concerns, and negotiates a shared agenda (Chou, Cooley, 2018). Though Puri emphasizes listening in her book, all of the data she is collecting is set against the agenda of "living well and dying well." Entering care with a set agenda is not therapeutic and does not seek a shared agenda. (Chou, Cooley, 2018). In the aforementioned documentary video, neither does Puri collect data in a therapeutic way. Statements about fighting the disease "for my family," fear of death itself, and not being "ready to die" are not

explored with open-ended questions. Rather than continuing to explore why people want to fight terminally ill diseases with open-ended questions, a situation that she says she encounters often, she feels compelled to teach them that "it's not about them, but their bodies."

Dr. Puri herself is a great example of a bumper sticker. Though her *living well and dying well* framework for palliative care seems reasonable, if we want to make sure there isn't a much deeper and wider agenda behind the bumper sticker, the findings are disappointing. Dr. Puri's framework is not medical, but is patterned after the philosophy of her mentor, a journalist and practicing Buddhist by the name of Katy Butler (Puri, 2020 p.297). Butler wrote a book about the death of her father who suffered a stroke, and from her viewpoint, excessive medical procedures to prolong his life resulted in undue suffering. However, the details of her view are interesting to say the least.

> In time, she saw her father's suffering prolonged by an advanced medical device, one of a panoply of recent inventions capable of prolonging "life" beyond its natural end (Mesa, 2024).

The device that Butler refers to is a pacemaker. Apparently, Butler believes that this pacemaker was responsible for prolonging her father's life and enabling him to live long enough to later suffer with dementia. However, Butler, a devout Buddhist, would be strongly influenced by the Buddhist idea that medical devices can interfere with the "natural cycle of life" (Emblem, 2024). In fact, Buddhist ideas concerning natural death, peaceful death with emphasis on lack of pain, good death, and "dying well" are peppered throughout her writings.

Butler's suggestion for changing the "prolonged disaster" (The Sun, 2014) problem of terminal care is a focus on how palliative care is performed. Butler notes something that she sees as a problem:

> I don't think people ever were free of fear of death, but clinging to life and being so unprepared for it is a modern experience. Our ancestors actually read books about how to prepare for death. It was considered your moral obligation to be prepared for your deathbed and to able to face it with equanimity. We offer such false hopes to people that every medical problem can be fixed even when you're starting to deal with an 80- or a 90-year-old body that is breaking down in multiple ways and doesn't have that resilience. And so it doesn't surprise me that someone who is completely unprepared for death may say, "Doc, do everything" (Mother Jones, 2013).

Butler's remedy for this problem is to begin preparing the elderly through education for a "good death." The word she used in a Mother Jones interview was "equanimity," which means, poise, calmness, composure and self-control. As seen in the demeanor of Dr. Puri while counseling patients, Butler considers this to be a "moral obligation." Butler believes this preparation should dominate palliative care and should be the focus of all siblings caring for their parents at home. In other words, *right to choose* is great if your choices come from the so-called right education. Otherwise, your choice to fight a disease is immoral. Butler also stated in an interview with The Sun:

> It's a question of the appropriate use of technology. When quality of life is high, the decisions are different. It's when quality of life is low and inexorably declining that you need to consider whether the cure is worse than the disease (The Sun 2014).

The primary problem with the *quality of life* idea follows: who decides what quality of life is, and should the philosophy of the person deciding either qualify them or disqualify them? And what are the social consequences if the assessment, whatever it might be, becomes law? And what would those laws look like if George Bernard Shaw set the standard for the definition?

Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs is a primary standard for priority setting frameworks in healthcare. *Priorities* and *quality of care* should be ideas that nurses are comfortable with. *Quality of life* is subjective, and in nursing, subjectivism is in the venue belonging to the patient, not the nurse. Nursing should be fact-based care. This is why the patient alone should judge what their quality of life is, and even if the patient thinks their quality of life is low, that doesn't necessarily mean they want to die. Again, the patient, for many different reasons, may deem staying alive a higher priority than an escape from suffering, especially when they do not know what happens after death. It also makes sense that a terminally ill patient may want to go down fighting, so to speak, rather than passively accepting the inevitable outcome.

Furthermore, if there is any merit to Elisabeth Kübler-Ross' five stages of death, why not let the patient work through those stages on their own time? Oddly, clinicians like Dr. Puri fail to recognize a correlation between wanting to fight a terminal illness and Kubler-Ross' initial stages of denial, anger, and bargaining. Instead, Puri, in an almost scolding demeanor, accuses the patients of not respecting the limitations of the body and biology, and thinking it is about them.

According to Maslow's priority framework commonly accepted in healthcare, it is about them. Nurses can fairly ask themselves, "What are the priorities in caring for this terminally ill patient?" Then, the priorities can be executed with best practice, or with the best quality possible. This makes sense, not judging the patient for how they are facing death. Nurse judgement should be confined to clinical applications. As stated by the Journal of Palliative Medicine:

> Although the widespread implementation of hospice in the United States has led to tremendous advances in the care of the dying, there has been no widely accepted psychological theory to drive needs assessment and intervention design for the patient and family (JoPM, 2006).

Recent adaptations of Maslow's theory to palliative care is a welcomed advancement.

> The five levels of the hierarchy of needs as adapted to palliative care are: (1) distressing symptoms, such as pain or dyspnea; (2) fears for physical safety, of dying or abandonment; (3) affection, love and acceptance in the face of devastating illness; (4) esteem, respect, and appreciation for the person; (5) selfactualization and transcendence. Maslow's modified hierarchy of palliative care needs could be utilized to provide a comprehensive approach for the assessment of patients' needs and the design of interventions to achieve goals that start with comfort and potentially extend to the experience of transcendence (NIH, 2024).

In addition, Elisabeth Kübler-Ross' five stages of death can be considered and applied along with Maslow's hierarchy. If Maslow's theory is a primary framework for setting priorities in nursing, and it is, then quality of life is far less subjective. Obviously, according to Maslow's theory, the level of self-actualization achieved determines quality of life. And if Maslow's theory can be applied to palliative care, quality of life can be achieved, even in the dying process.

In contrast, Puri's framework for palliative care is derived from a nonmedical source and is not therapeutic. The length of the death process should be determined by the needs and desires of the terminally ill patient without a concern for "lengthening the process of dying" and failing to recognize the limitations of the body and biology. Confrontation by a clinician does not make the patient feel safe or loved, and certainly does not bolster self-esteem.

Hard Cases Make Bad Law

There are commonalities shared by all those who make bumper stickers for some cause. First, their wider agenda is hidden by a pithy truism that most people would agree with.

Secondly, they are exercised by the idea of defending a person's right to choose, which is pretense on their part. Thirdly, they cite awful cases that are certain to illicit righteous indignation from people and thereby supposedly ending the argument. Who could possibly defend a situation where a patient screamed in agony for days so greedy healthcare professionals can make more money? And lastly, they are zealots.

When discussing so-called quality of life (bumper sticker number one), a discussion of euthanasia is not far behind, defended by bumper sticker number two, the right to choose, and supported by dreadful cases that should end the argument. But remember, those who make the bumper stickers are endeared to some logic that drives them, and they are zealots. Hence, the right to choose is predicated on making the right choice based on the zealot's wisdom. Right now, in the U.S., the zealots can only make patients feel guilty for the immoral decision to "prolong the dying process," but historically, societies that are duped into validating subjective concepts like *quality of life* end up with healthcare systems that revoke care (NIH, 2017).

It all starts with some philosophical movement that sells their ideology with a truism while hiding their larger agenda, and defending their argument with the hard cases. But, where are these hard cases? Katy Butler, while bemoaning the exploits of technologies that prolong life, acts as if there is little progress in comfort care. As far as prolonging life and providing comfort, today's medical technology can do both. Also, when the likes of Butler and others speak of "suffering," we must remember that they are conflating actual suffering with their perception of life quality.

> Hard cases make bad law is an adage or legal maxim meaning that an extreme case is a poor basis for a general law that would cover a wider range of less extreme cases. In other words, a general law is better drafted for the average circumstance as this will be more common (Hayek, 2013).

An inability to manage pain with contemporary medical resources is not a common circumstance in our day. Yes, some pain medications do cloud the mind, which would figure into Butler's palliative philosophy as a practicing Buddhist, and for that matter, Dr. Puri as well. Again, it is not enough to consider any position on face value, but listening to the perspectives of others must also include an understanding of their logic that drives their desires for particular actions. As historian John Immel has noted, there is a logic that drives every action (Immel, 2011). And again, fact-based research should always determine nurse action.

Slippery Slope

Few people would disagree that a culture that does not value life will eventually become a barbaric society. The word, "quality" denotes value, and when you put that word together with "life," it is really a statement concerning the value of life. Then, the *quality of life* idea is thrown into a batter of subjectivity. The term is very common in healthcare, but is completely undefined and completely subjective. Nevertheless, incredibly, everyone assumes the term is defined objectively and this is the reason it is an accepted term in healthcare. From there, it begs the question: who determines what quality of life is, and what is their criteria? Are those who determine *quality of life* socialists? Are they Buddhists? Are they the ones who control cost overhead at a health insurance company? Or is it George Bernard Shaw?

Initially, right to choose is merely a ploy to put the decision in the hands of people other than the patients, usually the government, doctors, or health insurance companies. Most, if not all euthanasia movements are spearheaded by the *right to choose* mantra, but the real goal is to take away the decision from those who do not "respect the limitations of our bodies" and "disrespect the limitations of biology." The real goal is to put the decision in the hands of those who supposedly know best...always.

How do we know this? In reality, people already have the right to choose. Yes, technically, suicide is against the law, but obviously, those who violate this law are not prosecuted, even when they are unsuccessful. Planning and painless methods are also readily available via books like *Final Exit* (Humphry, 2011). Furthermore, terminal sedation, or the softer term, palliative sedation, have been legally practiced in every state and every country for years. When people are in end-of-life care, or "actively dying," it is considered a last resort for refractory symptoms.

> Palliative sedation encompasses a broad range of activities aimed at relieving distress in terminally ill patients. It involves therapy targeted at resolving or alleviating refractory symptoms at the end of life. The most common refractory symptoms for palliative sedation are delirium, intractable pain, and shortness of breath. Despite clear palliative benefits in patients, the use of palliative sedation remains quite controversial. This is partly due to the lack of consistency in defining "refractory symptoms" and lack of adequate knowledge in patients, family members, and health care workers alike regarding the issue of palliative sedation. Additionally, ethical and legal issues surrounding this topic as it appears, at least superficially similar to the process of physician-assisted suicide or euthanasia, discourage physicians from initiating conversations or planning for palliative sedation in patients (NIH, 2022).

In other words, obviously, there is already a solution in place for the "hard cases." Though pain levels are subjective, the final determination of pain level is decided by the patient. A common rule in nursing follows: the level of pain is whatever the patients say it is. In dementia care, orders for palliative sedation can be obtained according to nurse judgement and if POAs are in agreement. Don't miss the point here: there is already a solution for undue suffering in the end-of-life process. The real concern is how long it is taking people to die. And if you are not ready, you are taking too long and lack

"poise, calmness, composure, and self-control."

Lastly on patient choice and technology, the hope of longevity certainly has merit because today's technologies can easily come up with treatments that can decrease symptoms or even cure symptoms in a short time span. In the case of this nurse's brother, he was given about five years to live, and fought ALS in hopes that new treatments could improve his condition or even cure it. As nurses, we are called to support that choice and collaborate with the patient accordingly. Right to choose is always framed within the context of ending the dying process, while for years terminally ill patients were prevented from trying experimental treatments that had not yet been approved by the FDA. Oddly, the American government allows for people to end their lives through assisted suicide, but prevented people from trying experimental treatments that might prolong their lives. This might be telling. This changed in 2018 through the Right to Try Act (Right to Try, 2018), and is indicative of why life and death decisions must be truly the choice of the individual, not a pretense for a philosophical agenda.

Conclusion

"Quality of life" terminology should be eradicated from nursing dialogue. It is not fact based and is not therapeutic. In addition, it places a value on life according to subjective notions. Acceptance of the *quality of life* idea will result in distorted healthcare promotion, and distorted care plans that violate best practice.

Furthermore, there is no need for nurses to become useful idiots for philosophical agendas disguised as medical care. For us, the end-of-life issue is settled; life, in and of itself has value, and the venue of subjectivism belongs to the patient. Therapeutic communication requires us to establish rapport through empathy, elicit a list of all concerns, and negotiate a shared agenda, not our agenda formed by listening to subjective opinions posing as fact-based care. Our care is based on accepted nursing principles and nothing else. It is not enough to merely

listen to various care theories, we must insist that we know the rationales behind the theory.

Once we have elicited all concerns through open-ended questions, our care plan must be based on patient-centered care and relationship-centered care. Our aim is mutual respect, legitimization of the patients concerns and feelings, and support (Chou, Cooley, 2018), not the legitimation and support for various and sundry philosophies outside of the patient's realm.

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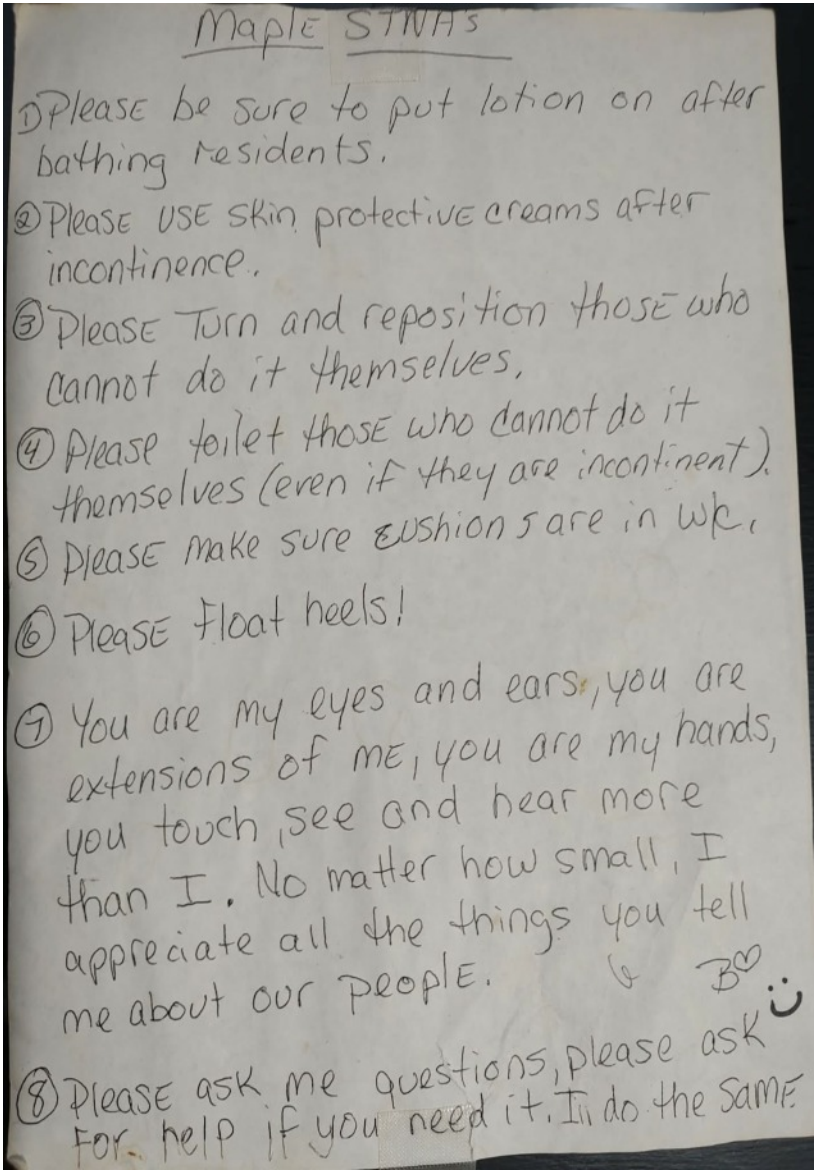
Maple STNAs

1. Please be sure to put lotion on after bathing residents.
2. Please USE skin protective creams after incontinence.
3. Please Turn and reposition those who cannot do it themselves.
4. Please toilet those who cannot do it themselves (even if they are incontinent).
5. Please make sure cushions are in wk.
6. Please float heels!
7. You are my eyes and ears, you are extensions of ME, you are my hands, you touch, see and hear more than I. No matter how small, I appreciate all the things you tell me about our people. B
8. Please ask me questions, please ask for help if you need it. I'll do the same

A note found by the author working as an STNA circa 2017

"You are my eyes and ears, you are extensions of me, you are my hands, you touch, see and hear more than I. No matter how small, I appreciate all the things you tell me about our people."

~ Unknown Nurse

Chapter Eight: How Nurse Aides Save Nurses

There are many positive elements to the greatest profession in the world, but if you only focus on one element to obtain your self-actualization, helping nurses, it would be plenty. The nurse profession is in shambles. Nurses need help; they need aides with the right heart...desperately.

And, as a nurse aide, this focus will do more for your success than anything else. Chapter Nine is about surviving in the toxic atmosphere of nursing; the beginning of this chapter is a head start on that subject. We have discussed the reason for toxicity among nurse aides—aides that don't have the aide heart, and are only functioning on the bottom tier of Maslow's pyramid. They are only on the hall or in a home to collect a paycheck and you will often hear them say, "That's not my job." And yes, because they are only functioning on one level towards self-actualization, they are not happy, and you have to work with them. And since misery loves company, you are not in their club.

And, because they have low self-esteem, they must bring you down in order to live with themselves. They are not on their own life building journey leading to progressive self-actualization, and, so, they endeavor to demolish other building projects so their dilapidated building appears relevant. Please note: you don't work for them; you work for the nurses. The heartless aides will make a lot of noise, but if the nurses value you for the right reasons, those aides whine, howl, and cry in vain. Their attempts to tear you down will fall on deaf ears.

Remember this: if the nurses value you as an aide, you have the keys to the city. This focus is win, win, and win. Nurses are easy to please, just do your job. You don't even need to worry about nurses liking you, they will at least respect you and value your service.

There is no category of people more worthy to be helped. While some unworthy ones are able to survive nursing school, they are rare.

For the most part, the medical industrial complex considers nurses to be like rubber bands; you stretch them until they break, and then you go out and buy more rubber bands. 62% of nurses experience burnout,[i] they have an 18% higher suicide rate than the general population,[ii] and 18% of newly licensed nurses leave the profession within the first year.[iii] Hundreds of hospitals close each year because of nurse shortages.[iv] Nurses are silent sheep led to the slaughter. They need someone in their corner, and that is you. If not nurse aides, who? Many others can comfort with words, but you, the nurse aide, can help substantively at ground zero. It is said that nurse aides are the extended eyes, ears, and arms of a nurse, and statistics tell us that nurses need as much of that as they can get. The choice to give it is yours, and if you are the real deal, you will, because that's who you are; it's what you do; and it's your identity.

Considering that nurses themselves are blamed for the crisis because they neglect self-care,[v] no real solutions are on the horizon. Again, as previously discussed, the American healthcare arena is notorious for poor leadership, and again, it is up to the aide to be a leader, and to lead by example in their acreage of the world. The nurse aide is called to control what they can control and let the chips fall where they may.

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Regarding aides, more is demanded of them in acute care where harm can occur in the short term, but little is expected of aides in LTC facilities. In LTC, aides will typically only use 10% of their required CNA (some states, STNA) training, which is geared more towards acute care. However, any aide can choose to equip themselves and apply it to any healthcare setting to help nurses. With that said, the dyer need is in LTC, which offers the aide unlimited opportunities to increase their value as an aide for themselves, the nurses, and the residents.

In reality, if LTC would fully exploit the nurse aide discipline, it would easily solve 90% of common LTC woes. It would result in less care being needed for residents (prevention), and a decrease in nurse burnout and subsequent staffing shortages. Remember, nurse aides are the foundation of care, and that foundation is strengthened if aides increase and refine their skills. In regard to helping nurses, the envelope should be pushed to its fullest extent. LTC should be built like all sound buildings…on a good foundation and from the foundation up.

Skills that nurse aides can obtain to help nurses are endless, but a few will be cited here. LTC aides, as well as HHAs, can become proficient in holistic (alternative) care. If a nurse is busy and a resident is in pain, there is nothing to prevent an aide from applying ice packs and other holistic applications to relieve pain in the interim. Nurse aides should be apt at redirection and other skills to mediate behaviors until the nurse is able to address the situation (memory care). By the way, memory care is a vast uncharted and unexplored discipline that offers low-cost opportunities for aides to become experts.

Obtaining vitals is usually within the scope of aide practice, and some monitoring skills for post falls are within the aide scope as well. This also contributes to aide upward mobility, which contributes to their self-actualization regarding accomplishment. Nevertheless, focusing and emphasizing the basics of care is lost upon most LTC administrations. They have no vision, and consequently, will hardly supply a vision to others.

The nurse aide, as it is often stated, “is the eyes, ears, and hands of the nurse.” On this wise alone, aides will save several lives, not to mention that CPR is also within the aide scope of practice.

The nurse aide must supply their own vision and purpose within their scope of practice, which is whatever they make it. If you are waiting for healthcare authorities to supply a vision for your discipline, you will be waiting a long time.

Among other elements, helping nurses is paramount.

DIGGING DEEPER
Go to nurse-aide.com and read Reference #1
Overcoming The Nursing Crisis

Chapter 9: Survival

It's true, there is no job more noble than nurse aide. It is truly God's work. Nevertheless, there are few jobs more thankless while taking place in toxic work environments. This chapter is about the mindset required to survive emotionally in healthcare settings, and this requires some basic considerations about human nature. Swimming against the normal tide will serve you well, and enable you to survive in toxic healthcare environments. The overall rewards are worth the effort, and will also serve you well in other areas of life.

In healthcare, personal rewards far outweigh the toxicity, but we cannot deny that healthcare is among the most toxic work environments. According to the American Nurses Association, incivility in the workplace is one of the top eight reasons for the present-day nurse staffing crisis. And the reader might as well know, being an excellent aide makes you a target for the brunt of workplace incivility. Unfortunately, in healthcare, persecution is often a confirmation that you are performing well. The keys to survival and personal satisfaction in healthcare are the right identity, the right focus, and the right information.

Let's start with the right information. Our world tends to be negative. If you watch cable or TV news, you know that good news doesn't sell. On a personal level, there is a human tendency towards condemnation. In fact, condemnation is the water we swim in. Religion is a large part of our culture, and it is mostly predicated on human failure. Yet, Maslow insisted that self-esteem is a basic human need, and human experience confirms this. For example, people, for the most part, do not commit suicide or neglect themselves because they think well of themselves. People do not choose abusive spouses because they think they deserve to be treated better.

This information about self-esteem teaches us the importance of life building. This is our work towards making us better people based on the facts, or what we actually do. Sometimes, things like religion are a shortcut around the work of life

building. While proclaiming ourselves as "sinners," we can still label ourselves as good people based on a mere affiliation with a religious organization. No work necessarily, just claim the label. In the same way, criticizing others is a way to lower the status of others around us as a shortcut to building our own life. If we lower others, we are higher in our own eyes without doing the work.

But, this brings us to an important point. Our goal is not to be higher than others to begin with, our goal is Maslow's self-actualization, which is being all that we can be, or want to be. This is very freeing; we are not competing with others, we are competing with ourselves. Everyone's self-actualization is different.

Which brings up another important point: in competing with ourselves, we are competing against all of the usual human suspects; self-doubt, judgement by others, and human weakness, usually in the form of sloth or lack of motivation. However, here is the most important point: we can almost always do more than we think we can do.

So far, we have the following points: do your own life-building without taking shortcuts, which excludes criticizing others; compete with yourself, not others; and you can always accomplish more than you think you can. A willingness to criticize others or judge others is not healthy to our well being. Strained relationships add to interpersonal stress. Jealousy is not a healthy emotion. You will be a much stronger person if you get along with people who don't necessarily deserve respect. Choose your battles carefully; battles with others take time away from your own life-building.

So, how in the world do we live in peace with problematic coworkers, and set an example for civility in healthcare? This is how we do it: recognize that almost everyone brings something to the table. If you focus on the positives of others, it will temper the negatives. And by the way, it will make you more inclined to like the facility where you work. Be sure of this: what we

focus on determines what we see, and how we see the world we live in. If our focus is negative, our perception will be a reality of darkness. Nasty, petty people have a negative outlook.

Remember, medically speaking, we prescribe medicine and treatments when the benefits outweigh the risk; human relationships are the same way. Yes, for certain, some people are utterly toxic and should be avoided, but those are rare situations if we give everyone the benefit of the doubt.

And by the way, cultivating a civil work environment can be part of your own life building project leading to self-satisfaction and self-actualization. Be the solution; it is demonstrably more self-satisfying than following the nay saying mob.

Here is another principle: it's easy to avoid criticizing others; merely set the example. Even when words are necessary, rather than saying, "That's wrong," you can say, "Here is what works well for me," or "Here is what I was taught." No one stops learning in healthcare, and we want to avoid the idea that anybody is better than anyone else because of knowledge. Comparing your knowledge with others is like trying to be the town tough guy, there is always going to be someone tougher; it's a fool's errand, and your motives for the effort are questionable.

Along the lines of criticizing other aides, we can consider tattling on other aides to the Director of Nursing (DON). Sure, aides are mandatory reporters, but that is not the issue here. Petty tattling is rampant in LTC facilities. Don't be a part of it. Set yourself apart from the crowd. Here is something that will help you do that: most DONs are smart enough to know that it is projection. Bad aides make an effort to put the spotlight on others and away from their own poor performance. In other words, in most cases, tattlers make themselves suspect.

Furthermore, and this is a hard one, ignore bad vibes between you and others that you suspect is a result of gossip. People put out bad vibes for a number of reasons, and in toxic healthcare

environments, you could be quickly consumed by such concerns. Hold everyone, including yourself, to this hard fast rule: if they have a problem with you for any reason, it is their responsibility to address it with you firsthand. Work hard on this, and you will eventually overcome unfounded concerns. In healthcare, there are ample concerns without adding subjective drama. Know that in a healthcare environment there is going to be inaccurate information about you in circulation, and that is out of your control. Focus entirely on what you can control: the truth about your performance. Regardless of anything, in the end, that is what prevails. Life building and bringing your A-game every day go hand-in-hand. And by the way, this will make it easier to own your own mistakes because they are the exception and not the rule. Oftentimes, because of the condemnation waters we swim in, another primary motive for illuminating the mistakes of others is the opportunity to extract a pound of emotional flesh. This shouldn't work with you because you know who you are as an aide; you're not perfect, but exceptionalism is your norm; hence, a mistake doesn't change who you are as an aide.

Gossip, in fact, is always an attempt to change the perception of you by others. If you are a good aide, it's going to happen for a number of reasons, including what we have discussed. Hence, the better aide you are, the more it is likely to take place. Therefore, only address objective accusations that are brought to you formally, and only address the specifics of those accusations. Always tend to the perception of you by others through performance (what you do) only. All other activities are a Wack a Mole game.

Lastly, this formula of knowing your identity, having the right knowledge (what makes people tick), and focus, boils down to prevailing towards the most important objective: resident care. Obviously, caring for others successfully is a powerful venue for purposes of self-actualization, but not at the expense of yourself. You can't build life while tearing yourself down, supposedly, for the sake of others.

To the degree that you protect yourself in a toxic healthcare environment, you can care for others.

DIGGING DEEPER

Go to nurse-aide.com and read reference #2

Therapeutic Communication: 10 Essential Techniques

Go to nurse-aide.com and read reference #3

The Nurse Aide Religion

"To be successful at anything, the truth is you don't have to be special. You just have to be what most people aren't: consistent, determined and willing to work for it."

~ Tom Brady

SECTION THREE
NURSE AIDE APPLICATIONS

Hi,

We just wanted to let you know that we loved the article that you submitted. Sorry it took us this long to respond. This is exactly the type of articles that we are looking for. We wanted to let you know that we will be publishing your article in this month's issue, which will be available in just a few minutes.

Drema Marshall
www.4cnas.com
The Online Magazine for Certified Nursing Assistants

Chapter 10: Aide Team Work

Should Aides Split a Unit or Work Together? As published by 4CNAs online magazine.

Nurse aides in nursing facilities will typically work on long halls with 20-30 residents or in units with two smaller halls. This chapter is about skilled nursing units, behavioral units, or Dementia units. In most cases, assisted living units would not beg the question as to whether or not two aides should work together on a hall or unit. However, some assisted living units are only that by name and require a lot of total care.

Among aides, working a unit together rather than splitting it up and working the two halves solo is not a popular notion, but for some reason, that is changing. In the last two months I have worked units together with another aide three times, but before that, only once in my entire career as an aide.

In all three cases, it was young aides that were very experienced and also very good. I was surprised that they were so readily open to working together. Most of the activity in the rooms was automatic. I paid close attention to time, which most aides, including myself, give too much concern to, and found that tasks do get done faster. The other day, the two of us got three people up with Hoyer lifts and did one shower in well less than an hour. That's pretty good and brings me to my next point.

Facilities have gotten good about abiding by laws that require two aides to transfer a resident with a Hoyer. So, let's think about this: if you divide a hall and work separately, the other aide has to stop and spot you on a transfer anyway. Usually, the other aide is in the middle of something and you end up waiting for them. Secondly, beyond that, you may have residents that require two aides anyway even if they are bed ridden. Some residents can lend little help with bed mobility.

Then, there is the whole issue of accountability. Two heads are better than one. Since you are not in such a rush, being by

yourself, you are thinking more about safety issues and other care issues. One aide may be turning the resident while the other one is making sure catheter tubes and other lines have plenty of slack. Many needs can be done separately at the same time. One aide can be helping with oral care while the other is making the bed and straightening up the room. And yes, being in the room and ending up without everything you need happens; so, the other aide can go fetch what you need while the other aide keeps the tasks moving along. In addition, having to leave the room to get something or find a nurse in the midst of a task can be a safety issue.

This is for certain: even if the time is about the same, quality of care is greatly increased. In addition, the residents like two aides in their room instead of one; it's additional personal contact that aides usually avoid because of time constraints.

Let's also discuss resident preference regarding the gender of the aide. That cuts all the different ways that you can think of; some male residents don't want male aides etc. Again, one aide can do the personal care while the other aide does the other tasks.

Another issue is residents needing to be "pulled up in bed" and having to go find the other aide to help you do that using a draw sheet. The point here follows; as mentioned prior in this chapter regarding other care items, the aides have to work together on a lot of tasks anyway. Let's also add the possibility that one aide is unfamiliar with the residents; not only is that a safety issue, but you don't have one aide looking for a nurse or aide to ask questions about resident care.

When an aide is going to get charting done can be a stressful issue, especially if the day is not going well. The two aides might want to split up for that. One aide can start second rounds while the other one charts and then rejoin the other aide after charting is done, or they can do the charting together. Break times are more likely to happen if you work together as well.

There is something unfortunate in aide work that is much

more likely to occur if a hall is split: walking past a call light. "Not my room, that's your room," right? Only problem is, an aide should never walk past a call light for any reason. During meals, residents needing assistance can't be evenly divided for several different reasons, so there is some crossing over in assignments for that as well. You can add these to the list of things that invariably lead to the assignments being intermixed anyway. In other words, splitting a unit is somewhat of a fallacy to begin with. I am convinced that it leads to a reduction in care quality.

COVID 19 is also an issue. While quality of care is increased, time exposure in each room is less, and there is a decreased possibility that a single aide that is behind schedule will cut corners on standard precautions. Two aides working together wash their hands more etc.

Lastly, aides are the eyes, ears, and nose for the nurse. When aides work together, that perception is doubled.

DIGGING DEEPER
Things Nurse Aides Should Know
Go to nurse-aide.com and read reference #4
Just The Science: N-95 Masks
Go to nurse-aide.com and read reference #5
A Nursing Old Wives' Tale: Effective CPR Always Results In Extensive Rib Fractures

"Anne Frank once wrote, 'How wonderful it is that nobody need wait a single moment before starting to improve the world.' Any nurse aide at any level has no need to wait for a moment to improve the world. It is simply a matter of being the best you can be at aiding nurses. Here, the void that needs to be filled is vast, and regarding improvement, the world is yours for the taking. Improving the world through improving nurses is not a bad gig. In fact, better than most."

Chapter 11: Expanding the Nurse Aide Toolbox

It is interesting what the healthcare industrial complex openly concedes by the medical disciplines they have put in place. It is a concession that nurses need a lot of help. The nurse aide culture of any facility will determine the quality of care delivered by the nurses. Good nurse aides magnify the effectiveness of any and all nurses always.

This chapter is about the medication aide discipline practiced in many states. This is a good thing that offers upward mobility (a level of Maslow's hierarchy) for aides and further empowerment to help nurses. It cannot be said enough: the primary role of nurse aides is to aid nurses. While this chapter is about medication aides, it serves as an example for many other certifications that nurse aides can add to their aide tool box.

It is interesting to note that the establishment of the medication aide discipline is an admission that nurses spend too much time passing medications in long-term care. In general, the medical industrial complex is guilty of squeezing every bit of sacrifice they can get out of nurses and are continually pushing the envelope. This makes the quality of any given aide culture critical to nursing.

This statement needs to be isolated to a single paragraph: the state of nurse aide culture contributes significantly to the nurse shortage. The abysmal state of aide culture in this country contributes to nurse burnout. And, a distortion of nurse aide identity is the primary cause of the culture's abysmal state.

Furthermore, nurse aides are a primary source for support, love, and respect towards nurses. Experience teaches us continually that the medical industrial complex puts little value on nurses regardless of their acquired extensive training. Even ADNs, BSNs, and MSNs are treated like serfs on a continual basis by the medical establishment regardless of plenary workplace shortages. LPNs are routinely treated like rubber bands meant to be stretched until they break because they can be

replaced with new rubber bands. Yet, experience also teaches us that nurses are a unique breed that are mostly indifferent to this reality and are focused on the opportunity to care for those in need. In other words, nurses see the medical industrial complex as a necessary evil primarily concerned with money. In the past, nurses have been notorious for accepting low pay, but that paradigm has shifted to some degree because of incessant disrespect. Money is not the problem, stress and burnout are the problem. The same is true for nurse aides; remember, there was a time when nurse aides were volunteers. In both cases today, they may tolerate disrespect, but will make sure they are compensated for it financially.

Meet nurse Bob. He passes medications to 32 residents. In addition, he is responsible for their overall care. His shift includes an AM med pass, noon med pass, and evening med pass. At the beginning of Bob's shift, he discovers that in addition to his normal responsibilities, a once-a-month full set of vitals are needed on every one of his residents, and unless these vitals are entered into the electronic medication administration record (MAR), the medications will not be shown as given. In addition, Bob works in an AL (assisted living) facility where state tested nurse aides are not required by law, so vitals are not an official scope of practice for the aides. Bob is about to have a very bad day.

Unless, the aide culture goes the extra mile to aid the nurses. This would mean the aides do more than they have to do, and within their scope of practice, though not the official scope, to help the nurses. In many cases, facility policy can expand the scope of practice beyond state code through in-house certifications and in-service. Most state codes allow for this. For certain, facilities and home healthcare agencies should exploit that opportunity to its fullest extent. If Bob's aide can help him obtain the vitals, the extra burden is neutralized. Because, like most facilities, the facility where Bob works does not supply a vision and purpose for the aides, most of the RAs (resident assistants) are not trained to obtain vitals and most muse that it is "not their job" anyway. However, Bob knows that there is an

aide at the facility who is different. He quickly goes to the schedule book to see if she is on the schedule. She isn't. Bob is going to have a rough day, and when he has more rough days than he can bear, he will leave for another facility, or sadly, in many cases, nurses leave the profession altogether. This book can be boiled down to this microcosm or at least this chapter; in large part, there is a nurse shortage for this reason: nurse aides have no identity, vision, or nurse theory.

Anne Frank once wrote, "How wonderful it is that nobody need wait a single moment before starting to improve the world." Any nurse aide at any level has no need to wait for a moment to improve the world. It is simply a matter of being the best you can be at aiding nurses. Here, the void that needs to be filled is vast, and regarding improvement, the world is yours for the taking. Improving the world through improving nurses is not a bad gig. In fact, better than most.

So, the focus is to aid nurses and make them more efficient for the benefit of providing the best care possible. Nurse aides should endeavor to add as many tools possible to their repertoire for that end. Medication administration is one example of that, but there are many, many more.

DIGGING DEEPER
Go to nurse-aide.com and watch reference #6
Med Pass Principles
Go to nurse-aide.com and read reference #7
Medication Administration and the Myth of Multitasking

"I attribute my success to this: I never gave or took any excuse."

~ Florence Nightingale

Chapter Twelve: The Nurse Aide Arrival

Day after day, millions of people arrive at work to begin the task of different jobs. The job of nurse aide is arguably the best job any person can have. One reason, among many, is the arrival.

Regarding most jobs, the arrival at work is routine, but for those working as nurse aides and possessing the heart of a nurse aide, the arrival is far from routine. In fact, it is fair to say that a nurse aide's arrival can be a matter of life and death. My brother was under the care of a nurse aide at home and had a medical episode at the time the aide was scheduled to arrive. Unfortunately, the aide was late, and when she arrived, she found my brother deceased.

There are other reasons a timely arrival is important for a nurse aide. It is a demanding job, and the aides you are relieving are probably ready to go home. However, it goes far beyond that motive. Among nurse aides, the arrival is an opportunity to honor your fellow aides. The point here will focus on shift change reports. Though the job is unique, in and of itself, with the focus here being the arrival, aides can make it even more unique by setting themselves apart with the right focus.

One focus of the arrival should be a relevant report. You see, reports shouldn't be the presentation of a case that you did your job so that my shift will be easier; good aides know that the pursuit of easy as an aide is a fool's errand anyway. Besides, the job is about the resident, not how hard your job is. If you are a good aide, it goes without saying that you did your job, and if you didn't, there is a good reason why and knowing the why is of no benefit to me. If you are a substandard aide, cleaning up your mess comes with the territory. Good aides know that tattling is a waste of time and smart DONs know that it is mostly the projection of your own guilt anyway. Good aides report abuse, but they don't tattle; they suck it up and take on the day. They know they are good, and don't need to bring others down to prove it, or for that matter, merely shine a spotlight on a poor performance that may or may not reflect someone's overall performance anyway.

Honor other aides by being on time and assuming the best about them; it's a great way to start a shift. Herein is really the first point of this chapter; the arrival of a nurse aide makes it a unique job because of who is glad to see your arrival. Too often, way too often, aides are not happy to see the arrival of their relief because it means, after putting in a hard day, they must make a case for how easy they have made the beginning of the shift for their relief.

Hence, unfortunately, for the most part, other aides are not among the two parties that are happy to see the aide's arrival. As an aide, pleasing other aides cannot be your focus. You won't last long. Nevertheless, changing the culture, beginning with the purpose of the shift change report, puts the aide profession in a more honorable light and improves care. Though it should never be your goal to include aides in those who are happy to see your arrival, a little extra icing on a cake is always good.

Few job participants are greeted with appreciation upon arrival like the nurse aide. We will start with the residents of a long-term care facility. The fact is, many residents pin their hopes on having a good day, or night, by which aide is scheduled to work. Residents know if the aide wants to be there or not. Residents know if the job is just a paycheck in the mind of the aide.

Full stop: nothing is worse than being cared for by someone who is put off or inconvenienced by your needs. If you are an aide, and you want to care for people; they know it, and your arrival makes their whole day worth the living. Few jobs may boast such a daily arrival.

Furthermore, we must ask ourselves, how many falls and subsequent injuries are due to a resident trying to do something they are unable to do because they know the aide is put off by their needs.

The next ones who are glad to see your arrival, and the last

subjects of this chapter, are the nurses. They are probably glad to see you, even if are not that great of an aide. Their job is nearly impossible without you.

Here is the key to surviving the rigors of being a nurse aide: please the nurses; it is very much mission possible. Aides eat their own and always will; you work for the nurses, not the aides. If you remember that, you will do well. If the nurses value you, the aides can bark at the moon till the cows come home, and probably will, but to no avail.

A few tips for winning over nurses. "'Nurse' is a noun and 'aide' is a verb." One of the elements of a fake aide is the expectation that nurses should have to help the aides. Most nurses don't even have time to go to the bathroom. If you think nurses should help you to remain humble, don't worry, the facility administration will take care of keeping nurses humble.

Dare to change the present culture. Don't sit down unless it is your break time, and never sit down on the hall. Down time is patrol time: that's when you are the extended five senses of the nurse. Stay off your phone while you are on a hall. And for crying out loud, don't text while you are assisting a resident with a meal. Just don't do it.

Put your STNA training to use. Instead of running to the nurse with every resident complaint to start with, apply your training and then report to the nurse. For example, SOB. Is the breathing apparatus properly inserted in the nose? Is the resident elevated to the semi-fowlers position? What is the oxygen saturation that can be reported to the nurse? You just saved the nurse 15 minutes. Applying your skills throughout the shift will save the nurse hours. That will not go unnoticed by any stretch of the imagination.

Lastly, empty the med cart trash can and keep the water pitcher iced and full. However, you may want to apply these tips gradually over time lest the nurses think you are mentally unstable.

If you do your job, you can know, while you are enroute to the facility, that your arrival will make people glad. Beside the residents, the nurse will look at you, and he or she may not say it, but they are thinking, "It's going to be a good shift." Not a bad gig. You are making good nurses better...and happier.

Like any difficult job, you will need to remember from time to time the objective reasons for wanting to be an aide. That will give you the staying power and the encouragement you need. You must remember why you are an aide. And if you think about it, it wasn't because you thought it was going to be easy; no good aide ever wanted an easy job, but rather something challenging that pays the dividends of self-fulfillment.

And there are many good reasons, more than any other profession, but perhaps the best one is the positive arrival you experience on every shift.

"One's only rival is one's own potentialities. One's only failure is failing to live up to one's own possibilities."

~ Abraham Maslow

Conclusion: Changing Long-Term Care Culture with Nurse Aides

Long term care in the United States is all but completely broken. Of course, the biggest problem is staffing shortages, and the response to staffing shortages by long-term care (LTC) management has created a downward spiral. For the most part, LTC facilities supply subpar care, are chronically understaffed, and have toxic work environments. This is because LTC facilities never analyze the reason for staffing shortages and treat the problem like a force that is out of their control. Hence, LTC has long ago given up on finding a cure, and treats staffing shortages with a palliative care approach. Viz, keep everyone and everything as comfortable as possible because the profession is terminally ill. Hence, temporary fixes are acceptable.

What does that look like? LTC facilities, for the most part, seek to fill positions with nothing more than warm bodies. Therefore, facilities capitulate to anyone willing to show up, and employees that are willing to pick up additional shifts for excessive bonuses can practically, so to speak, rape, pillage, and steal with no consequences.

Since the nurse aide position is the most challenging, this is where most staffing shortages occur. Hence, this is where facilities are most likely to capitulate. As a result, nurse aides are running most facilities and the idea that they are supervised by nurses is pretense. In addition, a care team approach between nurses and nurse aides is, for the most part, nonexistent. Nurses do not receive help from aides, leading to burnout, and the aides with heart are burned out because they are continually picking up the slack produced by “aides” that are merely there for a paycheck. Furthermore, clock-punching aides will abuse other aides who threaten the status qua, which is doing as little as possible for wages paid.

What is the answer? The answer begins with the foundation of care...the nurse aide discipline. The answer is supplying

nurse aides with a vision of who they are. The answer is a focus on the nurse aide identity. A good way to open this point is the experience of this author. As a longtime nurse aide, on one occasion only, a nurse began the shift by giving me a report on the residents. In other words, she received a report from the nurse she relieved and communicated a report with the oncoming nurse aide. She expected a care team approach with her aide.

Let's be honest; we must accept the fact that this is a completely foreign concept in LTC, and ask ourselves, "why?" The reasons are ample, but the answer is a return to the basics; the nursing discipline that is the foundation of care must be fully exploited. Said another way, the nurse aide discipline must be elevated to a never-seen-before grandeur in LTC. In acute care, for reasons we will not discuss here, this is not an issue; nurse aides are fully utilized as much as possible.

What will this look like? It goes further than doing skills that are not included in the LPN and RN job description. In other words, a *your job–-my job* kind of mentality. It must be a care team cooperative effort. This will solve two problems: nurse burnout and a lack of upward mobility among nurse aides. Obviously, nurse aides will experience more satisfaction with their role if they are doing tasks that vary in technical skills and make nurses more efficient at what they do.

The key to solving staffing shortages in healthcare, and for that matter, any profession, is an employment model based on Maslow's hierarchy. The employer will simply make sure the employment offered will enable the employee to obtain basic physiological needs and shelter (competitive wages), a feeling of safety, belonging, accomplishment, prestige, self-worth, and an increasing sense of self-actualization.

By the way, experience teaches us that nurse aides, and nurses as well, will trade higher pay for respect. Nurse aide shortages were no more severe before COVID when nurse aides were making 50% less. In many cases, if aides feel respected and appreciated at a particular facility, they will obtain another job

to make up the lack of compensation rather than leaving that facility. With that said, some employees judge the employers' respect for employees through wages, which is a valid assessment. Another observation follows: feeling safe is a priority need, and as shared elsewhere in this book, nurses often leave the profession due to unsafe work environments. But, don't miss the following on this point: if an employer attempts to motivate employees through fear, they will not feel safe. Feeling safe can include job security. In fact, an authoritative employee/employer model, rather than a cooperative model, is a bad idea altogether.

Nurse aides that are merely fulfilling their job description are not aiding nurses. In most facilities, the nurse aide's job description is limited to ADLs. Making the aide a team partner with the nurse will supply upward mobility for the aide resulting in higher self-esteem, respect, and a higher sense of accomplishment. Furthermore, aides should be educated about Maslow's theory regarding their own needs, and not just resident needs. They should be encouraged to be all that they were meant to be, which is different for everyone. Furthermore, they should be encouraged to view others regarding what they bring to the table, rather than what they don't bring to the table, and this should be constantly modeled by management. There should be zero tolerance for disrespect. This speaks to the issue of toxic work environments, which are epidemic in healthcare.

As far as modifying these goals for assisted living facilities because they are only required to use Resident Assistants (RA), this is not a valid concern; assisted living facilities are routinely inundated with residents requiring skilled care. Shockingly, memory care facilities are allowed to be designated as assisted living (AL) in most states. Obviously, memory care requires an elevated level of skill. And again, aides in general should be certified and trained in alternative medicine (Holistic/Wholistic care) as additional means to aide nurses and residents.

Expanding the role of nurse aides will supply self-actualization and self-fulfillment through their profession and decrease

nurse aide staff shortages. Remember, burnout is defined as a lack of self-actualization; a task oriented job that supplies basic needs only will always lead to burnout. In turn, nurses receiving help from aides will enable a higher quality of nursing care and subsequent self-actualization among nurses.

DIGGING DEEPER
Go to nurse-aide.com and watch reference #8
Staffing Shortages and Maslow's Hierarchy

"If you plan on being anything less than you are capable of being, you will probably be unhappy all the days of your life."

~ Abraham Maslow

“Anne Frank once wrote, ‘How wonderful it is that nobody need wait a single moment before starting to improve the world.’ Any nurse aide at any level has no need to wait for a moment to improve the world. It is simply a matter of being the best you can be at aiding nurses. Here, the void that needs to be filled is vast, and regarding improvement, the world is yours for the taking. Improving the world through improving nurses is not a bad gig. In fact, better than most.”

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