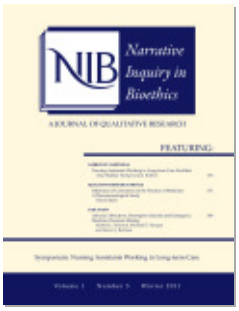
Changing Public Perceptions of Direct Care Professionals

Tracy Dudzinski



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Introduction
Learning From Those Working Most Intimately with the Residents in Long-term Care

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Certified Nursing Assistants (CNAs) are responsible for nearly all of the direct patient care in nursing homes or long-term care facilities in the United States and account for nearly two-thirds of the total staff.

Most nursing homes are for-profit enterprises with an average of 107 beds (Centers for Disease Control and Prevention, 2000). The typical resident is female, widowed, and white with the majority over 85 years of age. CNAs are overwhelmingly female and black or Hispanic, or members of immigrant populations that reflect the ethnic composition of a community. To put it bluntly, the least educated, worst paid members of the long-term health care team provide the majority of care to the most complex patients a health professional could encounter. The work is literally back-breaking as most of the residents in a nursing home need help with the basic physical activities of daily living such as walking, transferring, eating, dressing, and toileting. Many residents also suffer from at least one type of mental disorder such as depression or dementia.

Thus, interacting with this frail dependent population places heavy emotional demands on CNAs. The potential for exasperation and abuse is high under such circumstances and CNAs can react with harsh words or neglect. However, abuse isn't one-sided. Residents can become frustrated and angry when care isn't delivered in the time frame or manner they want which can lead to verbal or even physical abuse directed at CNAs. CNAs comprise a vulnerable group of employees in health care with the highest rate of absenteeism and turnover among all health professionals (Fitzpatrick, 2002; Parsons, et al., 2003). The oversight of CNAs is minimal in most facilities. Their orientation to the facility and the residents is often scant. Their work occurs in relative isolation, generally hidden from public scrutiny. Few researchers have studied the experiences and perceptions of CNAs and attempted to understand their attitudes toward their work and interactions with residents, families, and supervisors. The little research that is available, often the result of observational studies, portrays CNAs' behavior as one of extremes—compassionate care givers or abusers (Foner, 1994). Clearly, there are examples of great kindness demonstrated by CNAs who sometimes serve as surrogate family for residents who are literally alone in the world. As with many roles that cross age, race, and socioeconomic lines, the intimate relationship between CNAs and nursing home residents is far more nuanced than these polar opposite types indicate.

In an attempt to tease out some the subtleties in this relationship, the call for stories for this narrative symposium included this request and these questions:

> We would like stories written by nursing assistants that describe their work—what is most

rewarding and challenging, and what concerns they have about the care they provide and the care patients need. We are especially interested in stories that give the reader a "back stage view" of the life and work of nursing assistants. We want your true personal story. In writing your story you might want to think about:

- Do you feel that you make a difference in the lives of patients?
- What kinds of problems do you face working with residents, families, and other staff?
- Your job is physically challenging at times. Is it also emotionally or morally hard?
- Have you ever thought there might be something wrong with how someone was being treated? What can you do when that happens?
- Is there anything about your job that surprised you when you first started working?
- What things do you think others would want to know about your work?

Gathering these stories proved a very difficult task. Many CNAs do not have home access to computers and the internet. Several stories came in the form of painstakingly hand-written letters. Most were well written with few or no mistakes in spelling, grammar, or sentence structure. All of these writers were very aware that what they wrote and how it was written would directly reflect on their entire profession. They very much wanted to make sure readers knew that they were dedicated, hard working, and professional.

Finding these authors would have been impossible without the generous help of Genevieve "Jeni" Gipson, RN MEd RNC, Director, National Network of Career Nursing Assistants. She helped locate all but two of the authors for this symposium. More information about the National Network of Career Nursing Assistants can be found on the website: www.cna-networking.org

This narrative symposium on the experiences of CNAs reveals a great deal about the complexity of their work and the responsibilities they assume that are often outside their job descriptions and training. The CNA narratives include first person accounts on a variety of topics including: what is required of them in their work as caregivers; the nature of the relationship with residents, families and other staff members; training and support, or lack of it; burn-out and exhaustion; commitment to residents; coping strategies (both good and bad); and why they stay in a job that is difficult and low-paying. Since most of the CNAs who responded were women and since caregiving of an intimate and personal nature has so often been relegated to women, I thought it appropriate to ask my friend and colleague, Delese Wear, to write one of the commentaries. Writing as a feminist, she observes the nature of the work of CNAs from that perspective and also shares her personal experiences of a family member who received care from a CNA. Jacqueline Glover, the second commentator, was chosen because she is a friend and colleague and because she has an abiding interest in the moral implications of team work in health care settings. Stories from CNAs who are the closest to the most vulnerable among us are important for us to hear because care giving of this type is not valued, is desperately needed and will become increasingly necessary as the population ages. Martin and Post (1992) note in their work on care giving of persons with dementia, that there is too little appreciation of the human knowledge about the human need for care and attachment that this work requires and gives to those who do it well.

References

Centers for Disease Control and Prevention (2000). *An overview of nursing home facilities: Data from 1997 national nursing home survey* (DHHS Publication No. 311). Washington, DC: National Academy Press.

Fitzpatrick, P.G. (2002). Turnover of certified nursing assistants: A major problem for long-term care facilities. *Hospital Topics, 80*(2), 21–25.

Foner, N. (1994). Nursing home aides: Saints or monsters? *The Gerontologist, 34*(2), 245.

Martin, R.J., & Post, S. (1992). Human dignity, dementia, and the moral basis of caregiving. In R. Binstock, S. Post, & P. Whitehouse (Eds.), *Dementia and caregiving: Ethics, values, and policy changes (*60–61). Baltimore, MD: John Hopkins Press.

Parsons, S.K., Simmons, W.P., Penn, K. & Furlough, M. (2003). Determinants of satisfaction and turnover among nursing assistants. The results of a statewide survey. *Journal of Gerontological Nursing, 29*(3), 51–58.

Personal Narratives
Certified Nursing Assistants Working in Long-term Care Facilities

James Bradley, Tracy Dudziniski, Sue Gibson, Donald Koenig, Debbi Pitts, Danny Reed, Nanci Robinson, Leilani Roseberry, Donna Tucker, Renee J. Tillman, Margaret Fletcher

Lessons From my Life's Work

James Bradley

Almost thirty years ago, I entered the caring profession as an Auxiliary Nurse, on a temporary basis, as a prelude to taking formal training as a Registered Nurse. Since then I have had many titles, held many positions and roles and worked in many different care settings. I never did take that RN training but that temporary job became my life's work!

I am a carer. A hands-on, at-the-bedside, hand-holding, bed-bathing, carer. Not only that, I am a male carer. I am not a failed doctor, I am not "hired muscle," nor am I gay and I certainly didn't enter the profession to be amongst so many women, as the stereotypes would suggest.

Put simply, I care for people and do for them what they would do for themselves under normal circumstances, were they able to do so. I can cook, clean, sew, iron, and make beds, bathe, toilet and many other things besides. Not only that, I can do more than one simultaneously. Yes, I am a straight, male carer who can multitask, which is perhaps why so many people have difficulty in understanding people like me!?

Every day, come rain, hail or shine; morning, noon and night, I care for others, often with as much compassion and love as if they were my own family. Once you have built up a relationship with a client or patient and his or her relatives, they can seem as close as family. The anomaly in nursing these days though, is that most RNs don't get the time to "be" a carer to the same extent that I do. That is the main reason why I made the decision to not pursue RN training, as per my original plan.

Internal and external politics, in addition to the "culture of litigation," has created a growing chasm between what nurses should be, what they want to be and what they actually are in fact. Many RNs joined the profession to be what I am now, only to find themselves bogged down in paperwork, mandatory annual education and undertaking tasks which once were the domain of junior medical staff. This is not a criticism of those RNs, but an observation on the nature of care, from the grassroots level. As those RNs are pulled away from providing basic care, who is left to fill the void created? That is where my peers and I come in!

There are literally thousands of people like me across the country doing the exact same thing I do every day. Yet, as stated, I am in a minority, for I am a male carer in a female-dominated environment. That brings a whole set of differences in itself, some of which should never exist in a modern care environment and wouldn't, were they pertinent to females rather than males.

For example, imagine a male doctor telling an RN to "make the coffee" simply because she is female and used to being in the kitchen. Just consider how much upset that would create, with claims of sex discrimination and lack of professionalism. Quite rightly so, too. Then consider why it seems

acceptable for females to expect certain responsibilities be undertaken by males simply because "men are stronger than women" (not true either, based on some of the people I have worked with over the years!). These double standards rise up infrequently, thankfully, but the fact that they exist at all says much about the nature of formal RN training.

I was surprised at the job, initially, at how managers, education departments, etc. failed to recognize males in the profession—Florence Nightingale and her crew have a lot to answer for! It's even worse to see that discrimination against males still exists in some places, and by some people (who would claim to be "professionals") even today. There is no place in the Care Industry for those with such biased perceptions because, if they can hold such views about their colleagues, one wonders how they feel about their patients. Especially patients who may be challenging.

Sometimes patients' families can be difficult too, more so than the patients themselves. However, caring for a patient's family to the best of one's ability, and as far as is appropriate is, in fact, part of a holistic approach to patient care. Some staff forget or overlook that small fact. Patients' families may appear to be demanding, but they are just wanting the best for their relative—quite rightly, too. You have to pause and consider though, whether relatives seem to be difficult and demanding because they feel helpless or guilty that they cannot look after their loved one and are having to devolve that responsibility to you.

Such occasions are not helped much when the staff on duty are, themselves, difficult or lazy and take such things personally rather than seeing them from a professional viewpoint. Then the nursing assistant is seen as someone to vent to and who can sympathize with the aggrieved relatives regarding their perceived slight by the RN.

The same thing often applies to nursing assistants who are used on a 1:1 basis for the duration of their shift. You get the situation where unregistered nursing personnel are sitting in close proximity to, perhaps, a suicidal patient. That patient needs formal counseling and therapeutic intervention, not someone to just chit chat to, who is often someone with no empathic insight and whose input is of little real value to the patient.

Such negligence occurs because most junior and middle managers' priorities are not on patient care but on budgets, staff turnover, and patient to bed rotations. As carers though, we know we deal every day with VIPs and those VIPs are the people in the bed, the people actually needing the care. Without those people, none of us would be needed, regardless of one's position in the organization.

It is unfortunate that many managers, junior, middle and senior, do not value the input from Nurse Assistants. There are a few reasons for this though. They often do not "see" down to the level of Nurse Assistants, despite the fact that those very people are the ones providing the majority of the care and who know the characteristics of each individual client or patient in their care.

While it is professional courtesy to acknowledge RNs, it is negligent to ignore the valuable experiential input from Nurse Assistants simply because they are not deemed professional in the hierarchy of things. The front line carers are only too well aware that we are dealing with people, not products, profits and budgets. We do not care about such things. Managers do, but managers cannot or will not see that divide between us.

Patients do have higher expectations and standards these days, I believe, despite the frequent debates on the financing of health care. From our grassroots level, carers mostly think there is actually enough finance and resources but the problems arise through mismanagement, be that financial mismanagement or a more practical level.

Managers want everything to work smoothly, of course (don't we all?), but when dealing with something wrong, like abuse, the Nurse Assistant must speak up and if necessary, refuse to carry out a task or work with a certain individual. If necessary, the matter should be reported to an external source, if managers refuse to listen. Even if the consequences are financial penalization, or similar, for the employer.

This is but one of the emotional and moral challenges we, as carers, are called upon to judge every day. Our approach should always be one of being non-judgmental to all but we are, first and foremost,

human, and the human condition means that we are fallible, we make mistakes, we are not perfect after all. We might not get on well with everyone, both staff and patients, but we can be professional and give the exact same high standards of care to everyone.

The work itself can be very draining, but to beat the stress of it, you can follow all the usual stuff like going for walks, playing with your kids, watching TV etc. The best advice, though, is to, as far as possible, leave the work behind when you walk off at the end of your shift. That may be the hardest thing to do but it is the only way to retain the correct professional approach.

Overall, being a nurse assistant, a carer, is a great career, not just a job. But it is very definitely *not* a religious or spiritual calling. Many people (and some institutions/facilities) see nursing as a calling akin to that undertaken by nuns. Specifically, to serve God by extending his healing and caring to others. It may be a "calling" in that not everyone can or wants to do this kind of work, but no one has to be a Christian, or even religious, to do it. All that is needed is care and compassion for one's fellow human beings, regardless of their religious persuasion or anything else. In addition to this, I feel that citing nursing as a calling detracts somewhat from its professional image and that is something I have difficulty with. We are professionals, doing an excellent job of care, under sometimes very trying circumstances. There should be no scope for anyone to think that we should simply accept low standards and conditions because it is our "calling." And, as I have discovered, you don't have to be a nurse after all!

Changing Public Perceptions of Direct Care Professionals

Tracy Dudzinski

Let me take you back to 1996. I was working in a cheese factory and was notified that the factory was closing. My husband is disabled, so I needed to find a job to help support my family. There was an ad in the paper that the local nursing home was running a certified nursing assistant class. I thought, "I can do that"—I used to babysit and I do know how to change diapers. The first week was classroom instruction and the second week was instruction and skills training. After the two weeks, we took the CNA test and I passed.

The nursing home offered me a 72-hour position on second shift. I was supposed to receive a one week orientation, but that did not happen. The first night I worked, one of the other workers called in sick and I ended up working alone. I was responsible for ten residents. Toileting, repositioning, getting them up from a nap, monitoring the wanderers, getting them to the dining room for supper, and assisting those who needed help eating. After supper, I needed to make sure everyone got back to their room, toileted, repositioned, washed up for bed, or showered, and assist them to bed. Then there was charting and rounds. That first shift finally ended. On my drive home that night I asked myself, "What did I get myself into?" The training I received the previous two weeks did not prepare me the way it should have. I went back for my next shift and was lucky enough to be on the wing with an experienced CNA. She took me under her wing and became my mentor. Thanks to her, I fell in love with the job and stayed on second shift for five years.

A cook's position opened. I'm not sure why, but it paid more than doing the personal care, so I signed for the job. I figured I would still get to see the residents in the dining room, and I helped on the floor when they needed me, which happened with regularity.

After a year in the kitchen I took an office position. It was Monday through Friday, no weekends, and more money and I could still see the residents during the day. Well it wasn't long before I was doing all three jobs. Eventually this became too much and I made the difficult decision to leave the nursing home, after seven years of dedication to the residents. That was one of the hardest decisions I have ever had to make.

Leaving was so difficult because of the relationships I had built with the residents. The elders I

cared for gave me more than I could ever give them. Sure, I took care of their basic needs, but they gave me an ageless wisdom. When I was able to take the time to listen they gave me history lessons (because they lived it), and life lessons. One gentleman was in the WWII, and he taught me the importance of freedom and not to take it for granted. This same fellow taught me how to count to ten in German.

Another elderly gentleman I cared for was very special to me. We hit it off from the time of his admission. The day after he passed away, his son called to ask me to be a pallbearer for him, of course I did and was honored that I had touched his life in a special way.

I remember the first time a resident died while I was working. I was scared and not sure of what to do. Remember that mentor I mentioned earlier—she taught me how to care for a dead person. She also told me that washing up a dead person and getting them ready to go to the funeral home was the last good thing I could do for that person.

I wanted to stay in the profession of direct care because I could make a difference, so I applied for a job with a home health agency. It just so happened that they had a client I could work with 40-hours a week (which I now know is a rarity in the homecare field). I was told that I would be responsible for taking care of a quadriplegic man. "Okay," I thought, "I can do that." I went in to train with another caregiver (training was pretty good with that agency). The first day I trained, I thought, "I have to do *what?*" Learning to catheterize him, which is inserting a tube into his bladder through his penis, was not too bad, but the bowel program consisted of manually removing stool from his rectum while he was seated in a shower chair. At least I was no longer responsible for 10 to 15 residents. I could give my undivided attention to one person.

A typical day with this client consisted of arriving at 8am, changing his *Depends*, dressing him, and using a hoyer lift to transfer him to his wheelchair. Then I'd prepare and feed him breakfast and help him take his medication, floss and brush his teeth, and do range of motion exercises on his upper extremities. I'd read to him from the Bible and a daily devotional. At 10am I transferred him back to bed catheterized him, performed range of motion on his lower extremities and then transferred him to the shower chair. Once in the bathroom, I did a skin check and manually removed stool from his rectum. Then I gave him a shower, dressed his upper half, and transferred him back to bed. While he rested I cleaned the bathroom and prepared lunch. At noon I dressed his lower half and transferred him to his wheelchair, then fed him lunch and performed a range of motion on his upper extremities again. Then I would shave him and clean his razor, read from the daily paper about current events, give him a snack and assist him in taking his medication, then transferred him back to bed, catheterized him, positioned him on his side and hooked up the sip and puff life line that allowed him to call for help by blowing into a straw, clean the catheter, and do the dishes, making sure I was done by 2pm. I would go home for three hours and return at 5:30pm to start the routine over again minus the shower, shaving and bowel program. I was done at 8pm.

After a year my client switched to Cooperative Care, a worker-owned home care agency. The co-op asked me if I would move with the client and I said sure. I wanted to stay with the client I knew and had built a good relationship with. But working at Cooperative Care has been a whole new experience. When I worked at the nursing home I never questioned much of anything. Now if I have a suggestion about how I think things could work better, I voice my opinion. The caregivers own the business, and we have a say in how it is run. In 2006 I took an office position at Cooperative Care because I wanted to learn more about how the other side of the business worked. I work full time in the office, but I still work in the field when a shift needs to be covered. I'm also the president of the board of directors.

Since then, I was asked to chair the board of the Wisconsin Direct Caregiver Alliance and to attend the Direct Care Alliance's Voices Institute. I cannot say enough about what the Voices Institute has done for me. The co-op started my leadership journey but the Voices Institute helped me realize that I am a capable leader and helped me hone and polish my leadership skills. I like to say that I found my voice

during that week. I chair the board of directors of the Direct Care Alliance.

We all know there is already a shortage of direct care workers, and it is going to get worse as the baby boomers age unless we do something about it. So what should we do? In my opinion, a big reason for the shortage is that the profession of direct care is not respected. People look down on direct care workers and stereotype them as dumb lazy people. I can tell you we are not lazy; direct care workers are some of the hardest working people I know.

We are not dumb either. If given a chance, direct care workers are very capable people. The caregivers at Cooperative Care run a million-dollar business. We are psychologists, physical therapists, pharmacists, doctors, chauffeurs, personal shoppers, housekeepers, cooks, and *most of all, compassionate souls*. We care for your mother, your father, your daughter, your son, your grandmother or your grandfather. The sad fact is wages are low, and benefits such as health insurance are almost nonexistent. If health insurance is offered, it is often too expensive for the direct care worker.

I am so glad that I needed a job twelve years ago, because it led me to the most rewarding career I have ever had. The smile on the faces of the people I care for and the light in their eyes when I walk in for my visit make all the hard work and long days worth while. It also gave me the opportunity to be part owner of a business, and being part of Cooperative Care has given me opportunities beyond what I ever thought possible.

I would like to ask you to think: what can you do to change the public's perception about the direct care profession? One thing that will change the perception of this profession is the "Direct Care Alliance Personal Care and Support Credential," a competency-based test for personal assistance workers in home and community-based settings.

This country needs to respect the important work direct care workers do before it is too late. We need to make the direct care profession an appealing one. We need to pay a living wage with affordable benefits. We also need better training from the start to give workers enough skills to feel confident on the job. (Most new workers aren't lucky enough to have a great mentor like I did.) I also think if there were a career ladder or lattice with opportunities for advancement, more workers could stay in this profession.

And we need to respect the skills needed to do this job and hire the right people in the first place. Most people think anyone can do this job. I thought that myself, twelve years ago. But now I know it takes someone special. Direct care workers do not do this work because they are getting rich. They do it because they love the work and because it is the right thing to do. This is the hardest job I have ever done.

Importance of Respect in Patient Care

Sue Gibson

I have been a state-tested nurses aide (STNA) for 32 years. When I get up to go to work, I always start out with a positive attitude.

After I clock in for my shift, I go to my assigned floor to start my day. I gather up all my paperwork that is necessary and I'm off and running.

I feel the best way to make a resident feel comfortable in their surroundings is to have the resident help in making as many decisions in their day as possible. Decision-making helps a resident feel at home. As an STNA, I am there to help them if a resident needs any kind of assistance during the shift that I am working.One of the first priority questions of the day concerns their meals. The resident selects the lunch and dinner choice. If a resident is not sure what they would like to choose for their meals, I help them choose from what is available to them. I write their selection down for the dietary department and I always thank the resident and smile as I leave the area. Now that they know what their choices are for the day, they have something to look forward to.

Another decision a resident has for the day is their choice of what they would like to wear for the day. He or she may have a favorite article of clothing they like to wear. They may like it because it may be their favorite color or something they really feel comfortable in. I again thank the resident on their decision-making and helping me make their day. I compliment the resident on how nice and neat they look.

Showering is the next big thing of the day. Some residents love to get in the shower, while on the other hand, some residents hate to hear the word shower, let alone get into it. Some residents need a lot of encouragement to take a shower. I give the resident a choice as to when they would like to shower. All the residents have a regular shower day. If the resident is scheduled for a shower and would like to take the shower before going to bed, I tell the nurse and the shower is rescheduled for the afternoon shift. The decision is made by the resident and the resident is more likely to follow through with their decision.

Activities are scheduled on a daily basis. When the activity is announced over our intercom system, I ask the residents if they would like to attend the activity and sometimes I take them to the floor the activity is being held on.

Every Thursday there is a scheduled outing for either breakfast or lunch. It is my job on these outings to go with the activity staff and tend to the residents' needs, if necessary. We go out to a public restaurant and the resident chooses what they would like to eat. If they need help, I am there to help them. I'll ask them, "What are you hungry for?" or, "What sounds good to you?" I read the menu for them and give the residents time to choose what they would like. I have residents who need the food cut up for them because they cannot see well. I tell them where what food is on their plate. I sit by the resident who may need assistance or help in eating and drinking. I feel this outing is important to every resident who goes. Whether it is going out to eat, on a ride, or even to the doctor, they need to feel they have the freedom to choose to do this.

It is not unusual to be physically or verbally abused by a resident on a daily basis. A resident might be angry over some little thing and the STNAs are the people they take their anger out on. I take into consideration that the residents are here for a reason, so I never take their words or actions as a personal attack on me.

Staying in bed an entire shift is sometimes a choice the resident may make. When a resident does this, I accommodate the resident by giving them their meal in their room. If they choose not to eat the food tray, for whatever reason, I remove the tray and they wait until the next meal.

Anything a resident asks for, be it only a bar of soap, a razor, washcloth or towel, more ice water, an extra shower, it is very important to them. I accommodate them as soon as I can. A happy resident is a lot easier to care for than an angry resident and our day goes a lot smoother when everyone is happy. Residents can be very difficult to care for, but I always remember the residents are not here out of their own choice. I make the resident feel better by talking to them. If I can't help him or her, I have the resident talk to another person who can. Some residents also like more help better than others. I ask that person to try and help the resident.

Each resident is their own individual person, and they also have their own ideas. I deal with each resident's own uniqueness. The more we know about each resident, the easier it is for them to go on with their life in this setting. At the end of each shift, I am thankful I had a good day and made my residents happy to be alive. I feel my job is my second home and all the residents are my second family. They grow on you when you learn the ins and outs of each resident.

Some residents are very protective over their personal belongings. I never touch their area without their permission. I always ask my residents if they need any help cleaning up their area. This may be making or changing their bed, removing their dirty laundry, or removing their trash. Removing an item from their personal area without the resident's knowledge may cause an unnecessary behavior.

One thing I personally enjoy doing is making all people happy. One Christmas I had a box of chocolates someone had given to me; a resident who saw me with my gift stated all he received for

Christmas was an afghan. He told me how much he really loves chocolate. The following day I brought him three different chocolate candy bars wrapped as a gift, handed the gift to him and said, "Merry Christmas." After opening the gift, he said it was the best present he ever received. To this day, when he sees me, he still thanks me for the candy that is long gone. He remembers me for that gift.

Sewing is one other helpful thing I do for the residents. If the residents need something repaired, they know who and where to go to get their item mended. I make walker bags for walkers and also for our wheelchairs. The bags are for their items they like to carry around with them: books, brushes, chips, soda or whatever strikes their fancy on any given day.

If I work with an employee who is not familiar with the residents on the floor I am also working on, I educate them as much as possible about the residents before they work on the floor. I help them throughout the day and make sure that they are not in harm's way due to a behavior a resident might have. Residents have a tendency to take advantage of people unfamiliar with them. The more you care for the residents, the more they learn to know you also.

I try to encourage all residents to be as independent as they can be and praise them after they did whatever it was. I tell them I have confidence in them even if they feel they don't have confidence in themselves.

There are many steps to everything I do on a daily basis. I try my best to make things seem as simple as possible. I never exaggerate a situation even if it either is a big problem or could turn into one for the resident. Speak softly, look into their eyes as you speak and be sure to listen closely to the resident as they talk with you. The resident can walk away from a situation feeling more comfortable when you really look at them and listen to them.

I hope someday, if I'm ever in their shoes, I am treated with as much respect and care as I feel I extend to all of my residents.

The Joy and Aggravation of Being a Career Nursing Assistant

Donald Koenig

I am a male career nursing assistant with 10 years experience. I also happen to be the Ohio Chair Person for the Male Nursing Assistants Task Force. This task force is designed to help recruit, offer continuing education, increase public awareness, and help maintain the good quality men that work as career nursing assistants.

Today I want to talk to you about what it is like to be a nursing assistant. Let me walk you through a day of a nursing assistant. I work the day shift. My day starts at 6:45 am. The first thing I do when I arrive at work is to check the schedule for three things: first, to see what my assignment is; second, to note how many nursing assistants are scheduled for the whole nursing home for that shift; and finally, I check to see if there are any shower aides scheduled and, if so, what sections they are assigned to that day.

Once I arrive at my assignment area I check to see how many of my residents are showers and how many assistants from the night shift have already done the morning care of getting residents dressed and up for the day. Federal Regulations are one nursing assistant for every fifteen residents. There are some days that there are more staff scheduled and I will have fewer residents; unfortunately those days do not occur often enough. If I am lucky I end up only having six to eight residents to do morning care with.

Now it is time for the breakfast trays to arrive on the floor. Even though I am only assigned to take care of my residents, I have to help pass trays to all residents on my side of the building (61 in my case). First I pass the trays to all residents that require help eating or are total feeds. It is now about 8:30 a.m. and all the residents have been fed and it is time to pick up all the trays and record their intake.

Now I am ready to get my report from the nurse and start doing my morning get-ups. Like I said earlier, I have anywhere from six to eight residents to do morning care with.This will include washing,

dressing, mouth and hair care and finally getting them up into their chair. I usually have about two or two and a half hours to accomplish this before it is time for me to go to lunch. During the time I am doing morning care, I am also responsible for answering call lights in my section for all fifteen residents under my care. Most sections will have residents who require two or three assistants per resident for transfers from bed to chair, so when it is time to transfer I have to go looking for help in my area and also must help my co-workers with their transfers. So what this averages out to, if I am lucky, is about fifteen minutes with each resident. I do not know about you but I take longer than that to get ready in the morning. It is now 11:00 a.m. and time for my lunch break of 30 minutes, my first break of the day to sit and relax.

It is now lunchtime and there are four aides on the floor. Two at a time go to lunch, leaving the other two to cover the floor for the next hour. Hopefully, everyone got all their residents up and all you have to do is answer call lights, which can be for anything from wanting a pain pill, or wanting to go to the toilet, or needing to be changed because they had an accident. Oh yes, and in between all that I start to take residents down to one of the two dining rooms. One dining room is for those who can feed themselves and the other is for residents who need assistance eating or need to be fed.

Lunch is over for the aides and it is time for two aides to go to the feeding dining room for the next hour and a half, leaving two aides on the floor to pass trays and feed those residents who do not go to either dining room. Shortly after noon the trays for the floor arrive and I am busy passing them and feeding those that need help, and if I am lucky everyone has finished eating by 1:00 p.m. Once again it is time to pick up the trays and record the residents' intake. But now residents are returning from both dining rooms. It seems like all the call lights go on at once. Residents want to go to the toilet, or to be changed, or laid down for a nap.

For the next hour, the two of us are running to answer lights and attend to the residents' needs. The first thing I do is answer all the call lights and tend those needs first. Once I accomplish all that, then I start putting the residents who are two assists down to change them. The time goes by so fast, before I know it the other two aides who were in the dining room are back from their break and it is now 2:00 p. m. and I get a fifteen minute break. While I am gone the other two take over and continue to do the same thing I was doing. Hopefully, when I return most things have settled down. It is now time for me to do my charting for the day and get ready to do the walking rounds with the person coming to relieve me. I am sure you are wondering where is all the joy in being a career nursing assistant.

Let me share some of the joys of this job with you. When I walk on to the floor in the morning and one of the residents calls out my name, "John Henry," where he got that name I'll never know, I go over to say hello and he says, "You're my friend. I'm going to see you get a desk job so you do not have to work so hard." I smile at him and say thanks, see if he needs anything and tell him I will see him later on. Then there is a lady who does not like men to take care of her but for some reason she lets me. Her light is on and when I go in, her face lights up like a Christmas tree and a big smile is on her face from ear to ear. She says, "Where you been? I missed you." I tell her I have been here but just did not have her as one of my residents. I chat a little, attend to her needs and as I leave she calls me, "Donald Duck," which makes me smile. One day one of the nurses overhears all the different names the residents call me and comments that I have more names than anyone who ever worked here. I just smile knowing I made a difference, even if only for a short while. So now my day has ended and I know I gave my residents the best care I could in the eight hours I was here.

Would I like to give more time to each resident? Yes, we all would. How could that happen? Let's explore this idea for a minute. One way to have more time with residents is for the Federal Government to lower the aide-to-resident ratio. Will that happen? Only if we aides and the public get our elected officials to do so. There is also the possibility that the nursing home will add more staff, thus accomplishing the same results. Will this happen? Hard to say, since every time the federal or state

government has to balance a budget there always seem to be cuts in Medicare and Medicaid funding to nursing homes. Every time one of those cuts comes in, it is a cut in income. Nursing homes are just like other businesses, they have to find ways to cut back to make up for what they are not getting. Just like most businesses, there are those areas that cannot be cut: utilities, food, etc. But there is always one place to look to save and that is in raises and staff. In fact, right now in my nursing home our pay raises are on hold until the final budget cuts come out, at which time the decision will be made about how much, if any, of a raise we will get. Let us talk about wages for just a minute.

I know in every profession everyone thinks they deserve higher wages When I started ten years ago as a nursing assistant right out of training, I started out at $8.25 an hour. Today a nursing assistant right out of school starts out at $8.50 an hour. That amounts to a 3% raise in starting wages over ten years. This is what some of the nursing assistants are getting to care for residents and do 90% of all hands-on care for your loved ones. There are a lot of single parents who are working in this field. Imagine trying to have insurance coverage for your family, and also provide for their other needs. I know it is the same in many professions. People will say, "Go get a better job." My answer to them is, "Then who will take care of everyone's loved ones?"

I enjoy my job. I am good at being a nursing assistant and I hope I am making a difference in my residents' lives. I know I am in mine with the way I feel, knowing I did my best to make a difference in theirs.

Looking Back and Moving Forward

Debbie Pitts

I started my Nursing Assistant career forty-three years ago and have worked in the same long-term care facility for the past forty years now. Over the years, I have seen many cultural changes being made in the field. Back then everyone was referred to as patients, then residents and more recently elders. As these changes took place, it was difficult for us to change in the sense of calling them patients to residents and now elders but we all manage to accomplish it. Our elders have so many more choices nowadays, which has been a wonderful additive for those who live in a facility.

As I look back, I can remember when restraints were used routinely. The good old locked Posey belts, pelvic restraints, vest restraints and how many other types that we used to use. Already many years have passed since we have used these things and that is a blessing as they were nothing more than a pain to use for us and our elders. Sometimes they would be so knotted it was difficult to get them untied. I can remember that many who needed to have these were people that had symptoms of now what we call Alzheimer's or people with some sort of dementia. Back then they were unsure of this disease. These were definitely some challenging times to work in. Taking care of the combative person can be very difficult. At least now, we have much more knowledge through education as to how to handle and deal with these issues. I have been fortunate in my facility that we thrive on education, which helps me learn all the modern techniques and ways of dealing with the many issues we have today with dementias.

When I go to work daily, I not only have to take care of my elders, but then I also have to deal with their families as well. This too, can be somewhat difficult at times. Some of them can become quite demanding with the cares needed for their loved one. After dealing with them I often find that they have a guilty feeling for having to place them in a nursing home, but it can still create a problem for you and make it hard to get your cares done for other elders on your daily schedule. As much as I try to reassure them that their family member is getting the best care and attention they need, sometimes it isn't enough to satisfy them. There are times if I feel pressured or frustrated I will talk with my supervisor, or a social worker, and ask them if they could have a talk with the family for me. I find that having

good communication with every department and all supervisors is vitally important in my job. Unlike years ago, today we are all a team and are there for our elders and their every need.

On a more personal level, with my daily routine in care, I love when I can take my elder for a walk. Sometimes they may be fearful of falling or something else. Using reassurance and encouragement and getting them going can be a very rewarding situation. It's when they don't believe they are capable of doing this, and then they do, when you realize just how much you have done for them. The smiles, thank yous and hugs I get back can just warm your heart and even put tears in your eyes. The sense of accomplishment provided for them is very rewarding. This is just so true whether it be walking, eating, bathing or dressing. Taking the time to work individually with each elder on whatever levels needed is so important. When they tell their family member about their accomplishment that they achieved today, they are so proud. The smiles, twinkle in their eyes and the excitement shown is just amazing. Sometimes at this point I can develop a relationship with the difficult family member. Normally they will be happy for their loved one's accomplishment and grateful to you for helping them. My personal accomplishment is becoming a part of their family and developing their trust for the care I give. This friendship will grow; I have found that soon the family becomes dependent on me for everything, which actually lightens their load of worrying and concerns. Being taught in the old school, we were told to not get so close to our elders, but I always had a hard time doing that. Today is much different and is so much better.

Unfortunately, getting close can be difficult. If I have an elder who is starting the dying process, I find myself wanting to spend as much time as I can with them. So often, I have gotten so close to them that it almost feels like I am losing one of my own family members. This can be very hard, but I do realize it is a part of life. I find that I am grateful that I became a part of their life, cared for them, learned from them, and was able to help maintain some dignity for their remaining days.

Sometimes when I care for an elder, I will find myself disagreeing with someone else's idea about their care. Not knowing who is right or wrong can be a challenge. I do find that discussing and asking questions helps me to understand their decisions about the care to be given. This even includes our doctor. Lucky for me, we have a very friendly and open-minded one in our facility. One that you can ask questions to, make suggestions to, and work together with. I always appreciate that factor and am quite comfortable speaking with the doctor, who looks to the nursing assistant for input on our elders' care. This again shows that having good communications with your team members will only help to promote and continue with the quality of care that is needed for each of our elders. I have always been a firm believer in this. If I were to ever suggest anything for a new CNA, this would be one of the first things I would say.

As the years have flown past me as a CNA, I review all the changes I have observed, and been part of. Today I worry about the quality of care and about the nursing field itself. I watch the national statistics for nursing and we have already started a decline in this field. So knowing this, I wonder where we will stand in the future. Will we have the needed staffing in our nursing homes to care for our elders? I worry about the Medicare and Medicaid funding issues, higher acuity of cares needed, the requirement of more rehabilitation. Without the proper funding from the federal and state government, how are we going to be able to keep up with the quality of care that we want to give, and that elders deserve?

My facility depends greatly on reimbursements for many of the cares and therapies. Cutbacks in funding mean staffing reduction. How will we care for them? These issues seriously need to be addressed by our government. We are talking about human lives. People who have worked all their lives and now become dependent on us as direct caregivers. I can only encourage people to enter the field of nursing, as they are needed to help take care of our frail elderly, handicapped, veterans, clients and anyone who is in need of care. With a lifetime of experience in this field, a job I have loved, and

not any regrets for entering it, these issues really concern me now. I love the direct contact I have with my elders as a CNA and have learned so many things over the years. I don't think any other job could be as rewarding as this one is.

Learning Through Serving

Danny Reed

I am a male CNA currently registered in Wisconsin since 1991, having worked as such since 1980 when I left high school. I have worked with ten different employers and many precious people I remember very well.

I remember virtually everyone I have cared for in my over 30 years of work and yet there is not one person, place or moment that characterizes them all except perhaps, May. She died within 24-hours of admission and we never spoke, except with the eyes. May had end-stage nerve and muscle wasting disease that left her mind intact but her body immobile and in pain. Her boyfriend brought her in after taking care of her at home, but he was wasted on some kind of drug, maybe her pain medication, feeling he needed it more than her. We ordered morphine and got her settled and she finally relaxed. She was gone by morning.

May reminded me of Mary, another woman with a similar disease. Mary's husband Harold came to visit drunk. She could just point to a letter board similar to an Ouija board and spell out words and phrases with her right hand and then use her eyes to indicate if we were correct. Mary was a refined woman but very patient with me because I was an 18-year-old boy trying to be a man, sensitive but having a lot to learn. Mary taught me how to communicate without words—just using the eyes.

These women are the core of understanding the meaning of what I have done for 30 years. Whether imprisoned by hearing loss, loss of sight or mobility, failing bodies and minds or simply being alone—the challenge was the same, to know when to reach into another's soul and touch them, to stay out of the way, and have the good sense to know the difference. Can I honestly say I fell in love with the woman that quietly said, "I'm tired of being old?" These were largely rhetorical questions without an answer.

The men and women of this generation were far superior to me. I could only stand by and watch them die. Oh, I did the necessary things like I was paid to do, trained to do, but they were the ones patiently trying to teach me. I will spend the rest of my life trying to decipher their encrypted message because I am trapped here, too. Imprisoned by the ignorance of believing I understand what my eyes have seen, what I have heard, and experienced. That it can all be regulated and catalogued in journals of medicine.

Is it not ironic that primary caregivers struggle to stay alive while money movers make millions, even billions tax free, moving money from here to there and acquiring the power and influence to change the world, but will not lift a finger unless they can make more money doing it? Ironic because I have taken care of them in their final hours and they would give me it all had I the power to give them more life. Yes, I have turned down a fortune because in their grief they wanted to pay me money for an hour of genuine kindness that in reality they could not afford. If you must ask how much it is worth you cannot afford it. Sincere kindness is priceless so I don't charge for it.

It is not my intent to humiliate the achievements and status of professionals and others fallen upon hard times due to aging and disease because no one deserves these indignities. Indeed, I delight in restoring dignity to every human in need of it regardless of cause. I do not wish such suffering upon my worst enemy. Bill wanted one more hour. The cancer was sudden, painful, and terminal. Being sidetracked into a cozy hospice in the country is hardly comforting when given less than six months to live just when retirement promised the rewards earned from a life of hard work and sacrifice. Bill had spirituality and strong beliefs but it seemed to make matters worse because he cried every day begging God for answers to the Why?

questions. His family was always there. I had no wisdom to offer, only genuine kindness. And they seemed to appreciate that exquisitely. We were all passengers on the same runaway train.

These 30 years as a caregiver were never about us and them, we the young and restless and they the sick and dying. We the caregivers went home to our own hell and most of us are now dead and dying as well. Even those that got rich and stood in the spotlight for a day eventually were marginalized as the world moved on to the next big thing. I turned down the big cash reward from Bill's life insurance after he passed, though the family urged it upon me secretly saying I earned it somehow. That is the true value of genuine kindness. I hope in my final hour some young punk like me finds it in his or her heart to return the favor.

Relating these stories, I realize they are not about me. The copyright belongs to the people whose lives I had the genuine privilege of entering. After 30 years though, forgive me for intruding with what I have learned and interpreted. I was a participant observer in a caring relationship, not a detached clinician. Often this relationship included crossing personal boundaries to give voice to people who had lost their voice. To be an empath, as it were, and courageously enter the thoughts and feelings of people for the purpose of protecting their interests. Not imagining myself to be a savior, patronizing in a showy display of stilted affections, but carefully spending time with people and listening.

Humor is essential. Humor walks the fine line, often the straightedge razor, between tasteless, offensive, and unmentionable realities and the funniest things in the world. It made the most awful predicaments tolerable. Most things that were funny rarely left the room or facility because you have to be there. Trying to explain why something was hilarious does not usually work so you keep it to yourself. Sometimes it simply was at the expense of someone you care deeply about and sometimes it crossed the line and became cynical and sarcastic. The humor enriched the humanity of the experience but discretion prevents me from furnishing examples. I can only refer to it in generalities. I wish I could share it.

At my last job in a nursing home I finally filed a complaint with the state because every time it rained, the roof in the entire facility leaked to the point that it was an unmanageable hazard, causing slip and fall injuries. It was an old hospital and they did not want to buy a new roof. Within a month they sold the place to another company that was already building a new facility. I sought Whistleblower Protection from State and Federal laws but the attorney said they were useless laws and charged me $250 for the privilege of knowing that. So I got out of there before they could do anything to me further. They loudly proclaimed their high principles of problem solving and ethics through it all. Every facility I am aware of operates with a similar strategy. I am so angry. Even if a genuinely good person is in charge, it is the system that defeats anything good they can do. We cannot blame individuals when it is a systemic problem

The healthcare system has enormous flaws. Still, any system contains people with good intentions who sincerely want to help people. There are benefactors giving large gifts that have the place named after them as a memorial. I believe everyone should have something set aside for the mass of unknown caregivers providing the real cheap labor that constitutes a far greater gift than brick and mortar. Most will say, "I could never do what you are doing there." Caregivers do not benefit from a plaque in their honor. Caregivers benefit from the same thing patients and residents do: genuine kindness. Take care of the caregivers because one day they will be all you have left in the world.

There is no faster way to take the fun out of something than making a job out of it. I daresay taking care of people is fun until the over-regulated regulators take over. There are more offices and titles in any given facility to push papers around than there are nurses, aides, and patients or residents. And for good reason. There are more laws and regulations to comply with than there is paper to push around.

While most of the other support staff stick around, the vast majority of aides working on the floor at any given time have been there six months or less and receive the lion's share of blame when things go wrong. And things do go wrong. No one group of people contains all goodness and mercy remaining on earth, nor all that is wrong, so it is safe to assume much blame is undeserved and even more is a systems problem rather than personnel.

For over 30 years I have witnessed the truth of this statement. Although there are exceptions, most men and women seeking work in healthcare actually care and these individuals as a group serve to protect us from the ones that do not care, and the exceptions or predators. Regulations cannot enforce caring attitudes nor create a caring atmosphere. People do.

As a consequence, these caring people are subjected to what I call the law of escalating demands whereby they are mandated by law to uphold standards on demand with unpredictable and unstable resources that continuously call upon their instinct to care more, do more, and go above and beyond, endlessly. Many times aides are turned against each other and manipulated with gossip and propaganda that repeats over and over until it becomes considered indisputable truth. Turnover rates increase as some are wise enough to leave on the first day, sensing the toxic atmosphere. It is carved in stone that no more aides will be provided than what is absolutely necessary. There are facilities with aides working alone, at times with faulty or no equipment, with very high care levels and numbers, exhausted. Again, whether the exception or the rule, regulators and regulations do not stop the oppressive environments if the system allows it.

The rewards are still there in the warm appreciation of patients and residents. Even a little fun. People do care because the entire system continues without collapse solely upon the dwindling resource of sheer numbers of truly caring people. It is heartbreaking that these caring and loving men and women are so oppressed by a system that covers them like concrete and uses them as human shields to justify business as usual. This takes its toll, creating a depressing and debilitating post traumatic stress called burnout and making the profession the top injury-producing job around. Healthcare should be the hub of taking care of people indisputably.

It is redundant, and depressing, to continue. I suffer from burnout for these reasons and more. Although pursuing a nursing degree, I have stopped and accepted work in other non-medical fields. From time to time, I enjoy taking care of people in their homes one-on-one part time. I draw sustenance from the warm appreciation clients offer, which serves to keep me connected with what I care about most. I am not strong enough to change the system, but I can prevent the system from changing me.

Training and Other Important Needs for Nursing Assistants

Nanci Robinson

Training of Nursing Assistants

I think the nursing assistant (NA) training programs should be longer. My original course for Long Term Care was four weeks long after that I took an additional two months at a hospital to work on a Med/Surg floor. So, I have a combined three months of schooling.

Personally, I'd like to see certified nursing assistants (CNAs) given more responsibilities. I'd like to see a six-month program to include CPR and capillary blood glucose (CBG) training as well as more in depth anatomy training. I think six months would keep some, who are just looking for money, out of the field and help keep those of us who really want a career in nursing in the field. It would be a better stepping stone for those who plan to go on to a LPN or RN program.

I currently have CBG training but my employer will not let me use it. It's disappointing because it's a skill I have that I can't use and it could really help out the nurses. I think if courses were a bit longer, CNAs might be taken a bit more seriously by their employers and respected by their colleagues in the medical field.

I was trained in CBG while working for the hospital and received a card like a CPR card to show I was trained. I live and work and was trained in Arkansas. I'm not allowed to do CBGs in the long-term care and rehab facility where I work now, though. However, unless the resident is diabetic we do have to clip and file nails. It took many years for nurses to gain respect and be allowed to do some things that now CNAs do. For example, for many years doctors didn't feel nurses were qualified to even take vital signs. I suppose CNAs will have the same struggle.

"I'm wondering if extending the initial training time would not keep many out of the field, because they need a job with income ASAP." The same could be said for LPN training, could it not? Or even an RN. I don't understand why there is a train of thought that "anyone" should be allowed to be a CNA and as quickly as possible. I can tell when I'm working alongside a Certified Nursing Assistant who is in it because they want to be versus someone who wants the paycheck (not sure why, though, because to be honest Arkansas doesn't pay CNAs all that great, though I suppose for some it might be better than McDonalds). I took a $5 an hour paycut go get back into nursing because it's my passion, and while we all need a paycheck, that should not be the only reason for doing this work.

"If extending the initial training time would keep many out of the field because they need a job with income ASAP, maybe employer facility-specific follow-up training would seem to be much more feasible for all. A CNA-in-training could be responsible for a lighter than 'normal' shift assignment while under the guidance of a qualified proctor CNA. It could improve efficiency and quality of care in the long run and probably improve retention rate of CNAs, for those administrators that are astute enough to consider the long-term effects of their policies." This might be good—the only problem is that most facilities aren't going to want to absorb any cost this might create by having additional staff for this purpose. Also, on the job training is not appreciated by employers as much as what might be considered actual "education" hours. Most CNAs want to do as much patient care as they can for the nurse—learning to assist with dressing changes, CBGs and other things that would be beneficial for both CNAs and the Nurse.

Ensuring there is enough staff and that those staff members are there for the right reasons would do much more to improve the retention rate of NAs or CNAs. (I'm a CNA and don't like to be referred to as a NA, by the way, no worries I know you're not talking about me directly when you use NA, but most of us are certified. For example I wouldn't call an LPN a PN and leave out she's licensed.) It's my opinion because so many states just train as many as possible in as little time as possible. Many of these people get into job burnout and leave the industry because they don't *truly* understand what it takes to be a CNA, and I doubt anyone would argue that one of the reasons is because training is too short so they think it's gonna be fast and easy money.

Where I work I got a three day orientation and that's it. Having the "wrong" people there leads to multiple call-ins, etc. so those of us who are there because we want to be are "guilted" into or pushed into working more than we should.

Abandonment

"Your residents need you" or "abandonment." When I hear this, my thought is: The residents need the facility to hire enough of the 'right' people. They don't need me to overwork and burn myself out. Also that abandonment tool is pretty disrespectful itself, since leaving when I'm scheduled to leave is *not* abandonment. State Boards of Nursing do not involve themselves in "staffing" issues. It's the management's job to ensure enough people are there so that the state won't punish you for going home when you were scheduled—even if you have to give report to the Director of Nursing (DON) herself and she works the floor as an *Aide*. Trying to insinuate that it's abandonment and pull on my heart strings or even worse to make me feel I have *no choice* is just wrong. But like I said, "Make it a bit harder to become a CNA and maybe the retention rate wouldn't be so bad and maybe management would also have a bit more respect for their CNAs," as this is considered one of the biggest complaints of CNAs.

Respect

We already deserve respect—the problem is too often, we don't get it. I thought more education might help. What's the solution? I understand some people aren't going to respect others, period, but there seems to be a real correlation between aides and disrespect. Let me begin by giving you some background on me. At fifteen I joined a summer program to work at my local hospital as a candy

striper. I immediately loved patient care, even though at the time passing water and checking meals was all I was allowed to do. I enjoyed being in the hospital environment and learning about the medical field. I knew once I was done with high school I would want a career in the medical field. Once I finished high school, I became a CNA. I worked several years and enrolled in a community college for nursing. Unfortunately, due to financial reasons, I had to drop out. I continued to work as a CNA until I had an opportunity to gain some clerical experience and mix the two. I worked in clinics for a few years but then landed a job as an administrative assistant for $15.50 an hour and left the medical field all together.

I worked in this job for five years before realizing that I just wasn't fulfilling my dream. So I left, returned to being a CNA, took a job for $9.90 an hour and reenrolled in a school for nursing. When I worked as a highly paid administrative assistant I was respected. I had a job that was valued, yet did not affect anyone's life—only the company's profit margins. Seems odd that my position of helping a company to grow and make money was more valued than helping someone meet their daily physical needs. In my private life strangers respect me most of the time, yet when you put on your CNA hat many who once would have respected you simply as a human being somehow feel free to think of you as less. Nurses often treat you disrespectfully. The DON where I work doesn't even know half the names of the aides that work at the facility, sending the message we aren't worth knowing.

Also, where I worked we were told if we got CPR certified we were not allowed to use it—only LPNs could do CPR. Again, random people on the street with no medical training other than CPR can use CPR on strangers, but in the "medical field" an *aide* who has CPR training is not considered qualified to do such things. It's this kind of demeaning attitude that runs people off. That has been the hardest adjustment for me to make coming back to this industry. While I handle it by ignoring it and just dealing with those who do respect me and avoiding, at all costs, those who don't, that's not really a good solution.

Self Advocacy

The other thing that concerns me is that CNAs, STNAs (state-tested nurse aides), and patient care assistants (PCAs) do not seem to comprehend that if they do not advocate for themselves, nothing will change for the better for the profession or the residents that they serve.

The website for the National Board of Labor lists the job of CNA as "unskilled." Their description is so ignorant and derogatory! Legislators must be educated and held accountable. Even the "Safe Lifting" legislation that we are trying to get folks to bring to the attention of their congressmen was initially focused on nurses. Now, as a CNA who has done my share of direct care lifting and have a weakened back as a result, I want nurses and others protected also, but we know who does the most of the lifting in the long term care facilities.

In reality, they probably have to promote the legislation as being for nurses to get as much support as they have. So, CNAs need to utilize all of the people power that is available to get the respect of the public and the legislators. They have to be involved in this type of discussion and even initiate their own local networks. I realize that most CNAs are women and have kids and households to attend to, and involvement does take time and commitment. But if each would just commit to about 15 minutes per week to join a networking group, read the updates, join the discussion, or write to a congressman, it would be a lot more than what is happening now. Also, get on those Safety, Infection Control, and Quality Control committees where you work. Get informed, then speak up with integrity and pride in a very noble profession.

Committees

There are no committees for me to join where I work. Honestly, most long term care professionals where I work don't seem to think I can contribute in any kind of intellectual way. It's sad, but I'm rarely taken seriously as a member of the medical field. I take my job seriously and read outside of 'in services' at work as well. I *think* about my job and how

to do it better. I try to address issues I have but most of the time it's met with resistance, and I never do it in a "complain" way. If I have a concern, I always begin with "I need some clarification," and address my concern as a question. I *am* the eyes and ears of a nurse. I see things that an RN doesn't because I spend more time with each patient. While I may not be the one to call the doctor or the family about a loved one's condition you can bet it's an aide who has brought it to someone else's attention.

Where would patients or residents be without us? There is an almost elitist way about it at times. For example, where I work I don't even get the same kind of healthcare coverage the nurses are offered. Why is that? That sends a message directly to me that I'm not as valued. Yet I am a member of the nursing team. There is no way a nurse could work the floor without aides to help out. Occasionally you run into a nurse, usually one who was once an aide before, who respects her aides and is willing to work side by side with them. But most often you work under a nurse who sees you as just a "butt wiper." I once had a patient who had a fall on another shift. I knew this patient—I had taken care of her for days. Her speech was odd that day. She could not put together a sentence and didn't know my name and seemed all together out of sorts. In addition to this, I noticed the bruise on her face seemed to be swelling up. This really concerned me. I took this information to my nurse and stressed how I was very, very worried the patient was not okay and needed to be looked at right away. The nurse came in the room, looked at her face and said, "It's a bruise, Babe," and left. Dismissing my concerns altogether. Sadly, the woman died days later.

Now I'm not suggesting this was because I was ignored, she had other things going on as well, but the nurse who came on the next shift had this woman transferred to the hospital because of the very reasons I had brought to the attention of the nurse on my day shift. Yes, swelling was happening behind that eye and there were some other complications that resulted in her death. I do not believe my nurse taking me more seriously would have saved her life. However I feel the way she dismissed my concern was inappropriate and I was completely validated by the fact that this woman was sent later that night to the hospital. Why was I ignored? I feel it was because my nurse felt I couldn't possibly offer anything to patient care other than toileting needs. Also, calling me "Babe" was wrong. I have found that in the medical community what is normal "professionalism" and what would freak out most HR managers is common-day practice, including nurses physically putting their hands on aides, pushing them out of the way and getting in their faces and screaming at them.

I've written congressman about other issues and unfortunately I get "auto replies," which has left me a bit pessimistic about that process. I've joined several networking groups on Facebook, though, and read them daily. Trying to demand more respect from my employer would most likely only get me fired. Though I won't be yelled at, I do *demand* the basic respect any human being should get.

If being a CNA had more respect, better pay, better benefits and more staff, I'd consider it for a lifelong career. The problem is I know as much as I *love* direct patient care, my back can't handle it at 50-something, and if I want to provide a better life for my family financially I need to move on to become an RN. I have a grandma in a nursing home and I told my mom, "If you want to know what's going on, ask the aides (outside of medications)." I am a very good CNA and am proud I do something that helps my community. We deserve the same respect nurses, fireman and police get, yet sadly we don't get it. Activities of Daily Living (ADLs) may seem like no big deal, but when you can't do them for yourself or your loved one, they become very very important. my patients love me (occasionally I get a combative person and I try not to take it personally), but some of the greatest compliments I've received have been from patients telling me how wonderful I am—kind, sweet and compassionate and how grateful they are for my help. When I hear things like that it's what keeps me going. It reminds me why I want to be in this field. What a great way to make a living.

Training Revisited

Back to the training process. I had to recertify because I had left the field for 10 years. I had to

go and retake the written and skills test. I went to a local training program and bought the book to refresh myself. I *read and reread* it and tested myself, etc. I studied very, very hard for it. When I took the written (which I'm confident I aced though they don't tell you, just *pass* or *fail*), I was a bit insulted some of the questions were so common sense. Very few of the harder things that you'd know only if you *read* the book were asked. It made me feel like again the state of Arkansas just wants to push out as many CNAs as possible and not really make sure they know what they are doing. Of course, then state inspections come around and the facility gets in trouble and people get fired when they do something wrong. Yet who's to blame when the training and testing are so inadequate? I welcome any additional training they want to offer me.

It's unfortunate that CNAs are not heard. Even when we speak up, sometimes it falls on deaf ears. How can we begin to gain the recognition and respect we deserve if we don't have a voice in the medical community? I'm glad people like Genevieve Gipson are out there working hard to help us bring light to this important profession. We don't deserve to be kept in the shadows of the medical community.

I am currently enrolled in courses for nursing. God willing, I will be a nurse. It may be late in my life but there is no other thing I want to do so passionately as take care of other people. I do hold nurses in high respect. I think they are amazing people and I one day hope to join the ranks of those angels out there, but when I do I will remember being an aide and dreaming about being a nurse and show all aides I work with respect and compassion and encourage them to continue on with their education. CNAs are a vital factor in health care. We do so much more than toileting and most of us want to do as much as we physically can, often coming home exhausted and our backs hurting from taking care our communities' elderly or injured. We provide a very important service to our community and when someone says they are a CNA, they should be able to say it with pride. Images of caring, compassionate and educated people should come to mind, not someone holding a bed pan. CNAs want to be accepted as members of the *nursing* team. We deserve better wages, proper equipment and adequate health care. How can we not take care of those who have spent their lives taking care of our nation's elderly? With the baby boomers reaching retirement age we are going to need more CNAs. This nation is going to face a shortage, we need to evaluate training (proper training) and create better work environments so we can recruit the *right* people to this profession. Sadly, If we don't, it's our parents and grandparents who will suffer.

Cry of the Caregiver

Leilani Roseberry

My story is about the work-related grief I've experienced while working as a certified nurse assistant (CNA). I'll begin with my first days as a newly hired CNA. It was day two of my first week, and while I walked down the hallway I noticed something unusual lying on the floor near the opposite side of building. The hall of the retirement community was quite long and it wasn't until I was halfway down the hall before I realized it was a resident lying on the floor. I ran the rest of the way, only to discover the person was dead. I was very shaken.

I hadn't received proper orientation in regards to this facility and I didn't know whom I should contact. It didn't help that I wasn't carrying a cell phone (I had been taught that we shouldn't keep our cell phones with us while on duty). There were no emergency phones and no pull cords available in the halls. I was very shaky and nervous. I admit that I was scared. There was no one around but the body and myself. It was after hours and the staff at the reception desk had already clocked out, so I thought. I had no resort but to knock on the door of a nearby resident and ask to use the phone. This created a commotion in the hall and drew a crowd of residents from their apartments and the atmosphere then became extremely sorrowful.

It was only then that I learned that a night staff person was on duty and how I could contact them. I had to learn this from a resident who was not my client. The person on staff that night provided me with a thorough tour and orientation of the building. I believe that my agency should have been the one to provide such an orientation. It took me a few weeks or more before I could close my eyes at night without seeing the body lying in the hallway. I wasn't offered any support from the agency; the next day was business as usual.

About two weeks later, another resident I cared for passed away. Then another, and another, and so on, but I wasn't actually present when the deaths occurred. They passed away while I was off work. It bothered me just the same to know they were gone. I cared about my clients, but for the agency the clients meant money and I had to remain focused and keep on working.

At this retirement community the residents were not cared for in a one-to-one fashion by the agency I worked for, but were visited during intervals throughout the course of my shift. I was on call for emergencies and other needs as well. Again, I cared for all those in my run, but I never became as close to any client as when I changed agencies and accepted the following assignment.

The new homecare agency I worked for provided one-to-one care. It was shift work, eight hours, one-to-one with one client or a married couple. One day, just after I began my morning shift, my client suffered respiratory distress, his pulse raced while his oxygen level dropped, despite the O_2 he used. My client died while gasping for air. This was the first time I had been present and witnessed the fear in a dying person's eyes or experienced losing a client like this, but my emotions had to be set aside. I had work to do. I assisted the hospice team with the post-mortem care and other tasks, plus cared for the spouse.

After the post-mortem care was completed, I took a step back as the family gathered into the little room and surrounded my client. The room was silent except for the sighs, the sobs, and the wailing. It was heartbreaking to stay in the room. I bit my lip and tried to hold back tears. Not to mention the weak-in-the-knees floating feeling I experienced. I felt like crying, I had to take a deep breath. Then I returned to my duties as necessary.

That duty consisted of providing grief support to the family, to answer the phone, the door and to remain until the coroner departed. It was very difficult to work through this alone. I did receive compassionate support and concern, via phone, from my RN supervisor; but I was never prepared or trained for this aspect of the job. I'm referring to the emotional toll of working with the very elderly, those who are in their last days, and those who pass away before your eyes.

The very next morning, after the death of my client, I continued care for the wife of the deceased. I had no time to resolve my own grief from the day before. The remainder of my employment predominately consisted of caring for the widowed spouse. I spent almost a year with her. I watched her decline from a strong and rather independent woman, to a dependent woman, and then enter a hospice stage. Many times I thought she was about to pass away in my arms as I cared for her.

During the very moments of what seemed like the end, I was always alone. It would just be my client lying in my arms and myself. Although a Do Not Resuscitate (DNR) order was in effect, the intense sense of helplessness and isolation was always shattering and is still mostly indescribable. I entered every shift not knowing what to expect or what emotions I would experience. The constant shifting from caring and curing to letting go was exhausting.

The experience of working in homecare with the very elderly and those on hospice is a roller coaster of emotions. It is especially difficult when you must continue care for the surviving spouse and provide the shoulder for him or her to cry on. One client has passed away, the other may follow shortly, and the widow or widower is grieving as well. Now add the intense emotions of the client's children and family and you can't help but end your shift wondering if it's just yourself who is handling things poorly or do other CNAs experience the same. Since you are a homecare CNA, there are rarely any co-workers working alongside you during your shift and that means you yourself have no shoulder to lean on. The CNA is there for the client and his or her family

and friends, but the CNA is trapped alone within all these emotions. The brief support of co-workers during shift change provides very little healing.

This unresolved grief and constant exposure to dying and death had me looking at every day, even every moment, through the eyes of a dying person. This is an emotion that is very difficult to put into words. I guess I could say that my emotions of grief encircled my every thought with memories of dying and death, that my outlook on life had become depressed.

Dying, death and grief is the nature of this work, but many other nurse assistants, like myself, are not thoroughly trained for end-of-life care beyond post-mortem care. We work in a field, whether it's private homes, nursing homes or elsewhere, which lacks end-of-life training, grief counseling and support. Where is the support for grief in our professional lives? According to Genevieve Gipson, RN, MEd, RNC, Director of the National Network of Career Nursing Assistants, our support is found in training materials from other fields. "Sad to say that many text books for NAs only address stages of dying and how to do post mortem care. We don't have a lot of good training materials for NAs, so we borrow from other fields" (Gipson, 1985).

The experience of mourning is somewhat common to all of us and there are many forms of assistance for coping with grief in our private lives. I believe that if I had grief support opportunities available to me in my professional life, my level of care and compassion would have been much more resilient from the very beginning of my work as a CNA. Instead, only after sorting through emotions affecting my personal life and learning they were a compilation of what I experienced professionally, only then have I become much more resilient in the face of grief and mourning.

Reference

Gipson, G. (1985). *Dying, death grief and loss in long term care.* Norton, Ohio: The Nursing Assistants Press.

Handle With Care

Donna Tucker

My name is Donna Tucker, and I'm a state tested nursing assistant (STNA)! I have been an STNA for 33 years. I simply love it. It is so rewarding to me to know I make a difference in the lives of my patients. I go in to my job with a smile on my face, an upbeat attitude, open arms, broad shoulders, ears, and a caring heart. I set examples to all around me. I am a mentor, I am a go-to person for my director of nursing (DON). Other STNAs come to me with problems or questions or concerns and together we take care of it. I am an expert committee member for my state's aging panel. I am a committee member for Career Nursing Assistants. I work a lot with Geni Gipson, the founder of this committee. I am a published author and the mother of one daughter and two sons. I have six grandchildren. I just wouldn't like doing anything else. I love my job and family and my teacup poodle, Baby!

Let's say I have talked to friends who are not STNAs about my job. I tell them that there is always going to be someone's grandma, grandpa, sister, brother, aunt, uncle, mother, father, etc. who will one day need to be placed in a home. I tell them how good I feel when I can help them. STNAs are not going away, and the door to the home I work at will not close. In some cases it's like taking care of a child. The way you give them a bath, dress them, feed them, take care of incontinence problems. No, I agree, not everyone can do my job. I hear that from my friends a lot. So I tell them, I thank God I can do the job I have.

What I do when the resident comes to our facility, I introduce myself to them and to their family. I ask the resident, "Are you spoiled?" Sometimes they say no not at all. I tell them, "Well you are in for a treat. I love to spoil and that's one of the things we do around here." If they say yes, I tell them, "Well we have our work cut our for us, because we have to spoil you even more." I usually get lots of smiles from the family and resident. After they settle for a while, and the family is alone, I ask the

family questions about their loved one. I like to get a story about the resident from family so I can use it in my conversation later with the resident. I assure the family their loved one will be treated exactly the way they themselves would treat them. We are not trying to replace the family. We are filling in as family while they are away from the loved one. Then after the family is gone, I keep checking in on the resident, visit for a spell and chat. I ask them if they need anything. I just want the resident to feel safe, loved, and comfortable.

Demanding family members can mean different things. For example, if they come in to help feed their loved one—I had a family member tell me, "I want mother's food now so I can feed her." I tell the family the cart that is coming now is room trays and as soon as we deliver the room trays, because we want our residents to get hot meals, I will call the kitchen and get that tray for your mother ASAP. Some family members just want you to drop all you are doing to assist their loved one. When a family member asks for something we are pretty prompt to get up and take care of it. It assures them that we will not put off anything asked of us. Sometimes it's the family member's way to show their loved one, "Well, I'll take care of this" so their loved one knows they are loved by family. Some family members just feel bad and guilty for placing their loved one in a home. They have some ups and downs. I say, go in with a smile and a yes ma'am or yes sir. Do not give the family any reason to complain. And believe me, we have a lot of happy family members—heck, they even hug staff and talk with staff a lot. After all, we can all be one big family. We all want the same things, the staff and the family members. After time goes by and the family sees how much we care and how well we take care of all of our residents, they calm down. We don't always have demanding family but when it happens, well we handle it with TLC.

When is it too much beyond basic caring for their loved one? It's never, never too much. There is always more to do to please the resident. It's whatever makes them happy. You can care too much beyond the basics? Never!

If any one family member or STNA has any kind of misconduct it is stopped. If family is the one, I go to a supervisor, then that family member, when they are around, they are watched. Their actions with their loved ones are watched very carefully. If the problem continues our DON, administrator, and social worker then step in. Believe me, we do not tolerate it at all. No excuses.

If an STNA is talking hateful to a resident, that STNA is taken aside and told about our no tolerance policy for mistreating residents. If it happens again, that STNA will be leaving and a panel of our team members will review the action taken by the STNA. The DON, administrator, social worker and a mediator person will decide if the act by the STNA is enough for the STNA to lose their job or not.

Retention, Reliability, and Dedication

Renee J. Tillman

I love what I do. I am a Hospice and Palliative Nurse Assistant. I have been for 16 years. I have worked in this field for 37 years—in long term care, private duty and home health. I still like getting up and going to work. I have a great work ethic. I think it came about when I started working for Leader Nursing and Rehabilitation Center. My plans were to become a nurse, just like my mother. This employer believes that if he contributed to his employees by way of educating them he would accomplish two things. Loyal employees and highly skilled nurse aides. He knew we were the backbone of his center and believed in his strategy to give the very best care his employee's could provide.

I was one of the first nursing assistants in the building. I started on the 11-7 shift, myself and a licensed vocational nurse (LVN). She was a gem. In a four story building. They had security for us. They started from the top and filled the building up. I was never so proud to be a nurse aide. Pretty soon we were filled. I worked the night shift for three years and decided to go to the day shift, 7 to 3.

It was then that I decided this profession was for me, and I was going to be the best. Everything we did was a learning experience. We received report at the beginning of our shift. We were asked to be on the job 15 minutes before shift, and we did so without pay. We felt it was important to get information to care for the residents. The incentives were what they called the Leader Ladder. This Ladder was there for you to climb to the highest occupation in the nursing field you wanted to go, with the help from the scholarship program in place. The goals of the employer were retention, reliability, support, and dedication from the employees.

That is not in place today, especially in the long-term care settings. There is a revolving door in most places. In most places employees don't even have nametags. If they do have them, they're in the pockets just to swipe the clock. Uniforms are not decent, I mean wrinkle-free and clean. Even hair and faces are not groomed. Yes I see this today. We are the forgotten, the invisible. Shame on those watch dogs. When I was with Leader, I would watch my nurse do everything—catheters, suctioning, wound care—everything. We used to do wound care and finger sticks. In some places, they don't even let the aides do vital signs.

One of the cases I will never forget, this was at a rehabilitation center with a floor that was skilled. This lady was admitted. She was only 60. She had the biggest tumor I had ever seen on the side of her neck; it was cancerous. The tumor was growing outside her neck. I was just 25. When we received report that morning, we were told of physical and history, where she was with her disease, and that she had come there to die. She had no family. We quickly became her family. She was tall and skinny with dark hair. We were also told how she would die and to be prepared so it would not be scary for her or for us. She was going to bleed to death from the tumor. But, our biggest challenge, you see, was not to show that there was an odor when in her room or where ever she was. The cancer was very foul-smelling. I think that is why she loved us; we acted like there was no smell. The day she died, her tumor started a steady flow of blood. She knew it was the end. We had dark towels for her, she lay in her bed, she was never left alone. We had our work to do, but she was never left alone. What I remember the most is her eyes; you see, she could not speak that day. She looked at us as if to say, "Thank you, thank you so much for treating me so good and not like a monster."

I have good stories and bad stories. I will also never forget a young 32-year-old patient who befriended me and she asked me to help her pick out her clothes to be buried in, along with shoes. I asked her if she needed anything else, was there anything I could do for her. She was so weak and frail. I knew she did not have long. She asked me for a bracelet I was wearing. The bracelet was special to me. I had it made in Germany. I tried to convince her to take one of the others I had on, she declined, She wanted that one. I gave it to her. The next week she died.

I am getting up in my years. My plan is to teach and collect data on the results of continuing education in long-term care settings and its effects on retention, reliability and dedication, along with quality of care.

An Open Letter to Certified Nursing Assistants: Lessons from a Life Well Lived[1]

Margaret Fletcher

I can't be sure what I want to say, or how to say it. Seeing as how I'm now eighty years old, and somewhat forgetful, I cease remembering the good old days.

I have written a lot of short articles for the Nursing Assistant Program. My journey of life has been very interesting, very wonderful and fully blessed.

My career as a nursing assistant started in my 16th year back in 1947. Once I was involved in the work,

[1] *This piece came to us in a beautifully hand written letter. While it is not a narrative and the commentators did not work with this piece, we wanted to share it with our readers.*

I understood about the journey of life and all the things that living brings into a life of a human being.

I learned being a nursing assistant is not just a job and a paycheck. It's a beautiful and wonderful life of kindness, honesty, courtesy, fairness, pity, help, trust and forgiveness.

Its principles will take hold of your lifestyle and future. If we realize we are a valuable and unique person, then accepting life with optimism, making sure of our goals, striving to give our best, and growing in awareness helps us learn to be productive and efficient in our work.

Understand that everyone and every thing around us has something to teach us. It's not just the classroom learning that's going to put us on the road of good caregiving with a kind loving heart.

It's going to take desire, concern and total devotion with lots of hard work. We must learn from the day-to-day needs and expectations of our patients or residents, doctors, wing nurses and the patients' or residents' families.

There will be changes, and these changes can be frequent. Therefore, we will need to know and be aware what is expected of us.

Now as an old fogy, I'd like to point out that experience is required for developing expertise. And that a sound educational base is necessary for acquiring advanced skills because it forms the best position for developing our ability to sort through concepts and facts. And to focus on the aspects of the various types of patient care situations. It will indicate priorities and offer guidelines for action. Even in seemingly routine situations the nursing assistant must be alert to special circumstances and adapt their care accordingly.

Never once did I regret my choice of becoming a caregiver. I can remember one kindhearted doctor who always had his special way for chitchats, telling me, "What you leave behind is not engraved in stone, but what is woven into the lives of other human beings, you must always make the right connections." Then, jokingly, the good doctor asked, "If a cabbage, a tomato, and a faucet ran a race, who would win?" His answer, "The cabbage would be a head, the tomato would ketch up, and the faucet would still be running. Which would you be most like?" My answer, "but doctor, I'm not running a race, I'm on a journey." That journey is life and love. Life is so precious. Where there is love, love makes us whole.

No matter what obstacles we face, love gives us the strength to overcome them. As a writer, I'll share in this story. It should be as though we're all family now. Our world is as great as we make it.

Realize we all deserve a little lift now and then, but we also need to realize there is no cosmetic for beauty, like happiness. A very personal happiness is what you say and do as a nursing assistant making life better for those entrusted in our care.

Down through the years my patients and residents have taught me well what love is really all about. I want to share my lesson with you. Love is friendship that has caught fire, it is quiet understanding, mutual confidence, sharing and forgiving. It is loyalty through good and bad times. Love settles for less than perfection and makes allowances for human weaknesses. Love is content with the present, love hopes for the future, but doesn't brood over the past. Love: it's the day-in and day-out chronicles of irritations, problems, promises, disappointments, big victories, small victories, and working toward common goals.

So I have learned that love is the underlying principle that makes everything else in this life work. In Song of Solomon 8:7 it states, "Many waters cannot quench love, neither can the floods drown it."

As my dear friend would say, "Isn't life beautiful?"

Now that I am a retired old fogy, I hope and pray that I will finish well and gracefully live with life's changes. First, though, I want to share just a bit of my personal history, to maybe help you to better understand my finishing well.

I was born December 1, 1930. I just passed my 80th year. I believe in the Lord Jesus Christ as my everything. He has blessed my life, my work, and the love I feel for every human being on this earth.

I worked as a caregiver for nearly 58 years. Due to health problems I retired in Sept 2002 at the age of 72. Oh, how I wish I could be back doing and caring for the residents. I miss the work, the joy, the personal satisfaction of knowing I helped someone get through another day.

Now I'll get on with finishing my life well.

My contents for finishing well are:

1) Handling change with grace and foresight.
2) Dealing with physical decline.
3) Coping with vocational disappointment.
4) Adjusting to family changes.
5) Adapting to retirement.
6) Preparing for death.
7) Losing independence.
8) Planning a legacy.
9) Evaluation Performance.

It's not an easy road to hold. Due to the widespread moral and spiritual defection within our ranks, caregiving the last few years has been difficult for the caregiver.

Never has there been a better time to lift those who have fallen into distraction, disillusion, or despair. Never has there been a better time to be reminded of the important goal of finishing well.

Handling change with grace and foresight: how well we end our earthly days depends largely on how well we handle life's inevitable changes. We proceed from infancy to childhood to adolescence to adulthood, and as adults, we move rapidly through the changes from singleness to marriage, from parenthood to becoming grandparents, from getting ahead at work to the place where we peak and start going down, down the ladder.

Our relationships change. Parents, aunts and uncles and other members of today's generation grow old and die. Much to think about. Our children grow up and move out. The people of our generation leave us one by one. We know that our own death is not far down the road.

To finish well, we must cope with the changes gracefully and trustingly. We will always have mental and spiritual adjustments to make as we go down life's road.

Dealing with physical decline, I often hear people in their seventies and eighties say, "I don't feel old." I've said that too. But the fact that we're declining physically cannot be denied, even by those of us who are healthy. On my days of strenuous activity, I head for the pain medicine. I can consider myself blessed beyond measure to be able to function as well as I do and to be on my own.

My heart is telling me to take a good look at the obvious miscalculated consequences of the most brilliant among us, who are now trudging knee-deep in mud and a very confused condition. Then I have to think or believe no matter how mature we might be we all have an infinite amount of room to grow.

A person must be willing to commit to the growth process. You will not be forced to learn. No one will coerce you into becoming significantly involved in the lives of other people for your own growth and outreach to others. You must want to be more than you are now. You must be willing to pay the price. We all need greater wisdom in decision-making. We all need friends, and we all need an attitude of service.

We are a nation of individualists, living in an warped society. It is a virtue if we do not appear to need any one else. The picture of superiority through solitude is quite contrary to my belief and contrary to reality. For well-balanced and satisfying lives, we need each other. Others teaching us, nurturing us, training us.

The good life is caught rather than merely taught, and that comes through significant relationships with others that have required friendship and accountability. We need a grateful heart with love for all the lovely and the unlovely.

God Bless You.