Nursing Home Staffing and Training Recommendations for Promoting Older Adults’ Quality of Care and Life

Part 1. Deficits in the Quality of Care Due to Understaffing and Undertraining

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ABSTRACT
Caught between the inability or unwillingness of nursing home corporations and owners to redistribute revenue and the reluctance of federal and state agencies to increase payments to nursing homes, the nation's most vulnerable older adults are not receiving the care they deserve. Widespread recognition of substandard care and quality of life of older adults in nursing homes has existed for decades. In addition, there is substantial evidence that poor quality of care is related to inadequate numbers and training of nursing staff. Still, policy makers and nursing home owners have failed to take needed action. In the first article of this two-part series, major deficits in the care of older adult nursing home residents are reviewed, and research documenting the relationship between nursing home staffing and the quality of care and life of residents is summarized.
gerontological nursing for RNs and assisting nursing staff has repeatedly been found to be related to poor quality of care (Gregory, 2001; Harrington & Carrillo, 1999).

Increased standards for nurse staffing and revised requirements for staff training have been called for again and again (Harrington, Kovner, et al., 2000; Institute of Medicine, 1986), but federal and state policy makers, often citing costs, have yet to respond with higher standards that will improve the quality of care. Continued patience at the expense of older adults and their families is no longer tolerable.

This article presents evidence that the educational level and number of nursing staff are related to quality of care in nursing homes. Evidence of the need for more RNs and assisting nursing staff, including licensed practical nurses (LPNs), trained in gerontological and geropsychiatric nursing to improve the quality of care of older adults in nursing homes is described. Nurse staffing and training standards required for quality care of nursing home residents are recommended for immediate adoption by the Centers for Medicare & Medicaid Services and by legislators. Factors (e.g., the cost of increased staffing compared with current costs) that constrain higher staffing and training standards are also discussed. The recommendations underscore that now is the time for the nation to ensure that older citizens in nursing homes have the quality of care and life they deserve.

DEFICITS DUE TO UNDERSTAFFING AND UNDERTRAINING

Breaches in the quality of care and life of the estimated 1.6 million individuals in 17,000 U.S. nursing homes (U.S. General Accounting Office [GAO], 2002) remain. More than 750,000 of these older adults incur excess disabilities that deprive them of optimally autonomous and dignified quality of life. A range of serious care deficits are reported (Eaton, 2000; GAO, 1999; Harrington, Kovner, et al., 2000; Harrington, Zimmerman, Karan, Robinson, & Beutel, 2000; Rantz et al., 2004; Spector & Takada, 1991; Zhang & Grabowski, 2004). One U.S. study showed that care in one fourth of all U.S. nursing homes had either harmed residents or could have led to death or serious injury (GAO, 1999). There is also a large amount of research evidence that poor quality of care is due to too few professional and assisting nursing staff with adequate training in gerontological nursing in nursing homes (Anderson, Hsieh, & Su, 1998; Anderson & Lawhorne, 1999; Bliesmer, Smayling, Kane, & Shannon, 1998; Castle, 2000; Cherry, 1991; Cohen & Spector, 1996; Eaton, 2000; Gould, 1992; Grando et al., 2005; Harrington, Woolhandler, Mullan, Carillo, & Himmelstein, 2002; Kane et al., 1989; Kolanowski, Hurwitz, Taylor, Evans, & Strumpf, 1994; Kruzich, Clinton, & Kelber, 1992; Linn, Gurel, & Linn, 1977; Monroe, 1990; Nyman, 1988; Nyman, Bricker, & Link, 1990; Rantz et al., 1997, 1999; Rantz, Hicks, Grando, et al., 2004; Rantz, Hicks, Petroski, et al., 2004; Ryden, 1985; Sochalski, 2001).

Abuse and Neglect

Many nursing home residents experience neglect and abuse. National concern for the safety and security of older adults in nursing homes is exemplified by the recently introduced U.S. congressional bill (H.R. 1783) titled, “To amend the Social Security Act to enhance the social security of the nation by ensuring adequate public-private infrastructure and to resolve, prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation, and for other purposes” (Nursing Home Abuse Support Group, 2003).

When nursing home staff do not or cannot fulfill their duty to residents, it is neglect. Abuse encompasses the failure to provide adequate staffing and the falsification of medical records. Physical abuse consists of hitting, coercive restraint, force feeding, and depriving residents of food, among other physical mistreatments. Sexual abuse is improper touching or coercion to perform sexual acts. Psychological or emotional abuse is berating, ignoring, ridiculing, cursing, threatening punishment or deprivation, or depriving residents of control over decisions and choices that affect their lives. Although less well recognized, deprivation of social experiences with family, friends, or others is also emotional abuse. Finally, misappropriation of property or funds is another serious form of abuse that has emotional and, sometimes physical, effects.

A 1998 GAO study concluded that more than half of the suspicious deaths studied among the 1.6 million Americans residing in nursing homes across the nation were probably due to nursing home neglect, including malnutrition and dehydration (GAO, 1999). The study found that many nursing homes cause actual or potential death or injury to residents, with approximately 77% of the homes sampled in a secondary state survey continuing poor quality of care. Nearly one in three nursing homes was cited for an abuse violation from 1999-2001 (CBS News, 2001; Committee on Government Reform, 2001). Each of the reported violations had the potential to cause harm, but the abuse violations in 1,600 of the nursing homes were serious enough to cause actual harm to residents (U.S. House of Representatives, 2001). According to a GAO report to Congress in 2002, 6,603 cases of physical abuse by nursing home staff were documented each year. Sexual abuse in nursing homes is more insidious than other forms of
physical abuse but accounts for 10% of all reported physical abuse cases (U.S. Department of Justice, 1996).

According to the National Citizens’ Coalition for Nursing Home Reform (2007), failure to take a resident to the bathroom when requested or prescribed; failure to provide food, water, hygiene, medicine, and safety; incorrect body positioning; and lack of assistance with walking (which leads to lack of mobility) are examples of neglect. In a study of 882 nursing home residents in 34 California nursing homes, Bates-Jensen et al. (2004) found that staffing levels predicted increased time in bed, resulting in increased daytime sleeping, less social engagement, and less food and fluid intake at mealtimes, all of which are precursors of mental or physical disabilities and failing health, and are examples of neglect.

Abuse and neglect are likely substantially underestimated due to resident and family reluctance to file formal complaints and the relative isolation of many older adults in nursing homes (National Center on Elder Abuse, 1998). According to a 1998 National Center on Elder Abuse study, 57% of nurse aides working in nursing homes admitted that they had witnessed or participated in acts of resident abuse. In addition, according to Pillemer and Moore (1990), 40% of 577 nursing staff interviewed admitted committing psychological abuse within the past year, and 10% said they had physically abused a resident. Adding to the seriousness, elder abuse is associated with increased mortality rates, with a reported 91% of abused older adults dying within a 3-year period versus 58% of nonabused older adults (Lachs, Williams, O’Brien, & Pillemer, 2002). To prevent these acts, it is clear that more professional nursing leadership, greater oversight, improved working conditions, and screening and training of assisting staff are required in nursing homes (Nerenberg, 2002).

Falls

Many families seek nursing home residence for their older relatives because they fear for their safety, especially related to falling. Unfortunately, this is a false security. Falls are rampant in nursing homes, due at least in part to loss of residents’ physical functioning and inadequate facility staffing. Nursing homes average 1.5 falls per resident each year, ranging from 0.2 to 3.6 falls per resident, with 10% to 25% of those resulting in hospital admission or fractures (Vu, Weintraub, & Rubenstein, 2004). Falls have been shown to be underreported in Minimum Data Set (MDS) data by nearly one half (Hill-Westmoreland & Gruber-Baldini, 2005), reflecting insufficient assessment by qualified nurse professionals.

Problems with gait and balance, dizziness, weakness, confusion, poor vision, postural hypotension, and environmental dangers are often causes of falls and are compounded by failure to use assistive devices (Hill-Westmoreland & Gruber-Baldini, 2005). Sedative and psychoactive medications may be a factor, and lack of regular toileting or assistance with toileting contribute to some falls when frail older adults attempt to get to the bathroom. Despite the risk factors of weakness, poor balance, and gait disorders, therapy to maintain physical functioning is often minimal beyond physical therapy that is reimbursed by Medicare for a limited time and only if the resident is making substantial progress (CMS, 2006a). The CMS reimbursement policy for physical therapy assumes that routine exercise to maintain strength and mobility should be carried out by nursing staff, who are already too few in number to provide all of the required care.

Many falls in nursing homes are preventable with multifaceted intervention programs that include environmental assessment, assistive device evaluation and modification, medication management, gait assessment and training, staff education, exercise programs, and blood pressure evaluation (Becker et al., 2003; Vu et al., 2004). Better assessment, prescription of intervention strategies, and adequate staff to prescribe and implement the strategies are required to prevent falls (Castle & Sonon, 2006) without inappropriately restricting older adults’ movement and physical functioning. However, too often the latter is the case. Because too few qualified staff are available to prescribe and implement the strategies required to prevent falls, including sufficient surveillance and interaction with residents, many nursing home residents sit around wired with alarm systems designed to alert staff when movement indicates residents may be getting up from the chair. Many are sedated or rendered inactive with psychoactive medications if their behaviors are deemed difficult to manage. Thus, nursing home residents are not only more prone to falls due to lack of active therapy to maintain or improve physical functioning, but loss of functioning is reinforced by technology and chemical restraints that prevent movement and maintenance of function.

Physical and Chemical Restraints

Improper use of physical and chemical restraints in nursing homes is a major cause of functional loss and disability of residents, as well as a serious compromise of their quality of life. Seminal research by Strumpf and Evans (1988, 1991) documented the positive effects of restraint-free environments on quality of life for older adults in nursing homes without increases in falls or subsequent
Nutrition and Weight Loss

Some studies report that up to 50% of nursing home residents cannot eat independently (Kayser-Jones & Schell, 1997). Because there are insufficient staff to properly assist residents with eating, weight loss and undernutrition add to frailty, loss of function, and often death. Thirty-five percent to 85% of nursing home residents are reported to be malnourished, and 30% to 50% are below standard in body weight (Burger, Kayser-Jones, & Bell, 2000). In one study, one half of residents who received a trial of one-on-one assistance with eating significantly increased their oral food and fluid intake at mealtime. The one-on-one assistance with eating took 38 minutes per resident per meal to implement (Simmons, Osterweil, & Schnelle, 2001). Another study found that residents who received at least 3 hours of CNA time per resident day had a 17% decreased probability of weight loss (Dyck, 2007), while another (Schnelle et al., 2004) noted that facilities with total licensed and CNA staffing of 4.1 or more hours per resident day provided better assistance with eating.

A small evaluation study of one nursing home’s experience with eating assistance highlighted significant issues with staff retention, attendance, and late arrivals (Remsburg, 2004). Even with training, mealt ime resources, and compensation for the work, supervision by licensed nurses was necessary to ensure the residents’ quality of care (Remsburg, 2004). RN supervision is needed to demonstrate how dining is a pleasant and social experience, characteristics shown to positively improve appetite and weight maintenance (Milne, Avenell, & Potter, 2006). Although research has shown that more time with residents increases food intake and decreases weight loss, Simmons and Schnelle (2006) concluded that the current Resource Utilization Group System (RUGS) underestimates the staff time needed to assist residents in improving their oral intake.

In 2003, the CMS allowed nursing homes to hire supplemental, single-task staff to assist residents with eating, providing evidence that the problem is receiving some attention. Reporting from one small CMS-contracted evaluation study in seven sites, Simmons et al. (2007) stated that 84% of the single-task staff were non-nursing staff in the facility and that the quality of assistance with eating was comparable to that of the facilities’ nurse aides. The researchers further reported that there were no changes in the number of employed nurse aides or licensed nurses following the implementation of the supplemental, single-task staff. These findings are encouraging in regard to the effort to address insufficient staff to assist residents with meals.

Pain

The percentage of nursing home residents with untreated pain ranges from 45% to 89% (American Geriatrics Society Panel on Persistent Pain in Older Persons, 2002; Fries, Simon, Morris, Flodstrom, & Bookstein, 2001; Mobily, Herr, Clark, & Wallace, 1994). One study of 12 nursing homes revealed knowledge deficits in pharmacology, drug addiction and dependence, side effects, and the effectiveness of nonpharmacological intervention. Knowledge deficits were found in RNs, LPNs, and CNAs, although there were differences by job title. Nursing staff tended to interpret residents’ reports of pain by what they observed in the residents’ behavior (Jones et al., 2004). Jones et al. (2004) also found that persistence of knowledge deficits related to pain in nursing homes was primarily due to changing attitudes and beliefs. Consistent with these findings, Jeng, Guo, Drickamer, Marottoli, and Reid (2004) reported results from a telephone survey of Directors of Nursing (DONs) of 63 nursing homes in New Haven County, Connecticut. Seventy-six percent of the DONs reported that nurses assessed pain in residents who had no pain, whereas only 46% reported that nurses assessed pain in residents who complained of pain at least every shift. Only slightly more than one half (55%) of the DONs reported that nurses assessed pain at least every 30 to 60 days.

Although some progress has been made in the measurement of pain in older adults and in those with cognitive impairment, pain in nursing home residents remains underassessed and undertreated (Herr, Spratt, Mobily, & Richardson, 2004; Horgas & Elliott, 2004; Horgas, McLennon, & Floetke, 2003; Weiner & Hanlon, 2001). As many as 70% of nursing home residents have been estimated to be in pain...
Older adults with cognitive impairment present a particular challenge in assessing their pain, and they tend to receive less pain medication than those without cognitive impairment (Ferrell, Ferrell, & Osterweil, 1990). Although the prevalence of mental illnesses, such as depression and other mental illnesses, has decreased

Dementia

It is estimated that individuals with some form of dementia comprise 50% to 60% of the residents in the nation’s nursing homes (Magaziner et al., 2000). Individuals with dementia who live in nursing homes present difficult care problems for staff and family members. In addition to needing assistance with basic activities of daily living (e.g., bathing, grooming, toileting), older adults with dementia are often anxious and agitated, frequently pace continuously, and are often at risk for elopement and aggressive behaviors (Bridges-Parlet, Knoopman, & Thompson, 1994; Cohen-Mansfield, 2000). These care problems are difficult to handle, resulting in increased stress and burnout among staff. Family members, who usually find it difficult to institutionalize their loved ones, typically experience guilt and loss, as well as the stress of releasing control of their relatives’ care to staff (Butcher, Holkup, Park, & Maas, 2001; Caron, Ducharme, & Griffith, 2006; Maas et al., 2004).

Many residents with dementia are placed in special care units, but many also reside in traditional nursing home units with residents without cognitive impairment. After almost 2 decades of growth in the number of special care units, more than 22% of nursing homes have some kind of specialty unit for residents with dementia (Grant, 2002; Leon, Cheng, & Alvarez, 1997).

The special care unit strategy was designed to reduce the anxiety and agitation of individuals with dementia, which in turn was expected to decrease staff and family caregiver stress. Although most gerontology specialists agree that these units are useful for managing residents with dementia, a number of issues regarding the benefits to residents, staff, and family members are unresolved. Disagreement remains between proponents of segregation and nonsegregation, advocates of reduced and increased stimuli, those who believe rehabilitation strategies are useful and those who contend that environmental modification is most effective, and those who reject or embrace a medical versus social model of care (Boettcher, Kemeny, & Boerman, 2004; Camp, Cohen-Mansfield, & Capezuti, 2002; Day, Cameron, & Stump, 2000; Reimer, Slaughter, Donaldson, Currie, & Eliaziw, 2004; Slaughter, Calkins, Eliaziw, & Reimer, 2006).

As in all settings that care for individuals with dementia, there should be adequate staff to attend to the holistic needs of residents and their families, and all administrators, physicians, nurse practitioners, and interdisciplinary staff should be thoroughly trained in the care of older adults with dementia (Davis et al., 2000). Training of nursing home staff in the care of individuals with dementia is especially scant, although somewhat more frequent for staff in special care units. In addition, few educational programs have been available for training health care professionals and assisting staff in the care of individuals with dementia, and they continue to be a scarce resource (Gerdner & Beck, 2001; Stolley, Backwalt, & Shannon, 1991).

During the past decade, a number of guidelines for evidence-based practices with individuals with dementia have been developed and disseminated. However, the use of evidence-based practices by nursing staff in nursing homes remains very limited. This is despite recognition by most nurses and assisting staff that they need more knowledge about how to best care for residents with dementia. Many nursing homes do not provide funds for their staff to obtain continuing education beyond the few hours mandated by regulations. A limited number of qualified RNs to provide the training and constraints on staff time also account for a lack of sufficient inservice education.

Staff access to Internet-based resources on best practices is also typically very limited. Inservice education that is provided is often not based on the most current evidence-based best practices. The implementation and sustained use of evidence-based practices for individuals with dementia and their families requires the leadership of qualified RNs with the knowledge and skills to help assisting staff adopt these best care practices (Meret-Hanke, Weech-Maldonado, Neff, & Mor, 2003).

Depression and Other Mental Illnesses

Although the prevalence of mental illnesses, such as schizophrenia and other clinical psychoses, has decreased...
during the past 2 decades, the reduction has mainly been among residents younger than age 60 (Mechanic & McAlpine, 2000). A substantial number of older nursing home residents have chronic mental illnesses and emotionally disabling conditions. Many nursing home residents have subclinical and clinical depression that is often undiagnosed and untreated (Cohen, Hyland, & Kimby, 2003). Twelve percent to 16% of nursing home residents have been diagnosed with major depression, with 30% to 40% more exhibiting symptoms of depression (Mulsant & Ganguli, 1999).

Depression in older nursing home residents is a common and insidious condition that negatively influences a number of conditions and behaviors, including emotional suffering, less participation in social and other activities, excess physical and cognitive disability, and lack of adherence to treatments (Kallenbach & Rigler, 2006; Onishi et al., 2006). Unhappiness and loss of hope and morale have been found to characterize depression in nursing home residents (Onishi et al., 2006). Depression can be misdiagnosed as dementia, although individuals with dementia are often also clinically depressed. Either circumstance will have untoward effects unless diagnosis is accurate and appropriate treatment is instituted and properly managed.

Unfortunately, treatment with antidepressant medications often contributes to falls and further disability. The health of residents of nursing homes tends to worsen around the time they begin to receive antidepressant agents (Slaughter, Beck, McDonald, Ray, & Thapa, 1999; Thapa, Gideon, Cost, Milam, & Ray, 1998). For this reason, it is important that medication effects and mood status are regularly evaluated. Depression in older adults is treatable if it is recognized and if the management of medications and associated behaviors adheres to quality indicators (Kallenbach & Rigler, 2006; Serby & Yu, 2003).

The use of psychotropic drugs for treating mental illness in older adults is associated with more frequent hospitalization and some effects that increase disabilities (Ron, 2004). RNs trained in geropsychiatric nursing can often use nonpharmacological interventions that avoid or reduce the use and misuse of psychotropic medications (Voyer & Martin, 2003). More qualified RNs are needed in nursing homes to decrease the unfortunate outcomes related to the misuse of psychotropic drugs for older adults. Although there is evidence of a trend toward recognition of the need for more RNs with geropsychiatric training in nursing homes, this need remains mostly unaddressed by policy makers and nursing home owners (Kaas, 2006).

**Urinary Incontinence**

Older adults are at increased risk for urinary incontinence (UI); some risk factors are due to the aging process, and others are due to lifestyle factors. Although risk factors do not cause UI, they do increase its potential. UI is a common problem for older adults and has major effects on the quality of their lives, but it is not an inevitable or irreversible consequence of aging. A number of interventions can be used to prevent or treat incontinence. There is growing evidence that treatment can reduce the incidence, prevalence, and cost of UI in older adults living in institutions and in their homes (Newman & Palmer, 2003; Specht, Lyons, & Maas, 2002).

Despite the progress in research and treatment of UI, its prevalence is rising among older adults (Newman & Palmer, 2003). More than 50% of nursing home residents have untreated UI (Watson, Brink, Zimmer, & Mayer, 2003). Hypothesized reasons for these findings are lack of health care provider knowledge about UI, myths about incontinence in older adults, the reluctance of older adults to report their problems with incontinence, and the lack of individualized care (Specht, 2005). It has been shown that many individuals with incontinence, including those with dementia, can be maintained continent if they are regularly assisted with toileting (Specht & Maas, 2004).

Nurses have been slow to recognize their role in the diagnosis and treatment of UI and often do not possess the knowledge needed to appropriately intervene. Many nurses are not aware of the eight kinds of UI, including stress, urge, overflow, functional, reflex, iatrogenic, mixed, and total (Specht & Maas, 2004). In addition, delirium; infection, particularly urinary tract infections; atrophic urethritis/vaginitis; medications, specifically hypnotic and sedative agents that dull the senses and slow response to the urge to urinate; excess excretions (i.e., after receiving diuretic medication); restricted mobility (e.g., bed rest, physical restraints); and stool impaction that obstructs the urethra are common reversible etiologies of transient UI. In one study of 52 nursing homes, investigators identified potentially reversible causes of UI in 81% of the residents (Watson et al., 2003).

There is much evidence that UI is treatable, and much of the treatment falls within RNs’ and advanced practice RNs’ scope of practice (Lyons & Specht, 2000; Specht et al., 2002). The most promising treatments include scheduled toileting, prompted voiding, bladder training, pelvic exercises, and intermittent catheterization. Most cases of UI can be effectively managed with nonpharmacological treatments that nurses can prescribe and implement (Bulechek, Butcher, & Dochterman, 2008; Specht & Maas, 2001; Wyman, 2003).

Unfortunately, nursing staff are not properly assessing and treating UI. Schnelle et al. (2003) reported that quality of UI assessment and treatment was poor, regardless of whether residents’ MDS rated UI outcomes as good or poor.
For example, even if residents were on a scheduled toileting program, they were toileted an average of only 1.8 times per day. Assessment and prescription of interventions by knowledgeable RNs, who will also lead and direct assisting staff in implementing the interventions, are required.

The expectation for UI before thorough assessment, diagnosis, and treatment is exemplified by the use of incontinence pads (Specht, 2005; Specht & Maas, 2001). The result is an infantilizing disservice to older adults and malpractice by those who are responsible for their care. This misuse and other concerns about the inappropriate use of incontinence pads constitute a serious breach of nursing ethics and are tantamount to elder abuse. Catheters are also used inappropriately for long-term management (more than 30 days) of UI (Newman, Fader, & Bliss, 2004). National rates of use of indwelling catheters in long-term care was 6% in 2005 and has been increasing in recent years (CMS, 2007).

Unfortunately, many nurses do not understand the importance of identifying the kind of UI or the numerous causes of transient UI for selecting the most appropriate outcomes and treatments. Many also view continence as the only outcome for UI, although decreased frequency of incontinence episodes, increased percentage of dry time, number of times urinating in the toilet, waking-time dryness, and nighttime dryness are outcomes that can greatly improve the quality of older adults’ care and lives (Iowa Outcomes Project, 2008; Specht & Maas, 2001).

The CMS issued a surveyor guidance for incontinence and urinary catheters in June 2005, collapsing Tags F315 and F316 into one: Tag F315 (CMS, 2006b). The CMS surveyor guidance expects long-term care facilities to have timely assessment and specific intervention procedures in place to implement, monitor, and revise according to current standards of practice. The guidance document puts greater emphasis on evaluating and treating UI from the time of admission and when there is a change in cognition, physical ability, or urinary tract function. The intent is to ensure that residents with incontinence are identified, assessed, and provided with appropriate treatment; that indwelling catheters are not used without clear justification; and that care is provided to prevent urinary tract infections.

**Pressure Ulcers**

Pressure ulcer indicators as a quality measure in nursing homes have received much attention. According to MDS quality indicator reports, at least 9% of older adults in nursing homes still have pressure ulcers, and the prevalence has not decreased since implementation of the Omnibus Reconciliation Act of 1987 (CMS, 2007; Coleman, Martau, Lin, & Kramer, 2001).

However, reports have indicated that the incidence and prevalence of pressure ulcers is decreasing and that some progress in preventing ulcers has occurred. The National Nursing Home Improvement Collaborative collected data from 29 quality improvement organizations and 6 multistate long-term care corporations, recruiting 52 nursing homes in 39 states (Lynn et al., 2007). Using quality improvement methods, evidence-based recommended practices were implemented. Monthly pressure ulcer incidence and prevalence, healing, and adoption of key care processes were monitored. The incidence of progression from Stage III to Stage IV and from Stage II to Stage IV declined. Healing time of Stage II, III, and IV ulcers remained the same. The results indicate that the incidence of Stage III to Stage IV lesions can be reduced, that the incidence of Stage II lesions may not be associated with the incidence of Stage III to Stage IV lesions, and that the MDS quality indicator is likely insensitive to improvement.

Other studies have shown improvement in prevention (Berlowitz, Bezerra, Brandeis, Kader, & Anderson, 2000). Brandeis, Ooi, Hossain, Morris, and Lipsitz (1994) found several factors associated with the formation of pressure ulcers in nursing homes with high incidence rates, including ambulation difficulty, fecal incontinence, diabetes mellitus, and difficulty feeding oneself. It is noteworthy that nursing interventions will negate the effects of fecal incontinence, difficulty with ambulation, and difficulty feeding oneself if prescribed and delivered appropriately.

That these risk factors resulted in pressure ulcers indicates a lack of qualified RNs to prescribe interventions and lead assisting staff, an inadequate number of assisting staff to deliver delegated evidence-based interventions, and a lack of knowledge of evidence-based practice, or all of the above. RNs with expertise in gerontological nursing and evidence-based interventions to maintain residents’ mobility, skin integrity, continence, and nutrition are critically needed. If the evidence of some progress with the reduction of pressure ulcers is valid, it is clear that increased numbers of qualified RNs knowledgeable in the recommended interventions to reduce risks, accompanied by an adequate number of assisting staff, would further reduce the incidence and prevalence of these debilitating, costly, and preventable lesions.

**Social Isolation and Inactivity**

Many residents, especially those with dementia, have negligible social contact with their communities and often have infrequent continuing interactions with family members (Oliver, Demiris, & Hensel, 2006). The importance of social support of older adults, especially from their families, for quality of life is recognized (Clarke, 1993; Gaugler,
Pearlin, Leitsch, & Davey, 2001; Tomaka, Thompson, & Palacios, 2006).

It is widely understood that without family and friends who visit regularly and oversee their well-being, older adults are more vulnerable to loneliness, poor care, and even abuse or neglect (Bondevik & Skogstad, 1998; Hicks, 2000; Menio, 1996). One kind of benign neglect is the relative social isolation or lack of social activities experienced by many nursing home residents (Ljubic, 2005). Many residents rarely get outside.

A number of studies have tested a variety of interventions to establish and increase family involvement in nursing home care, although the positive effects on resident outcomes are not well established (Clarke, 1993; Gaugler, 2005; Laitinen-Junkkari, Merilainen, & Sinkkonen, 2001; Maas et al., 2004; Ross, Carswell, & Dalziel, 2001; Ryan & Scullion, 2000). Nurses’ holistic view of health and quality of life is needed to promote social interaction and activity, as well as to increase the involvement of families in the care of older adults in nursing homes.

Alternative models of care that offer smaller and more homelike physical environments and well-trained professional and assisting staff hold some promise for improving the quality of the social lives and other outcomes of individuals with dementia (Specht & Maas, 2004). Specht and Maas (2004) demonstrated a nursing model of care that emphasized a familiar home environment, family involvement, well-trained supportive staff, and intensive individualized and group activities. Residents were maintained continent, socially accessible, and physically functional for an average of 2 years with no weight loss and rare instances of agitation or wandering.

Kane, Lum, Cutter, Degenholtz, and Yu (2007) reported significantly better quality of life of residents of the Green House® model, which offers a smaller, more homelike environment. Immediate action by policy makers to support and enable these or similar models should be demanded. It is time for approaches other than increasing Medicare payments for facilities to increase staffing. More innovative models of care are needed that empower sufficient numbers of qualified RNs to implement holistic nursing models of evidence-based care.

CONCLUSION

The continued poor outcomes for older adults in nursing homes are a national tragedy and are unacceptable. It should weigh heavily on the collective conscience that older adults and their caregivers are socially devalued and marginalized in U.S. society (Diamond, 1992; Gorski, 2004; Mendelson, 1974: Mor & Zinn, 2004; Tellis-Nayak & Tellis-Nayak, 1989; Vladeck, 1980) and that the country has substantially abdicated its obligation to its vulnerable older citizens who reside in nursing homes.

Research on the relationship of the number and kind of nursing staff to quality of care in nursing homes has been reported for at least 3 decades (Aaronson, Zinn, & Rosko, 1994; Bliesner et al., 1998; Cherry, 1991; Cohen & Spector, 1996; Dellefied, 2000; GAO, 1999; Harrington, 2005; Institute of Medicine, 1986; Linn et al., 1977; Meret-Hanke et al., 2003; Monroe, 1990; Nyman, 1988; Nyman et al., 1990; Spector & Takada, 1991). Wells (2004) made the case for minimum nursing standards in nursing homes through a review of the literature verifying the connection between staff-to-resident ratios and quality care. The prevalence of avoidable medical conditions and hospitalizations when staffing falls below a certain level is noteworthy. These reports consistently document a positive relationship between RN staff and higher quality outcomes.

To make small gains and minor improvements in quality of care and outcomes for older adults in nursing homes is simply not enough. Top-notch quality of care and life are the only acceptable standards. Part 2 of this article (pp. 134–152) reviews the evidence supporting increased nurse staffing standards in nursing homes and recommends RN and CNA staffing standards needed to provide the care that older adults deserve. Leadership training for RNs and increased gerontological nursing training for CNAs are recommended. To address the shortage of RNs with gerontological nursing and leadership training in nursing homes, a program to prepare RNs as geriatric nursing long-term care specialists is also proposed.

REFERENCES


Nurse Staffing and Training Recommendations: Part 1


