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Recommendations from the International Consortium on Professional Nursing Practice in Long Term Care Homes

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Abstract

In response to the International Association of Gerontology and Geriatrics' global agenda for clinical research and quality of care in nursing homes, the International Consortium on Professional Nursing Practice in Long Term Care Homes (the Consortium) was formed to develop nursing leadership capacity in nursing homes and address the concerns regarding the current state of nursing leadership in long-term care homes (LTCHs). At its invitational, two-day inaugural meeting, the Consortium brought together international nurse experts to explore the potential of registered nurses (RNs) who work as supervisors or charge nurses within the LTCHs and the value of their contribution in nursing homes, consider what RN competencies might be needed, discuss effective educational (curriculum and practice) experiences, health care policy, and human resources planning requirements, and to identify what sustainable nurse leadership strategies and models might enhance the effectiveness of RNs in improving resident, family, and staff outcomes.

The Consortium made recommendations about the following priority issues for action: (1) define the competencies of RNs required to care for older adults in LTCH; (2) create a LTCH environment where the RN role is differentiated from other team members and they can practice to their full scope; and (3) prepare RN leaders to operate effectively in person-centered care LTCH environments. In addition to clear recommendations for practice, the consortium

identified several areas where further research is needed. The research agenda the consortium advocated for emphasizes an international coordination of research efforts to explore similar issues, the pursuit of examining the impact of nursing and organizational models, and the showcasing of excellence in nursing practice in care homes, so that others might learn from what works. Several studies already underway will also be described.

Introduction

In response to the International Association of Gerontology and Geriatrics' global agenda for quality of care in nursing homes¹, the International Consortium on Professional Nursing Practice in Long Term Care Homes (the Consortium) was formed to develop nursing leadership capacity in nursing homes and address the concerns regarding the current state of nursing leadership in long-term care homes (LTCHs). A global crisis is building regarding our present and projected capacity to provide competent, dignified, and high-quality long term care (LTC) to frail older people and their families. Health care systems in most developed countries are striving to increase the quality of LTC by improving the availability and preparation of the professional nursing and assistive personnel workforce² and by making evidence-informed care for older people common practice.³ Occurring simultaneously with these efforts, however, is the aging of our populations and staff shortages to provide the required care and services to older people and their families. Within this context, there is an increase in long-term care home (LTCH) utilization in countries (e.g., China) that previously had little demand for this level of care.^{1,4} The residents moving into, and currently living in, LTCHs are older, with increasingly complex co-morbid conditions (including dementia) compared to the resident profile years ago.⁵ To meet resident care needs, skilled care is a necessity in LTCHs to provide competent, dignified, and high-quality care to frail older people and their families.⁶⁻⁸

While there is a vast knowledge base on the importance of nurse assistants (NAs) on residents' quality of care⁹ the RN, as supervisor of all other nursing personnel, also has an influence on the resident and staff outcomes.¹⁰⁻¹³ Providing direct care and working through

Licensed Practical Nurses (LPNs) and NAs, the effectiveness of the RN has been shown to be pivotal in determining the overall quality of care provided. A recent literature review described the current evidence as suggesting that the ratio of Registered nurses (RNs) to other nursing personnel in LTCH improves quality of life outcomes for residents,¹⁰ reduces the probability of hospitalization,^{11,12} and improves the quality of work environments for staff.¹³ However, in many countries there is a pervasive struggle to recruit and retain RNs in LTCHs resulting in a poorly trained workforce.^{14, 15, 16} As members of our consortium have written about, the potential of the RN impact is undermined by problems in the practice environment, staffing practices/patterns, local and federal regulations over practice, and concerns with nurse educational preparation and competencies which all impact quality of care.¹⁷ The role of the RN in LTCH has also been changing in response to regulation that requires RNs to spend the majority of their time completing paper work. This effectively removes them from giving and overseeing direct care, undermining quality of provision.¹⁸ In response to the recognition that these issues are global, an international consortium was formed to develop nursing leadership capacity in LTCH. The objective of this paper is to describe recommendations the consortium generated about priority issues for action and a research agenda regarding the RN in LTCH.

Development of the International Consortium on Professional Nursing Practice

When the International Association of Gerontology and Geriatrics released a global agenda for clinical research and quality of care in nursing homes, one of its recommendations was that an international alliance be formed to develop nursing leadership capacity in nursing homes.⁴ The intent of the consequently established International Consortium on Professional Nursing Practice in Long Term Care Homes (the Consortium) is to improve the professional role

of the RN through sharing across nations and identifying the evidence that will support recommendations for improvements in RN leadership. Our aim of the global collaboration is focused on research, leadership, and knowledge transfer, and through the creation of evidence-based recommendations for practice, policy, and administrative actions. The Consortium is comprised of nurse researchers in aging and long term care who are currently engaged in research, policy, administration/ operations, and education from Canada, the U.S., the U.K., Australia, New Zealand, Thailand, Norway, Spain, and Ireland. Concerned about the previously discussed trends in LTCH, the Consortium focused its invitational, two-day inaugural meeting on analyzing the latest evidence regarding RN leadership in nursing homes, as well as on sharing international experience related to nurse staffing and care provision in the LTCH setting, and to describe the ideal role and scope of practice of RNs in LTCHs. The attendees, collectively, brought extensive and varied knowledge and experience related to LTCH. We used an integrative and collaborative approach to reach consensus on priority issues identified for action and to set an agenda for future research.

Priority Issues Identified for Action

Before this first meeting, all experts were asked to respond to the question, “What are the current issues related to the RN role in LTCHs?” Participants across the globe provided similar responses, identifying a number of issues including (1) lack of gerontological nursing knowledge; (2) professional isolation of the RN; (3) highly regulated environment that limits RNs’ scope of practice; (4) RNs not realizing their leadership potential; (5) heavy workloads; (6) non-competitive pay; (7) lack of opportunities for professional development (compared to acute care); (8) lack of leadership and supervision; (9) lack of support, resources, and role models; and (10) lack of understanding of their contribution to facilitate person-centered care. Overall the

need for a critical mass of better trained/prepared RNs would have a substantial impact if they worked to the potential of the professional scope of their practice, acknowledging that both preparation problems and insufficient numbers of well trained nurses, contribute to quality problems. Participants indicated that the survey responses reflected the issues that arose from their own programs of research and/or areas of practice. Collectively, we agreed to focus on the next steps and action plan from an international perspective.

Content analysis was used to examine trends and patterns in the participants' responses (N = 33) to the survey. We chose frequency counts to identify the three most common areas of concern. Consortium members felt strongly that the following three priority issues for action were critical and would provide a clear anchor point for the group's work from the outset:

1. Define the competencies of RNs required to care for older adults in LTCH
2. Create a LTCH environment where the RN role is differentiated from other team members and they can practice to their full scope
3. Prepare RNs to operate effectively in person-centered LTCH environments that support professional nursing practice.

Define the competencies of RNs required to care for older adults in LTCH

Instead of participating further in the ongoing debate about staffing levels, we first need to outline work that needs to be done, the competencies that are needed to do that work and then the number and competencies of staff needed for the work can be determined. The competencies of the RN are pivotal in (1) providing comprehensive assessments, (2) delivering interventions, (3) overseeing care to prevent complications, and (4) recognizing and responding to changes in resident condition that often result in avoidable hospitalization and re-hospitalization.¹⁹ Although

licensed and unlicensed assistive personnel implement components of residents' care plans and collect data about residents, it is the clinical assessment and care management expertise within the RN's training and scope of practice that facilitates integration and synthesis of data to accomplish quality care, which unfortunately they often have insufficient time to do.

Accordingly, researchers found that in care homes where RNs and LPNs have clearly differentiated roles, effective collaborative relationships, and greater RN presence on the units, there were fewer deficiencies and lower prevalence rates for undesirable resident quality measures, such as pressure ulcers, falls with injury, incontinence, and physical restraint use.²⁰

As the worker with overall responsibility and the one delegating and overseeing the work of others, identifying the leadership competencies that will achieve the greatest effect is imperative. Researchers within the consortium have found consistently that RNs pay minimal attention to the leadership dimensions of their role.²¹ A careful reflection of required leadership skills are necessary and will most likely include team-building, conflict management, and time management, as well as situational leadership and how to empower others. The ability to influence patient outcomes through LPNs and NAs require sophisticated skills from the RN and these leadership skills are often not well recognized.

One of the Consortium's main recommendations is to develop policies and standards based on required competencies of staff and explicitly clarifying and supporting the role of the RN in LTCH. Such policies and standards need to take into account the legislative and regulatory frameworks that form the operating context for the RN in LTCHs. To achieve these aims, RNs, researchers, members of academia, and LTCH operators must participate and collaborate at multiple levels (local, national and international) and from multiple sectors (education, health, and social care). Discussions of competencies must occur in such a way as to

strengthen the overall team by considering the mix and expertise of *all* staff (including NAs/unlicensed workers), and to include a focus on fostering the collaborative relationship between RNs, LPNs, and NAs.²² Identifying the needs of the residents and determining who has the competencies and preparation and are legally sanctioned to meet those needs are vital for addressing the strengths of all team members. These discussions need to be predicated on a firm understanding of how care practices are organized and delivered in nursing homes, the optimal mix for achieving high quality, and the laws governing practice.²³ It is suggested that additional local stakeholders, including the medical director and nursing home administrator, partner in these discussions to identify necessary administrative and team supports to leverage the full capacity of the care team, allowing all members to function within and at the top of their scope of practice which requires looking beyond just getting the tasks done. Such models should be evaluated regarding their impact on resident, family, team, financial, and organizational outcomes.

Create a LTCH environment where the RN role is differentiated from other team members and they can practice to their full scope

The importance of the role and scope of RNs in LTCHs has recently been examined by exploring nursing practice patterns of RNs and Licensed Practical Nurses (LPNs) in LTCH environments, how nursing care is enacted, and how organizational factors influence RNs' scope of practice.¹⁷ When there are fewer RNs in LTCHs, LPNs find themselves engaged in nursing practice activities for which they are unprepared and that are outside of their legal scope of practice in the U.S.²³ These include such activities as conducting comprehensive assessments, initiating care plans from those assessments, evaluating the effectiveness of the care plan, and

delegating to and supervising unlicensed nursing personnel. LPNs have reported that they are practicing outside their scope because the number of RNs in their facility is inadequate, and those who are employed are unavailable due to their engagement in administrative work.²³ In Canada the scope of practice between the RN and LPN is very similar, and is dependent upon the acuity and unpredictability of the resident. Regulators in Canada have noted that RNs study for longer periods of time, allowing for greater foundational knowledge in clinical practice, decision-making, critical thinking, leadership, research utilization and resource management. As a result of these differences, regulators claim that the level of autonomous practice of RNs differs from that of LPNs.²⁴ Similarly in all countries, RNs may not recognize the broader scope of leadership and clinical expertise they bring to practice in a nursing home and may be forced by the regulations to conform to more task-oriented activities (e.g., medication administration). This may also be as a direct result of staffing levels as RNs are forced to spend their time completing tasks that direct them away from assessment and care planning and oversight of other staff. As LPNs scope of practice also includes these responsibilities, the result is compression of the RN role and merging of the RN/LPN role. The overall outcome of this trend is that RNs and LPNs end up fulfilling the same responsibilities, which means that RNs do not operate at their full scope of practice, and the LPNs are stretched to go beyond theirs. This practice is referred to as *interchangeability*, in which RN and LPN roles are not differentiated.²³

A challenge to having sufficient numbers of RNs, even when their value is recognized, is that they are not easily recruited nor retained in LTCHs both in the U.S. and abroad.²⁵⁻²⁷ Few nurses are interested in this work environment,^{28, 29} where the work is seen as emotionally and physically demanding, and perceived as low status compared to acute care. Salaries for RNs employed in LTCHs are also consistently lower than those of peers working in other sectors. A

recent study found that the largest percentage of health care providers who intended to leave their job within a year were RNs working in LTCHs.²⁸ Conditions prompting LTCH nurses to consider leaving include (1) the impact of regulations on nurse role and professional judgment, (2) insufficient resources and staffing, (3) working in isolation, (4) work/family conflict, and (5) a lack of supportive leadership from their Directors of Care/Nursing.³⁰

As identified in some Consortium members' earlier work,²¹ many RNs cope with heavy workloads. They have described their work as consisting of a long list of responsibilities, such as ensuring regulations are met, conducting quarterly minimum data set assessments, engaging in quality improvement, following up on physicians' and pharmacy orders, and updating care plans. Completing these tasks leaves them with very little time available to utilize their clinical skills, developing care plans, ensuring quality and coordination of care, conducting comprehensive assessments when changes are noted and provide leadership to the nursing team,²¹ which negatively influences the quality of care they provide to residents and families.³¹ Nurses therefore require adequate support and resources to entice them to come to LTCHs and empower them to stay to use their knowledge and skills, which will drive improved care in LTCHs.

In order to address these issues, the Consortium recommends that opportunities for networking be created among RNs in the LTCH sector, including offering safe places for RNs to share their expertise and to compare and contrast how they are operationalizing their role and teams in comparison with others. Enabling positive peer relations for RNs across homes and across jurisdictions would help mitigate RNs' feelings of working in isolation in LTCH. RNs' specialized knowledge and qualifications in the care of older adults also need to be emphasized and valued through formal acknowledgments in job descriptions, performance reviews, accreditation submissions, resident/family newsletters, and other vehicles. Finally, formal

mentorship plans and processes that will assist RNs in LTCHs to learn to mentor other team members, as well as new recruits, should be created to provide the support RNs need to stay.³² Continual support, along with a formal preceptorship program will aid the new nurse and the creation of a supportive and healthy work environment. Specifically, organizational supports within LTCH should be created to enable nurses to practice to their full scope. Recently in Canada, investigation is underway to promote RNs prescribing medications to residents living in LTC.³³ Additional educational preparation courses are being developed to allow this expansion in scope, and policy decision makers are fully supportive of this initiative as they believe it will benefit residents in LTCH.

Prepare RNs to Operate Effectively in Person-centered LTCH Environments that Support and Reward Professional Nursing Practice

Long term care for older people is undergoing a significant change internationally.³⁴ This change reflects a shift in philosophy from an institutional model of care to one that seeks to recognize and celebrate the continuing place of the older person in community, ensuring the “person” is at the heart of decision-making and in care delivery in order to enhance both quality of life for seniors and their relatives and well-being for staff. This philosophical movement calls for developing teams to facilitate relationships that enhance the personhood of the older person and others significant to them.³⁵ Residents have the right to feel at home, to be comforted when upset or lonely, to maintain connections with peers and people in the community at large, and to live in a place where relationships with family, friends, and visitors of significance can flourish. Pursuing person-centered care is truly at the core of our work in light of evidence that teams led by RNs in LTCHs can influence this outcome.^{34, 36, 37}

The consortium recommends that to foster practice in a person-centered and relationship-centered way, RNs must work with others to ensure that care and programs are delivered and informed by the best evidence available and that care is organized around residents' preferences and choices. Developing positive relationships within the home with older residents, relatives, and staff helps the residents feel a sense of security, belonging continuity, purpose, achievement, and significance.³⁸ For RNs to lead in person-centered and relationship-centered approaches to care, they require competencies in leadership, facilitation, clinical excellence, and critical thinking skills so that they can mentor others and facilitate relationship centered approaches. To increase the quality of clinical care and residents' quality of life, the articulation and expansion of RN competencies along with organizational support to engage in the activities is recommended to ensure the provision of person-centered care in LTC.³⁷

To fully prepare RNs for work in this environment, the positives of working in LTCHs must be demonstrated early within nursing curricula, along with a focus on the importance of leadership development and person-centered and relationship-centered care skills. From an academic perspective, creating opportunities for student nurses to gain meaningful experiences in nursing homes is essential. These placements should be focused on making students aware of the specific nuances and complexities of caring for this population as part of a team rather than being seen only as a learning venue for acquiring basic nursing skills, such as providing bed baths. Schools of nursing could then promote pre-graduate placements in LTCHs to senior students, thereby introducing the potential pool of soon-to-be newly graduated nurse recruits to the benefits of working with older adults in a team setting. This opportunity would enable student nurses to begin acquiring the knowledge and leadership experience necessary to work with older people before they graduate as RNs.

Development, implementation, evaluation, and long term sustainability of an international standard that incorporates best practices/guidelines for geriatric and leadership skills for RNs working in LTCHs is also a building block of success. An international qualification should be created that specifically outlines RN competencies for LTCH environments, including areas such as essentials of gerontological nursing, mentoring, leading a team, and critical thinking. Emphasis should also be placed on skill development to manage typical resident scenarios that RNs may encounter in order to avoid such Band-Aid approaches as employing acute care dispatch teams to evaluate a resident's status. International standards for residency programs for graduate RNs following their undergraduate training in LTCHs should be developed as well, in order to expose nurses to comparable experiences about the role of the RN in LTC. Currently a program is being developed in the US that is ready to be adapted to an international audience.³⁹ In addition, because a great number of foreign born nurses, in many countries, work in LTC settings, having an international standard would ensure foreign-born nurses, regardless of what county they are from or have migrated to, have internationally recognized skills sets.

Recommendations for Developing International Standards

Ideally, the Consortium, with its international focus and members have the potential to effect change at a broader and more upstream level than individual members could accomplish working in silos. The Consortium will serve as a venue in which international scholars can collaborate to seek more comprehensive solutions and recommendations for excellence in LTC. The Consortium is intended to support the aforementioned recommendations in order to comprehensively address the three priority issues identified. Our aim will be to develop international standards for aged care where staff work to their full scope, develop competency

expectations, build training and residency programs for professional nurses working in LTCH environments; and support the creation of LTCH environments where professional nursing is enabled to lead and optimize person-centered and relationship-centered care. We will showcase international exemplars of excellence (high-performance, person-centered LTCHs) in a variety of ways, such as conferences, on-site LTCH seminars, mass media publications, social media, and radio, and highlight factors influencing professional nursing practice that are within the capabilities of nursing home owners/administrators to adopt to affect quality.

We realize also that the per diem rates LTCHs receive ultimately impact these issues and our recommendations, and that actualizing this work depends, in part, on having enough staff to deliver basic resident care and building from there. Also, because care in different settings is often funded separately, this per diem rate in LTCHs is isolated from the overall costs to the health care system. If the impact of costs in other environments (like community and hospital) were integrated, the cost benefit ratio would at least be more visible. In this way, minimizing per diem rates for LTCH and the impact this has on the patient and health care system outcomes would be more evident. The Consortium will work to consider its role in advocacy, in this respect, as it continues to grow and take further shape.

Recommendations for a Research Agenda

The following research recommendations should enable movement towards this goal, by both the Consortium and others working in related research fields. Research efforts will be focused on: (1) evaluation of LTCH environments where professional nursing is enabled to lead and optimize person-centered care; (2) move from observational to intervention research in order to develop and test care delivery models that are both collaborative and clearly identify the roles of RNs, LPNs, and NAs, and (3) testing the efficacy of residency programs. Currently our

collaboration has one funded research study underway focused on the role of RNs and their supervisory performance in Canadian nursing homes, with the aim of having future associated projects internationally funded. Nurse sensitive resident outcomes influenced by effective supervisors will also be investigated. This study is being replicated in Spain to uncover factors influencing supervisory effectiveness so that cross-country comparisons can be made. In addition, another member is investigating how RNs collaborate with assistive caregivers in LTCHs in Sweden and the U.K. with the aim of informing relevant EU committees and initiatives. Another project includes a survey being trialed to investigate staffing and care of older persons in LTCHs in multiple countries. Finally, consortium members can provide research opportunities/internships and enable access to provide learning opportunities for students interested in areas related to RN leadership in LTC or for those who are researching.

Conclusion

Our vision for RNs, specifically, is that they are able to practice to their full scope, which includes evidence-based clinical assessments and interventions that direct person-centered care and mentorship of other staff members, in a supportive professional practice environment that supports person-centered care residents to live their best life as their capacities allow. However, RNs can only accomplish these goals with adequate preparation, a supportive environment and sufficient numbers of support staff to allow RNs to work to their full scope and not be inundated by tasks that others could successfully carry out. The Consortium will continue to support our mandate and goals through a solid international collaboration built on research partnerships, knowledge exchange, and joint research initiatives to help implement the recommendations and transform them into action. It is the Consortium's hope that our general recommendations will

be considered and acted upon by academics, educators, practitioners, and policy makers committed to maximizing the quality of LTCHs everywhere.

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