2013 LONG-TERM CARE MONOGRAPH

Improving the Quality of Long-term Care
through Regulation, Practice and Education

NCSBN

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Mission Statement

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Introduction

Conference Overview

"Finding Common Ground: Improving the Quality of Long-term Care through Regulation, Practice and Education" brought together diverse stakeholders to participate in discussions about some of the most challenging problems facing long-term care (LTC) organizations and nurses. This NCSBN sponsored conference provided a rare opportunity for nurse leaders with regulatory, practice and educational responsibilities to discuss ways to improve the quality of nursing home care. Attendees heard from national experts about evidence based strategies for: 1) implementing culture change, 2) improving the effectiveness of staff development, 3) implementing transition to practice strategies for novice nurses, and 4) developing safe environments for residents and staff. Through facilitated discussions, participants worked together to generate ideas for establishing a culture that embraces quality of care within the context of regulatory requirements. Each group was comprised of participants from practice, government, academia and various state boards of nursing. Themes from the discussions are presented in this monograph along with brief summaries of published research on each of the major themes. A post-conference survey was sent to all participants six months following the conference to identify any steps taken or changes made as a result of attending the conference. The results of the survey are also presented and discussed.

Intended Audience

This monograph is intended for conference participants, nurses practicing in LTC, nursing home leadership, and organizations/agencies representing nursing homes and nursing home leadership.

Participant Demographics

The 87 conference attendees were a diverse group, coming from 30 states, two Canadian provinces, the District of Columbia and two U.S. territories. Of the attendees, 42 were from state boards of nursing (BONs), 29 from practice settings and 16 from academia.

Background

LTC nursing is highly challenging work, having experienced notable increases in resident acuity and dependency, regulatory requirements ,and the number of admissions and discharges over the past decade (Coleman, 2003; McConnell, Lekan-Rutledge, Nevidjon,

& Anderson, 2004; Mor, Caswell, Littlehale, Niemi, & Fogel, 2009). Available evidence suggests that the resulting increased demands have not been matched by increases in staffing levels, skill mix or knowledge (McConnell, Lekan, & Corazzini, 2010). Despite this, expectations for care quality and clinical outcomes have intensified. At the same time, resident quality of life is increasingly viewed as equal in importance to the quality of clinical care and outcomes.

The intensified significance of quality of life is most clearly evidenced in the strong shift to person-centered care, most clearly expressed in the nursing home culture change movement (Koren, 2010). According to the American Association of Retired Persons, (2014), the Advancing Excellence in America's Nursing Homes Campaign (2014), and the Centers for Medicare & Medicaid Services (2014), resident quality of daily life, including a home-like environment and care routines guided by resident preferences, is becoming a widespread expectation. The following section summarizes group discussions about these issues. Discussion following each theme includes findings from relevant research.

Focus Area Discussions

LTC Culture Change

Organizational Change

Conference participants were asked to identify the characteristics of nursing home cultures that make person-centered care difficult to achieve, but that could be changed. The following summarizes discussion themes.

Resisting Change

While participants recognized that resistance to change is common, they agreed that changing "the way it has always been done" is certainly possible. They observed that change is most difficult when the current way of working appears satisfactory to staff and there is no perceived reason for change. However, altering routine practices can be challenging, even if everyone is supportive of the idea of person-centered care and agrees that it is an important goal.

Strong Leadership

Participants identified strong organizational leadership as key to overcoming resistance to change. Most concurred with the view that leaders who are skilled, directly involved, and highly supportive of culture change are necessary to motivate staff and overcome the "natural" resistance to change. They also noted that any change requires risk-taking on the part of leadership and staff, which again indicates the importance of strong, skilled leadership. The groups identified the importance of informational meetings with residents, staff and others who will be affected by the change prior to implementation. This includes careful revision of organizational policies and availability of necessary resources. Leaders can play an important role in identifying the policies that need to be changed and initiating new policies that will support the desired change. There was general agreement that organizations could benefit significantly if nurses were supported to develop greater leadership skills.

Facility Characteristics

Participants identified building size, design and physical layout as possible barriers to change. There was a strong belief that larger facilities, long hallways, large public dining areas and shared resident rooms are all in conflict with implementing a person-centered environment. Participants suggested that facility ownership might also be a barrier, particularly for facilities owned by large corporations.

Some participants also saw attitudes of leadership and staff toward residents as making the implementation of person-centered care difficult, in some cases. Perspectives such as, "people come here just to die," were identified as interfering with efforts to implement person-centered care and practices, particularly if those in leadership positions hold this view.

Barb Bowers discusses how to get from the ideal of culture change to reality.

Research on Organizational Change

Much of what the group discussed is consistent with the research on organizational change. However, the participants seemed more aware of the barriers to change than the strategies demonstrated to be effective at implementing and maintaining organizational change. This suggests that more could be done to disseminate effective practices for implementing and sustaining culture change practices.

Organizational change has been the focus of considerable research, both within and outside health care. While implementing organizational change is generally recognized as difficult regardless of setting, much has been learned about effective change strategies. In LTC, just as in other settings, strong, effective leadership is necessary to both implement and sustain significant change (Tourangeau, Cranley, Laschinger, & Pachis, 2010). Research in nursing home organizational change, including culture change, supports this and further confirms the importance of strong supervisory skills in staff at the unit and departmental level (Dellefield, 2008; Eaton, 2000). Other important factors influencing the ability to implement and sustain change include: the presence of champions within the organization (Bradley et al., 2004; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Warrick, 2009); consistent messages from leadership about the importance of and reasons for the change (Rantz et al., 2003); consistency between the change sought and existing organizational policies (Eby, Adams, Russel, & Gaby, 2000); and staff sense (at all levels) of having participated in the process (Kash, Naufal, Cortes, & Johnson, 2010). Sustainability research demonstrates that sustaining any organizational change is an ongoing process and that ongoing efforts must be put in place (Buchanan et al., 2005).

While size alone has not been found to influence an organization's capacity for change, research supports the negative influence of distant decision authority and policy development that can occur in multiple site organizations such as nursing home chains (Kruzich, 1995). Ownership status has been shown to relate to care quality, with not-for-profit status being correlated with more registered nurse time and fewer deficiencies (Harrington, Woolhandler, Mullan, Carrillo, & Himmelstein, 2001). A recent study supports the idea that not-for-profit homes are more likely to implement culture change (Grabowski, Elliot, Leitzell, Chohen, & Zimmerman, 2014).

A study examining the relationship between human resource practices and both work environment and care quality in LTC, found a strong relationship between the "service" and support experienced by workers and the outcomes of care (Eaton, 2000; Kash et al., 2010). This suggests that general management of the home and management philosophy are relevant to care and work life quality and should be considered important components of organizational change.

Staff and Staffing

Another theme that emerged during the discussion of LTC culture was the failure to implement consistent assignment, undermining the possibility of person-centered care. The major factor contributing to inconsistent assignment was turnover of staff in both direct care and leadership positions. The causes of turnover were believed to be related to: lack of teamwork, shortcomings in staff competencies, low levels of staff satisfaction, failure to acknowledge resident acuity in staff assignments, poor wages and benefits, lack of ongoing education and training, not feeling appreciated or recognized for hard work, and not feeling empowered. The group agreed that there are insufficient or insufficiently used opportunities for direct care staff, in particular, to participate in decisions about their assignments or how the overall program would be implemented.

In addition to consistent assignment of staff, participants highlighted the importance of awareness of cultural differences, both among staffs and between staff and residents. They suggested that appreciation of cultural differences starts with, and is modeled by, leaders in the organization. Making time for person-to-person hand off between shifts not only improves resident safety but also allows for the flow of important personal information about residents, an important component of person-centered care.
The importance of having the right staff mix was also discussed. Specifically, there was acknowledgement by some (although not all) that a sufficient number of registered

nurses (RNs) was necessary to ensure a high quality of care. This had implications for a careful balance between RNs and licensed practical/vocational nurses (LPN/VNs) and between licensed staff and certified nurse assistants (CNAs). Particularly with development and oversight of resident care plans, conference participants were supportive of including CNAs in both development and ongoing assessment of care plan appropriateness. Finally, while expressing strong support for the skills and commitment of LPN/VNs, some participants expressed the need for a higher ratio of RNs to LPN/VNs, given the increased complexity of resident conditions and the focus on preventing readmissions. Of note, there was not consensus around the need for a higher RN/LPN/VN ratio. Some participants believed that LPN/VNs and RNs are equal in skill and could (and often do) provide the same level and quality of care.

Research on Staffing

The conference participants called for more research on staff turnover. It is important for staff to feel understood, appreciated and supported. This is true in any work environment, not just in nursing homes. CNAs are particularly likely to feel unappreciated, increasing their likelihood of leaving (Bishop et al., 2008; Zhang, Punnett, Gored & the CPH-NEW Research Team, 2014). A recent study by McGilton et al., (2014), also found that licensed nurses were affected by the lack of feeling appreciated or understood by supervisors and organizational leadership. Staff turnover has been identified as a significant care quality issue (Kash et al., 2010). Numerous studies over the past few decades have documented ongoing barriers to achieving high quality care for LTC residents and to implementing person centered care. A major challenge is that no environment has a higher rate of nurse and nurse aide turnover than the LTC settings (Barry et al., 2008). The resulting staffing instability has been well documented as an impediment to quality of care and quality of life (Castle, 2012). The resulting widespread use of agency staff and low nurse/patient ratios has been shown to undermine both quality of care and quality of life (Castle & Engberg, 2007). Insufficient staffing also poses a challenge to implementing practice change (Castle & Anderson, 2011). Most of the conference participants identified staffing levels as a major obstacle to implementing culture change.

Consistent with the views of the conference participants, published research supports the link between work environment/experience and turnover for nursing home nurses and CNAs. In particular, research confirms the impact of high quality leadership from the top as well as at the unit level (Anderson et al., 2002) on turnover of both nurses and front line staff. Conference participants' views on preventing CNA turnover through recognition

and appreciation and the ability to participate in decision making are also supported by research (Tellis-Nayak, V. & Tellis-Nayak, M. 1989).

While there have been only a few studies examining the relationship between consistent assignment and person-centered care, and findings are somewhat inconsistent, they generally support the importance of consistent assignment for resident quality of life and quality of care (Rahman & Schnelle, 2008; Roberts, Nolet, & Bowers, 2013). High turnover is certainly one barrier to achieving consistent assignment of staff. However, a general failure to monitor the consistency of assignments also contributes to a wide range of staffing levels in homes that claim to use consistent staff assignment (Rahman, Straker, & Manning, 2009; Roberts et al., 2013).

The conference participants' experiences were also consistent with findings from research. Although highly controversial, the link between an appropriate mix of staff types has been well documented as important in achieving high quality care (Castle & Engberg, 2007). While the appropriate mix of RNs, LPN/VNs and CNAs has been the focus of research for some time, recently reported research supports the significance of finding the right balance as the basis for improving care quality. In addition, research on the impact of including advanced practice nurses, particularly in LTC settings, has shown a significant positive impact on resident outcomes (Kane, Keckhafer, Flood, Bershadsky, & Siadaty, 2003). As LTC organizations become increasingly accountable for the outcomes of patient care, staff mix will likely take on even greater significance. Recent research has also documented a significant difference in care outcomes depending on the staff mix of care providers (Castle & Engberg, 2007; McConnell et al., 2010). This suggests that the widespread practice using RNs and LPN/VNs interchangeably, rather than as workers with differing sets of skills and legal responsibilities, may undermine the quality of care. In order to achieve the best outcomes, nursing staff ratios should be based on a match between the work to be done and the preparation of the staff, recognizing both the difference in scope of practice and preparation. Staffing level has also been generally supported as an important factor in care quality.

Residents

Another theme identified in the discussion of LTC culture was the high acuity of current residents, as well as the common cognitive limitations of residents. When considering what is most important for residents to achieve a person-centered environment, participants suggested that residents need to be empowered, to be involved in decisions

about their care (resident directed care), to have choices (such as when showers are taken), flexibility, to have their voices heard and to feel safe. They agreed that residents generally prefer and benefit from consistency in staff assignments (continuity of care). A more home-like setting, particularly while dining, would enhance resident satisfaction and increase their feelings of wellness. It was also suggested that a greater effort to match staff and residents based on culture and language might improve resident quality of life.

Research on Resident Involvement in Person-centered Care

Core components of person-centered care are not entirely consistent, although certain components are considered vital. For example, resident choice of waking and sleeping times, what is eaten and when, choice of dining partners, consistency of staff assigned to them, and engagement in meaningful activities are all routinely mentioned in person-centered care components. While research has been inconsistent on whether person-centered care actually improves clinical outcomes, it has consistently been shown to improve resident quality of life (Kane, Keckhafer, Flood, Bershadsky, & Siadaty, 2003; Kane et al., 1989). While very little research has been conducted on culture and ethnicity in LTC settings, some studies demonstrate the importance of staff understanding the resident's culture and having someone who is able to speak the resident's native language (Yeboah & Bowers, 2013) as necessary for person-centered care. However, as this is not always possible, more effective ways to create a familiar, comfortable environment for culturally and ethnically diverse populations will become increasingly relevant.

Regulation

Not unexpectedly, regulation was seen by all as creating challenges to implementing culture change. Some felt that non-nurse regulators lack insight into nursing practice and are largely responsible for regulations that do not support high quality or person-centered care. Many believed that nursing practice in nursing homes, unlike other settings, is driven by the regulators and the regulations, and that nurses in this setting have lost control of their practice. Participants also wondered why regulators seem to always take a punitive approach rather than helping or supporting facilities to achieve desired outcomes.

Research on Regulation and Person-centered Care

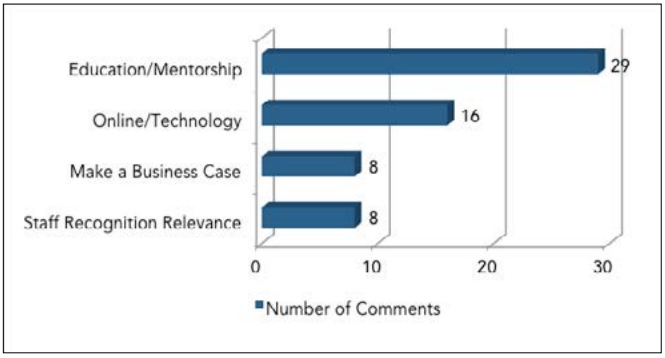
There is currently little research related to the impact of regulation on patient/resident-centered care or on how culture change is implemented. However, contrary to the belief expressed by participants, one recent study of 16,000 nursing homes in the U.S.

demonstrated a significant improvement in four clinical outcomes where regulation stringency was higher (Mukamel et al., 2012).

Staff Development

There was considerable distress expressed by participants over the minimal budgets available for staff development. Groups brainstormed about ways that a small LTC facility could effectively use their limited resources for staff development. Suggestions fell into four main categories, including mentoring, using online programs, making a business case for staff development and openly recognizing the importance of staff development. Graph 1 illustrates the number of comments supporting each method of staff development.

Graph 1 - Themes Identified for Staff Development in LTC



Education/Mentorships

Participants noted the importance of ongoing education as a basis for successfully implementing person-centered care and maintaining necessary skills and knowledge. They were quite supportive of developing mentoring programs (as opposed to short orientation programs) and of using nurse champions for change implementation. Some felt that mentorships might be easier to implement in larger facilities. Some creative and inexpensive strategies suggested by participants included: using more case studies for teaching staff, hosting "lunch and learn" programs, holding patient huddles, selecting a topic of the month, posting a word of the day, presenting posters/storyboards and turning meetings into "teachable moments." There were a number of suggestions for specific training programs, such as more use of one-on-one training, leadership training and teacher training. One group suggested that training programs could be designed to foster a sense of community. Another group suggested they could use vendor support of training. Free educational resources were identified, such as assistance from ambulance

services, and training from respiratory therapy and dieticians. Some suggested that staff development nurses should find and collaborate with internal champions; nurses who are engaged in and were enthusiastic about learning, to increase knowledge throughout the staff.

Research on Education in LTC

There is considerable research on the effectiveness and sustainability of educational programs in LTC settings. In addition to the long-standing (but not always attended to) wisdom about using adult learning principles when teaching adults, there is research that identifies the elements of successful staff education in general (Cromwell & Kolb, 2004) and in LTC (Aylward et al., 2003). This research highlights the importance of supervisor involvement in selecting and encouraging the right staff person to attend an educational program, support for implementing practice change following the educational program, support and guidance in adapting learning to a range of situations, and the significance of gaining peer support for the change (Cromwell & Kolb, 2004; Davidson et al., 2007). Many of these important components are not routinely included in staff development efforts. Coaching and mentoring have also been shown to be highly effective educational strategies, as suggested by conference participants (Cope, Cuthbertson, & Stoddart, 2008 & Wheeler, 2009). Often overlooked, however, is the importance of appropriate training for mentors (Harris-Kojentin, Lipson, Fielding, & Stone, 2004).

Online Educational Programs

Many participants suggested that online resources could be used to a much greater extent in LTC for staff development. A major obstacle is the current lack of sufficient resources. Making effective use of online technology would require considerable investment in computers and support for group use of these resources during work time. One group suggested, "It doesn't have to be all or none. It can be a hybrid of online and one-on-one return demonstration." Others suggested that "Education should be interactive, for example incorporating games like jeopardy into teaching in order to engage staff." Some wondered how they could move beyond the 30-minute video; that is, some staff development programs consist of administrators merely sitting staff in front of a 30-minute video. Others suggested that subscribing to e-journals, blogging, using the Hartford Institute website or the Silverchair Learning Systems could replace less effective practice of sitting in front of a video. The Advancing Excellence in America's Nursing Homes Campaign was emphasized as an exemplary source of quality improvement resources. Additionally, using the "All Hands on Deck" leadership practice

was suggested, as was using Local Area Networks for Excellence (LANE) programs, the "Hand in Hand: A Training Series for Nursing Homes" and the Incumbent Worker Training Program (IWTP), which provides grants for workforce training. The "Clinical Teaching in Nursing Homes" was also suggested as a great, free website for educators.

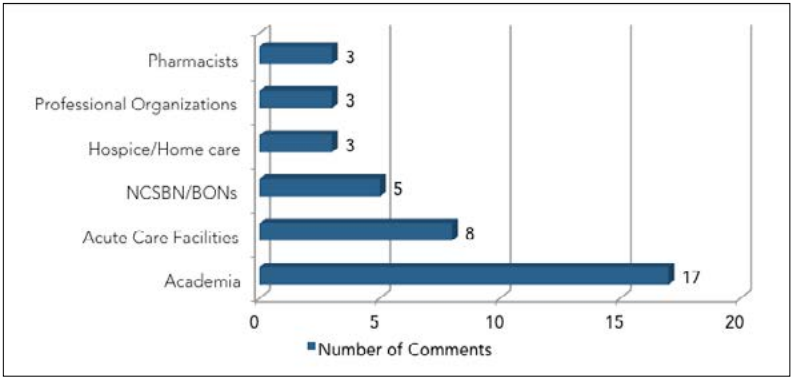
Research on Internet-based Education

Use of online technology for staff development is growing rapidly. However, research on its effectiveness is scant. As many LTC settings have limited resources for staff development and do not often have an expert educator on staff, online forums present an important option. Many nursing homes do not provide Internet access to their staff, creating a barrier to accessing evidence-based practice and useful clinical information.

Creating and Sustaining Partnerships

Participants were asked to work in groups to envision potential partnerships for collaboration and identify how these partnerships might be sustained. Graph 2 illustrates the number of comments that made up the themes from this discussion.

Graph 2 - Potential Partnerships for LTC



Academic Partnerships

Schools of nursing and other academic institutions were the leading choices for partnership development. Many participants mentioned the possibility of using simulation labs and other learning centers in schools of nursing to teach their staffs. They also suggested that this opportunity could be exchanged for bringing nursing students to LTC facilities. For example, one group suggested exchanges where staff could use a university's resources in exchange for student internships in LTC facilities. Another group asked, "How do we make progress on this if students cannot gain experience?" They were lamenting that many nursing homes do not allow student nurse practice

experiences. Therefore, this group was very supportive of academic partnerships with nursing homes. Other specific ways participants suggested that partnerships with nursing programs might work included establishing joint appointments, sharing library resources and collaborating on research.

Partnerships with Acute Care Facilities

Another suggestion that had wide support was to create partnerships with acute care facilities. One group gave an example of how sharing expertise with acute care staff could be valuable. They theorized that LTC nurses could teach hospital nurses about care of residents with dementia. This might be particularly appealing considering the recent dramatic increase in hospitalized patients who have dementia. One person suggested that hospitalized patients with dementia are often treated inappropriately with antipsychotics. Similarly, another group noted that hospital and nursing home staff could share perspectives on admissions and transfers in both directions. One person suggested that acute care facilities might allow LTC staff members to take part in hospital education sessions.

Other Suggestions

There were other recommendations for partnerships, such as boards of nursing (BONs) partnering with nursing programs to assist students in gaining CNA certification. Other potential partners included hospices, pharmacies and schools of business. With the latter partnerships, LTC staff could develop basic business and leadership skills. For example, partnerships with business schools could facilitate the use of LEAN principles. They also believed that business partnerships could help them develop skills in supervision and mentoring, particularly with "problem employees."

Sustaining Partnerships

Participants generally recognized the importance and challenges of sustaining partnerships once established. Several groups emphasized the importance of ensuring that both partners benefit from the arrangement. One group suggested that partnerships are initiated, and sustained, by ongoing communication and that a partnership agreement should include:

- An overall plan;
- Clear goals and strategies; and
- A plan for evaluating the success of the partnership.

Suggestions were made about how partners could be brought together to identify

challenges and opportunities for growth. "Benchmarks could be established and data collected to track project success."

Challenges for Larger Facilities

Participants were asked whether the partnership strategies they discussed would also work for larger LTC facilities. The majority of participants did not think facility size would require a change in strategies. There were suggestions that mentorships and access to educational institutions could be easier for larger facilities to attain, but that communication might be more difficult across large systems. For example, "Larger facilities might have a hierarchy that would allow specialization of RNs and CNAs, thus facilitating mentorship and support." One group mentioned that the larger facilities often purchase proprietary programs for staff development, negating the benefit from educational programs provided by academic partnerships. One participant cautioned that, "Larger facilities may need to cultivate local partnerships that might not be as strong as the smaller facilities are able to develop." Yet the consensus was that the larger facilities had more resources for staff development.

Lastly, participants were asked what additional strategies larger LTC facilities could use to support staff development. One group suggested that return demonstrations and one-on-one education are more useful in large organizations than are online resources alone. Another group recommended enhancing the teaching skills of LTC education staff because, "Good clinical skills don't necessarily translate to good teaching skills." Yet another group emphasized the importance of creating a learning environment in larger LTC facilities. The participants also noted the importance of identifying LTC champions in the organization. For example, one group suggested that, "Champions in each department should be identified as resource development extenders." Participants stressed that the larger facilities have more resources to train staff and certify specialists in areas such as dementia and wound care. Additionally, there are more opportunities to collect data and set benchmarks.

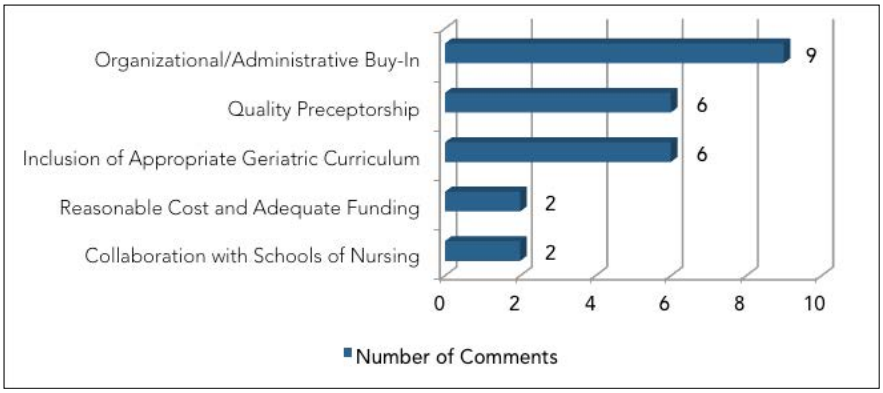
Transition to Practice

There was general support for transition to practice programs targeted specifically for LTC settings and recognition that such programs are not currently available to LTC facilities. Participants believed that organizational/administrative buy-in and support was the most important element necessary for implementing a successful transition to practice program, once again calling out the importance of strong leadership.

Participants thought that having a quality preceptorship and an appropriate geriatric curriculum would be fundamental to executing a sustainable transition program, and that offering continuing education credits would assist in acceptance of the program by nursing staff. Reasonable cost and funding for the program were identified as necessary. Participants also suggested that partnerships with schools of nursing could facilitate the implementation of the programs. The attendees described the importance of making a business case of establishing LTC transition to practice programs.

Graph 3 illustrates the numbers of participant comments related to the elements of successful implementation of transition to practice programs in LTC.

Graph 3 - Elements for Successful TTP Programs in LTC



Several positive outcomes of developing and implementing a transition program in LTC were identified. These could be used to make a business case for establishing a transition program. Most participants stated that TTP programs would decrease turnover and increase retention with a subsequent decrease in cost. Another positive outcome is increased staff and resident satisfaction. Additionally, participants thought that TTP programs would improve quality of care and increase resident safety. Finally, TTP programs could increase new nurse confidence and competence. For example, one of the participants said, "They are scared, residents all look the same! There are no name bands - just photos. Give them just five patients - not all the patients on the floor."

BONs, other regulators, LTC facilities and educators can collaborate to develop TTP programs that include quality preceptor and new nurse training, information on nurse practice acts and delegation. In addition, key LTC stakeholders should brainstorm to realize ways to provide funding to develop TTP programs in LTC.

Graph 4 shows the number of comments made for each theme that was identified in trying to develop a business case for TTP programs in LTC.

Graph 4 - Making the Case for Developing TTP Programs in LTC

Participants suggested that educating directors of nursing, charge nurses and staff nurses (RNs and LPN/VNs) on delegation, supervision, communication and clinical reasoning would assist in nurturing an environment with improved oversight and supervision of unlicensed assistive personnel (UAP). Additionally, educating CNAs and other UAPs on their scope and job-related responsibilities and expectations could facilitate better supervision. The participants expressed that recognizing UAPs as a critical part of the team and including them in the plan of care is key to promoting better oversight and supervision of UAPs.

Research on Educational Preparation in LTC Settings

Lack of educational preparation for LTC can be partially traced to the continued practice of using predominantly acute care environments as clinical sites for nursing students. Significant differences in the role of the nurse, regulatory requirements, and on-site resources pose challenges for a new graduate prepared primarily in an acute care setting to understand LTC nursing (Nolet et al., 2014). These challenges leave new nurses unprepared for LTC environments. LTC environments are often used for early clinical experiences for nursing students, focusing on specific clinical skills (such as medication administration, urinary catheter insertion, wound care), rather than the leadership role of nurses in LTC.

Research on nursing staff turnover in LTC has documented that the highest turnover occurs in newly hired, younger, BSN prepared nurses. That is, new graduates with

a BSN are least likely to stay. Reasons given by nurses leaving LTC include: lack of preparation for the environment and the work, heavy workload, minimal opportunities for advancement, poor supervision, insufficient resources and lack of support for continued learning. Although the turnover rate among newly graduated hospital nurses is lower than the rate in LTC settings, many hospitals have addressed both turnover and insufficient preparation to practice by establishing nurse residency programs. These educational, support programs that guide new nurses as they become socialized into the profession are common in hospital settings but quite rare in LTC. Both practical and financial barriers have impeded the establishment of residency programs in this setting.

Scope of Practice

Participants were asked to reflect upon the two-day conference and identify the major delegation and scope of practice issues that should be addressed. The following themes were identified from the groups' scope of practice discussion:

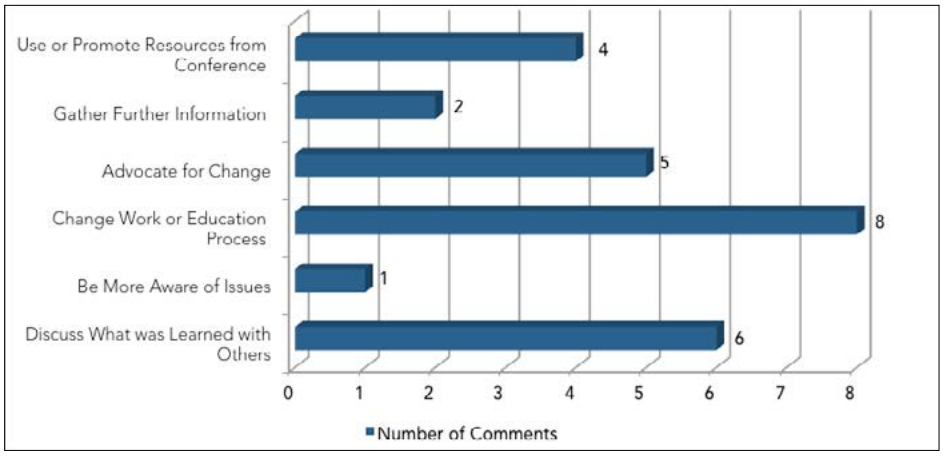
- Clarify RN, LPN and CNA roles and scopes of practice (seven comments)
- Define and practice safe delegation (seven comments)
- Educate about scope of practice across RN, LPN and CNA roles (five comments)
- Recruit nursing students for LTC settings (three comments)
- Align scope of practice and regulations with realities in LTC (two comments)
- Enforce scope of practice (two comments)
- Establish role models for RN practice in LTC (one comment)
- Promote education among leaders on LTC (one comment)
- Standardize scope of practice across states (one comment)

Clarification of advanced practice registered nurse (APRN), RN, LPN/VN, and CNA roles were identified as the most significant issues; for example, one participant commented, "How to move from RN to LPN scope confusion is a big issue; power and control is not well defined or delineated." "Every level needs clarification of scope of practice. Scope of practice should be a bigger part of curriculum or transition to practice." Safe delegation, grounded in defined scope of practice and appropriate levels of supervision, was also deemed important. Education about scope of practice was identified as another challenge for individuals and institutions, "[One problem is] the lack of knowledge that license holders have regarding their own delegation and scope of practice. The educators also have a lack of knowledge concerning these issues and we are not prepared to address them." Several opined that scope of practice is ignored or not enforced by either regulators or the LTC industry. Others expressed concern that regulations, scope of practice and the realities of LTC are not aligned. This observation had wide support. Standardizing scope of practice across states, promoting education among LTC nurse leaders, establishing role models in LTC, and providing clinical opportunities for students in LTC were all identified as important and challenging.

Intentions for Action

Participants were asked to identify three things that they would do differently because of the conference. See Graph 5 for the themes identified from this discussion, along with the numbers of comments that make up each theme.

Graph 5 - What Will Participants Do Differently?

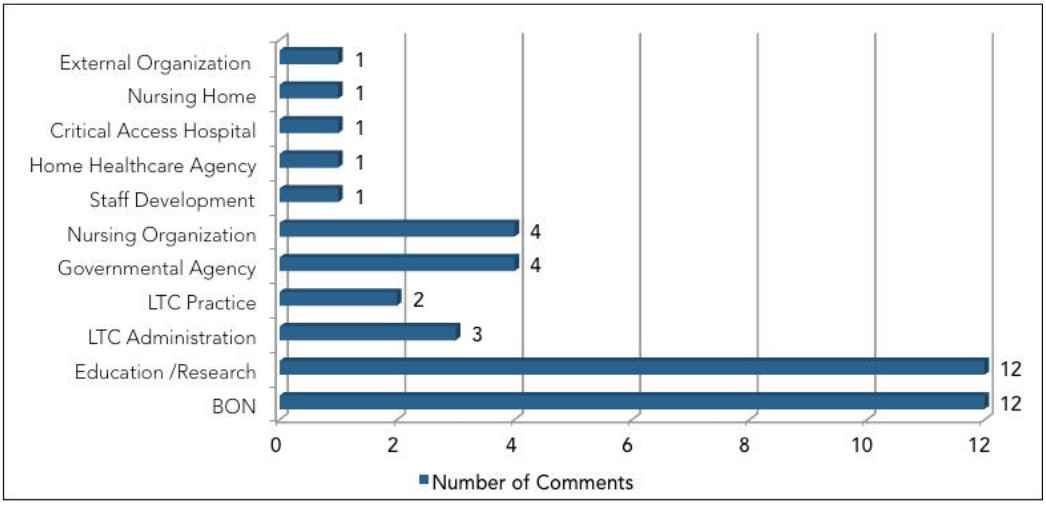


Most commonly, participants committed to changing a current work or educational process: "…look at systems of communication at the facility level; examine how to spread communication across departments; involve the CNA/housekeepers in the daily care interventions." Several planned to discuss the LTC conference and what they learned with others: "Discuss the things I learned with other board members as we work on writing the rules," and "share the LTC conference—spread to key stakeholders to share information." Others planned to advocate for change by contacting their local schools of nursing, boards of nursing, and trade associations.

Impact of the Conference

The day after the Long-term Care Conference the participants received an online conference evaluation. Responses were very positive. However, it was too soon to determine whether there was a lasting impact of the conference and the planners wanted to know this. Did this conference make a difference to LTC? Did participants make any changes because of attending this conference? The answers to these questions would determine the success of the conference. Therefore, six months following NCSBN's Long-term Care Conference the conference planners sent the participants another online survey asking about the conference impact. The response rate of the impact survey was 50 percent (84 surveys sent out; 42 surveys submitted), which is quite good considering the five-month gap between the meeting and the survey. The majority of responses were from academia and BONs. See Graph 6 for a distribution of the respondents.

Graph 6 - Distribution of the Respondents Six Months Following the Conference



The participants were asked about the top two things they learned from the conference. There were a variety of responses to this question. The four most popular responses were:

- The conference provided them with strategies for implementing culture change;
- They realized the importance of transition to practice programs in LTC;
- They gained insights into nursing (BONs) and federal (Centers for Medicare and Medicaid Services) regulation in LTC; and
- The need for better integration of LTC into nursing education.

For example, one respondent learned that "implementing cultural change in LTC facilities requires persistence through staff education, quality practice measures and evaluation." Another participant became acutely aware of the need for transition to practice programs in LTC, noting "the passion of the attendees to make sure that newly graduated nurses are being taught and mentored well." Another attendee reported learning that, "Regulations should not stop facilities from being creative." Related to nursing education, one participant reflected on the need to add many new concepts to her teaching. This participant wrote that she would "introduce ideas and discussions to students on how we can practically give residents more control and independence. What qualities of care are most important to focus on?"

Other salient themes included the importance of implementing resident-centered models, acknowledging the nursing shortage in LTC, implementing collaborative strategies and developing a vision of the future of LTC. Related to implementing resident-centered models, one attendee indicated that the conference "served as a reminder to re-ground my thoughts, step back and think about the evolution of nursing homes. Nursing homes should be where individuals reside, not an extension of the hospital, and they should create a home-like culture." Yet, another participant reflected on the dichotomy between patient safety initiatives and resident-centered care models. She said, "nursing practice implications of resident-directed care will likely include the need to balance safety with resident autonomy and self-determination." In thinking about the future of LTC, another respondent realized that "long-term care has a need for well-prepared, high-performing nurses."

The next question asked if the participants at the LTC Conference were able to use what they learned to make changes. There were 95 percent of the attendees who reported that they shared conference information with their colleagues. Nearly 30 percent of the respondents altered an approach based on the conference. Other actions taken included meeting with administration to make suggestions (15 percent), holding an inservice (15 percent) and changing orientation strategies (15 percent). Those who answered "other" provided some specific changes they made. For example, one respondent said, "I will use what I learned for planning for a sabbatical that will focus on transition of new graduates to their first job in LTC/community settings." Another responded, "As a nursing assistant instructor, I spend more time on quality of life for residents in LTC and the importance of giving them as many choices as possible on a daily basis." Still another said, "I invited our state board of nursing to our meetings for Advancing Excellence."

Another question asked if they were planning to make any changes. Nearly 40 percent reported that they will evaluate procedures with an eye toward what was learned at the LTC Conference. Another 24 percent said they would make changes to future planning, while 15 percent said they'd initiate changes in the current system. Under "other," some specific plans were highlighted. For example, one participant stated they would evaluate board of nursing position statements affecting nurse aide and med aide roles in LTC. Still another said they would, "share information with the Department of Health and Senior Services," which regulates LTC in their state.

The attendees were asked whether they have had conversations with other leaders (such as BONs, staff development, administration, governmental agencies, etc.) about what they learned at the Long-term Care Conference. There were 84 percent of respondents that replied "yes" to that question, and then many of them explained their answers. For example, five respondents reported that they shared the information with their BON. Others shared it with the hospital association, the Department of Human Services staff and state Action Coalitions. One participant stated, "I discussed implementing culture change in LTC facilities that mimic home-like environments and empower direct care staff with implementing and evaluating quality care with facility administrators." Another reported that she "discussed culture change and reported to the National Committee for Quality Assurance (NCQA)." Still another said, "I originally had some in-depth conversations with my boss when I returned. We have started the process of looking at our orientation procedures when hiring new staff and making sure they are equipped with all the essential tools and knowledge before being put on the floor."

The last question simply asked the participants how useful the conference format was in bringing together a diverse audience from practice, government, education and administration. The 4-point scale was labeled as A "very useful," through D "not at all useful." Nearly three-fourths (73.17 percent) of the respondents selected A, or "very useful," while another 24.39 percent selected B. Only one respondent answered C and none answered D.

The results of this survey were very positive, although they were skewed toward academics and staff from BONs. While there may have been a response bias (the more active and positive attendees responded), the 50 percent response rate, after a five-month delay, was impressive. Specific actions taken showed the importance of this conference for increasing communication across the disciplines of practice,

education/research and nursing regulation. Further, clear examples were provided to show how attendees have begun to implement and teach about the current best practices in LTC.

Conclusion

The Long-term Care Conference brought together leaders from nursing regulation, practice, education and research to:

- Discuss strategies for implementing culture change in LTC
- Create a common understanding among nurse educators, regulators, researchers and nursing staff on key issues in LTC nursing
- Examine the integration of quality of care and quality of life and their implications for LTC regulation
- Generate cutting-edge ideas about achieving organizational LTC culture change that fosters safe and effective patient care.

Karen Schoeneman reflects on the two-day conference and encourages attendees to disseminate the information.

Meeting participants have taken beginning steps towards improving LTC practices as a result of the Long-term Care Conference in April 2013, including the dissemination of meeting information, alteration of approaches/strategies based on meeting information, discussions with management in order to bring about change, holding educational in-services, and changing orientation strategies.

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