Improving the Quality of Long-Term Care

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Many factors affect quality care in long-term care (LTC) settings. A supportive organizational culture, strong leadership, appropriate staff and staffing, and effective training and professional development of staff members are all fundamental elements necessary for influencing quality care in LTC settings. This article discusses challenging issues confronting LTC settings and provides strategies for managing the complexities of culture change, staffing, and education in LTC.

Over the past decade, long-term care (LTC) has experienced notable increases in resident acuity and dependency, regulatory requirements, and the number of admissions and discharges (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 staff skills and knowledge (McConnell, Lekan, & Corazzini, 2010). Despite this, expectations for quality of care and clinical outcomes have intensified. Moreover, resident quality of life is increasingly viewed as equal in importance to the quality of clinical care and outcomes.

The increased significance of the quality of life is most apparent in the strong shift to person-centered care, most clearly expressed in the nursing home culture change movement (Koren, 2010). Person-centered care is the practice of honoring and respecting the preferences of residents and allowing them to be equal partners in their care (Advancing Excellence in America's Nursing Homes Campaign, 2015). According to AARP (2014), the Advancing Excellence in America's Nursing Homes Campaign (2014), and the Centers for Medicare & Medicaid Services (2012), resident quality of daily life, including a homelike environment and care routines guided by resident preferences, is becoming a widespread expectation.

The National Council of State Boards of Nursing (NCSBN) brought together stakeholders to participate in discussions about some of the most challenging problems facing LTC organizations and nurses. This forum provided an opportunity for experts from nursing practice, government, academia, and state boards of nursing (BONs) to discuss evidence-based strategies for implementing culture change, improving the effectiveness of staff development and education, implementing transition-to-practice strategies for novice nurses, and using partnerships in developing safe environments for residents and staff. This article presents a literature review on the current challenges facing LTC and summaries of the discussions, including evidence-based recommendations and solutions.

Literature Review

The literature on LTC identifies the greatest challenges facing LTC organizations and nurses as inconsistent quality of leadership, the need to implement culture change, the shift to person-centered care, inadequate staffing levels and staffing mix, and insufficient development of nursing staff given the increasing resident acuity.

Organizational change has been the focus of considerable research both inside and outside health care, and much has been learned about effective change strategies. In LTC, just as in other settings, strong, effective leadership is needed to implement and sustain significant change (Tourangeau, Cranley, Laschinger, & Pachis, 2010). Research on nursing home organizational change, including culture change, supports the need for such leadership and confirms the importance of strong supervisory skills in staff members at the unit and departmental levels (Dellefield, 2008; Eaton, 2000). Other factors that influence the ability to implement and sustain change include champions in the organization (Bradley et al., 2004; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Warrick, 2009), consistent messages from leaders about the importance of and reasons for change (Rantz et al., 2003), consistency between the change sought and existing organizational policies (Eby, Adams, Russel, & Gaby, 2000), and a staff sense of having participated in the process (Kash, Naufal, Cortés, & Johnson, 2010).

Not-for-profit homes, in the aggregate, are correlated with higher nurse-resident ratios and fewer deficiencies (Harrington, Woolhandler, Mullan, Carrillo, & Himmelstein, 2001), and they are more likely to adopt a culture change initiative (Grabowski, Elliot, Leitzell, Cohen, & Zimmerman, 2014). A strong relationship between the support experienced by workers and clinical outcomes has been documented (Eaton, 2000; Kash et al., 2010). Thus, the general management of the home and the management philosophy are relevant to care and work life quality and should be considered important components of organizational change.

Although person-centered care is widely supported and has been shown to improve resident quality of life, the impact on clinical outcomes has been inconsistent (Kane, Keckhafer, Flood, Bershadsky, & Siadaty, 2003; Kane et al., 1989). Little research

has been conducted on culture and ethnicity in LTC settings, but some studies demonstrate the importance of having staff members who understand the resident's culture and having someone who can speak the resident's native language as necessary for person-centered care (Yeboah, Bowers, & Rolls, 2013). Consistency in staff assignment has been identified as vital to achieving person-centered care because such care relies on staff familiarity with resident needs and preferences. Although many nursing homes claim to have a commitment to consistency in staff assignments, all do not carefully monitor its implementation (Rahman, Straker, & Manning, 2009; Roberts, Nolet, & Bowers, 2013).

A major barrier to achieving either person-centered or high-quality clinical care is the high rate of nurse and nurse aide turnover (Barry, Kemper, & Brannon, 2008; Castle, 2012; Kash et al., 2010). The resulting widespread use of agency staff and low nurse-patient ratios have been shown to undermine the quality of care and quality of life (Castle & Engberg, 2007). An appropriate staff mix has been shown to have a significant clinical outcomes and is important in achieving high-quality care (Castle & Engberg, 2007; McConnell et al., 2010).

The highest turnover occurs among newly hired, younger, BSN-prepared nurses. Significant differences in the role of the nurse, regulatory requirements, and on-site resources pose challenges for a new graduate who was prepared primarily in an acute-care setting (Nolet et al., 2014). Although the turnover rate among new graduate hospital nurses is lower than the rate in LTC settings, many hospitals have addressed both turnover and insufficient preparation to practice by implementing transition programs.

Often in LTC settings, the scopes of practice of the registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) are not clearly delineated, especially regarding delegation (Corazzini, Anderson, Mueller, Thorpe, & McConnell, 2013; Mueller, Anderson, McConnell, & Corazzini, 2012). Interchangeability of RNs and LPNs with widespread disregard for scopes of practice can pose a challenge to providing high-quality care (Castle & Anderson, 2011; Castle & Engberg, 2007; McConnell et al., 2010; McGilton, Boscart, Brown, & Bowers, 2014).

Variations in scope of employment and function have been identified among unlicensed assistive personnel (UAP) (Budden, 2011; Mitty et al., 2010; Vogelsmeier, 2011). Inadequate staffing mix and lack of staff engagement can have a negative impact on the RN and LPN/VN collaborative relationship (Corazzini et al., 2013). Subsequently, this can affect the entire team dynamic between the licensed nurses and the UAP.

Although not often considered in discussions of the nurse staffing mix, the presence of advanced practice nurses in LTC settings has shown a significant positive impact on resident outcomes, particularly on hospitalization rates (Kane et al., 2003). Advanced practice nurses have been used in multiple roles with impressive improvements in quality of care in LTC settings (Ouslander et al., 2010; Rantz at al., 2009; Stone et al., 2002).

Although little research exists on the educational preparation of new nurses transitioning into LTC practice, considerable research has been done on the effectiveness and sustainability of educational programs in LTC settings. Some research identifies the elements of successful staff education in general (Cromwell & Kolb, 2004) and in LTC (Aylward, Stolee, Keat, & Johncox, 2003). This research highlights the importance of supervisor involvement in the selection and encouragement of the right staff person to attend an educational program, support for implementing practice change after 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 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-Kojetin, Lipson, Fielding, Kiefer, & Stone, 2004).

Challenges in LTC Settings

Resistance to culture change, issues with staffing, and inadequate staff development and education are among the central challenges facing LTC. The following discussion addresses these challenges by providing potential strategies to achieve improved quality of care in LTC.

Resistance to Culture Change

Frequently, the high acuity of residents and their cognitive limitations as well as inappropriate management of staff can negatively affect change. Strong organizational leadership is needed to overcome resistance to culture change. Leaders who are skilled, directly involved, and highly supportive of culture change must motivate staff. Any change requires risk taking on the parts of leaders and staff members. Informational meetings with residents, staff, and others who will be affected by the change before it is implemented can help reduce resistance. 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.

For residents to achieve a person-centered environment, they need to be empowered, involved in decisions about their care, have choices (such as when showers are taken), have their voices heard, and feel safe. Providing a more homelike setting (for example, while dining) enhances resident satisfaction and increases feelings of wellness. Additionally, residents generally prefer and benefit from consistency in staff assignments (continuity of care). Consistent assignments provide opportunities for licensed nurses and UAP to get to know their patients intimately. LTC staff members need to make time for person-to-person handoff between shifts not only to improve resident safety but also to allow for the flow of personal information about residents, an important component

of person-centered care. Moreover, an awareness of cultural differences among staff members and between staff and residents is key. A greater effort to match staff and residents based on culture and language may improve resident quality of life.

Staffing Issues

In the LTC setting, the failure to implement consistent assignments presents a challenge to realizing person-centered care. The major factor contributing to inconsistent assignment is turnover of staff in direct-care and leadership positions. The causes of turnover are 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.

A sufficient number of RNs is necessary to ensure a high quality of care. A careful balance between licensed staff and UAP is required, although in LTC practice this is not always possible. There is a reported lack of RN presence in clinical leadership, which thrusts LPNs unwillingly into leadership roles, making them responsible for delegation to UAP that can extend beyond their scope of practice (Corazzini et al., 2010). In LTC, effective delegation processes are necessary. 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 the differences in scopes of practice or employment, and educational preparation and training.

Staff Development and Education

Most LTC facilities have limited financial resources for staff development and education. Given the fiscal environment in LTC, possible approaches to maximize resources to continuously develop and educate staff members include conducting staff in-services (traditional and nontraditional), employing mentoring, establishing transition programs for new nurses, developing partnerships, and using online programs.

Some creative, inexpensive strategies include using 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 and storyboards, and turning meetings into teachable moments.

Peer mentoring programs (as opposed to short orientation programs) ease the transition of new staff members while providing opportunities for advancement for committed employees. Peer mentors help new staff members acquire the necessary knowledge and skills and also provide ongoing support.

To create a learning environment in larger LTC facilities, leaders should support staff development by enhancing the teaching skills of LTC. The importance of identifying LTC champions in the organization was also noted. For example, one suggestion was to identify champions in each department as resource development extenders. Larger facilities have more resources to train staff and certify specialists in such areas as dementia and wound care.

Educating directors of nursing, charge nurses, and staff nurses (RNs and LPN/VNs) on delegation, supervision, communication, and clinical reasoning would help nurture an environment with improved oversight and supervision of UAP. Additionally, educating certified nursing assistants and other UAP on their scope and job-related responsibilities and expectations could facilitate better supervision.

Unfortunately, the task of educating licensed nurses and UAP on effective delegation is complicated by the fact that variation exists among states/jurisdictions surrounding scope of practice related to delegation (Corazzini et al., 2010; Corazzini, Anderson, Mueller, Thorpe, & McConnell, 2013; Mueller, Anderson, McConnell, & Corazzini, 2012), which at times leaves nursing practice in LTC misaligned with BON rules and regulations.

Currently, NCSBN is in the process of addressing this concern by developing delegation guidelines that will provide clarification on the responsibilities associated with the delegation process. The intent is for these guidelines to assist BONs, health care facilities/organizations, professional associations, nurse educators, licensed nurses, and UAP with issues surrounding delegation in order to promote patient and public safety.

Transition-to-Practice Programs

Lack of educational preparation for LTC can be traced in part to the continued practice of using predominantly acute-care environments as clinical sites for nursing students. LTC environments are often used for early clinical experiences for nursing students, focusing on specific clinical skills (such as medication administration, urinary catheter insertion, and wound care) rather than for the leadership role of nurses in LTC. This continued practice can leave new nurses unprepared to practice in the LTC environment.

Transition-to-practice (TTP) programs are more common in hospital settings but still quite rare in LTC settings. Practical and financial barriers have impeded the establishment of the programs in this setting. The most important elements for implementing a successful TTP program are organizational and administrative buy-in and support, requiring strong leadership. Partnerships with schools of nursing could facilitate the implementation of such programs. Having a quality preceptorship and a comprehensive geriatric curriculum are fundamental to executing a sustainable transition program, and offering continuing education credits to preceptors would promote acceptance by experienced nursing staff.

Several potential positive outcomes of developing and implementing a transition program in LTC include the following:

- Decreased turnover
- Increased retention
- Decreased cost as a result of improved retention
- Increased staff and resident satisfaction
- Improved quality of care

- Increased resident safety
- Increased new nurse confidence and competence.

Online Educational Programs

Online resources could be used more often for LTC staff development. A major obstacle is the lack of sufficient resources. Education could include a hybrid of online and one-on-one return demonstration. Making effective use of online technology would require investment in computers and support for group use of resources during work time but could provide an alternative method of staff education. Some free online resources include e-journal subscriptions, the Hartford Institute website, and Silverchair Learning Systems.

The Advancing Excellence in America's Nursing Homes Campaign is an exemplary source of quality improvement resources. Other resources include using the All Hands on Deck leadership practice, Local Area Networks for Excellence programs, the Hand in Hand: A Training Series for Nursing Homes, and the Incumbent Worker Training Program, which provides grants for workforce training. Clinical Teaching in Nursing Homes is a great, free online resource for educators to reinforce LTC clinical experiences.

Developing Partnerships

Partnerships with various nursing stakeholders, such as schools of nursing and acute-care facilities, may provide additional resources for staff development. Simulation labs and other learning centers in schools of nursing and other academic institutions could be used to teach nursing staff members in LTC. This opportunity could be exchanged for allowing nursing students to conduct clinical experiences in LTC facilities, which provides potential clinical sites to schools struggling to secure them. Nursing programs also could share library resources and collaborate on research with LTC facilities.

Acute-care facilities could allow LTC staff to participate in hosting hospital education sessions to provide a venue for sharing expertise on nursing care specific to the LTC population. This type of information exchange could be valuable to acute-care staff. For example, LTC nurses could teach hospital nurses about caring for residents with dementia, which is an appealing concept considering the recent dramatic increase in hospitalized patients who have dementia. Additionally, hospital and LTC staff could share perspectives on admissions and transfers in both acute care and LTC.

For partnerships to be sustained, both parties would have to benefit from the arrangement. Partnerships are initiated and sustained by ongoing communication. Moreover, a partnership agreement should include an overall plan, clear goals and strategies, and a plan for evaluating the success of the partnership. As part of the evaluation process, partners would need to come together to identify challenges and opportunities for growth.

Conclusion

Key stakeholders, such as LTC administrators and staff, schools of nursing, and BONs, need to advocate for change in the LTC setting. LTC administrators and staff could implement some of the strategies to promote culture change from a person-centered perspective. Additionally, they can partner with schools of nursing to provide education on LTC, introducing the specialty of LTC nursing to nursing students and possibly recruiting them when they become licensed. Schools of nursing can make efforts to integrate LTC into nursing education by partnering with LTC facilities for didactic and clinical training. BONs could take into consideration the issues related to LTC staffing, education, and staffing development when writing nursing rules or position statements related to the LTC setting.

By understanding the challenges that confront LTC, leaders, staff, schools of nursing, and BONs will be better equipped to implement strategies that bring about positive, lasting changes. Stakeholders must generate cutting-edge ideas to achieve organizational LTC culture change as well as examine the integration of quality of care and quality of life and their implications for LTC regulation.

References

AARP. (2014). *Moving Toward Person- and Family-Centered Care.* Retrieved from www.aarp.org/relationships/caregiving/info-03-2012/moving-toward person-and-family-centered-care-insight-AARP-ppi-ltc.html

Advancing Excellence in America's Nursing Homes Campaign. (2014). *Person-Centered Care.* Retrieved from www.nhqualitycampaign.org/goalDetail.aspx?g=PCC#tab4

Advancing Excellence in America's Nursing Homes Campaign. (2015). *Person-Centered Care.* Retrieved from www.nhqualitycampaign.org/goalDetail.aspx?g=PCC

Aylward, S., Stolee, P., Keat, N., & Johncox, V. (2003). Effectiveness of continuing education in long-term care: A literature review. *The Gerontologist*, *43*(2), 259–271.

Barry, T., Kemper, P., & Brannon, D. (2008). Measuring worker turnover in long-term care: Lessons from the better jobs better care demonstration. *The Gerontologist*, *48*(3), 394–400.

Bradley, E. H., Webster, T. R., Baker, D., Schlesinger, M., Inouye, S. K., Barth, M. C., ... Koren, M. J. (2004). *Translating research into practice: Speeding the adoption of innovative health care programs*. New York, NY: The Commonwealth Fund.

Budden, J. (2011). The first national survey of medication aides. *Journal of Nursing Regulation*, *2*(3), 4–12.

Castle, N. G. (2012). Reviewing the evidence base for nurse staffing and quality of care in nursing homes. *Evidence-Based Nursing*, *15*(1), 23–24.

Castle, N. G., & Anderson, R. (2011). Caregiver staffing in nursing homes and their influence on quality of care: Using dynamic panel estimation methods. *Medical Care, 49*(6), 545–552.

Castle, N. G., & Engberg, J. (2007). The influence of staffing characteristics on quality of care in nursing homes. *Health Services Research, 42*(5), 1822–1847.

Centers for Medicare & Medicaid Services. (2012). *CMS 2012 Nursing Home Action Plan.* Retrieved from www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2012-Nursing-Home-Action-Plan.pdf

Coleman, E. (2003). Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. *Journal of the American Geriatrics Society, 51*(4), 549–555.

Cope, P., Cuthbertson P., & Stoddart B. (2008). Situated learning in the practice placement. *Journal of Advanced Nursing*, *31*(4), 850–856.

Corazzini, K. N., Anderson, R. A., Mueller, C., Thorpe, J. M., & McConnell, E. S. (2013). Licensed practical nurse scope of practice and quality of nursing home care. *Nursing Research*, *62*(5), 315–324.

Corazzini, K. N., Anderson, R. A., Rapp, C. G., Mueller, C., McConnell, E. S., & Lekan, D. (2010). Delegation in long-term care: Scope of practice or job description? *The Online Journal of Issues in Nursing*, *15*(2), doi:10.3912/OJIN.Vol15No02Man04

Cromwell, S. E., & Kolb, J. A. (2004). An examination of work-environment support factors affecting transfer of supervisory skills training to the workplace. *Human Resource Development Quarterly*, *15*(4), 449–471.

Davidson, J. E., Powers, K., Hedeyat, K. M., Tieszen, M., Kon, A. A., Shepard, E., ... Armstrong, D. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American College of Critical Care Medicine Task Force 2004–2005. *Critical Care Medicine, 35*(2), 605–22.

Dellefield, M. E. (2008). The work of the RN minimum data set coordinator in its organizational context. *Research in Gerontological Nursing, 1*(1), 42–51.

Eaton, S. (2000). Beyond 'Unloving Care': Linking human resource management and patient care quality in nursing homes. *The International Journal of Human Resource Management, 11*(3), 591–616.

Eby, L., Adams, D., Russel, J., & Gaby, S. (2000). Perceptions of organizational readiness for change: Factors related to employees' reactions to the implementation of team-based selling. *Human Relations, 53*(3), 419–442.

Grabowski, D. C., Elliot, A., Leitzell, B., Cohen, L. W., & Zimmerman, S. (2014). Who are the innovators? Nursing homes implementing culture change. *The Gerontologist, 54*(Supp1), S65–S75.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Millbank Quarterly, 82*(4), 581–629.

Harrington, C., Woolhandler, S., Mullan, J., Carrillo, H., & Himmelstein, D. U. (2001). Does investor ownership of nursing homes compromise the quality of care. *American Journal of Public Health, 91*(9), 1452–1455.

Harris-Kojetin, L., Lipson, D., Fielding, J., Kiefer, K., & Stone, R. I. (2004). Recent findings on frontline long-term care workers: A research synthesis 1999–2003. *Institute for the Future of Aging Services*. Retrieved from http://aspe.hhs.gov/daltcp/reports/insight.htm

Kane, R. L., Garrard, J., Skay, C. L., Radosevich, D. M., Buchanan, J. L., McDermott, S., ... Kepferle, L. (1989). Effects of geriatric nurse practitioner on process and outcome of nursing home care. *American Journal of Public Health*, *79*(9), 1271–1277.

Kane, R. L., Keckhafer, G., Flood, S., Bershadsky, B., & Siadaty, M. S. (2003). The effect of Evercare on hospital use. *Journal of the American Geriatrics Society, 51*(10), 1427–1434.

Kash, B. A., Naufal, G. S., Cortés, L., & Johnson, C. E. (2010). Exploring factors associated with turnover among registered nurse (RN) supervisors in nursing homes. *Journal of Applied Gerontology*, *29*(1), 107–127.

Koren, M. J. (2010). Person-centered care for nursing home residents: The Culture-change movement. *Health Affairs*, *29*(2), 312–317.

McConnell, E. S., Lekan, D., & Corazzini, K. (2010). Assuring the adequacy of staffing of long-term care, strengthening the caregiving workforce, and making long-term care a career destination of choice: From mission impossible to mission critical. *NC Medical Journal, 71*(2), 153–157.

McConnell, E. S., Lekan-Rutledge, D., Nevidjon, B., & Anderson, R. (2004). Complexity theory: A long-term care specialty practice exemplar for the education of advanced practice nurses. *The Journal of Nursing Education*, *43*(2), 84–87.

McGilton, K. S., Boscart, V. M., Brown, M., & Bowers, B. (2014). Making tradeoffs between the reasons to leave and reasons to stay employed in long-term care homes: Perspectives of licensed nursing staff. *International Journal of Nursing Studies, 51*(6), 917–926.

Mitty, E., Resnick, B., Allen, J., Bakerjian, D., Hertz, J., Gardner, W., ... Mezey, M. (2010). Nursing delegation and medication administration in assisted living. *Nursing Administration Quarterly, 34*(2), 162–171.

Mor, V., Caswell, C., Littlehale, S., Niemi, J., & Fogel, B. (2009). *Changes in the quality of nursing homes in the US: A review and data update*. Washington, DC: American Healthcare Association.

Mueller, C., Anderson, R. A., McConnell, E. S., & Corazzini, K. (2012). Licensed nurse responsibilities in nursing homes: A scope-of-practice issue. *Journal of Nursing Regulation, 3*(1), 13–20.

Nolet, K., Roberts, T., Gilmore, A., Roiland, R., Gullickson, C., Ryther, B. & Bowers, B. (2014). Preparing tomorrow's nursing home nurses: The Wisconsin Long Term Care Clinical Scholars Program. *Gerontology & Geriatrics Education.* doi:10.1080/02701960.2014.954040

Ouslander, J., Lamb, G., Perloe, M., Givens, J., Kluge, L., Rutland, T., ... Saliba, D. (2010). Potentially avoidable hospitalizations of nursing home residents: Frequency, causes, and costs. *Journal of the American Geriatrics Society, 58*(4), 627–635.

Rahman, A., Straker, J. K., & Manning, L. (2009). Staff assignment practices in nursing homes: Review of the literature. *Journal of the American Medical Directors Association, 10(*1), 4–10.

Rantz, M. J., Chesire, D., Flesner, M., Petroski, G. F., Hicks, L., Alexander, G., Aud, M. A., Siem, C., Nguyen, K., Boland, C., Thomas, S. (2009). Helping nursing homes "at risk" for quality problems: A statewide evaluation. *Geriatric Nursing, 30*(4), 238-249.

Rantz, M. J., Chesire, D., Flesner, M., Petroski, G. F., Hicks, L., Alexander, G., ... Thomas, S. (2009). Helping nursing homes "at risk" for quality problems: A statewide evaluation. *Geriatric Nursing, 30*(4), 238–249.

Roberts, T., Nolet, K. A., & Bowers, B. J. (2013). Consistent assignment of nursing staff to residents in nursing homes: A critical review of conceptual and methodological issues. *The Gerontologist*. Retrieved from http://gerontologist.oxfordjournals.org/content/early/2013/08/30/geront.gnt101.full.pdf

Stone, R., Reinhard, S., Bowers, B., Zimmerman, D., Phillips, C., Hawes, C., Fielding, J., & Jacobson, N. (2002). *Evaluation of the Wellspring Model for improving nursing home quality*. New York, NY: The Commonwealth Fund.

Tourangeau, A., Cranley, L., Laschinger, S., & Pachis, J. (2010). Relationships among leadership practices, work environments, staff communication and outcomes in long-term care. *Journal of Nursing Management, 18*(8), 1060–1072.

Vogelsmeier, A. (2011). Medication administration in nursing homes: RN delegation to unlicensed assistive personnel. *Journal of Nursing Regulation, 2*(3), 49–53.

Warrick, D. D. (2009). Developing organizational change champions: A high payoff investment. *Organizational Development Network, 41*(1), 14–19.

Wheeler, T. (2009). The role of skin assessment in older people. *British Journal of Community Nursing, 14*(9), 380–384.

Yeboah, C., Bowers, B., & Rolls, C. (2013). Culturally and linguistically diverse older adults relocating to aged care. *Contemporary Nurse, 44*(1), 50–61.

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