Nationally, over 3 million certified nursing assistants and licensed nurses work in long-term care (LTC). Of these 3 million providers, about 2.5 million are certified nursing assistants (CNAs) and the remaining 500,000 licensed nurses are evenly divided between licensed practical nurses (LPNs) and registered nurses (RNs). With the aging of our population, experts estimate that the demand for this workforce will double in the coming decades, requiring up to 5 million direct care workers, 868,000 RNs, and 231,000 LPNs nationally. In 2007, an estimated 109,900 full-time equivalent direct care nursing positions at nursing facilities across the United States were vacant; approximately two-thirds of the vacancies were for CNAs and one-third for licensed nurses. National turnover rates among CNAs, LPNs, and RNs remain high, most recently estimated at 66%, 50%, and 41% respectively. The situation in North Carolina is even grimmer: annual turnover rates for CNAs and one-third for licensed nurses. National turnover rates among CNAs, LPNs, and RNs remain high, most recently estimated at 66%, 50%, and 41% respectively. The situation in North Carolina is even grimmer: annual turnover rates for nursing staff are conservatively estimated at 86%, with CNA turnover most recently estimated at over 100%.

Supply of and demand for advanced practice nurses (APNs) practicing in LTC (board-certified nurse practitioners and clinical nurse specialists) is not currently tracked systematically, but studies demonstrate their value in managing chronic and acute illnesses in nursing homes, as well as in helping staff integrate quality improvement approaches into routine care. The growing evidence of APN effectiveness in LTC at both the patient and organizational level has led to calls to include APNs in nursing home staffing standards. In addition to providing primary care to LTC residents, APNs have shown positive impacts when providing acute or transitional care to older adults, serving in an educational role to residents, families, and staff, and providing consultation to staff or organizations on patient care and systems level issues.

The sheer size of the gap between what we have and what we need to ensure adequate nurse staffing in LTC is staggering. Given the high turnover and growing need for a higher skill set among the LTC nursing workforce, simply enticing larger numbers of personnel to enter the field will not suffice to ensure adequate numbers of competent LTC nursing staff in the coming decades. Three key challenges in the LTC work environment need urgent attention before incentive programs to address the current shortfall in personnel will have any lasting effect:

1. Recognizing that a diverse nursing staff mix is required, with educational preparation and competency commensurate with the increasingly complex case mix and organizational challenges of LTC.

2. Enhancing the work environment of LTC to address the extremely high turnover rate. Improvements in pay, supervisory approaches, career advancement opportunities, and development of learning organization approaches that improve quality of care

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are each evidence-based approaches that should be implemented to lower staff turnover.

(3) Integrating LTC into the mainstream of academic work so that scientific advances in the fields of gerontology and geriatrics can be rapidly integrated into LTC practice and so that LTC challenges are routinely addressed by educational and research programs. Such integration would also increase the potential for accelerating translation of care innovations that arise in LTC settings, such as approaches to restraint reduction, rehabilitation, and person-centered care.

The work of LTC, done properly, is time-consuming and must take into account an increasingly complex array of clinical and social factors. Older adults, the primary recipients of LTC, become more individualized as they age; the disability that drives LTC needs is typically accompanied by multiple comorbid chronic diseases and a complex set of social circumstances that also require attention if acceptable quality of life for disabled older adults is to be maintained. The nursing staff who currently work in LTC face considerable challenges in the work environment that add to the substantial clinical challenges inherent in LTC work, including chronic staff shortages, limited access to needed expertise to deal with clinical and social complexities, unrealistic work assignments, low pay, little respect, and few opportunities for career advancement. The shift in case mix in LTC toward greater acuity of illness to accommodate declining hospital lengths of stay has been well-documented, and has exacerbated the factors that contribute to turnover. As acuity of resident care has risen in nursing homes, RN hours per resident day have declined by 25% to an average of 19 minutes per day, while nursing assistive personnel levels have remained relatively stable. In many nursing homes the director of nursing may be the only RN on staff. Such staffing trends result in consistently fewer opportunities for staff to access professional nursing expertise to learn how to provide quality care to the growing numbers of older adults in need of increasingly complex care, and undoubtedly compromises the quality of supervision available to staff. The decline in the level of RN staffing is particularly troubling in light of the mounting evidence that RN staffing levels influence care quality.

Even as the case mix in LTC has become more complex clinically, contemporary thinking about long-term care quality emphasizes resident-centric and family-centric approaches in direct contrast to traditional notions of profession-centric approaches to care. Few would challenge the value of moving toward resident-centered approaches; however, the process of changing to a more resident-centric approach requires that staff have access to a much more sophisticated leadership climate than has typically been available to them. Although those who have dedicated their professional lives to the important work of LTC may characterize the work as challenging yet highly rewarding, the circumstances just described, coupled with the resource-constrained nature of LTC financing, and the many potential roles available for nurses in other care sectors makes LTC a perfect set-up for continued workforce shortages.

What Incentives Would Attract People to LTC?

The research on staff satisfaction and turnover in LTC increasingly points to the circular relationship between care quality and turnover. Put simply, good nursing staff do not want to work where they cannot carry out their responsibilities effectively and humanely. In order to systematically address nursing staff turnover, there is no escape from confronting the issue that LTC is currently woefully understaffed, with an impoverished skill mix. The problem will only get worse as scientific advances in medicine and geriatrics mean that people can live with increasingly complex chronic diseases. Therefore, the first incentive needed to bring needed nursing personnel into the field of LTC is to recognize the complexity and demand of LTC work by hiring adequate numbers of diverse staff who are paid competitive wages. A recent systematic review summarizing studies conducted by the Centers for Medicare and Medicaid Services (CMS) and others to quantify staffing thresholds associated with minimum care quality outcomes recommends the following: (1) “total minimum direct care staffing levels of 4.1 hours of care per resident day, which should be subject to change to account for differences in resident case mix or comorbidity measures,” as is already required by nursing home law; (2) direct care RN staffing levels of 0.75 hours of care per resident day, not including administrative RNs, which would also reflect differences or changes in resident case mix characteristics, and (3) 24-hour RN staffing. Adequacy of staffing levels in long-term care requires attention to both sufficient numbers of staff and their level of preparation. Licensure status matters, but increasingly, adequate educational preparation and demonstrated ability to function in the complex world of geriatrics and long-term care will be required. Not only is RN care critical to quality outcomes such as preventing pressure sores, urinary tract infections, hospitalization, mortality, and promoting more rapid discharge home for post-acute patients, but also to reducing the likelihood of expensive litigation. Adding APNs with geriatric competencies would further enrich the care environment by injecting additional combined nursing and medical expertise and enhancing communication between medical and nursing personnel.

In addition to ensuring adequate staffing levels, North Carolina must ensure that those who work in LTC do not suffer serious economic disadvantage compared to workers in other sectors of health care, by mandating LTC payment levels that allow direct care nursing staff to be adequately compensated. Recent salary surveys suggest that RNs in...
LTC make approximately $10,000 less per year than in acute care. Although much has been made of the dedication of LTC nurses and their willingness to sacrifice better wages to engage in satisfying work, serious attempts to attract nurses to LTC cannot continue to ignore serious economic disincentives.

A Second, Critical Incentive

The expansion of a meaningful career ladder for staff working in LTC is a significant incentive that should simultaneously address organizational climate factors that impede the staff’s ability to implement evidence-based practices. Promising achievements toward this goal have been made through the North Carolina New Organizational Visions Award (NC NOVA) which provides a special licensure status for LTC agencies that provide safe and balanced workloads for staff and that have an organized approach to training and career advancement. Likewise, the innovative WIN A STEP UP program, where CNAs take 30 hours of clinically-oriented continuing education with a modest raise in pay upon successful completion, is another excellent example. Importantly, when integrated with a supervisor training program, this program had greater impact on outcomes of pressure sores and turnover among nurse aides. We cannot overemphasize the importance of coupling pay with training and organizational-level interventions. As noted by one LTC researcher, although frontline workers in LTC, when questioned about what keeps them on the job, almost invariably point to the importance of their ability to care for aging patients, that is not the same as saying adequate pay is not important. Increasingly, the evidence points to wage increases as being necessary but not sufficient to produce increases in job satisfaction.

To be sustainable, attention to career pathways must go beyond the level of nursing assistants to include licensed nurses, as they struggle to obtain the needed skills required to be effective in LTC. The evidence is clear that nursing assistant turnover is tied to the quality of supervision they receive. With the majority of supervisors in LTC prepared as LPNs, there is clearly a need to prepare LPNs with supervisory skills. But, as we have observed when teaching delegation/supervision skills to undergraduate nursing students at Duke—systematic preparation for supervisory roles is critical. Organizations such as the Paraprofessional Health Institute have developed useful toolkits for training in supervision—the challenge now is how to best integrate these into basic nursing curricula so that all who graduate have the capacity to be effective as supervisors of frontline staff.

Many LTC employers already recognize the value of recognizing nursing staff who are passionate about care of the elderly and who are committed to working in LTC settings. Employer-supported scholarships for advancing education and adoption of career ladders are initiatives that have been shown to improve retention and provide opportunity for increased wages, but a diversified set of approaches will be required to obtain the needed workforce. The workforce needed in LTC today must be better educated about the complexities of geriatric care, geriatric syndromes, comorbid conditions, and the interrelationships of biologic, psychosocial, and spiritual domains. Supervisors and clinicians will need to be experts at managing the multiculturalism that increasingly pervades all levels of the organization. Staff need to be more diverse and must be capable of interacting effectively with diverse coworkers as well as diverse patients. Investing in CNAs, who often are from racial or ethnic minority groups, to help advance their education to professional RN and advanced practice roles is a logical approach to addressing both recruitment into the licensed nurse segment of the LTC nursing workforce and aligns with the goal of developing a meaningful career ladder.

Fortunately, an array of educational interventions have demonstrated success in addressing the knowledge deficits that may exist among LTC nursing staff as the clinical case mix and supervisory challenges increase. These include both workplace-based continuing education approaches conducted in partnership with universities, as well as the development of advanced practice nursing expertise through more traditional graduate level education.

LTC and Health Professional Schools

There is an urgent need to strengthen partnerships between LTC and health professions schools to foster adequate preparation of graduates for practice in the LTC setting and to foster accelerated implementation of new knowledge into LTC. Again, North Carolina has made some promising initial starts, but the breadth and depth of these partnerships needs to expand beyond individual university, school, or faculty efforts, to mobilize efforts that reach across LTC settings and programs. One particularly compelling model has been developed in Oregon, where nursing educators have come together to develop a seamless approach to integrate the ADN (associate degree in nursing) and BSN (bachelor of science in nursing) education to address the broader nursing shortage. Key to this model is coordination among academic centers on admission processes, curriculum development and integration, and matriculation across the education programs. A similar strategy is currently being pilot tested in North Carolina through the Foundation for Nursing Excellence. Combining innovations to streamline access to university preparation for nurses with transitions into practice initiatives that are also underway to improve nurse retention, and shifting their focus to LTC settings could have an incredibly strong impact on nursing practice in LTC. Encouraging high performing LTC nurses to enter innovative academic programs, such as the doctor of nursing practice program, with its emphasis on translation, transformation, and quality could also accelerate the pace of transformational change in LTC.

Training alone will not suffice to eliminate the large shortfall of LTC workers. LTC organizations, nursing
organizations, and educational institutions will need to partner as never before to develop, test, and facilitate implementation of the knowledge that is required to keep an appropriately skilled workforce in LTC in a cost-effective manner. No one organization has yet shown they have the full set of knowledge needed to address LTC workforce needs on the scale that is needed, but many of the universities and schools in North Carolina have led effective LTC innovations, suggesting that the key ingredients needed for productive academic-practice partnerships exist that could lead to sustainable improvements in the LTC work environment. For example, Duke University’s Center of Excellence in Geriatric Nursing Education36 and the Duke Aging Center provide two examples of innovations led by the private sector; the UNC system schools have also demonstrated the capacity to innovate in LTC, through inter-school initiatives such as the UNC Institute on Aging, and through school-specific innovations such as UNC Chapel Hill School of Nursing’s simulation learning innovations36, and work by the UNC Greensboro School of Nursing37 to improve access to geriatrics at the bachelor’s level. Finally, the innovative work of the Foundation for Nursing Excellence points to the full set of knowledge needed to address LTC workforce needs on the scale that is needed, but many of the universities and educational institutions will need to ensure an adequate LTC nursing workforce. However, North Carolina is better positioned than most states to mobilize the evidence base to address nursing workforce shortages in LTC, as it is home to a critical mass of talented scholars with a demonstrated capacity to collaborate with innovative LTC workplaces and leaders. Will this be the decade where we finally find a way to join forces to move this problem from its status as “mission impossible” to “mission critical?”

REFERENCES


