Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Nurse Aide Training

JANET REHNQUIST
Inspector General

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EXECUTIVE SUMMARY

PURPOSE

To determine whether nurse aide training prepares nurse aides for their jobs in nursing homes.

BACKGROUND

Nurse aides are the front-line workers in nursing homes. The well-being of a nursing home resident depends not only on the skills of the nurse aide, but also on the relationship that develops between the nurse aide and the resident. Federal regulations require that all nurse aides, who work in nursing homes that participate in Medicare and Medicaid, complete a State-approved training program, pass a competency exam, and receive certification from the State in which they are employed. State-approved training programs must be a minimum of 75 hours and include 16 hours of supervised clinical training. To maintain certification, all nurse aides must complete 12 hours of continuing education annually.

We reviewed the Federal nurse aide training requirements as mandated in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). We examined factors affecting nurse aide training by obtaining data about current State nurse aide training requirements from 48 States and the District of Columbia. We compiled responses from nearly 1,000 nurse aides. We interviewed 29 nursing home administrators and nurse supervisors (hereinafter referred to as nursing home supervisors), 14 nurse aide trainers, 5 long-term care ombudsmen, 3 academicians, and 5 experts in the field. Overall, we held discussions with 39 licensed or registered nurses from the different respondent groups.

FINDINGS

Nurse aide training has not kept pace with nursing home industry needs

Approximately 90 percent of our respondents (nursing home supervisors, nurse aide trainers, State ombudsmen, State directors of nurse aide training programs, and experts) reported that the medical and personal care needs of today's nursing home residents have

changed since implementation of OBRA 87. We held discussions with nursing home staff and experts who indicated that compared to nursing home residents 15 years ago, today's nursing home residents are older, sicker, require more assistance with activities of daily living, and take more medications. Approximately half of the nursing home supervisors we interviewed, and 61 percent of State directors of nurse aide training programs believe that nurse aide training has not kept pace with demands of the changing care needs of nursing home residents.

Nurse aides need more skill training on behavior and cognitive disorders, catheter care, colostomy care, lifting, feeding, hydration, and infusion therapies. They also need more training in interpersonal skills, including communication, teamwork, coping with death and dying, time management, and new technologies.

Teaching methods are often ineffective, clinical exposure is too short and unrealistic

Although Federal law requires that State-approved nurse aide training programs consist of at least 75 hours of total instruction, 26 States have already extended their training programs beyond 75 hours. Eighteen of twenty-nine nursing home supervisors reported that nurse aides were not ready to begin work on the nursing home floor upon completion of nurse aide training. Fifty percent of nurse aides we surveyed reported a lack of "hands on" experience and unrealistic training scenarios.

In-service training may not be meeting Federal requirements

We had difficulty determining whether nursing homes are meeting the Federal requirement that in-service training address areas of weakness for individual nurse aides. Besides recording the number of hours of completed in-service training, there are no other documentation requirements in the Federal regulations for in-service training.

RECOMMENDATION

Responses from 29 nursing home supervisors, 14 nurse aide trainers, 5 long-term care ombudsmen, 3 academicians, and 5 experts (39 of all these respondents were licensed or registered nurses) show that the nurse aide training curriculum needs to be updated, and clinical experience needs to occur earlier and needs to be more realistic. Responses from nearly 1,000 nurse aides and 48 State directors of nurse aide training programs also indicate that nurse aide training programs need improvement. Although the nursing home

environment has changed considerably since OBRA 87 nurse aide training regulations were implemented, nurse aide training has not kept pace with nursing home resident needs.

We are recommending that CMS:

Improve nurse aide training and competency evaluation program requirements

- Ensure that the content of the nurse aide training curriculum and testing (as described in 42 CFR Part 483) remains relevant to today's complex resident care needs. Strengthen nurse aide training by recognizing current nurse aide needs and by embracing modern technologies and equipment. Consider enhancing the communication and interpersonal skills of nurse aides (i.e., by including training in time management and teamwork).

- Continue to work with States to assure that nurse aide training is effective and efficient. This collaborative effort could include (but not be limited to) increasing the ratio of clinical hours and ensuring that clinical experience occurs earlier in the training period, is more realistic, and includes a full range of skills needed on the job.

- Ensure that nursing homes are in compliance with in-service training requirements. Revise 42 CFR §483.75 to include a requirement that nursing homes document that in-service training is conducted to address weaknesses identified in nurse aides' performance reviews.

AGENCY COMMENTS

The draft of this report was reviewed by CMS, and the agency concurred with our recommendations. In concurring with our recommendations, CMS stated that the agency's own independent study reached essentially the same conclusions as found in our study. The CMS reports that the agency has a contract in place to examine nurse aide training curriculum, content, and skills. The CMS also intends to develop specific policy and programmatic options for improving the administration of nurse aide training programs and for ensuring that nursing home in-service training complies with regulatory requirements. The full text of CMS' comments can be found in Appendix A.

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INTRODUCTION

PURPOSE

To determine whether nurse aide training prepares nurse aides for their jobs in nursing homes.

BACKGROUND

Nurse aides are healthcare workers in various settings, such as hospitals, home care, and nursing homes. In long-term care nursing homes, nurse aides assist residents in their activities of daily living, such as bathing, dressing, eating and toileting. Nurse aides also tend to the psychological, social, and spiritual needs of residents. Because a nurse aide's primary duty is direct care, they are often the first to identify changes in a resident's condition. Some nursing home administrators liken nurse aides to "the eyes and ears" of the facility.

Nurse aides must also demonstrate a professional attitude and behavior to enhance communication between herself/himself and the resident, the resident's family members and nursing home staff. The scope of duties for nurse aides varies among States and also among nursing homes within a State.

Federal Training Requirements

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) mandated the Nurse Aide Training and Competency Evaluation Program (NATCEP) to establish minimum requirements for nurse aide competency. Nursing homes participating in Medicare and Medicaid may not employ anyone as a nurse aide for more than four months, unless the individual has completed a State-approved nurse aide training program and passed a competency exam.[1] Federal regulations require that the training:

- Consist of no less than 75 hours;

[1] 42 CFR §483.75(e)(2)

- Be performed by, or under the general supervision of, a registered nurse who has a minimum of 2 years of nursing experience, at least 1 year of which must be long-term care;
- Include hours in certain nursing skill areas; and
- Include at least 16 hours of supervised practical training [hereinafter referred to as "*clinical*" training].

Some States have chosen to require additional hours of classroom and clinical training. For more information, see our Office of Inspector General companion report on "State Nurse Aide Training: Program Information and Data".[2]

For classroom training, Federal regulations require instruction in the following areas:

- *Basic nursing skills*--includes taking and recording vital signs; measuring and recording height and weight; caring for the resident's environment; recognizing and reporting abnormal changes in body functioning; and caring for the dying resident.
- *Personal care skills*--includes bathing, grooming, dressing, toileting and skin care; assisting with eating (proper feeding techniques) and hydration; and transferring, positioning and turning.
- *Mental health and social service skills*--includes responding to a resident's behavior; raising awareness of developmental tasks associated with the aging process; allowing the resident to make personal choices; and using the resident's family as a source of emotional support.
- *Caring for cognitively impaired residents*--includes addressing the behaviors of residents with dementia; and communicating and responding to residents with cognitive impairments.
- *Basic restorative skills*--includes training the resident in self care; using assistive devices in transferring, ambulation, eating and dressing; maintaining range of motion; proper turning and positioning in bed and chair; bowel and bladder training; and caring for and using prosthetic and orthotic devices.
- *Residents' rights*--includes providing privacy and maintenance of confidentiality; promoting residents' rights to make personal choices to accommodate their needs; giving assistance in resolving grievances and disputes; providing needed assistance in getting to and participating in resident and family groups and other activities; maintaining care and security of residents' personal possessions; promoting the resident's right to be free from abuse, mistreatment, and neglect,

[2] OEI-05-01-00031

and the need to report any instances of such treatment to appropriate nursing home staff; and avoiding the need for restraints.[3]

During clinical training, under the direct supervision of a registered or licensed practical nurse, the nurse aide trainee must demonstrate knowledge while performing tasks on an individual, such as taking vital signs of one of their fellow students. Upon completion of training, a nurse aide trainee must pass a State exam to become certified to work in a nursing home. As required by the regulations, the exam must include a written or oral component and a skills-demonstration component. Candidates for certification must pass both components.

Continuing Education Requirement

The OBRA 87 also mandates that nursing homes provide regular in-service education for nurse aides. Specifically, the regulations require a nursing home to complete a performance review of every nurse aide at least once every 12 months. Using the performance reviews, nursing homes must provide regular in-service education to address identified needs. The in-service training must:

- Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year;
- Address areas of weakness, as determined in nurse aides' performance reviews, and may address the special needs of residents as determined by the facility staff; and
- Address aides providing services to individuals with cognitive impairments.[4]

States may develop their own, more stringent, requirements for in-service education. As a result, States vary as to the number of in-service hours and topics they require.

The Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is responsible for establishing and enforcing regulatory requirements designed to ensure that nursing homes that participate in Medicare and Medicaid meet specific criteria (called Conditions of Participation) that are

[3] 42 CFR §483.152

[4] 42 CFR §483.75

designed to ensure resident health, safety, and quality of care.[5] The CMS also is responsible for establishing the regulatory standards for State nurse aide training programs and providing funding for nurse aide training programs sponsored by nursing homes.[6] According to information from CMS, a total of $45.5 million was spent for nurse aide training in Fiscal Year 2000.[7] Approximately $20.2 million of this total was paid by the Federal government. The remaining funds were paid by State governments. Oversight and enforcement of the nurse aide training regulatory requirements are left to the States.[8]

The CMS contracts with State agencies to certify long-term care nursing homes to participate in the Medicare and Medicaid programs. These State agencies also are responsible for surveying nursing homes to ensure that they continue to meet both Federal and State requirements. As part of their nursing home survey, State surveyors review facility records to ensure that nurse aides employed in the nursing home have completed their nurse aide training and are certified by the State. Generally, these records are reviewed only when surveyors have severe quality of care concerns or observe incorrect performance by a nurse aide.

The States' Oversight of Nurse Aide Training

The States have responsibility for approving nurse aide training programs. State NATCEP directors oversee nurse aide training programs and the administration of the competency exams. State NATCEP directors are charged with periodically recertifying all training programs and conducting on-site visits to ensure that they continue to adhere to Federal and State requirements. The director also may be in charge of the State's nurse aide registry, which is a repository of information about nurse aides certified to work in the State.

States have considerable freedom in developing nurse aide training programs. They determine the total hours of training required (as long as the 75-hour minimum is met). They may develop training manuals and curricula or approve those developed by the private or public sector. States also have considerable latitude in the administration of exams. States may administer exams directly or contract for this service. Thirty-two States hire private subcontractors to administer their State nurse aide exams. The remaining 17 States use their own staff or work

[5] P.L.100-203 §4201(f)(1)

[6] P.L. 100-203 §4201(f)(2)(A)(i)

[7] Based on Medicaid Financial Management Reports (HCFA-64) for FY 2000.

[8] 42 CFR §§483.152 - 483.158

with other State or private entities to administer the State exams.[9]

Training programs may be either facility-based (i.e., in a nursing home) or non-facility based, such as in a community college, vocational-technical school, high school, or private school. States report fees for non-facility based training ranging from a low of $190 to a high of $9,372.

Changes in Long-Term Care Environment

There have been many changes in the long-term care environment since passage of OBRA 87. Today, long-term care not only includes nursing homes, but also home care, personal care homes and assisted living facilities. Healthcare policy changes that encourage shorter hospital stays have created a niche whereby nursing homes are providing sub-acute care that was previously provided in a hospital setting.[10]

Longitudinal data suggests that acuity levels and complexity of care for elderly long-term care users have increased over time. The National Long-Term Care Survey[11] indicates that in 1984, 35.4 percent of elderly long-term care users required assistance with 3 to 6 activities of daily living (ADLs)[12] and 33.7 percent were cognitively impaired. In 1999, 75 percent of nursing home residents required assistance with three or more ADLs.[13] Data from 2001 indicate that almost 60 percent of nursing home residents had moderately or severely impaired cognitive skills.[14]

Other Studies

Several other studies have examined the subject of nurse aides in nursing homes. These studies have mainly focused on staffing issues. The Institute of Medicine published two reports in this

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[9] Two State NATCEP directors did not respond to our survey.

[10] *The Characteristics of Long-Term Care Users*, AHRQ Research Report, January 2001.

[11] The National Long-Term Care Survey, Center for Demographic Studies, Duke University.

[12] ADLs are activities related to personal care and include bathing or showering, dressing, getting in and out of bed or a chair, getting around inside, using a toilet, and eating.

[13] Jones A. The National Nursing Home Survey: 1999 summary. National Center for Health Statistics. Vital Health Stat 13(152).2002.

[14] The Centers for Medicare & Medicaid Services, Minimum Data Set, 2001.

area. The first, "Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?" (1996) looked at the evolving role of nurses in the health care system. The second, "Improving the Quality of Long-Term Care" (2001), identified problem areas, and offered recommendations for strengthening the caregiving workforce. The General Accounting Office provided testimony related to the current and projected supply of nurse aides in their report entitled "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern".[15] This report included full demographic descriptions of nurse aides and a portrayal of current salary issues. The CMS issued a report to Congress entitled, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes" (2001) which examined nurse aide training. That report, in its examination of nursing home staff turnover and retention, described the relationship between nurse staffing levels and the quality of care in nursing homes.

SCOPE AND METHODOLOGY

Pre-Inspection

We conducted extensive pre-inspection work in three States[16] to gain background knowledge and learn about pertinent issues in nurse aide training. We met with the State NATCEP directors, nursing home administrators, licensed and registered nurses, nurse aides, nurse aide trainers, and long-term care ombudsmen during our pre-inspection visits to these three States. We also met with CMS regional and headquarters staff and attended conferences sponsored by a national nurse aide association and the Agency for Healthcare Research and Quality. We also interviewed representatives from industry and association groups. One team member attended a full day of nurse aide training.

Inspection Process

Throughout the inspection process, we systematically gathered both quantitative and qualitative data from the different stakeholder groups to identify issues and learn their perspectives of nurse aide training. We used three methods for collecting data in this inspection. First, we gathered information from NATCEP directors in 48 State agencies and the District of Columbia. Twenty of the NATCEP directors identified themselves as registered nurses. Two State NATCEP directors did not respond to our request for information. We collected detailed information about nurse aide training requirements and numbers of hours of training in their States. We gathered information about the various curriculum and clinical requirements in their

[15] GAO-01-750T

[16] Missouri, Ohio, and Wisconsin

State and the State's role in oversight of these training programs. We received information on updates to training course content since the implementation of OBRA 87. We also received suggestions from these State directors based on their years of experience in the field on whether any improvements needed to be made to the nurse aide training curriculum.

Second, we conducted site visits in five States: Florida, Louisiana, Minnesota, New York, and Washington. States were selected following discussions with CMS staff and experts. States were also selected based on geographic location, nursing home population, and State budgets for nursing home care. These site visits were conducted during June and July 2001. We systematically held discussions with State NATCEP directors, State long-term care ombudsmen, nursing home supervisors and nurse aide trainers in each of the five States.

In each State, we selected five or six nursing homes, based on criteria, such as bed size, type of ownership (for-profit/not-for-profit), location (urban/suburban/rural), and the presence of facility-based training. In each nursing home, we administered structured discussion guides with the nursing home administrator and nurse supervisor (hereinafter referred to as nursing home supervisor) as well as two to four nurse aides. We found out whether nurse aide training needs are met at the individual nursing homes, whether nurse aide training curricula can be improved, and whether nurse aides are prepared for their first day on the job after they complete their training.

Appendix B contains descriptive information of the nursing homes we visited. During our on-site visits, we gathered information systematically to assess quality of current nurse aide training and to determine whether improvements need to be made to nurse aide training programs. Whenever possible, we met with experts and members of academia to get their perceptions of nurse aide training programs. Overall, we met with 29 nursing home supervisors, 14 nurse aide trainers, 3 academicians (two of whom are actively involved in the education of nurse aides and registered nurses), and 5 experts. Of these respondents, 39 identified themselves as licensed or registered nurses.

Third, we surveyed nurse aides. To elicit the opinions of a large number of nurse aides, we mailed ahead surveys and return envelopes for each nurse aide in each nursing home that we visited. We sent 2,639 surveys to nurse aides working in the 29 nursing homes that we visited and obtained 889 completed surveys. Response rates ranged from 0 to 100 percent for each nursing home.

We analyzed the response rates to see if they differed based on the size of the nursing home (small and large) or type of ownership (for-profit and not-for-profit/government), and found no significant differences in response rates. Using the SAS statistical software, we conducted a t-test to test the statistical significance of the difference between response rates from the nursing homes based on size and type of ownership. Appendix C contains demographic information

about the nurse aides who responded to our survey. Since we did not conduct a random sample of nurse aides, any statements regarding the responses we received cannot be generalized to the entire population of nurse aides working in nursing homes.

Overall, we obtained information from nearly 1,000 nurse aides. In addition to the 889 nurse aides who completed our written survey, we interviewed 92 nurse aides. We also conducted a focus group with17 nurse aides. The focus group occurred in June 2001. Topics of discussion included how well the training prepared them for the job, and what content areas needed to be better addressed. We collected information on specific skills that were lacking from their nurse aide training, since many years had passed and they had acquired many years of experience at nursing homes since their original training. In addition to those areas of nurse aide training that they rated as deficient or poor, participants also identified other areas in which they still need training,

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

According to an Institute of Medicine report, nurse aide training is an essential element in the provision of quality care to nursing home residents. Nurse aides make up the largest proportion of caregiving personnel in nursing homes and provide most of the direct care to residents. Nursing homes that participate in Medicare and Medicaid cannot employ anyone as a nurse aide for more than four months, unless the individual has completed a State-approved training program, passed a competency exam, and received certification by the State in which they are employed.

We examined factors affecting nurse aide training by obtaining data about current State nurse aide training requirements from 48 States and the District of Columbia. We compiled responses from nearly 1,000 nurse aides. We interviewed 29 nursing home supervisors, 14 nurse aide trainers, 5 long-term care ombudsmen, 3 academicians, and 5 experts in the field. Overall, we held discussions with 39 licensed or registered nurses from the different respondent groups. Based on this evidence, we found that nurse aide training has not kept pace with nursing home industry needs; training hours, clinical exposure, and teaching methods are often inadequate; and in-service training may not always meet Federal requirements.

Nurse aide training has not kept pace with nursing home industry needs

Although approximately 70 percent of State NATCEP directors (33 of 48 who responded to our question) said that their States had updated nurse aide training curriculum requirements since implementation of OBRA 87, 61 percent (30 of 49 State directors) believe there are still training needs that are not being met in their States. All of our respondent groups identified areas in which the training did not meet the needs of the current nursing home industry.

Training does not meet needs of current nursing home residents

Approximately 90 percent of our respondents (nursing home supervisors, nurse aide trainers, State ombudsmen, NATCEP directors, and experts) said that the medical and personal care needs of today's nursing home residents have changed since implementation of OBRA 87. Recent research on the characteristics of nursing home

residents supports our respondents' opinions.[17] Shorter hospital stays have resulted in nursing homes seeing more residents who are sicker and who require more care.

In addition, new healthcare settings for the elderly population, including home care and assisted living facilities, have delayed entry into nursing homes. Consequently, nursing home residents are much older, require more help with their ADLs, and take more medications than nursing home residents of 15 years ago. Although the overall nursing home population is older, our respondents also report an increase in the number of younger nursing home residents. Many of these younger residents have chronic conditions, such as multiple sclerosis or a traumatic brain injury.

More than half (63 percent) of the nursing home supervisors we interviewed said that training has not kept pace with the care demands imposed by current resident diagnoses. Many of these supervisors pointed out that they are seeing more combative and violent residents. Accordingly, we were told that nurse aides need more training on caring for residents with behavioral and cognitive disorders, such as Alzheimer's disease. Six State NATCEP directors specifically emphasized the need for more training in this area.

The need for training related to caring for residents with greater needs was voiced also by nurse aides and trainers. Specific skills mentioned by nurse aides include: catheter and colostomy care, lifting (e.g. Hoyer lift), skin care, feeding, hydration, infusion therapies, and dealing with behavioral problems. Nurse aide trainers and supervisors point to the need for more information on specific diseases, such as diabetes, pneumonia, and cancer. These respondents further commented that nurse aides also need knowledge of medical equipment used by residents, such as feeding tubes and ventilators.

Training does not adequately address interpersonal skills

Nearly half (48 percent) of the nursing home supervisors we interviewed explained that it is not only the medical needs, but the psycho-social needs, that are lacking in nurse aide training. This involves training on communicating with residents, awareness of the aging process and treating "residents as people, not just bodies."

One out of every four nurse aides who responded to our survey reported that there were skill areas they used frequently on the job that their initial training did not adequately address. These nurse aides have worked in nursing homes for an average of 3.5 years. After they began working, they realized that training did not prepare them for skills

[17] Sayhoun NR, Pratt LA, Lentzner H, Dey A, Robinson KN. The Changing Profile of Nursing Home Residents: 1985-1997. Aging Trends; No.4. Hyattsville, Maryland: National Center for Health Statistics. 2001.

associated with caring for nursing home residents. Examples of interpersonal skills that nurse aides mentioned as lacking in their initial training include time and stress management, teamwork, developing relationships with residents, and coping with death and dying.

Nationally, nurse aides care for 10-15 residents on a shift. Nurse aides told us they have difficulty finding enough time to deliver quality care to all of the residents entrusted to them. This problem is exacerbated when one or more nurse aides do not report to work or positions remain unfilled.

Almost seventy percent of nurse aides responding to our survey question on death and dying reported experiencing the death of a resident at some time during their work week, and half of these reported experiencing a resident death on every shift or almost every shift. The nurse aides we spoke with in-person said that they were not prepared for helping residents at the end of life, and often felt helpless in reducing their pain and making them comfortable. Nurse aides also talked about their own difficulty in dealing with the grief they experienced when a resident under their care had passed away. Based on our conversations with nurse aides, it appears that some training programs cover the topic of death and dying in more detail than others. To address this issue, one nursing home that we visited is conducting a demonstration program consisting of 45 hours of training in end-of life care.

Training has not kept pace with nursing home practices and new technologies

During our discussions with nursing home supervisors, nurse aides, and nurse aide trainers, we learned that nurse aide training curriculum and testing may not reflect the current practice in nursing homes. The nursing home supervisors we spoke with mentioned that a lot more technology is being used in nursing homes today than a decade ago. These supervisors and the experts we spoke with agree that nurse aides need training on newer technologies during their initial training. A 1996 Institute of Medicine report states that medical technologies, such as intravenous feedings, ventilators, and oxygen, are now being used extensively in nursing homes. Previously, these medical technologies were available only in a hospital setting. The report further noted that these services require more nursing care, judgment, and supervision than in the past.

Nurse aides told us that they were taught outdated practices and how to use outdated equipment. They believe that the time spent learning these obsolete skills could be better spent on skills needed to care for today's nursing home residents. They specifically mentioned that time would be better spent not only on resident care skills but also on communication, teamwork, and advances in disease treatment.

While not asked specifically about outdated practices, 2 out of 14 nurse aide trainers expressed frustration with outdated curricula and tests. These trainers complained about having to "teach to the test," instructing nurse aides how to perform obsolete procedures so that trainees can pass exams. An example was a change in a State regulation with respect to the use of side rails; however, the change was not reflected in the nurse aide curriculum for that State. The trainers say they teach this procedure twice: once, so that the nurse aide can pass the test, and once, to allow nurse aides to adhere to State regulations.

Teaching methods are often ineffective, clinical exposure is too short and unrealistic

Over half the States require more than 75 hours

Although Federal law requires that State-approved nurse aide training programs consist of at least 75 hours of total instruction, 40 of 49 State NATCEP directors believe that 75 hours of nurse aide training is not sufficient to prepare nurse aides for their first day on the job. Twenty-six States have already extended their nurse aide training programs beyond the 75 hours required by Federal law. These State nurse aide training programs that were extended run from 76 hours to 175 hours (see Appendix D).

Of the States that have minimum 75-hour programs, two-thirds of our State respondents believe that the number of training hours in their State is too low. These respondents report having difficulty justifying more hours to their State legislature when the Federal requirement is only 75 hours. Some of these respondents argue that nurse aides have to care for "terribly debilitated people" and require classroom instruction in many topics and resident care skills that may not be adequately addressed within 75 hours. As one NATCEP director said, "I believe it is unreasonable to expect students to assimilate all the material in 75 hours."

Respondents seek improved clinical experience

When asked how nurse aide training programs could be improved, the overwhelming response provided by our respondent groups was that nurse aides needed more and better clinical exposure. Nursing home supervisors (18 of 29) reported that nurse aides were not ready to begin work on the nursing home floor upon completion of nurse aide training, and needed more clinical exposure. In addition, 10 of 17 supervisors who hire nurse aides from community colleges and other non-facility based training sites said that these nurse aides were not adequately prepared for their first day on the job. We were

told that this may be due, in part, to difficulties that some private programs have in arranging clinical training at nursing homes.

Nurse aides themselves reported dissatisfaction with their clinical experience during training. Fifty percent of nurse aide survey respondents, who reported not being satisfied with their clinical training, cited not enough time on the floor, a lack of "hands on" training and unrealistic training scenarios. During our in-person interviews with nurse aides and in the focus group, nurse aides frequently told us that they needed to experience, or at least witness, real-life scenarios during clinical training so that they would not be surprised or alarmed when something (such as a combative resident striking out at them) occurred on the job.

Nurse aide training programs often do not expose students to the full range of resident care demands that they will experience in a nursing home environment. One nurse aide student told us that he was alarmed and felt unprepared when he had to change a resident after they had soiled themselves. We were repeatedly told that training focuses on acquiring skills needed to pass the State exam. Other skills needed for the job may receive only limited coverage during their initial training.

Nurse aides also told us about ineffective teaching methods they encountered during their training. Participants in our focus group of 17 nurse aides told us that watching videos during training did not give them a realistic picture of the job. Once they started working, they realized there were far more demands than the videos portrayed. They described the videos as "sugarcoated" and "unrealistic," often depicting a nurse aide "grooming a resident." These nurse aides reported having a difficult time once they started a job, and realized what a full day's work entails.

Early clinical exposure prepares and screens students

Nearly all (26 of 29) nursing home supervisors stressed the importance of clinical training, and three supervisors specifically mentioned that an earlier introduction to the nursing home floor (or clinical skills) would greatly improve the preparedness of nurse aides. Nursing home supervisors believe that early exposure to resident care will help to screen out those nurse aide students who cannot handle the real-life stressful situations demanded by the job.

Federal and State funds are wasted by the large numbers of students who are trained each year and drop out when exposed to the realities of the nurse aide job. Of the nursing homes we visited for this study, 12 conducted onsite training programs. The completion rates from their most recent nurse aide training class ranged from 20 to 100 percent. Four nursing homes reported that more than 70 percent of the students in their training

programs dropped out when exposed to the actual realities of caring for a nursing home resident. Three nursing homes reported that in earlier nurse aide training classes, no student completed the training course. It appears that early, realistic exposure to the job requirements helps to "weed out" nurse aide students, who may not be the most appropriate job candidates.

Respondents cite ineffective teaching methods and formats

We heard complaints about large classrooms and limited or no exposure to the actual job requirements. Respondents felt that the following teaching methods and formats *impeded* nurse aide training:

- poor instructional videotapes and presentations
- too much medical technology jargon
- classes "taught over the heads" of students
- failure to recognize diversity or backgrounds of students, including language barriers
- emphasis on tasks, rather than interpersonal communication skills
- teaching skills that will not be used often
- lack of feedback on the quality of the program
- training which lacks geriatric framework
- one-size-fits-all approaches to teaching
- limited time to practice clinical skills

The teaching of nurse aides varies by site. The actual instructor of the program may not be the person listed on the application to the State, and this person may not have any experience in adult education. While all States report that they periodically visit training sites, few reported that they do so to assess the quality of instruction. Only five States report that they make some effort to evaluate instructor or training effectiveness.

In our discussions with nurse aides during our on-site visits, nurse aides said that they preferred instructors who included personal examples or anecdotes from their past nursing home jobs. Instructors who were willing to be candid, and those who did not mince unpleasant details were among those considered to be the most helpful.

In-service training may not be meeting Federal requirements

We had difficulty determining whether nursing homes are meeting the Federal requirement that in-service training address areas of weakness for individual nurse aides. Federal in-service training regulations[18] do not define how in-service training should be documented. Our review of in-service training at 29 nursing homes disclosed that training log documentation was not consistent across nursing homes. Only 8 of the 29 nursing homes we visited had documentation about why in-service sessions were held. We also learned that nursing homes sometimes conduct informal one-on-one or unit-specific training to immediately address any skill deficiencies, but this information was not regularly recorded in the in-service logs we reviewed.

When we spoke with nurse aides in a focus group setting, we learned that in-service is not always looked upon favorably. During an in-depth discussion on the subject, almost half of the participants believed that in-service education sessions were not very helpful. They reported that in-service sessions were often repetitious and sometimes not relevant to everyday work situations. Furthermore, aides stated that in-service training occasionally consisted of reading and signing a bulletin board on a training topic (whether or not the information was understood), rather than absorbing the material through class participation.

Long-term care ombudsmen and experts we spoke with also expressed concerns about in-service education. They reported that nursing home supervisors tend to view in-service sessions as cutting into resident care, and that nurse aides or nursing home staff do not view the classes as a way to improve their skills. Often, nurse aides are not covered on the floor when they attend in-service sessions, so they are thinking about the work waiting for them when they get back to the floor, rather than concentrating on the class material. Ombudsmen also stated that insufficient time is devoted to in-service training, which reduces its effectiveness.

Respondents offered suggestions for improving in-service training

Nursing homes we visited highlighted the various methods they employ to improve in-service training for nurse aides:

- Using educational tools, such as realistic videos, workbooks, interactive computer programs, and games.

[18] 42 CFR §483.75

- Having a system for documenting individual nurse aide training needs that indicates a problem area, and outlines the intervention taken to remedy the problem. This system is used when making decisions about in-service training needs.
- Providing crisis intervention training to help nurse aides deal with the emotional aspects of the job.
- Having nurse aides participate in pharmaceutical in-service training to understand behavior changes and side effects of drugs.
- Involving other nursing home staff and healthcare professionals in in-service education. For example, using the social service director to talk about residents' psycho-social needs, or having the long-term care ombudsman come in to talk about resident's rights.
- Having nurse aides involved in the planning and presentation of the in-service sessions (peer teaching).
- Having family members come and talk to aides about their concerns regarding care of their relatives, and having nurse aides interact with families to help improve communication.
- Holding short in-service training every week (usually 15-30 minutes in length) or holding impromptu in-service training for specific units and for specific staff.
- Offering in-service training on all shifts to accommodate nurse aide schedules.

Nurse aides play an important role in the overall resident care team because they have the most interaction with the residents. Nursing homes differ as to the amount of resources they have to invest in in-service training, and not every home has the capacity to implement these best practices. Nevertheless, the nursing home supervisors and trainers we spoke with highlighted the above practices as creating positive changes for nurse aides working in their homes, and they thought other nursing homes might benefit from exploring similar practices for their staff.

CONCLUSION AND RECOMMENDATION

Responses from 29 nursing home supervisors, 14 nurse aide trainers, 5 long-term care ombudsmen, 3 academicians, and 5 experts (39 of all these respondents were licensed or registered nurses) show that the nurse aide training curriculum needs to be updated, and clinical experience needs to occur earlier and needs to be more realistic. Responses from nearly 1,000 nurse aides and 48 State directors of nurse aide training programs also indicate that nurse aide training programs need improvement. Although the nursing home environment has changed considerably since OBRA 87 nurse aide training regulations were implemented, nurse aide training has not kept pace with nursing home resident needs.

We are recommending that CMS:

Improve nurse aide training and competency evaluation program requirements

- Ensure that the content of the nurse aide training curriculum and testing (as described in 42 CFR Part 483) remains relevant to today's complex resident care needs. Strengthen nurse aide training by recognizing current nurse aide needs, and by embracing modern technologies and equipment. Consider enhancing the communication and interpersonal skills of nurse aides (i.e., by including training in time management and teamwork).

- Continue to work with States to assure that nurse aide training is effective and efficient. This collaborative effort could include (but not be limited to) increasing the ratio of clinical hours and ensuring that clinical experience occurs earlier in the training period, is more realistic, and includes a full range of skills needed on the job.

- Ensure that nursing homes are in compliance with in-service training requirements. Revise 42 CFR §483.75 to include a requirement for nursing homes to document that in-service training is conducted to address weaknesses identified in nurse aides' performance reviews.

AGENCY COMMENTS

The draft of this report was reviewed by CMS, and the agency concurred with our recommendations. In concurring with our recommendations, CMS stated that the agency's own independent study reached essentially the same conclusions as found in our study. The CMS reports that the agency has a contract in place to examine nurse aide training curriculum, content, and skills. The CMS also intends to develop specific policy and programmatic options for improving the administration of nurse aide training programs and for ensuring that nursing home in-service training complies with regulatory requirements.

Some grammatical and technical changes were also made to this report following receipt of CMS's comments. The full text of CMS's comments can be found in Appendix A.

APPENDIX A

Centers for Medicare & Medicaid Services
Comments on the Draft Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

RECEIVED
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OFFICE OF INSPECTOR GENERAL

DATE: OCT - 4 2002

TO: Janet Rehnquist
Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Nurse Aide Training" (OEI-05-01-00030)

Thank you for the opportunity to review and comment on the above-referenced draft report regarding whether nurse aide training prepares nurse aides for their jobs in nursing homes. The Centers for Medicare & Medicaid Services (CMS) appreciates the effort that went into this report.

OIG Recommendation

Improve nurse aide training and competency evaluation program requirements.

- Ensure that the content of the nurse aide training curriculum and testing (as described in 42 CFR Part 483) remains relevant to today's complex resident care needs. Strengthen nurse aide training by recognizing current nurse aide needs, and by embracing modern technologies and equipment. Consider enhancing the communication and interpersonal skills of nurse aides (i.e., by including training in time management and team work).

CMS Response

In the Phase II Staffing Report, we examined a number of staffing-related factors including the training and supervision of nurse aides (NAs). The methods employed in our analysis included a review of the literature; consultation with nursing assistants, trainers, researchers, policymakers and other experts in the field of nursing assistant training; field observations of nursing assistant training programs; and interviews of nursing facility staff who hire newly certified nursing assistants or are responsible for ongoing education and training of nursing assistants. In general, our findings are in agreement with those provided in this report. Our analysis concluded that the job of a nursing home NA is relatively complex and requires comprehensive initial training supported by ongoing supervision and education.

We have a contract in place to more thoroughly examine specific aspects of nurse aide training including curriculum content, incorporation and exposure of current technology, and the expansion of skill sets. We have attached a copy of the scope of work for this contract in order to provide more detail about this effort.

- Continue to work with States to assure that nurse aide training is effective and efficient. This collaborative effort should include (but not be limited to) increasing the ratio of clinical hours and ensuring that clinical experience occurs earlier in the training period, is more realistic, and includes a full range of skills needed on the job. If States identify and agree that certain Federal laws or regulations are impediments to training, CMS should work with States to sponsor new legislation or change regulations to eliminate Federal impediments.

CMS Response

The administration of nurse aide training programs like the nurse aide training curriculum is an area we also found problematic. We intend under our current contract effort to more extensively document the problem and develop specific policy and programmatic options for improvement.

- Ensure that nursing homes are in compliance with in-service training requirements. Revise 42 CFR §483.75 to include a requirement for nursing homes to document that in-service training is conducted to address weaknesses identified in nurse aides' performance reviews.

CMS Response

We concur with this recommendation and will consider the appropriate vehicles to implement a response. This would include proposing to add a requirement that nursing homes document that in-service training is conducted to address weaknesses identified in nurse aides' performance reviews in a future update to the conditions of participation for long term care facilities.

Attachment

APPENDIX B

Characteristics of Participating Nursing Homes

The tables on the following pages provide descriptive information about the nursing homes in the five States that we visited during this inspection. The information was obtained using the Online Survey, Certification, and Reporting System (OSCAR), except where noted. The deficiency information was obtained from the results of each nursing home's most recent survey, as reported in the OSCAR database.

Table 1--Florida Nursing Homes In Our Sample

Nursing Home Characteristics	**FL1**	**FL2**	**FL3**	**FL4**	**FL5**	**FL6**
Approximate Number of Nurse Aides[19]	12	28	71	79	30	134
Nurse Aide Survey Response Rate	83% (n=10)	54% (n=15)	87% (n=62)	84% (n=66)	0% (n=0)	7% (n=10)
In-House Training Program	No	Yes	No*	No*	No	No*
Total Number of Certified Beds	29	80	179	153	76	212
Total Number of Residents[20]	29	74	162	165	57	209
Type of Ownership	NFP-Corp	FP-Corp	NFP-Corp	FP-Corp	NFP-Corp	NFP-Corp
Located Within a Hospital	Yes	No	No	No	No	No
Overall Deficiencies	3	4	10	4	9	18
Health Deficiencies	2	3	5	4	8	13
Date of Most Recent Survey	9/26/01	7/19/01	12/15/00	6/22/01	7/3/01	6/14/01

* These nursing homes have a local technical college provide training, but the classes and clinical trainings are conducted at the nursing home.

[19] This information was provided to us by the nursing homes we visited.

[20] This number reflects the resident census on the date of the nursing homes most recent survey.

Table 2--Louisiana Nursing Homes In Our Sample

Nursing Home Characteristics	**LA1**	**LA2**	**LA3**	**LA4**	**LA5**	**LA6**
Approximate Number of Nurse Aides[21]	53	125	20	61	36	14
Nurse Aide Survey Response Rate	23% (n=12)	38% (n=48)	35% (n=7)	20% (n=12)	67% (n=24)	100% (n=14)
In-House Training Program	No	No	Yes	Yes	No	No
Total Number of Certified Beds	117	200	171	120	64	66
Total Number of Residents[22]	110	172	171	118	63	32
Type of Ownership	NFP-Church Related	NFP-Church Related	NFP-Corp	FP-Corp	NFP-Other	FP-Corp
Located Within a Hospital	No	No	No	No	No	Yes
Overall Deficiencies	5	9	9	19	15	1
Health Deficiencies	0	1	0	16	12	0
Date of Most Recent Survey	1/18/01	2/1/01	9/14/01	2/9/01	4/25/01	9/13/01

[21] This information was provided to us by the nursing homes we visited. When they did not provide this information, we used the number of nurse aide surveys sent to the nursing home.

[22] This number reflects the resident census on the date of the nursing homes most recent survey.

Table 3--Minnesota Nursing Homes In Our Sample

Nursing Home Characteristics	**MN1**	**MN2**	**MN3**	**MN4**	**MN5**	**MN6**
Approximate Number of Nurse Aides[23]	85	197	50	24	93	54
Nurse Aide Survey Response Rate	85% (n=72)	62% (n=123)	24% (n=12)	25% (n=6)	43% (n=40)	61% (n=33)
In-House Training Program	No	Yes	No	No	No	Yes
Total Number of Certified Beds	303	559	93	54	200	134
Total Number of Residents[24]	301	555	75	52	193	126
Type of Ownership	NFP-Church Related	NFP-Corp	FP-Corp	FP-Corp	FP-Corp	FP-Individual
Located Within a Hospital	No	No	No	No	No	No
Overall Deficiencies	1	0	7	4	5	0
Health Deficiencies	1	0	7	4	5	0
Date of Most Recent Survey	6/8/01	2/1/01	2/2/01	4/2/01	3/1/01	2/15/01

[23] This information was provided to us by the nursing homes we visited. When they did not provide this information, we used the number of nurse aide surveys sent to the nursing home.

[24] This number reflects the resident census on the date of the nursing homes most recent survey.

Table 4--New York Nursing Homes In Our Sample

Nursing Home Characteristics	**NY1**	**NY2**	**NY3**	**NY4**	**NY5**
Approximate Number of Nurse Aides[25]	228	230	77	111	346
Nurse Aide Survey Response Rate	20% (n=46)	1% (n=2)	21% (n=16)	55% (n=61)	31% (n=106)
In-House Training Program	Yes	No	Yes	Yes	Yes
Total Number of Certified Beds	561	1389	81	262	705
Total Number of Residents[26]	523	1366	82	256	686
Type of Ownership	FP-Individual	Govt-City/ County	NFP-Corp	NFP-Corp	NFP-Corp
Located Within a Hospital	No	Yes	No	No	No
Overall Deficiencies	2	10	5	6	2
Health Deficiencies	1	2	3	3	1
Date of Most Recent Survey	5/5/00	1/31/00	7/17/01	8/15/01	1/24/01

[25] This information was provided to us by the nursing homes we visited. When they did not provide this information, we used the number of nurse aide surveys sent to the nursing home.

[26] This number reflects the resident census on the date of the nursing homes most recent survey.

Table 5--Washington Nursing Homes In Our Survey

Nursing Home Characteristics	**WA1**	**WA2**	**WA3**	**WA4**	**WA5**	**WA6**
Approximate Number of Nurse Aides[27]	85	24	37	73	102	160
Nurse Aide Survey Response Rate	22% (n=19)	36% (n=15)	51% (n=19)	5% (n=4)	0% (n=0)	22% (n=35)
In-House Training Program	No	Yes	No	No	No	Yes
Total Number of Certified Beds	22	117	129	135	190	215
Total Number of Residents[28]	144	70	94	124	168	200
Type of Ownership	NFP-Other	FP-Corp	FP-Partnership	FP-Corp	FP-Corp	NFP-Church Related
Located Within a Hospital	No	No	No	No	No	No
Overall Deficiencies	17	15	10	29	14	14
Health Deficiencies	14	12	10	24	14	6
Date of Most Recent Survey	10/16/00	5/24/01	5/21/01	8/31/01	4/24/01	11/21/00

[27] This information was provided to us by the nursing homes we visited. When they did not provide this information, we used the number of nurse aide surveys sent to the nursing home.

[28] This number reflects the resident census on the date of the nursing homes most recent survey.

APPENDIX C

Demographics of Nurse Aide Respondents

The following demographic information characterizes the nurse aides who responded to our survey.

Characteristic	Data Point	Number of Respondents
Age (mean)	36	793
Gender	84% female	859
High school graduation or greater	92%	820
Hourly wage (mean)	$10.33	751
Minorities	65%	775
Household income of $15,000 or less	32%	631
Working as a nurse aide for 3 years or more	70%	868

APPENDIX D

Hours of Training by State

State	Minimum Training Hours (Total)	Minimum Clinical Hours
Alaska	140	80
Alabama	75	16
Arkansas	75	16
Arizona	120	16
California	150	100
Colorado	75	16
Connecticut	100	50
District of Columbia	120	not specified
Delaware	75	37.5
Florida	120	40
Georgia	85	16
Hawaii	did not respond to survey	did not respond to survey
Iowa	75	30
Idaho	120	40
Illinois	120	40
Indiana	105	75
Kansas	90	45
Kentucky	75	16
Louisiana	80	40
Massachusetts	did not respond to survey	did not respond to survey

APPENDIX D

Hours of Training by State

State	Minimum Training Hours (Total)	Minimum Clinical Hours
Maryland	100	40
Maine	150	50
Michigan	75	16
Minnesota	75	37.5
Missouri	175	100
Mississippi	75	16
Montana	75	25-30
North Carolina	75	16
North Dakota	75	16
Nebraska	76	not specified
New Hampshire	100	60
New Jersey	90	40
New Mexico	75	not specified
Nevada	75	not specified
New York	100	30
Ohio	75	16
Oklahoma	75	16
Oregon	150	75
Pennsylvania	75	37.5

APPENDIX D

Hours of Training by State

State	Minimum Training Hours (Total)	Minimum Clinical Hours
Rhode Island	100	20
South Carolina	80	40
South Dakota	75	16
Tennessee	75	35
Texas	75	24
Utah	80	16
Virginia	120	40
Vermont	75	16
Washington	85	50
Wisconsin	75	16
West Virginia	120	55
Wyoming	75	48

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John Traczyk, *Project Leader*
Dennis Tharp, *Lead Analyst*
Tricia Fields, *Program Analyst*
Erin Guay, *Program Analyst*

Stuart Wright, *Director, Medicare and Medicaid Branch*
Sandy Khoury, *Program Specialist*
Bambi Straw, *Program Specialist*
Barbara Tedesco, *Mathematical Statistician*

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