[COMMITTEE PRINT]

94th Congress
1st Session

SENATE

REPORT
No. 94-00

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

Supporting Paper No. 4

NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)

PREPARED BY THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

APRIL 1975

Printed for the use of the Special Committee on Aging

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PREFACE

Federal support of long-term care for the elderly has, within a decade, climbed from millions to billions of dollars.

What is the Nation receiving for this money?

This report explores that, and related questions.

It concludes that public policy has failed to produce satisfactory institutional care—or alternatives—for chronically ill older Americans.

Furthermore, this document—and other documents to follow—declare that today's entire population of the elderly, *and their offspring*, suffer severe emotional damage because of dread and despair associated with nursing home care in the United States today.

This policy, or lack thereof, may not be solely responsible for producing such anxiety. Deep-rooted attitudes toward aging and death also play major roles.

But the actions of the Congress and of States, as expressed through the Medicare and Medicaid programs, have in many ways intensified old problems and have created new ones.

Efforts have been made to deal with the most severe of those problems. Laws have been passed; national commitments have been made; declarations of high purpose have been uttered at national conferences and by representatives of the nursing home industry.

But for all of that, long-term care for older Americans stands today as the most troubled, and troublesome, component of our entire health care system.

It is costly and growing costlier.

It is increasing in numbers, already providing more beds than there are beds in general hospitals.

And there is every reason to believe that many more beds will be needed because the population of old persons in this Nation continues to grow faster than any other age group.

Nursing home care is associated with scandal and abuse, even though the best of its leaders have helped develop vitally needed new methods of care and concern for the elderly, and even though—day in and day out—underpaid, but compassionate, aides in many homes attempt to provide a touch of humanity and tender care to patients who, though mute or confused and helpless, nevertheless feel and appreciate kindness and skill.

This industry, which has grown very rapidly in just a few decades—and most markedly since 1965, when Medicare and Medicaid were enacted—could now take one of three courses:

> It could continue to grow as it has in the past, spurred on by sheer need, but marred by scandal, negativism, and murkiness about its fundamental mission.

It could be mandated to transform itself from a predominantly proprietary industry into a nonprofit system, or into one which takes on the attributes of a quasi-public utility.

Or it could—with the informed help of Government and the general public—move to overcome present difficulties, to improve standards of performance, and to fit itself more successfully into a comprehensive health care system in which institutionalization is kept to essential minimums.

Whatever course is taken, it is certain that the demand for improvement will become more and more insistent.

Within the Congress, that demand has been clearly expressed in recent years. But often congressional enactments have been thwarted by reluctant administration, or simply have been ignored. Now, facing the prospect of early action upon a national health program for all age groups, the Congress must certainly consider long-term care a major part of the total package. Wisely used, the momentum for a total health care package could be used to insure better nursing home care.

Within the administration, there has been drift and unresponsiveness to congressional mandate since 1965. There are signs, however, that rising costs and rising public concern have aroused certain members of the executive branch to see the need for long-term care reform more clearly than before. Their actions and initiatives are welcome, but it is essential that the Department of Health, Education, and Welfare take far more effective, well-paced action than it has thus far.

Everywhere, the demand for reform is intensifying. People know that a nursing home could be in everyone's future.

They ask why placement in such a home should be the occasion for despair and desperation, when it should be simply a sensible accommodation to need.

The Subcommittee on Long-Term Care of the Senate Special Committee on Aging continually has asked the same question.

Care for older persons in need of long-term attention should be one of the most tender and effective services a society can offer to its people. It will be needed more and more as the number of elders increases and as the number of very old among them rises even faster.

What is needed now? As already indicated, the forthcoming debate over a national health program will offer opportunity for building good long-term care into a comprehensive program for all Americans.

But the issues related to the care of the chronically ill are far from simple. Tangled and sometimes obscure, technical questions related to such matters as reimbursement, establishment of standards, enforcement, and recordkeeping, often attract the attention of policymakers, to the exclusion of other questions, such as:

Could nursing homes be avoided for some, if other services were available?

What assurance is there that the right number of nursing homes are being built where they are most needed?

What measures can Government take to encourage providers themselves to take action to improve the quality of nursing home care?

What can be done to encourage citizen action and patient advocacy at the local level?

Such questions intrude even when the best of care is given. In other settings, however, scandal and calamity enter the picture; and dark new questions emerge.

The subcommittee, in this report and succeeding Supporting Papers, recognizes the importance of the nursing home industry; and it pledges every effort to continue communication with representatives of the industry and with members of the executive branch.

For these reasons, the subcommittee has devised an unusual format: After publication of the Introductory Report, a series of follow-up papers on individual issues will follow; then we will publish a compendium of statements invited from outside observers; after this will come our final report. In this way, the subcommittee can deal with the many parts needed to view long-term care as a whole.

Testimony from many, many days of hearings and other research have been tapped for this report, which is extensive and heartfelt. Concern about people has been at the heart of this effort. The subcommittee has, therefore, been especially dependent upon responsive staff effort. Mr. Val Halamandaris, associate counsel for the Senate Special Committee on Aging, deserves specific mention for his role in assuring that subcommittee inquiries remained directed at their real target: to wit, people in need of good care. Mr. Halamandaris has had the primary responsibility for directing the subcommittee's hearings: he is responsible for the excellent research on data and for writing this report. He is more than a skilled and attentive attorney; his investigatory skills are rooted in concern and, when necessary, outrage. He has made it possible for this subcommittee to compile and offer more information and insights into the nursing home industry than the Congress has ever had before.

He has been helped considerably by other committee personnel. Staff Director William Oriol has provided guidance and consultation leading to the design and special points of emphasis in this report. Committee Counsel David Affeldt has given generously of his legislative expertise, as well as painstaking attention to detail.

Particularly fortunate for the subcommittee was the fact that a professional staff member, John Edie, had special qualifications for making a substantial contribution to this effort. Mr. Edie, an attorney, formerly served as counsel to a program on aging in Minneapolis, Minn. When the subcommittee went to that city for intensive hearings on scandalous shortcomings in nursing home care there, Mr. Edie testified and then continued his efforts on behalf of reform. In the preparation of this report, he has worked closely and at length with Mr. Halamandaris and his associates.

The subcommittee also stands in debt to a select group in the nursing home industry and within the executive branch. Usually without much

attention or encouragement, these public servants have stubbornly refused to compromise their goal, seeking high, but reasonable, standards of care.

With the publication of the Introductory Report, the subcommittee begins a final exploration of issues. We will publish responsible comments on findings expressed in this document and the Supporting Papers which precede and will follow. And we will, in our final report, perhaps 8 to 10 months from now, make every effort to absorb new ideas or challenges to our findings. The care of chronically ill older Americans is too serious a topic for stubborn insistence upon fixed positions. Obviously, changes are needed. Obviously, those changes will occur only when public understanding and private conscience are stirred far more than is now the case.

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

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NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

SUPPORTING PAPER NO. 4

NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)

ABOUT THIS REPORT

To deal with the intricate circumstances and governmental actions associated with nursing home care in this Nation, the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging is issuing several documents under the general title of *Nursing Home Care in the United States: Failure in Public Policy.*

An Introductory Report, published in November, declared that a coherent, constructive, and progressive policy on long-term care has not yet been shaped by the Congress and by the executive branch of this Nation.

Examining the role of Medicare and Medicaid in meeting the need for such care, the report found that both programs are deficient.

Further, it raised questions about current administration initiatives originally launched personally by President Nixon in 1971.

These shortcomings of public policy, declared the report, are made even more unfortunate by the clear and growing need for good quality care for persons in need of sustained care for chronic illness. It called for good institutions and, where appropriate, equally good alternatives, such as home health services.

(A more detailed summary of major findings from the Introductory Report appears later in this section of this report.)

Supporting Paper No. 4 is in three parts.

Part 1 examines the heavy burden on the nurses working in today's nursing homes and examines the effects of reliance on untrained and unlicensed personnel.

Part 2 contains an important new report prepared by the American Nurses' Association at the request of Subcommittee Chairman Senator Frank E. Moss. ANA's Committee on Skilled Nursing Care conducted 10 regional hearings and called 3 national conferences attended by 22 organizations most involved with the care of the aged. The report examines national policy with respect to long-term care, alternatives to institutionalization and the role of nurses and other health care workers in long-term care.

Part 3 contains recommendations by the Subcommittee on Long-Term Care.

THE FACTUAL UNDERPINNING OF THIS STUDY

Fifteen years of fact-gathering preceded publication of this report. In 1959, the Senate Committee on Labor and Public Welfare established a Subcommittee on Problems of the Aged and Aging. Findings from subcommittee reports and hearings have been evaluated. That subcommittee acknowledged in 1960, as this report acknowledges in 1974, that nursing homes providing excellent care with a wide range of supportive services are in the minority.

With the establishment of the U.S. Senate Special Committee on Aging in 1961, additional hearings were conducted. The most recent phase began in 1969 with hearings on "Trends in Long-Term Care." Since 1969, 22 hearings were held and some 3,000 pages of testimony were taken, as of October 1973.

These hearing transcripts have provided valuable information and expert opinions, as have several supplementary studies by the subcommittee staff, the General Accounting Office and private groups such as Ralph Nader's Study Group on Nursing Homes in 1971. The Library of Congress and other congressional committees, as well as professional organizations such as the American Nursing Home Association, have also been helpful. Finally, a great portion of the data is from the Department of Health, Education, and Welfare and other administrative or independent agencies, such as the Securities and Exchange Commission. The assistance of State officials proved especially helpful.

ORGANIZATION OF THIS STUDY

The Introductory Report and this Supporting Paper will be followed by other Supporting Papers to be published at approximately monthly intervals over the next few months. Each will deal with a fairly specific issue, and each of these issues will be examined in the detail needed for understanding, not only by legislative and health specialists, but by laymen.

A study of this magnitude would be incomplete without reaction by the nursing home industry and by representatives of the executive branch. Accordingly, national organizations and appropriate governmental units will be invited to submit statements within 2 months after publication of the final Supporting Paper. Finally, the subcommittee will issue a concluding report intended to update earlier information and to analyze the situation at that time.

The format is unusual, perhaps unprecedented. But the nursing home industry is too vital a part of our health system and of the national scene for lesser treatment.

MAJOR POINTS OF THIS SUPPORTING PAPER

There are few nurses in the Nation's 23,000 nursing homes. Of the 815,000 employed registered nurses (RN's) in the Nation, only 65,235 can be found in U.S. long-term care facilities.

There are many reasons why this is true:

● There is a general nurse shortage. The U.S. Department of Labor estimates the need for 150,000 more RN's. Others claim it is simply a matter of maldistribution or that the 400,000 RN's presently out of the work force could be induced into service—given better wages and working conditions. Still others assert that if there is a shortage it is because nurses are required to spend their time with administrative duties and paperwork rather than with patients.

● Few nurses are required by law. At present the Federal standard requires only the 7,300 Skilled Nursing Facilities in the United States to have an RN as their highest nursing officer—and this only applies to the day shift. The 8,200 Intermediate Care Facilities are required to have only a licensed practical nurse in charge—again only during the day shift. The remianing 7,500 facilities need have no "licensed" nursing officer at all. To make matters worse, there are no requirements for ratios between nurses and patients in Federal regulations. By contrast the State of Connecticut requires one RN for every 30 patients on the day shift, one for every 45 on the afternoon and one for every 60 in the evening.

● Poor working conditions. RN's working in nursing homes do not have the support of physicians and trained personnel that they find in hospitals. Many nursing homes are poorly administered and there is a lack of authority vested in the nursing service department. A very real problem is the fact that nursing homes are isolated from other health care facilities.

● Nursing homes have a poor image. "Hospitals have their pick while nursing homes take what they can get," is a common statement among nursing home employees. An RN who goes to work in a nursing home will often be asked, "Why are you here? Where did you foul up?"

● Wages and fringe benefits are low. The consensus is that nursing homes do less well in compensating nurses than other health care entities. Many nursing homes also lag behind in fringe benefits, stimulating nursing personnel to seek work elsewhere.

● Nurses have little training in geriatrics and the needs of nursing home patients and are therefore unprepared to work in long-term care facilities. Of the over 1,000 schools of nursing surveyed by the Subcommittee, only 27 responded that they had a program wherein geriatrics was treated as a specialty.

● There are no graduate programs in geriatic or gerontology nursing. Federal government programs likewise neglect geriatrics. In 1970 there were 144 programs for the training of nurses and health care personnel administered by 13 agencies. None of these programs emphasized geriatrics.

It goes without saying that the few nurses working in nursing homes are grossly overworked. Because they are overworked or simply not present in significant number, the result is the reliance on aides and orderlies to provide 80 to 90 percent of the care in nursing homes.

• Only one-half of the 280,000 aides and orderlies are high school graduates. Most have no training. Most have no previous experience. They are grossly overworked and paid the minimum wage. It is little wonder that they show a turnover rate of 75 percent a year. Put simply the absence of RN's and the reliance on untrained aides and orderlies result in poor care. Poor care runs the gamut from essential tests not being performed to negligence leading to death and injury.

• In Illinois, an investigator sought employment as a nursing home janitor. Within 20 minutes he was hired, not as a janitor, but as a nurse; he carried the keys to the medication and narcotics cabinet on his belt and distributed drugs to patients. His references were never checked. He never represented that he had any prior experience.

• In Minnesota, aides were instructed how to distribute drugs "in case of an emergency." The "emergency" began the next day; aides continued distributing drugs even though this constituted a violation of Federal regulations and Minnesota law.

• A recent national HEW study notes that some 37 percent of the patients taking cardiovascular drugs had not had a blood pressure reading for more than a year. More than 25 percent of this number who were receiving heart medication had no diagnosis of heart disease on their charts. Some 35 percent of those taking tranquilizers which might lower the blood pressure markedly had not had a pressure reading in more than a year.

The solution for these problems lies in greater emphasis on geriatrics in schools of nursing and in government programs training health care personnel. Funds should also be provided for the in-service training of nursing home personnel.

This paper also contains a major report analyzing the role of nurses in long-term care facilities prepared by the Committee on Skilled Nursing of the American Nurses' Association. See highlights, Part 2, pages 385–417.

MAJOR POINTS OF INTRODUCTORY REPORT

(Issued November 19, 1974)

Medicaid now pays about 50 percent of the Nation's more than $7.5 billion nursing home bill, and Medicare pays another 3 per-

cent. Thus, about $1 of every $2 in nursing home revenues is publicly financed.*

There are now more nursing home beds (1.2 million) in the United States today than general and surgical hospital beds (1 million).

In 1972, for the first time, Medicaid expenditures for nursing home care exceeded payments for surgical and general hospitals: 34 percent to 31 percent.

Medicaid is essential for growing numbers of elderly, particularly since Medicare nursing home benefits have dropped sharply since 1969. Average Social Security benefits for a retired couple now amount to $310 a month compared to the average nursing home cost of $600. Medicaid (a welfare program) must be called upon to make up the difference.

The growth of the industry has been impressive. Between 1960 and 1970, nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and expenditures for care by 465 percent. Measured from 1960 through 1973, expenditures increased almost 1,400 percent.

Despite the heavy Federal commitment to long-term care, a coherent policy on goals and methods has yet to be shaped. Thousands of seniors go without the care they need. Others are in facilities inappropriate to their needs. Perhaps most unfortunate, institutionalization could have been postponed or prevented for thousands of current nursing home residents if viable home health care and supportive services existed. Although such alternative forms of care may be more desirable from the standpoint of elderly patients—as well as substantially less expensive—the Department of HEW has given only token support for such programs.

Despite the sizable commitment in Federal funds, HEW has been reluctant to issue forthright standards to provide patients with minimum protection. Congress in 1972 mandated the merger of Medicare and Medicaid standards, with the retention of the

*The Committee's Introductory Report, as released on November 19, 1974, incorporating the latest statistics from HEW reported that total revenues for the nursing home industry in 1972 were $3.2 billion and $3.7 billion for 1973. Subsequent to publication of this report the Social Security Administration released new estimates for 1974. Total expenditures are estimated at $7.5 billion. This change reflects spending for the Intermediate Care program, which until recently was a cash grant program to old age assistance recipients. With its change to a vendor payments program such expenses are properly countable as nursing home expenditures. Consequently, changes were made in this report.

highest standard in every case. However, HEW then watered down the prior standards. Most leading authorities concluded at subcommittee hearings that the new standards are so vague as to defy enforcement.

There is no direct Federal enforcement of these and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the enforcement system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.

The President's program for "nursing home reform" has had only minimal effect since it was first announced in 1971 and actions in 1974 fall far short of a serious effort to regulate the industry.

The victims of Federal policy failures have been Americans who are desperately in need of help. The average age of nursing home patients is 82; 95 percent are over 65 and 70 percent are over 70; only 10 percent are married; almost 50 percent have no direct relationship with a close relative. Most can expect to be in a nursing home over 2 years. And most will die in the nursing home. These patients generally have four or more chronic or crippling disabilities.

Most national health insurance proposals largely ignore the long-term care needs of older Americans. Immediate action is required by the Congress and executive branch to improve past policies and programs which have been piecemeal, inappropriate, and short lived.

MAJOR POINTS OF SUPPORTING PAPER NO. 1

(Issued December 17, 1974)

"THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY"

The subcommittee's Supporting Paper No. 1 reveals the following were the most important nursing home abuses:

- Negligence leading to death and injury;
- Unsanitary conditions;
- Poor food or poor preparation;
- Hazards to life or limb;
- Lack of dental care, eye care or podiatry;
- Misappropriation and theft;
- Inadequate control of drugs;
- Reprisals against those who complain;
- Assault on human dignity; and
- Profiteering and "cheating the system."

The inevitable conclusion is that such abuses are far from "isolated instances." They are widespread. Estimates of the number of substandard homes (that is, those in violation of one or more standards causing a life-threatening situation) vary from 30 to 80 percent. The subcommittee estimates at least 50 percent are substandard with one or more life-threatening conditions.

These problems have their roots in contemporary attitudes toward the aging and aged. As Senator Frank E. Moss, chairman of the Subcommittee on Long-Term Care, has said:

> It is hell to be old in this country. The pressures of living in the age of materialism have produced a youth cult in America. Most of us are afraid of getting old. This is because we have made old age in this country a wasteland. It is T. S. Eliot's rats walking on broken glass. It's the nowhere in between this life and the great beyond. It is being robbed of your eyesight, your mobility, and even your human dignity.

Such problems also have their roots in the attitudes of the elderly toward institutionalization. Nursing home placement often is a bitter confirmation of the fears of a lifetime. Seniors fear change and uncertainty; they fear poor care and abuses; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and "going on welfare." To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

However, these arguments cannot be used to excuse nursing home owners or operators or to condone poor care. Those closest to the action rightly must bear the greatest portion of responsibility.

To deal with the litany of abuses, action must be taken immediately by the Congress and the executive to: (1) Develop a national policy with respect to long-term care; (2) provide financial incentives in favor of good care; (3) involve physicians in the care of nursing home patients; (4) provide for the training of nursing home personnel; (5) promulgate effective standards; and (6) enforce such standards.

MAJOR POINTS OF SUPPORTING PAPER NO. 2

(Issued January 17, 1975)

"DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS"

The average nursing home patient takes from four to seven different drugs a day (many taken twice or three times daily). Each patient's drug bill comes to $300 a year as compared with $87 a year for senior citizens who are not institutionalized. In

1972, $300 million a year is spent for drugs, 10 percent of the Nation's total nursing home bill.

Almost 40 percent of the drugs in nursing homes are central nervous system drugs, painkillers, sedatives, or tranquilizers.

Tranquilizers themselves constitute almost 20 percent of total drugs—far and away the largest category of nursing home drugs.

Drug distribution systems used by most nursing homes are inefficient and ineffective. An average home of 100 beds might have 850 different prescription bottles and 17,000 doses of medication on hand. Doctors are infrequent visitors to nursing homes. Nurses are few and overworked. All too often, the responsibility for administering medications falls to aides and orderlies with little experience or training.

Not surprisingly, 20 to 40 percent of nursing home drugs are administered in error.

Other serious consequences include: the theft and misuse of nursing home drugs; high incidence of adverse reactions; some disturbing evidence of drug addiction; and lack of adequate controls in the regulation of drug experimentation.

Perhaps most disturbing is the ample evidence that nursing home patients are tranquilized to keep them quiet and to make them easier to take care of. Tragically, recent research suggests that those most likely to be tranquilized sometimes may have the best chance for effective rehabilitation.

Kickbacks are widespread. A kickback is the practice whereby pharmacists are forced to pay a certain percentage of the price of nursing home prescription drugs back to the nursing home operator for the privilege of providing those services.

The atmosphere for abuse is particularly inviting when reimbursement systems under Federal and State programs allow the nursing home to act as the "middle man" between the pharmacy (which supplies the drugs) and the source of payment (private patient, Medicare, or Medicaid).

Kickbacks can be in the form of cash, long-term credit arrangements, and gifts of trading stamps, color televisions, cars, boats, or prepaid vacations. Additionally, the pharmacist may be required to "rent" space in the nursing home, to furnish other supplies free of charge, or to place nursing home employees on his payroll.

The average kickback is 25 percent of total prescription charges; over 60 percent of 4,400 pharmacists surveyed in California reported that they had either been approached for a kickback or had a positive belief that kickbacks were widespread; these same pharmacists projected $10 million in lost accounts for failure to agree to kickback proposals.

In order to lower costs to meet kickback demands, pharmacists admitted numerous questionable, if not illegal, practices such as: billing welfare for nonexistent prescriptions, supplying outdated drugs or drugs of questionable value, billing for refills not dispensed, supplying generic drugs while billing for brand names, and supplying stolen drugs which they have purchased.

Congressional action in 1972 to make kickbacks illegal has had little effect. HEW has yet to announce regulations to implement this law.

MAJOR POINTS OF SUPPORTING PAPER NO. 3

(Issued March 3, 1975)

"DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY"

Physicians have shunned their responsibility for nursing home patients. With the exception of a small minority, doctors are infrequent visitors to nursing homes.

Doctors avoid nursing homes for many reasons:

- There is a general shortage of physicians in the United States, estimates vary from 20,000 to 50,000.
- Increasing specialization has left smaller numbers of general practitioners, the physicians most likely to care for nursing home patients.
- Most U.S. medical schools do not emphasize geriatrics to any significant degree in their curricula. This is contrasted with Europe and Scandanavia where geriatrics has developed as a specialty.
- Current regulations for the 16,000 facilities participating in medicare or medicaid require comparatively infrequent visits by

physicians. The some 7,200 long-term care facilities not participating in these programs have virtually no requirements.

- Medicare and medicaid regulations constitute a disincentive to physician visits; rules constantly change, pay for nursing home visits is comparatively low, and both programs are bogged down in redtape and endless forms which must be completed.
- Doctors claim that they get too depressed in nursing homes, that nursing homes are unpleasant places to visit, that they are reminded of their own mortality.
- Physicians complain that there are few trained personnel in nursing homes that they can count on to carry out their orders.
- Physicians claim they prefer to spend their limited time tending to the younger members of society; they assert there is little they can do for the infirm elderly. Geriatricians ridicule this premise. Others have described this attitude as the "Marcus Welby Syndrome."

The absence of the physician from the nursing home setting leads to poor patient care. It means placing a heavy burden on the nurses who are asked to perform many diagnostic and therapeutic activities for which they have little training. But there are few registered nurses (65,235) in the Nation's 23,000 nursing homes. These nurses are increasingly tied up with administrative duties such as ordering supplies and filling out medicare and medicaid forms. The end result is that unlicensed aides and orderlies with little or no training provide 80 to 90 percent of the care in nursing homes.

It is obvious that the physician's absence results in poor medical and to some degree in poor nursing care. Poor care has many dimensions, it means:

- No visits, infrequent, or perfunctory visits.
- The telephone has become a more important medical instrument in nursing homes than the stethoscope.
- No physical examinations, pro forma or infrequent examinations.
- Some patients receive insulin with no diagnosis of diabetes.
- Significant numbers of patients receive digitalis who have no diagnosis of heart disease.
- Large numbers of patients taking heart medication or drugs which might dangerously lower the blood pressure, do not receive blood pressure readings even once a year.
- Some 20 to 50 percent of the medication in U.S. nursing homes are given in error.
- Less than 1 percent of all infectious diseases in the United States are reported—a special problem in nursing homes where patients have advanced age and lessened resistance. This fact was graphically proven in 1970 when 36 patients died in a Salmonella epidemic in a Baltimore, Md. nursing home.

o Physicians do not view the bodies of patients who have died in nursing homes before signing death certificates.

The need for physicians to exercise greater responsibility for the 1 million patients in U.S. nursing homes is abundantly clear from these and other facts. Until doctors take a greater interest the litany of nursing home abuses will continue, the majority of America's nursing homes will be substandard, and the quality of patient care will be unacceptable.

MAJOR POINTS OF FORTHCOMING SUPPORTING PAPERS

Supporting Paper No. 5

"THE CONTINUING CHRONICLE OF NURSING HOME FIRES"

In 1971, there were 4,800 nursing home fires; 38 persons were killed in multiple death fires and some 500 more in single death fires. An estimated $3.5 million loss was directly attributable to nursing home fires.

Nursing home patients are especially vulnerable to fires. Many are under sedation or bound with restraints. Physical infirmities and confusion often cause resistance to rescue.

There is reason to believe the number of nursing homes failing to meet fire safety standards is actually increasing.

In 1971, the General Accounting Office reported that 50 percent of U.S. nursing homes were deficient in regard to fire safety. A January 1974 study by the U.S. Office on Nursing Home Affairs said that 59 percent of skilled nursing facilities are certified with deficiencies. HEW spokesmen indicated that in excess of 60 percent of intermediate facilities do not comply with existing standards. The requirements are on the books, but they are not heeded. Even more dramatically, the GAO 1974 study indicates 72 percent of U.S. nursing homes have one or more major fire deficiencies.

Supporting Paper No. 6

"WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS IN LONG-TERM CARE"

It is unjust to condemn the entire nursing home industry. There are many fine nursing homes in America. A growing number of administrators are insisting upon positive approaches to therapy and rehabilitation, innovations in physical structure of the physi-

cal plant; employee sensitivity training and cooperative agreements with local schools of nursing; and even self-government and other activities for the patients.

"Ombudsmen" programs have been established by Presidential direction and are making some headway. In some States, the nursing home industry has launched an effort to upgrade its facilities by establishing directories, rating systems, and a "peer review" mechanism. These efforts offer the prospect of improving nursing home conditions if conducted in a vigorous and effective manner. In Chicago, nursing homes have a "cool line" telephone number for relatives, visitors, or patients who have complaints.

Supporting Paper No. 7

"THE ROLE OF NURSING HOMES IN CARING FOR DISCHARGED MENTAL PATIENTS"

Thousands of elderly patients have been transferred from State mental institutions to nursing homes. The number of aged in State mental hospitals decreased 40 percent between 1969 and 1973 according to subcommittee data, dropping from 133,264 to 81,912. This trend is caused partially by progressive thinking intended to reduce patient populations in large impersonal institutions. Another powerful reason, however, may be cost and the desire to substitute Federal for State dollars. It costs the States an average of $800 per patient per month to care for mental patients in State hospitals while these same individuals can be placed in boarding homes at a substantially reduced cost. Charges of "wholesale dumping" of patients have been made in several States. Acute problems have been reported, most notably in California, Illinois, and New York.

Supporting Paper No. 8

"ACCESS TO NURSING HOMES BY U.S. MINORITIES"

Only 4 percent of the 1 million nursing home patients in the United States are members of minority groups, even though their health needs are proportionately greater. Part of the problem is caused by cost obstacles or lack of information about Medicaid. Discrimination is the greatest obstacle to greater utilization by blacks. But discrimination need not be overt; often relatives are made to feel that their parent or grandparent would not be made comfortable. In the case of Asian-Americans and Spanish-speaking Americans, language barriers often cause insurmountable difficulties. Cultural and other problems, including rural isolation, cause problems to American Indians.

Members of minority groups at subcommittee hearings have been sharply critical of the Nixon administration's nursing home

"reforms." They protested the "arbitrary and punitive" closing of a few minority owned nursing homes that do exist and the absence of assistance to help upgrade standards.

Supporting Paper No. 9

"PROFITS AND THE NURSING HOME: INCENTIVES IN FAVOR OF POOR CARE"

Profits by nursing homes have occasioned serious and persistent controversy. Nursing home administrators say that Medicaid reimbursement rates are low and that they can hardly become the basis for profiteering. Critics say that the economics of nursing home operation, supported in such large measure by public funds, should be examined more closely and publicly than they now are.

On the basis of available evidence, including a subcommittee survey made in 1973–74, the subcommittee has found that the 106 publicly held corporations controlled 18 percent of the industry's beds and accounted for one-third of the industry's $3.2 billion in revenue (as of 1972). Between 1969 and 1972 these corporations experienced the following growth:

- 122.6 percent in total assets;
- 149.5 percent in gross revenues; and
- 116 percent in average net income.

One recent HEW study, however, shows marginal rates of return in a sample of 228 nursing homes. Thus, the issue is far from settled. But a joint study—conducted by the General Accounting Office and the subcommittee—suggest significant increases in total assets, revenues, and profits for individual operators as well.

Two final documents will be issued as part of this study: A compendium of statements by national organizations and administration spokesmen, and a final report by the Subcommittee on Long-Term Care.

94TH CONGRESS
1st Session

SENATE

REPORT
No. 94–

NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY

SUPPORTING PAPER NO. 4

NURSES IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL)

—Ordered to be printed

Mr. Moss, from the Special Committee on Aging, submitted the following

REPORT

INTRODUCTION

Nursing homes, as seemingly implied by their very name, might be expected to place major responsibility for patient care upon nurses.

But the name is misleading.

One government survey says that 80 percent of care in long-term institutions is provided by aides and orderlies. Nurses were said to perform only 17 percent of all tasks, and there is reason to believe that even this overstates the case.

Throughout the nation, only 65,235 nurses are on duty in the 23,000 nursing homes now caring for 1 million patients.

And this number must be divided by three: the morning, afternoon, and night shifts needed for 24-hour care.[1]

As was seen in Supporting Paper No. 3, *Doctors in Nursing Homes: The Shunned Responsibility*,[2] there are complex reasons for the paucity of physicians in nursing homes.

The same is true of nursing.

This Supporting Paper explores those reasons.

[1] This division is not precisely equal. Government standards permit fewer nurses on afternoon and night shifts. One expert witness commented: "The regulations seem to suggest that at 3 p.m. every day, through 7 a.m. the following morning, skilled nursing facilities suddenly become less ill. and therefore less in need of the services of a registered nurse (p. 2564, "Trends in Long-Term Care").

[2] Issued on March 3, 1975.

It concludes that part of the problem arises from the early history of nursing homes. Originally, they were viewed as secondary institutions to which "chronic" hospital patients could be transferred. Physicians tended to overlook patients transferred from hospitals to the nursing homes, which began to proliferate slowly in the 1930's and markedly after World War II. Lack of interest and close attention by doctors forced heavy burdens on those nurses who were in nursing homes.

Those nurses, even in the face of the remarkable growth in the nursing home field since passage of Medicare and Medicaid in 1965, still face major difficulties:

—They must struggle against negative attitudes toward nursing home care. The general public and fellow professionals tend to regard their work as uninteresting, depressing, and even second-rate.

—They are saddled with more and more administrative responsibilities, cutting down on the time they can devote to actual patient care.

—They are hampered by a nursing shortage which tends to place a low-priority on training nurses for care of the chronically ill, a field receiving scant attention at most nursing schools.

—They face poor wages and working conditions in many institutions. Scandals and persistent reports of abuses discourage even dedicated nurses who have committed themselves to long-term care.

—They encounter fluctuating standards and regulations for nursing care in the Medicare and Medicaid programs. Despite persistent Congressional efforts to upgrade these standards, the issue is far from settled.

These factors and others have made it difficult, if not impossible in many cases, for the nurse in today's nursing home to give the skilled, professional, and motivated care historically associated with that profession.

Fortunately, the American Nurses Association is taking positive actions to change this situation. One of their major initiatives was made in response to an invitation by this subcommittee. ANA's report, "Nursing and Long-Term Care: Toward Quality Care for the Aging," is printed in this paper.

But it is essential that the Congress and the Administration should do their share, as well. Confusion and stalemate on essential issues—such as Federal support for nurses' training, ratios of skilled personnel needed per nursing home patient, standards for inspection of nursing care, and upgrading of training for aides and orderlies—should be overcome at the earliest possible date.

Nursing homes should be places in which the nurse can proudly perform her (or his) essential, professional, and compassionate service to humanity.

PART 1

NURSES IN NURSING HOMES: THE HEAVY BURDEN

The origin of present-day nursing homes in the United States can be traced to the Social Security Act of 1935. In those years there was a great public reaction against the public poor houses that were prevalent during the depression era. Accordingly, Congress mandated that old age assistance funds could not go to persons in public institutions. However, these payments could go to the aged in private boarding homes.

What naturally followed was a tremendous expansion in the number of boarding homes throughout America. In time these homes began hiring nurses to take care of the infirm aged, and, soon thereafter, the term "nursing home" became widely used.

At that time, and even today, the term "nurse" was used to describe a broad spectrum of nursing home employees. In reality, there are three kinds of nursing personnel in nursing homes:

The *professional, or registered nurses* (hereinafter referred to as RN) must complete a minimum of two years of education at an accredited school of nursing.

The *licensed practical nurses* (or LPN) must complete one year of instruction in a school of nursing or vocational training. In some cases these nurses must first pass State equivalency exams before they can claim the LPN title.

No training, experience, or license is generally required to become *an aide or orderly*. Whatever training they receive is usually in the form of, in-service, or learn-by-doing, programs conducted in nursing homes. In a few cases States have special training programs for these employees.

What functions are performed by these categories of employees?

THE ROLE AND DUTIES OF A REGISTERED NURSE

Registered nurses might be thought of as the axis of the nursing home wheel. Ideally, they should provide much of the patient care. They also should supervise other nursing home personnel and carry out various administrative duties.

In describing patient care, it is important to differentiate between medical care provided by physicians and nursing care provided by nursing personnel. Physicians, and physicians alone, are allowed to diagnose disease and prescribe drugs and therapies designed to ameliorate the illness. Nurses have traditionally received guidance from physicians in establishing a plan of treatment and for carrying out such a plan.

Some of the functions which RN's perform include:

- Dressings of all kinds
- Clysis
- Catheter insertion and changes
- Impactions
- Tube feeding
- Oxygen therapy
- Intravenous injections
- Intramuscular injections
- Dispensing medications
- Subcutaneous injections
- Ostomy irrigations—all kinds
- Ostomy care
- Urological irrigations—all kinds
- Ear and eye irrigations
- Lavage and gavage
- Isolation
- Assistance with thoracentesis and paracentesis
- Suctions

Registered nurses are quick to stress that some of the functions mentioned above should be performed only by a professional nurse; or, put another way, they should not be performed by aides and orderlies. They also stress that nurses have considerable room for independent decisions with respect to patient care. One RN put it this way:

Nursing has been defined as a profession and, therefore, nurses do have areas of independent judgment and action in the care of the sick person. Bedsores, contractures (stiffening of muscles and joints) and many of the horrendous conditions afflicting patients in nursing homes are the direct result of inadequate professional nursing care—not inadequate medical care.[3]

As important as these functions are, still other responsibilities occupy much of the time of a nursing home RN. Paul de Preaux, Administrator of Church Homes, Inc., Hartford, Connecticut and former President of the Connecticut Association of Homes for the Aged, compiled a partial list of such supervisory activities as follows:

DUTIES AND RESPONSIBILITIES OF A NURSING SUPERVISOR

1. Development and maintenance of nursing service objectives.
2. Standards of nursing practice.
3. Nursing policy and procedure manuals.
4. Written job descriptions of each level of nursing personnel.
5. Methods for coordination of nursing services with other patient services.

[3] Letter to Senator Moss from R. Allen, San Francisco, Calif., dated October 5, 1971; in committee files.

6. Recommending number and levels of nursing personnel to be employed.
7. Dispensing medications and rendering treatments.
8. Supervising nursing personnel.
9. Hiring and terminating nursing personnel.
10. Indoctrination lectures.
11. In-service training.
12. Making out time card and assignment sheets.
13. Checking housekeeping and dietary personnel.
14. Maintaining patient's records.
15. Consulting with:
    - Physicians
    - Patients
    - Patient's families
    - Administrator
    - Dietician
    - Dentist
    - Podiatrist
    - Social workers
    - Program directors
    - Bookkeepers
    - Speech therapist
    - Physical therapist
    - Community services
    - Outside Professional Groups
16. Member of:
    - Utilization Review Committee
    - Pharmacy Committee
    - Patient Care Policies Committee
    - Social Services Committee
    - Restorative Services Group
    - Infection Control Committee
    - In-Service Training Committee
17. Documenting all the above.[4]

These heavy burdens place in proper perspective the present Federal Medicare and Medicaid requirement which requires only one registered nurse for every participating nursing home on the day shift and the minimum of an LPN on each of the other two shifts. (Federal requirements discussed in part 1, p. 378 of this Supporting Paper.)

THE ROLE OF LICENSED PRACTICAL NURSES

As implied from the last paragraph, LPN's are functioning in the stead of the RN. They are in charge of nursing in the absence of an RN. They must perform all the supervisory functions listed above, the care-giving and the administrative function. It is important to reemphasize that LPN's generally are in charge of the 3 p.m. to 11 p.m. afternoon shift and the 11 p.m. to 7 a.m. evening shift.

In addition to these functions, nurses are often asked to perform administrative duties such as ordering supplies, answering the telephone, and showing relatives or visitors around the nursing home.

[4] Letter to Senator Moss from Paul de Preaux dated October 12, 1973, in committee files.

AIDES AND ORDERLIES

Aides and orderlies work under the direction of an RN or an LPN. They are responsible for helping patients get out of bed and dressed in the morning; they help wash the patient, make the beds, and clean the rooms; they bring meals to the patients and feed them if they are unable to feed themselves. They are often called upon to help administer treatments, or distribute medications. Supporting Paper No. 1 [5] reports some of the disastrous results caused by untrained aides providing treatments. Supporting Paper No. 2, in part, describes the results of allowing them to set up and pass medications. Certainly not all aides and orderlies are incompetent, but far too many receive little training, and consequently they should not be allowed to perform certain duties.

I. HOW MANY RN'S, LPN'S, AIDES AND ORDERLIES ARE IN U.S. NURSING HOMES?

The table on page 361 provides an inventory of nursing home personnel. These figures clearly indicate the heavy reliance upon unlicensed aides and orderlies in U.S. nursing homes.

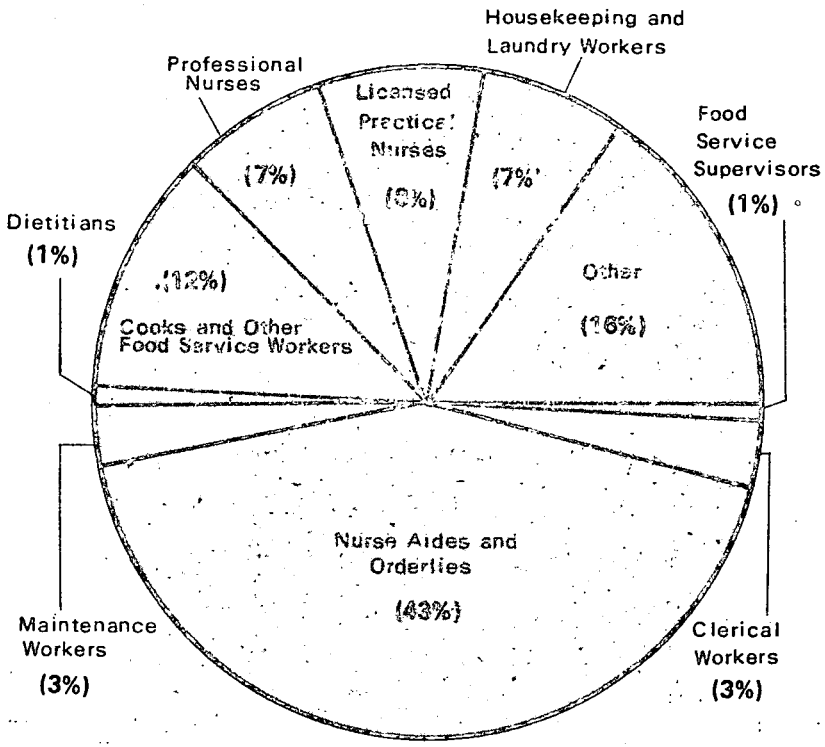
The number of nursing home employees increased by 405 percent from 1960 to 1970. In 1970, some 215,000, or 43 percent were aides and orderlies (280,000 in 1972); 7 percent were professional nurses; and 8 percent were licensed practical nurses. Nursing home employees have an average yearly turnover rate of 60 percent.[6]

In terms of the total U.S. health industry, nursing homes have a disproportionate number of aides (26 percent of the 830,000 total). They account for few LPN's (10 percent of 370,000) and for a miniscule number of the nation's RN's (.05 percent of 700,000) in 1970.

[5] See pages 169–204 of Supporting Paper No. 1, issued December 17, 1974.

[6] See p. 2, *White House Fact Sheet* issued on August 16, 1971. This reference is reprinted in "Trends in Long-Term Care," Part 18, hearing by the Subcommittee on Long-Term Care, Washington, D.C., October 28, 1971, pp. 2017–19; *"Nursing Homes and Related Health Care Facilities,"* U.S. Department of Labor, Manpower Administration, Industry Manpower Surveys, No. 116, 1969, pp. 3–6; *Health Resources Statistics 1972–73*, Department of Health, Education, and Welfare, Health Services and Mental Health Administration, National Center for Health Statistics, p. 401; and *"A Business and Financial Analysis of the Long-Term Care Industry (Interim Final Report)"*, U.S. Department of Health, Education, and Welfare, Health Resources Administration, National Center for Health Statistics, prepared for the Office of Nursing Home Affairs (May 31, 1974).

Occupational Composition of Employment in Surveyed Nursing Homes and Related Health Care Facilities.



Note : Percents do not add due to rounding.
Source : U.S. Department of Labor, Manpower Administration.

PROFESSIONAL NURSES

In 1974, 65,235 registered nurses were in nursing homes. They made up 20 percent of all personnel in Connecticut and 3 percent in Oklahoma and Arkansas.

Registered nurses received $3.75 an hour on the average in 1970. They show a vacancy rate of 8 percent and a turnover rate of 71 percent a year.[7]

LICENSED PRACTICAL NURSES

There were some 40,000 licensed practical nurses employed in nursing homes in the United States in 1970. Twenty-five percent were licensed by waiver (that is, by past experience rather than on the basis of formal education). Licensed practical nurses received about $2.60 an hour for their work. They had a vacancy rate of 14 percent and a turnover rate of 35 percent.[8]

AIDES AND ORDERLIES

Unlicensed personnel comprise 43 percent of the staff, and most are women. The 215,000 aides and orderlies received an average of $1.70 an hour in 1970 for their work. They had a job vacancy rate of 4 percent and a turnover rate of 75 percent a year.[9]

RATIO OF EMPLOYEES TO PATIENTS

All in all, there were 5.3 nursing home employees for every 10 nursing home patients in 1971. General and surgical hospitals by contrast average 26 employees for every 10 patients.[10]

The fact that there are few RN's in nursing homes is just as obvious from testimony received by the Subcommittee as from statistics.

EARLY TESTIMONY ON NURSING SHORTAGES

In 1960 the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare concluded:

> Nursing home personnel lack the proper experience and training to render skilled nursing.[11]

This factor, along with the shunning of responsibility for nursing home patients by the medical profession, were the two most important explanations for the Subcommittee's charge that the quality of care in America's nursing homes was "generally inadequate." [12] The report noted that only 18 percent of the nursing homes in Ohio had an RN as their highest nursing officer with 74 percent having an LPN in that position.[13]

The poor quality of nursing home care and the paucity of licensed and professional nurses was a consistent theme in the Subcommittee's

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[7] *"Nursing Homes and Related Health Care Facilities,"* U.S. Department of Labor, Manpower Administration, Industry Manpower Surveys, No. 116, 1969, p. 8; see also: "Facts About Nursing," p. 7, American Nurses Association.

[8] See footnote 7, pp. 10–11.

[9] See footnote 7, p. 13. There were 280,000 aides and orderlies employed in 1972. Aides today average $2.00 per hour—the minimum wage.

[10] Assuming there are 1.1 million nursing home patients and 583,974 full-time employees in 1971, the ratio would be .53 employees per patient. See footnote 6, *White House Fact Sheet,* p. 2, indicates 900,000 patients in 1970 and 505,031 employees for a ratio of .67 for 1970. See also February 16, 1971, *New York Times,* pp. A1 and 27. HEW advises that there were 6.6 full time equivalent (FTE) employees for every 10 nursing home patients in 1973, while hospitals average 32.3 (FTE) employees for every 10 patients.

[11] "The Aged and the Aging in the United States: A National Problem," Subcommittee on Problems of the Aging and Aged, U.S. Senate Committee on Labor and Public Welfare, p. 138.

[12] Source cited in footnote 11, p. 131.

[13] Source cited in footnote 11, p. 138.

1965 hearings on nursing home problems.[14] In Portland, Maine, the Subcommittee heard that 32 percent of the nursing homes in that State had no RN or LPN.[15] In Indiana 27 percent of the homes were not adequately staffed; 20 percent had neither RN nor LPN.[16] The Boston hearings followed newspaper charges that unlicensed personnel working in nursing homes were responsible for reprehensible conditions.[17]

The Subcommittee in 1965, based on hearings and other studies, concluded that 45 percent of America's skilled nursing homes had no registered nurse available.

"TRENDS IN LONG-TERM CARE," HEARINGS: 1969–73

More recent hearings by the Subcommittee on Long-Term Care have focused on the question of whether there is a general nurse shortage in the United States as well as a particular shortage in nursing homes.

The U.S. Department of Labor estimates that there is a shortage of some 150,000 nurses in the United States.[18] This problem is multiplied by maldistribution, with severe shortages in some rural areas and too many nurses in some urban areas. However, some people challenge the notion of a nurse shortage with respect to nursing homes.

Dr. John Mason of the American Lutheran Church told the Committee that good nursing homes have no difficulty attracting nurses even in rural areas where they would be in the shortest supply.[19]

Mary Shaughnessey, testifying for the American Nurses' Association told the Subcommittee that about 400,000 RN's have dropped out of the work force.[20] Reportedly, they have abandoned their nursing careers for many reasons; some, of course, wish to raise families; others because of dissatisfaction with their work role. Some claim there are "inadequate definitions of the nurses' role in the organization, poor communication and coordination and unreasonable work pressures." Nurses more and more are demanding a larger role in health care and no longer wish to see themselves as the "physician's technical assistant" or the "patient's servant." [21]

This search for greater responsibility, freedom of action and greater approval could conceivably have the paradoxical effect of bringing nurses into nursing homes. Clearly the nursing home offers the perfect setting for the RN to perform in an expanded role, perhaps as a nurse practitioner.[22]

A recent study in the publication *Nursing Homes* provides more perspective on the question of whether there is a nurse shortage within the specific context of nursing homes.

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[14] "Conditions and Problems in the Nation's Nursing Homes," Hearings by the Subcommittee on Long-Term Care.
[15] Source cited in footnote 14, p. 816.
[16] Source cited in footnote 14, p. 7.
[17] *Boston Record American*, August 5, 1965.
[18] Letter to Senator Moss from Paul J. Fasser, Jr., Deputy Assistant Secretary for Manpower and Manpower Administration, U.S. Dept. of Labor dated October 19, 1971.
[19] "Trends in Long-Term Care," Hearings by the Subcommittee on Long-Term Care, Part 1, July 30, 1969, p. 74.
[20] Source cited in footnote 19, p. 63.
[21] Source cited in footnote 19, p. 206.
[22] On June 22, 1973 Senator Frank Church and Senator Frank E. Moss introduced legislation to provide funds to schools of nursing for the training of nurse practitioners. The bill was numbered S. 2052. Similar legislation was introduced by Senator Moss on March 18, 1975 as S. 1160, passed Senate as an amendment to S. 60 on April 10, 1975.

The author cites time and motion studies conservatively indicating that nursing home RN's spend an alarming 54 percent of their time on non-nursing activities.

The study reports that administrative and clerical work such as ordering supplies, preparing forms, and answering telephones consumed 40 percent of the RN's time. Other nursing tasks, many of which could be performed by nurses aides, such as making beds and bathing patients, accounted for 3 percent of the nurses time; and non-work activity such as socializing, reading non-nursing magazines, eating meals and attending to personal hygiene accounted for 14 percent of her time. In short only 43 percent of the time was spent with tasks properly performed by the registered nurse, such as administration and recording of medications, preparing nurses' notes, and instructing or supervising other nursing personnel.[23]

These facts demonstrate that there are comparatively few RN's in nursing homes and that the ones who work in nursing homes are generally overworked and burdened with administrative duties. The general nurse shortage and the discontent with the nurse's traditional role may be part of the reason why there are so few in nursing homes. Other reasons are examined in the following section.

II. WHY NURSES AVOID NURSING HOMES

There are many reasons to explain the limited number of professional nurses in nursing homes. To begin with, Federal regulations require registered nurses only in America's 7,300 skilled nursing facilities; even then only one RN is required 7 days a week (exceptions are made in rural areas). Some nursing home operators, intent on limiting costs and increasing profits, have refused to hire more than the minimum number of nurses required by law. Instead they seek to "make do" with unlicensed aides and orderlies whom they need pay only the minimum wage. Other reasons more directly explain the comparative absence of nurses. These include: the poor image of nursing homes, poor working conditions, low job satisfaction, low wages, and few fringe benefits. At the same time U.S. Schools of Nursing and Federal government programs have failed to stress geriatrics in nurse training programs. There is also a general dissatisfaction with the role of nurses in the nursing home setting.

THE POOR IMAGE OF NURSING HOMES: LOW WAGES AND FEW BENEFITS

Nurses, like doctors, want to feel that they are useful and contributing to the well-being of humanity. It is a commonly held opinion that there is satisfaction associated with seeing patients improve and return home from the hospital; conversely, such satisfaction is not thought to be available in nursing homes. Dr. Victor Kassel, geriatrician from Salt Lake City, Utah, put it this way:

> The nursing home is the low rung on the ladder. Nurses who have been in the hospital will not accept a job in a

[23] "Is There a Nurse Shortage?", *Nursing Homes*, August 19, 1969, p. 17.

nursing home even if you pay them a good salary. If they do take a job, somebody will ask, "Why are you in a nursing home; where did you foul up?" [24]

In testimony before the Subcommittee, Mary E. Shaughnessey, RN, speaking for the American Nurses' Association, and Lois Knowles, Assistant Dean of the University of Florida School of Nursing, explained why registered nurses by-pass nursing homes:

1. Nursing homes have a poor image as far as nurses are concerned;
2. The average nurse is ill-prepared to meet the needs of elderly people with long-term, complex, medical problems without supplementary training;
3. The difficulties of practicing safe nursing care according to accepted standards of practice are very great because of restricted policies or lack of policies in many of these institutions;
4. The lack of authority vested in the nursing service department makes it very difficult to carry out the kind of care that is required;
5. The isolation of the nursing home from other health facilities makes it an unpopular place to practice;
6. There is a lack of stimulation and support from nurses, physicians, and other health workers; and
7. The poor overall administration of many of the facilities prevents well prepared nurses from continuing to work in them.

Dean Knowles highlighted one of the less obvious reasons there are few nurses in nursing homes: the design of long-term care facilities and the delivery of services to their residents. Historically, nursing homes evolved as sort of "junior hospitals" following the small hospital design with little thought as to what kind of services were needed and if such a design would be the most appropriate means of reaching those ends.[25] Ms. Shaughnessey described this as the dilution of the kind of services provided in a hospital by two-thirds or one-half.[26] Both experts stressed that some attention should be given to clarifying the product which nursing homes are to offer and to designing long-term care services accordingly.

Ms. Shaughnessey and other witnesses before the Subcommittee have reported a special dissatisfaction in some quarters of the nursing profession. Such unrest stems from the traditional perception of the nurse's role as one who works for and under the supervision of a physician. More and more nurses are coming to insist that they be given credit for the wide degree of judgments they must make, and for which, they are legally responsible. In addition to independent judgment, many nurses believe that, with additional training, they could perform many of the routine examination functions performed by physicians. Registered nurses with such additional training would be called nurse practitioners. Legislation has been introduced by Senator Frank Church, Chairman of the Senate Committee on Aging, and Senator Frank E. Moss, Chairman of the Subcommittee on Long-Term Care, would provide funds to schools of nursing to train nurse

[24] Hearings cited in footnote 19, part 7, Salt Lake City, Utah, February 14, 1974, p. 560.
[25] Hearings cited in footnote 19, Part 2, St. Petersburg, Fla., January 9, 1970, pp. 226–7.
[26] Hearings cited in footnote 19, Part 1, Washington, D.C., July 30, 1969.

practitioners in geriatrics with the thought that they could provide primary care in nursing homes.[27]

Despite the negative attitudes so often associated with nursing care in nursing homes, it can be argued that special demands are made on those who give such care. Patients often have three or four different diseases at the same time, requiring sophisticated, as well as prolonged, attention. Sudden and marked changes in condition can occur at any time of day or night. And, if the goal really is "restorative nursing," the challenge is even greater.

Sister Marilyn Schwab, testifying on behalf of the Division of Geriatric Nursing of the ANA, gave this view of that challenge in testimony in 1973.

> ANA believes that guiding the innumerable activities which constitute restorative nursing requires broad nursing knowledge and skills, the exercise of sensitive clinical judgments, persistence when progress seems halted, and the ability to guide patients in forming positive attitudes and abandoning old habits. One of the most important prerequisites of a functioning program in restorative nursing is the capacity to plan and direct the work of all members of the nursing care team. Registered nurses are prepared by education to guide and direct the work required to meet nursing care needs.[28]

U.S. SCHOOLS OF NURSING SHORTCHANGE GERIATRICS

In early hearings conducted by the Subcommittee, it was a common assertion that schools of nursing did not stress the care of the aged. The same was true at the Subcommittee's 1969–1973 hearings, where the lack of training in geriatrics was given as one reason for the comparatively few professional nurses in nursing homes.

In order to document the degree to which schools of nursing emphasize geriatrics, Senator Moss in November 1971 directed a questionnaire to all 1,072 U.S. schools of nursing, asking:

—Does your program now include or are you planning to make geriatrics a specialty in your curriculum?

—Do you have a program whereby students or interns can fulfill requirements by working in nursing homes?

—Does your nursing program in any other way serve nursing homes?

Of the 512 returns received only 27 answered the first question in the affirmative; 274 answered that geriatrics was included in their curriculum as part of a more general course on human development; and only 135 answered that they had a program whereby students worked with nursing homes.

Assuming that those who had programs in geriatrics would have been the most likely to return the questionnaire, the result confirms that comparatively few schools of nursing emphasize geriatrics to a significant degree.

Largely as a result of leadership provided by the American Nurses Association from 1971 through the present, however, the care of the

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[27] See footnote 22.

[28] Hearings cited in footnote 19, Part 21, Washington, D.C., October 10, 1973, p. 2576.

aged has received greater prominence in many schools of nursing since 1971. But attention is still far short of what is required. For example, there are presently no *graduate* programs for gerontological nursing.

WORKING CONDITIONS AND FRINGE BENEFITS

Until recently, literature in the field of Aging has tended to by-pass all these explanations and assigned poor wages as the reason for the high turnover of professional nurses in nursing homes. (Studies indictate a turnover rate from 40 to 71 percent.) However, two sociologists assert, as a result of their extensive study,[29] that conditions and fringe benefits may be the most important elements in the decision. The study reported that for-profit nursing homes have twice the turnover rate of non-profit homes, while wages were about the same.

It added:

> In other areas, however, the gap between the two types of homes was marked. Almost all non-profit homes, for instance, provided for paid vacations, sick leave, paid holidays, and hospitalization insurance. Among the proprietaries, however, only 35 percent were allowed sick leave, 22 percent holidays, and 12 percent hospitalization.

The authors concluded that an even more important factor in the turnover of nurses was "proprietary homes' scanty services":

> Although all the homes retained a staff physician, many lacked provision for dental care, radiologic services, a dietitian or clinical librarian. Only half of the proprietaries had an occupational or speech therapist, and only three of ten a physical therapy program. Less than half had a recreational area and only 12% had a library. All of these shortages, detrimental as they are to the level of care that can be provided, the sociologists pointed out, meant that the nurses had to carry a heavier load. "It may be that the nurses' indication upon leaving employment that the pay is too low does not present the entire picture.
>
> "What they may really mean is that the pay is too low considering the conditions in which work must be performed." Physicians involved with nursing home administration would be better off to concentrate on improvement of facilities and services rather than on attempting to raise salaries, the sociologists conclude.[30]

TRAINING PROGRAMS IGNORE GERIATRICS

As of 1970 there were 144 separate programs administered by 13 separate agencies for the training of nurses and health care personnel. Some 94 of these programs were exclusively for the training of nursing personnel. These 94 programs together received a total of $1.1 billion in fiscal 1970. Because it is impossible to separate the portion of the other 50 programs that went for the training of nurses it is

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[29] "Why Nurses Leave Nursing Homes," *Medical World News*, March 23, 1973, p. 65. Study by Robert Pecarchick of Penn. State University and Barden H. Nelson, Jr. of St. Lawrence University.

[30] Source cited in footnote 29.

impossible to tell exactly how much money is being spent to help train nurses.[31]

Up until the present time there has been little utilization of these programs to train personnel specifically for nursing homes and there has been little emphasis on geriatric nursing generally.

However two programs now offer great promise:

- The Nurse Training Act of 1972 as sponsored by Senator Harrison Williams included amendments which will allow nurses who elect to work in proprietary health facilities to be eligible for the loan forgiveness provisions of the act. Students who work in nonprofit facilities, in theory, had been exempt in the past. The forgiveness provisions apply only if nurses are willing to work in areas designated by the Secretary of HEW as "high need" areas.[32]
- The Comprehensive Manpower Training Act of 1971 provides special project grants to schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy and podiatry for several purposes including: experimental teaching programs, new techniques in the delivery of health care services, interdisciplinary training programs among schools of the health profession, other innovations in education including traineeships in family medicine, pediatrics, internal medicine or other health fields designated by the Secretary. This is another program of potential benefit, and hopefully geriatrics and geriatric nursing will receive the requisite attention they deserve.[33]

Two other experimental programs deserve mention. The MEDIHC (Military Experience Directed Into Health Careers) program administered by the National Institute of Health of HEW's Public Health Service in 1971 trained and placed 4,800 individuals into health careers and an additional 7,200 returning servicemen in 1972.

The MEDEX (Medical Extension) program began with five experimental projects in medical schools in the following cities: Seattle, Washington; Hanover, New Hampshire; Los Angeles, California; Grand Forks, North Dakota; and Birmingham, Alabama. The program consists of phases 1) university training and 2) on-the-job training (preceptorship). Special emphasis in the MEDEX program is placed on pediatrics, geriatrics, history taking, physical examination and transition from military to civil medical practice. By June of 1973, 425 independent duty trained medical corpsmen had been enrolled and 120 were beginning their preceptorships.[34]

III. CONSEQUENCES: POOR PATIENT CARE

British expert Dr. Lionel Z. Cosin, Clinical Director of the United Oxford Hospital Geriatrics Unit in London, England, observed that the absence of sufficient numbers of professional nurses trained in

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[31] Inventory of Federal Programs That Support Health Manpower Training, 1970, Bureau of Health Manpower, National Institute of Health, Public Health Service, HEW, page III.

[32] The Nurse Training Act of 1974, H.R. 17085, essentially an update and extension of the original legislation was passed in December only to be vetoed by President Gerald Ford. The Senate passed bill was reintroduced as S. 66 which passed the Senate on April 10, 1975.

[33] The latest extension of this program was in December 1974 through The Emergency Job and Unemployment Assistance Act, Public Law 93-567.

[34] On March 18, 1975, Senator Moss introduced S. 1158 to extend the MEDEX program. Medical corpsmen trained in geriatrics could then assume much of the burden in nursing homes.

geriatrics is a primary reason for the problems in the American system of long-term care.[35] He and other experts have stressed that this absence results in the failure to perform necessary nursing services and the heavy reliance upon aides and orderlies.

FAILURE TO PERFORM ROUTINE NURSING SERVICES

Throughout its investigation the Subcommittee has received much testimony and other evidence which pinpoints the nurse's role in poor patient care. Perhaps most serious are disclosures that routine medical and nursing procedures intended to insure the maintenance and well-being of the patient are not carried out. Perhaps most significant in this respect was the 1971 study of 75 nursing homes conducted by the Department of Health, Education, and Welfare. In that study, HEW found that:

37% of the patients taking cardiovascular drugs (digitalis or diuretics or both) *had not had a blood pressure reading in over a year;* and for 25% of these there was no diagnosis of heart disease on the chart.

35% of the patients on phenothiazines had not had a blood pressure recorded in more than a year. Some were taking two and often three phenotriazine drugs concurrently.

Most of the patients reviewed were on one to four different drugs; and many were taking from seven to twelve drugs; some were on both psychotropic uppers and downers at the same time.

A third of the patients being treated for diabetes mellitus had no diagnosis of diabetes on their charts; and over 10% of those receiving insulin or oral hypoglycemic agents were not on diabetic diets; and a large number of these *had not had a fasting blood/sugar test in more than a year.*

Revised treatment or medication orders had been written in the past 30 days for only 18 percent of the patients.

40% had not been seen by a physician for over three months.

In the full year preceding reviews:

- Only 6% of the patients had had follow-up physical examinations
- Only 28% had had follow-up urinalyses
- Only 20% had had follow-up hemoglobin/hematocrit tests.

8% of the *patients had decubitus ulcers;* and 15% *were visibly unclean.*

39% of the patients reviewed were inappropriately classified and placed.

No nursing-care plans existed with respect to diets and fluids for 19%; personal care for 23%; activities for 14%; and individual treatment needs for 18% of the patients.

In-service staff training programs were conducted by only 39% of the homes.[36]

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[35] Hearing cited in footnote 19, Part 14, Washington, D.C., p. 1395.

[36] "Implications of Medical Review of Long-Term Care Facilities," by Carl Flath, consultant to the Health Services and Mental Health Administration, DHEW, October 1971, reprinted in Supporting Paper No. 2, p. 302.

The study emphasizes: "These findings are neither isolated nor atypical in terms of the rest of the country."

RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL

In order to understand the consequences of relying upon unlicensed aides and orderlies, it is important at this point to take a closer look at what they are.

What is a nurse's aide and what do they do?

The most comprehensive study on nurse's aides available [37] describes the following duties for nurses' aides:

> They are responsible for bathing, dressing, feeding, toilet care, grooming, making beds, cleaning nightstands, passing trays and fresh water, and generally observing the well-being of [the] residents. In some homes aides specialize: one may do all the grooming; one may do skin care and treatments. In other homes experienced aides are "team leaders" and carry out these and other duties with overall supervision by nurses. In still other homes, aides are directly responsible to floor or unit charge nurses or to the director of nursing. Other activities, such as running a bingo game, shopping for residents, or setting and styling ladies' hair, are also within the scope of the aide's job.

Male nurses' aides who perform these identical duties are usually called "orderlies". Other salient facts:

1. Most nurses' aides and orderlies receive no training for their jobs; 53 percent of those applying have no previous experience.[38]

2. Aides have little formal education; only one-half of the 280,000 U.S. aides and orderlies are high school graduates.

3. The turnover rate for aides is 75 percent a year.[39] This leads some operators to assert that there is no use in training people who will stay only a few days and then move on.

4. It is very easy to obtain a job as a nurse's aide or orderly in a nursing home. The ease in obtaining employment may attract drug addicts and those with criminal records because references are seldom checked.[40]

5. The pay is low. Starting pay is usually the minimum wage of $2.00 an hour or about $80 a week. The study adds:

> To dramatize the importance of these poor wages, our data show 38 percent of aides reporting themselves as the main support of their households. Job benefits are typically few, days off are irregular and include only one or two weekends a month. Many aides report that they are often called and persuaded to work on their days off. Several have told us they would like a policy of providing aides with two consecutive days off.[41]

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[37] "Nursing Home Research Project—Report on Nurse Aides," by Len Gottesman, Philadelphia Geriatrics Center, Spring 1972, p. 3.

[38] Page 2760, Part 22, hearings cited in footnote 19. Profile of the Nurses Aide, An Argument for Expanding Her Role as Psycho-Social Companion to Nursing Home Residents, Susan Stellar Handschu and Leonard Gottesman, January 1972.

[39] See statistics, p. — this report.

[39] See statistics, p. 362 this report.

[40] Hearings cited in footnote 19, Part 2, St. Petersburg, Fla., January 9, 1970, p. 184, also Part 15, Chicago, Ill., September 15, 1971, p. 1456.

[41] Source cited in footnote 37, p. 10.

6. The work is very hard, undesirable and unpleasant. Few people relish employment calling for cleaning up after the abandoned members of society, many of whom are incontinent.

7. There is little hope for advancement. The chances for promotion are slim and wages will never get much beyond the minimum wage.

The study sums up:

> It would be difficult to find in our society a working role more deserving of recognition and less recognized. We assign to this group of workers the role and the functions of family members. They give the care which relatives and friends are not available to give. We believe that most often they do it with gentleness and compassion. Yet we fail to define the role or develop it by means of even the most minimal requirements.[42]

To experts like Dr. Victor Kassel these facts speak volumes. He insists that the level of patient care in nursing homes is dependent on the training and competence of nurse's aides.[43]

Miss Mary Shaughnessey, testifying for the American Nurses Association in the 1969 hearings, said:

> Too long have we relegated the care of the long-term patient to persons least qualified to meet his needs. At this moment in time we do not know how many nurses or what kinds of nurses can best meet the needs of the long-term patient. We do know that effective nursing service can only be derived from the needs of patients and that the identification of nursing needs requires clinical knowledge and expertise.[44]

Lallie Lloyd, a member of the Nader Task Force on nursing home problems, testified in December 1970:

> Aides do all the work around the home. Everything but medication. We do the baths, laundry, meals, dressing, cleaning, etc., and we don't even get paid minimum wage. Therefore, it's to the home's advantage to have lots of aides and only one nurse.[45]

Dr. Charles Kramer, President of the Kramer Foundation and Clinical Director of the Plum Grove Nursing Home, told the Committee:

> What I am trying to say is that most of the patient care is given by people with the least education in the psychology of people, the sociology of old age, and the dynamics of interpersonal relationships in the institution. This means that if you are going to give patients the kind of care they need, you have to train everyone in the institution.[46]

Reporters Mike Richardson and Peggy Vlarebome of the *St. Petersburg Times*, working in many Pinellas County (Florida) nursing homes prior to writing a series on nursing home problems, were

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[42] Source cited in footnote 37, p. 9.
[43] Hearings cited in footnote 24, p. 560.
[44] Hearings cited in footnote 19, p. 38.
[45] Hearings cited in footnote 19, p. 881, Part 11.
[46] Hearings cited in footnote 19, p. 1445, Part 15.

critical of the "learn-by-doing" method for training aides, provided this list of "Dos and Don'ts" for Nurse's Aides:

> **Don't make trouble for your fellow employees. This means you don't report that the only nurse on the 3 p.m. to 11 p.m. shift is not licensed in Florida. "She is a good nurse," the 11 p.m. to 7 a.m. nurse tells you.**
>
> **Don't do anything you don't have to do. "The other shifts don't do any work, so why should we–"**
>
> **If you discover a wet bed at 2:30 a.m., don't change it until 5:30, "so we don't have to do it twice," a nurse advised.**
>
> **Don't use cups or utensils used by patients; "you don't know what you might get from them."**
>
> **Don't touch a runny bedsore because you might get a staph infection. Let the other shifts worry about the patients getting staph infections.**
>
> **Don't waste your time talking to patients. "They're so senile they don't know what you're saying anyway."**
>
> **When you do talk to patients, talk as if they were children; don't ask if they have to go to the bathroom, ask, "Do you have to pee-pee?"**
>
> **Don't spend a lot of time feeding patients who can't feed themselves; they won't know the difference.**
>
> **If you have a headache, just ask the nurse for aspirin and she will give you some of a welfare patient's "and let someone else pay for it."**
>
> **Don't change the top sheet unless it is really soaked as the patient will be charged extra for it. Presumaby the patient would rather be wet and get a urine burn.**
>
> **If patients "get in the way," strap and lock them in their chairs by day and their beds by night. Don't bother checking on them "vigilantly" as required by State law—a law unknown to most caretakers and ignored by the others.**
>
> **If you have a patient who uses a catheter, "irrigate it when you get a chance" instead of every eight hours as required, a nurse said. Do it when you can—right or wrong.**[47]

Dr. Raymond Benack, founder of the American Association of Nursing Home Physicians, and President of the Maryland Association of Physicians in Chronic Disease Facilities, contends that 90 percent of the medical care in Maryland and the United States is being given by untrained and poorly educated aides and orderlies.[48] Dr. Benack is not alone in this view. He is supported by a report from the Surgeon General of the United States and by an October 1970 HEW study which notes:

> Eighty-one percent of the nursing care tendered to patients was given by ancillary personnel (74 percent by aides and 7 percent by others, principally relatives); the LPN gave 12 percent and the RN 7 percent. The report goes on to comment that the 7 percent figure for RN's is somewhat lower than expected but is explained

[47] Hearings cited in footnote 19, p. 206, Part 2.
[48] *Baltimore Sun*, January 21, 1971.

by the fact that the role of the RN in the nursing home is primarily one of administration and supervision of the nursing staff.[49]

THE END RESULT: PATIENTS SUFFER

The heavy reliance on untrained and unlicensed personnel predictably results in poor patient care. Through trial and error some of these employees become very competent, but many do not. The work is difficult and unpleasant and attracts only those from the lowest rungs of the economic ladder. Understandably, some take their work less than seriously. For example:

Mrs. Ida Mae Dentler, Chairman of the Citizens Committee HELP (Helpless Elderly Lonely People) in Houston, Texas, after several years of investigation in Texas nursing homes concludes "that 50 percent of the complaints against nursing homes in her State were caused by unlicensed, uncontrolled health care workers." [50] Mrs. Dentler provides a list of complaints against aides compiled from her records including:

- Drinking on the job
- Sleeping on duty
- Abusing patients
- Stealing patient's belongings
- Showering individuals in hot or cold water as punishment
- Eating patient's food
- Stealing medications [51]

Most of the complaints received by the Subcommittee relating to the failures of aides and orderlies fell into the following categories: drug problems, theft and negligence.[52]

EXAMPLES OF POOR CARE: DRUGS

Mrs. Daphne Krause of the Minneapolis Age and Opportunity Center whose staff worked with the Committee in preparation of the Minneapolis hearing in November 1971 provided the following summary and examples of abuse from sworn affidavits presented to the Committee:

> We will see that the responsibility for nursing care falls primarily on the nurse's aides and orderlies, hired literally off the street and paid the minimum wages, at the same time asked to undertake one of the most difficult jobs imaginable. Because the aides are untrained, perhaps unschooled, overworked, and poorly paid, poor care results. Nurse's aides on their own initiative prescribe drugs for patients and even assess the cause of death to be recorded on death certificates.
>
> For the beleaguered nurse's aides tranquilizers are a happy solution. If patients are sedated, they cause the staff few problems.

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[49] Nursing Home Research Study, Quantitative Measurement of Nursing Homes. October 1970, HEW, Public Health Service, National Institute of Health, Bureau of Manpower Education, prepared by Eleanor M. McKnight. p. 19: see also p. 358 this report.
[50] Letter to Senator Moss dated January 12, 1972, in committee files.
[51] Source cited in footnote 50.
[52] See Supporting Paper No. 1, "The Litany of Nursing Home Abuses and An Examination of the Roots of Controversy."

The administrator is happy, too, because bed-bound patients bring the highest rate of reimbursement.

From the affidavit of nurse's aide Barbara Lace, re the David Herman Nursing Home:

> There is a heavy use of tranquilizers on our floor. We had a discussion about this once and I got kind of angry and told the nurse. There have been times when they woke the patients in order to give them tranquilizers so that the patients would stay out of their hair. By keeping the patients drugged up, they are being turned into vegetables. Many of these patients are having psychological problems that they are not being treated. They are medicated so that we don't have to deal with them.

From the affidavit of L.P.N. Kay Schallberg, re the Crystal Lake Nursing Home:

> This nurse would also deliberately increase the dosage of a sedative much higher than the prescription in order to quiet down patients, but then she would put on the chart that she had administered the required dosage. She would take sedatives from the prescriptions of other patients in order to do this.

From the affidavit of orderly Dan Henry, re the 2200 Park Nursing Home:

> My impression was that they would hire anyone off the streets who would come and could stand the conditions and would accept the wages they offered.
>
> I was given absolutely no training whatsoever in the passing of medication; however, I did this on a regular basis. Nurse's aides would also pass medications, and they did not have training in the effects of medications. All the nurses, nurse's aides, and orderlies had access to the narcotics cabinet. It was very common when there were drugs left over from a patient who had left or had died to re-use these drugs.[53]

Doris Allemand, RN, writing in the November 16, 1969, edition of *Hospitals*, notes that drugs are stored in nursing homes without the continuing presence of the pharmacist. She describes a serious problem in nurses—or even aides—accepting unwritten orders from physicians to dispense drugs. She notes the possibility the drug prescribed will not be compatible with those the patient is already receiving. She states that some employees feel it is wasteful to destroy drugs belonging to dead and discharged patients. "Employees may build up stockpiles which may be the source of improper or the illegal use of drugs." [54]

In Chicago, Mr. Bill Recktenwald, Chief Investigator with the Better Government Association which helped the Committee with its Chicago inquiries, testified that he applied for a job as a janitor in one Chicago nursing home: although he clearly stated he had no experience except janitorial he was hired as a nurse's aide and within a short time

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[53] Hearings cited in footnote 19, pp. 2097–8, Part 19A.
[54] *Hospitals*, November 16, 1969, p. 86.

was on the home's third floor administering medications with the keys to the medication and narcotics cabinet on his belt.[55]

He also testified that during an investigation of Chicago nursing homes with the Chicago Tribune Task Force he learned that one of Chicago's "flea bag" hotels was the recruitment center for nursing home orderlies. He investigated and found the story true. Residents were told that if they would board a nearby bus and agree to serve as orderlies at a nearby nursing home for a month that they would have their board and room plus $40 and a bottle of wine at the end of the month.[56]

Mrs. Krause provided numerous other examples of aides having access to medications and narcotics cabinets including:

(a) From the affidavit of L.P.N. Kay Schallberg, re the Crystal Lake Nursing Home:

> On my shift an aide would work the first floor and had the key for the medications. This aide would set up the medications and pass them, and then would set up the medications for the morning shift.

(b) From the affidavit of nurse's aide Barbara Lace, re the David Herman Nursing Home:

> The setting up of medications should be done by an RN, but on weekends, the key to the medications room and the narcotics cabinet is given to aides. I have seen a nurse stealing meds.

(c) From the affidavit of Occupational Therapist Assistant Sandra Dhar, re the White Bear Lake Nursing Home:

> I have seen aides training aides to set up medications for passing. In direct violation of State regulations.

(d) From the affidavit of L.P.N. Nancy Fox, re the Woods No. 2 Nursing Home:

> Medications have already been meted out onto trays by the night aide. Here, aides pour and administer medications, in spite of the fact . . . that they have no idea what they are giving or why. Digitalis is shoved down throats, pulses are never taken.

(e) From the affidavit of nurse's aide Gladys Danielson, re the Bryn Mawr Nursing Home:

> There is a constant problem with the giving out of medicines. There is an aide who has no nursing training who occasionally gives insulin injections. On one occasion she gave one diabetic patient an injection of insulin in the morning and did not mark it up in the day book. Later that morning an L.P.N. gave her another injection, and I had to feed her sweets all day long.
>
> Medications are often set up by aides, only occasionally by R.N.'s. They make mistakes often. They mix up the pills or

[55] Hearings cited in footnote 19, p. 1456, Part 15.
[56] Hearings cited in footnote 19, p. 1032.

leave some out, and the aides do not check to be sure the pills are taken. Many times my sister has found pills of my mother's on the floor at night.[57]

Further evidence of the lack of control on nursing home drugs and the effect on patient is contained in Supporting Paper Number 2. Given the fact that untrained and unlicensed personnel have access to the medication room in many U.S. nursing homes and because they set up and pass drugs and sometimes even prescribe drugs and tranquilizers on their own initiative there is little wonder the incidence of drugs administered in error may be as high as 40 percent.[58] The consequences to the patient are severe and sometimes tragic.

THEFT

Mrs. Daphne Krause told the Committee of the frequent occurrences of theft in U.S. nursing homes, providing the following from her collection of sworn affidavits:

There are also numerous examples of misappropriation and theft in the nursing homes. It seems that anything is worth stealing. On the other hand, some things merely get lost because the staff can't keep track of the personal effects of patients. In other instances, money belonging to patients, whether in cash or checks, has been apparently appropriated to their own use by unscrupulous operators. Here are some examples.

From the affidavit of relative Ruth Lehman, re the Crystal Lake Nursing home:

Money was stolen from Mrs. Eight while she was in this home. Mrs. Eight had a little money in her billfold. Bud would see to it that she always had a little money to spend if she needed it. She got $9 a month from the welfare and he'd always give her a little bit more in case she wanted to get a permanent or something. At one point she had about $50 in her billfold because she wanted to get her hair fixed and buy a few things. So Bud wanted to make sure she had enough money so that on the weekend she could do what she needed to do. But Mrs. Eight never did get a chance to go down to do that at that point, and a few days later she told Bud that she didn't want to keep that much money around and would he please take $35 out of there and leave her $15. Bud said OK and went over to get the money and it was all gone, someone had taken it. . . . She had unfortunately no place to lock this money up, and at one point someone stole over $100 from her. She was so upset from this that she didn't sleep for a week.

From the affidavit of orderly John Marotz, re the Capitol View Nursing Home:

Often they will leave the home without their teeth, without their rings, watches, and without any personal effects which

[57] Hearings cited in footnote 19, p. 2098, Part 19A.
[58] See pp. 250–56, Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks."

they had come in with. One patient bought a brand-new suit because he knew he was going to die before too long. When he died he left the home without that suit. It was never found. * * * Employees regularly take food and groceries from the home. One time a 50-pound roast disappeared.

From the affidavit of nurse's aide Barbara Lace, re the David Herman Nursing Home:

Of the welfare money allotted to the patients, they are allowed to keep $2 with them on the floor. Any more than that is kept in the office. If they go to the hairdresser, the transaction is then carried through the business office. However, there was a woman who received $5 for a Mother's Day present. They talked her into putting the money in the office. She agreed and was assured that she could get the money any time she wanted. When she wanted to send it to a grandson, someone went down to get it and they were told that the $5 had been taken because the husband owed the nursing home $25. Now he owed them only $20.[59]

NEGLIGENCE

Committee files are full with examples where the neglect of aides and orderlies has resulted in the death and injury of patients. There were numerous examples in the Chicago hearings where a patient was allowed to both smoke and drink in bed, dropped a match and became a human torch.[60] Another example related to the mother of a patient who faced an amputation of her leg due to the negligence on the part of the staff in leaving early gangrene unattended despite repeated pleas from the daughter.[61] Other examples relate to patients contracting infectious disease because of the lack of proper hygiene.

All of these examples and many, many more can be found throughout the Committee hearings and records. Each of these examples are rather extreme. An even more common occurrence is negligence in the performance of essential tests. Several studies have indicated that essential tests are not being performed on about 40 percent of the patients.

In one study 37 percent of the patients taking cardiovascular drugs, such as digitalis, had not had their blood pressure taken for more than a year prior to the taking of these drugs; 35 percent of patients taking drugs which might have lowered their blood pressure markedly did not have their blood pressure reading taken for over a year.[62]

In short, the results which flow from the reliance on untrained aides and orderlies to provide 80–90 percent of the care offered in today's nursing homes is predictable. Put simply, it means no care or poor care and in all too many cases, negligence and abuse.[63]

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[59] Hearings cited in footnote 19, p. 2107, Part 19A.
[60] In committee files dated December 31, 1970.
[61] Hearings cited in footnote 19, pp. 999–1002, Part 12.
[62] Hearings cited in footnote 19, p. 317, Part 3.
[63] See p. 370, this report.

IV. MEDICARE AND MEDICAID: FEDERAL NURSE COVERAGE REQUIREMENTS

Medicare and Medicaid standards for skilled nursing facilities were unified in 1972. Some 7,300 of the 23,000 U.S. nursing homes participate in one or both programs offering skilled nursing care. A second level of care called intermediate care is offered under the Medicaid program where some 8,500 homes participate. The remaining 7,200 homes are largely personal care homes offering minimal nursing services. There are Federal nursing standards with respect to skilled nursing and intermediate care facilities as set forth below. There are no Federal standards for personal care homes; if there are regulations at all, they are State regulations.[64]

SKILLED NURSING FACILITY STANDARDS

Every Skilled Nursing Facility (whether participating in Medicare or Medicaid) must have the minimum of one registered nurse in charge of nursing on the day shift, 8 hours a day, 7 days a week. In addition, a minimum of one licensed practical nurse must be in charge of nursing on the 3 p.m. to 11 p.m. (afternoon) shift and the 11 p.m. to 7 a.m. (evening) shift. The law allows the Secretary of HEW to make exceptions in rural areas where there is a shortage of nurses; there, registered nurse coverage is required only 5 days a week.

INTERMEDIATE CARE FACILITY NURSING STANDARDS

Nursing homes participating in the Medicaid program as Intermediate Care Facilities are required to have one LPN in charge of nursing on the morning shift, 7 days a week. In addition, such facilities must make arrangements for consultation with an RN 4 hours per week.

The Subcommittee's Introductory Report, released on November 19, 1974, concludes that these standards are severely inadequate. The Report contrasts these weak Federal standards with more realistic standards in effect in some of the States. Connecticut, for example, requires the minimum of one registered nurse on the day shift for every 30 patients; one RN on the afternoon shift for every 45 patients and one for every 60 patients on the evening shift. The Subcommittee is particularly critical of the Intermediate Care Facility standard which permits ICF's 14 hours of each day without licensed nursing personnel in charge. Implicit in the latter standard is that there will be total reliance on aides and orderlies during the afternoon and evening hours.

The Introductory Report also makes clear the prolonged battle waged by Senator Moss and consumer advocates to insure that the present Federal minimums (inadequate as they are) would not be further weakened. For example, the July 1973 interim regulations (HEW's first attempt at providing unified Medicare-Medicaid standards) attempted to lower nurse coverage requirement. HEW regula-

[64] Full details of existing Federal regulations can be found in the *Federal Register* of January 17, 1974 as augmented by the *Federal Register* of October 3, 1974.

tions attempted to require RN coverage for skilled nursing facilities only 5 days a week. This action prompted hearings by the Subcommittee on Long-Term Care.[65] In response to protests from senior citizen and consumer groups, HEW reinstated the 7-day a week RN coverage standard which is presently the law.

In 1969 Senator Moss had another battle with HEW over the term "charge nurse"; in other words, over who would be permitted to be in charge of the facility (i.e., directing activities of the nurses). Interim regulations proposed by HEW in June of 1969 would have allowed the charge nurse function to be performed by LPN's licensed by waiver—that is, licensed on the basis of past experience rather than on the basis of any formal course of instruction.[66]

V. DISPUTE OVER STAFF-PATIENT RATIOS

Another battle between the Subcommittee and HEW has not been resolved. Senator Moss and senior citizen representatives have long argued that the Moss amendments of 1967 require HEW to establish minimum ratios between the number of nurses in the facility and the number of patients. Other ratios were requested to fix the number of nurses working under one nurse supervisor.

Experts in the field of long-term care continue to assert that ratios are necessary to insure proper patient care. For example, Reverend William T. Eggers, then President of the American Association of Homes for Aging, testified before the Moss Subcommittee in July 1969:

The Association has consistently deplored the fact that national standards and many state standards for skilled nursing facilities have not established a number of significant ratios *between patients and staffs* and *between supervisory staffs and nursing personnel.* The Association believes, for example, that the original proposals of HEW personnel to provide more professional nursing staff in long-term care facilities at this time deserve further study and further exploration. Despite the acute problem in establishing these ratios, it is the Association's contention that the solution is *urgent* and wholly *possible.*

In view of the fact that the proposed standards at best provide that a nursing facility of any size, even one with 500 beds, can legally be operated with only one licensed practical nurse on duty in the entire facility on two of its three shifts, the Association feels a sense of urgency about upgrading the standards of caring for the ill in such facilities. It poses these questions: What is an adequate ratio of professional nurses to patients? What is an adequate ratio of all nursing personnel to the number of patients they serve? While the Association is mindful of the inherent difficulties in these questions—which include the difficulty of measuring quality by quantitative standards—the Association also recognizes that some states have written ratios of this nature into their state codes. The Association would deplore the possibility

[65] October 10 and 11, 1973.
[66] See pp. 66–68 of the Introductory Report.

that inadequate federal standards would undercut whatever progress may already have been achieved in these states.[67]

In testimony before the Subcommittee the Nader Task Force supported ratios[68] as did the National Council of Senior Citizens. Marilyn Schiff, Director of the Council's Ombudsman project, stated:

> Failure to set staffing ratios is one of the deficiencies of the current regulations that would be perpetuated if the proposed regulations are adopted. . . . As a result, a 400-bed nursing home could be staffed by one registered nurse 40 hours a week and one licensed practical nurse on each shift. The number of aides apparently would be left up to the nursing home.[69]

Still HEW has flatly refused to issue even minimum ratios for personnel per patients, describing such ratios as "a false benchmark."

In a memorandum (reprinted as Appendix 8 to the Introductory Report) Dr. Faye Abdellah, Director of the Office of Nursing Home Affairs (HEW), defends the Department's refusal to require ratios. She argues:

> The ratio of patients to personnel as a guide and an index to the amount of care available to patients is a crude index at best. But over and above, the ratio is not an indicator of quality of care.
>
> The assumption is often made that the total time expressed in the ratio is time available for patient care. This is not necessarily true because ratios may or may not exclude from the total time activities spent on activities which are not patient care activities, e.g., charting and doctors' rounds.
>
> * * * * * * *
>
> Ratios cannot answer all the questions pertaining to staffing since staffing is complex. There are many factors to be considered when staffing units in either acute or long term care units. These factors include: patient numbers and characteristics; staff competency and staff supervision; unit design; and logistic support to nursing service. For example, there is a difference between staffing based on 100.0 percent occupancy versus the needs of patients. In order to staff to meet patient needs, some institutions build on a basic staff or the minimum number of staff needed to operate a unit. Complementary personnel are added to the basic staff when indicated to provide the additional patient care required.
>
> Further, the interrelationships among and between factors affecting staffing are not clearly understood. For example, hospitals with larger and more active medical staffs usually have higher occupancy rates. Indications are that with a greater proportion of specialists among the active medical staff, the greater the proportion of non-nursing personnel among the hospital employees. This would be expected since specialists utilize a greater number and variety of ancillary medical workers than do non-specialists. This may indicate a greater complexity with a greater

[67] Hearing cited in footnote 19, p. 74.
[68] Hearings cited in footnote 19, pp. 889–90, Part 11.
[69] Hearings cited in footnote 19, p. 2759, Part 22.

number of coordinating, scheduling and preparatory procedures being delegated to nursing.

As has been mentioned, there are many factors pertaining to staffing that need to be considered. Many of these factors have and are being studied. No single method, e.g., patient/personnel ratio, will provide the answer. The many questions that still remain need research to provide the answers.[70]

The Subcommittee does not contend, as HEW implies, that ratios are a panacea for solving the problems of poor patient care. Instead, the Subcommittee simply urges ratios as one way to increase the numbers of registered nurses required in today's nursing homes. This suggestion is grounded in the fact that homes with more registered nurses have higher quality care. For example, one study illustrates that the number of drugs administered in error is markedly reduced when RN's are employed around the clock.[71]

The inadequacy of one RN in charge of a nursing home with 150, 200, 300 or 400 beds is obvious on its face. HEW contends that ratios are not the answer to providing minimal nurse coverage for patients in large facilities but has offered no proposal of its own to deal with the problem.

HEW's failure to set ratios will mean that unlicensed aides and orderlies will continue to provide 80 to 90 percent of the nursing care in long-term facilities.

The disadvantages of this practice are illustrated in HEW's own testimony (in another context):

Nursing personnel less qualified than the RN are not capable of recognizing many sudden and subtle, potentially dangerous changes that take place in an ill patient, nor are they prepared to exercise the nursing judgment necessary to respond appropriately in any number of patient crises.[72]

It is just as clear that whatever the Federal nursing standards may be, they must be enforced. Part Five of the Introductory Report describes the inspection and enforcement system as a "national farce". It asserts that there is no direct Federal enforcement and that enforcement of Federal standards is left up to the States. While some States do a good job, most do not. In fact, the enforcement system is characterized as scandalous, ineffective, and in some cases, almost nonexistent. This analysis applies equally to standards for coverage which are the subject of this section. As an example of the questionable enforcement in the past, the U.S. General Accounting Office disclosed that 50 percent of the nursing homes surveyed in its May 1971 three-State sample did not meet the existing Federal standard: one RN on the day shift and the minimum of an LPN in charge of the other two shifts.[73]

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[70] See p. 149 of Introductory Report.

[71] Brady, Edward S., et al., *Drugs and the Elderly,* a series of papers published by the Ethel Percy Andrus Gerontology Center, University of Southern California, 1973; paper by Ronald C. Kayne and Alan Cheung, "An Application of Clinical Pharmacy in Extended Care Facilities," pp. 65–69; see also "A Prospective Study of Drug Preparation and Administration in Extended Care Facilities," by Alan Cheung, Ron Kayne, and Margaret M. McCarron, unpublished study in subcommittee files.

[72] Hearings cited in footnote 19, p. 2721, Part 22.

[73] May 28, 1971, audit of New York, Michigan, and Oklahoma.

VI. NEW DEVELOPMENTS

There are a number of new and positive developments which deserve mention at this point because of their importance and probable future impact.

1. By recent action of Congress nurses were covered by the provisions of the Taft-Hartley Act. These provisions became effective on August 25, 1974, giving nurses the right to organize, the right to strike, and the protections of the National Labor Relations Board. Significantly, the Illinois State Nursing Association immediately filed a petition with the Board seeking recognition and certification as a collective bargaining representative on behalf of its members.[74]

This action will undoubtedly result in increased unionization, collective bargaining, and other union activity in nursing homes which themselves have been covered by the provisions of the act for only a few years. The NLRB may now intervene to protect the rights and safety of workers, and by so doing, improve the quality of care in nursing homes.

2. A similar development with even greater impact on the quality of care is the recently enacted Williams-Steiger Occupational Health and Safety Act of 1970.[75] This law seeks to guarantee all workers with a safe place to work. Employers will have to comply with a set of safety standards. Employees in nursing homes are accorded the protections of the act. If a nursing home fails to provide a safe living environment, nurses (and other employees) may notify the Department of Labor and ask for an inspection. If the employer is found in violation, a citation and a penalty will be issued.

For the convenience of nurses and employees toll-free "hot lines" have been established to the Department of Labor. In Washington, D.C., the number is 202–961–2603. In other areas the numbers are as follows:

Toll-free 24-hour OSHA "hot lines" are in operation in Atlanta and Chicago regions of the Occupational Safety and Health Administration.

Callers can use the "hot line" to report situations of imminent dangers in the workplace or jobsite accidents any hour of the day or night. During office hours, callers also can receive answers to questions about the Occupational Safety and Health Act.

In the Atlanta dialing area, the hot line number is 892–0259. For the remainder of Georgia, outside the Atlanta dialing area, the number is 800–282–1048. Callers from Alabama, Florida, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee—all covered by the Atlanta region—should dial 800–241–8598.

In Chicago, the local number is 939–5494. For those in Illinois outside area code 312, the number is 800–972–0581. The rest of the Chicago region—Indiana, Ohio, Michigan, Minnesota, and Wisconsin—should dial 800–621–0523.[76]

3. The American Nurses' Association has increased its role in improving the quality of nursing home care.

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[74] *The American Nurse,* October 1974. p. 3.
[75] Standards can be found in the *Federal Register,* May 29, 1971, Vol. 36, No. 105, Part III. See also appendix 1, page 449.
[76] *Job Safety and Health,* May 1973, p. 23..

In 1971 ANA received a $355,000 grant from the Department of Health, Education, and Welfare to give training in geriatrics to 3,000 RN's working in nursing homes. Numerous seminars were conducted throughout the United States. The results have been widely acclaimed by nursing home spokesmen.

An even more courageous effort grew out of ANA's testimony before this Subcommittee on October 10, 1973. The focus of those hearings were the unified Medicare and Medicaid standards for skilled nursing facilities. Senator Moss requested that ANA undertake a difficult task:

> Would the American Nurses Association be prepared to form a committee of appropriate groups and nurses to report back to this committee, let us say in a year from now, at the latest, on the following issues: (1) A definition of skilled nursing care that could guide those in developing Federal programs; (2) how and where such care could be provided.
>
> I would also like you to include alternatives to institutional care, what factors now inhibit utilization of such settings, and so forth, the kind of personnel needed to provide adequate care in the various settings, methods of reimbursement for care that will promote best use of funds for quality services, and training programs needed to assure a supply of up-to-date nursing personnel. Would you be prepared to consider that? [77]

ANA responded, calling 22 major organizations together to discuss these and other problems. Sister Marilyn Schwab was named the chairperson of the ANA Committee on Skilled Nursing Care. But ANA's response was not limited to its calling national organizations to three major conferences. Some 6 hearings were held all across the nation.

Testimony at these hearings offered innovative approaches to long-term care and there was a general focus on the need for better education of both the health care providers and the public to the needs of those persons requiring long-term health care and a better understanding of old age by the consumer and the public.

Persons testifying represented a wide spectrum of interests, included an administrator of a nursing home, representatives of State departments of public health, consumer groups and nursing home ombudsman programs, church groups, university programs, and health care providers such as occupational therapists.

In addition to the plea for better education, the rights of the long-term patient were championed. A better understanding of the patient and the promotion of patient independence was urged by many of those testifying.

The ANA Committee on Skilled Nursing Care completed its report in time for inclusion in this report. The report is destined to become a landmark in the field of long-term care. Because of its excellence and because of the importance of the issues it raises, the full report was included in this Supporting Paper at this point.

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[77] Hearings cited in footnote 19, p. 2580, Part 22.

PART 2

NURSING AND LONG-TERM CARE: TOWARD QUALITY CARE FOR THE AGING

A Report from the Committee on Skilled Nursing Care, American Nurses' Association, To the Subcommittee on Long-Term Care*

PREFACE

Historically the American Nurses' Association has assumed a leadership role in confronting problems related to securing adequate nursing services for our nation. Therefore, it is not only appropriate but rather an obligation for the American Nurses' Association to accept the charge by Senator Frank E. Moss to prepare a report on nursing and long-term care which could be used in planning changes in health care legislation by the Subcommittee on Long-Term Care of the Special Committee on Aging of the United States Senate.

The following recommendations, reports and excerpts of testimony represent the concerns identified by members of the American Nurses' Association, as well as by many health professionals, health care organizations, and most important, consumers of health care services, in their testimony and as members of task force groups.

The report is not a critical paper, but rather a document which points out needs and provides suggestions as to how these needs can best be met.

The American Nurses' Association and its Committee on Skilled Nursing Care expresses gratitude to the many individuals and agencies who have contributed material, personal findings, and testimony, as well as many hours of research, all of which were necessary to make an effective report.

If the standards of health care in America, and particularly health care for the aged, can be raised—if health care can become a right—then this document will have performed a vital and necessary role in providing for the health of the American people today and in the future.

ROSAMOND GABRIELSON, R.N.,
President, American Nurses' Association.

*This document was prepared by the American Nurses' Association from information and recommendations compiled by the Association's Committee on Skilled Nursing Care. The research project was instituted in response to a charge from the Subcommittee on Long-Term Care of the United States Senate Special Committee on Aging that ANA study and report on issues related to Long-Term Care.

LETTER OF TRANSMITTAL

Senator FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care, Special Committee on Aging, United States Senate.

The following document is the result of over a year of planning and work on the part of the American Nurses' Association to fulfill the charge your subcommittee gave that organization on October 10, 1973. After hearing ANA's testimony to your subcommittee on that date, you asked the American Nurses' Association to prepare a report on the problems of providing "skilled nursing" as it is presently defined by Medicare and Medicaid, as well as the related problems of alternatives to institutional care, supply and training of qualified personnel, and methods of reimbursement for quality care. The ANA responded enthusiastically and immediately in the affirmative.

A committee of ANA members representing various units and interests within the organization formed an Advisory Committee to design the strategy for the report, including broad representation of other health professional groups, and to finalize the document, once the input was received.

The strategy used was twofold: First, to call representatives of 22 national organizations concerned with health delivery, with aging, and with the aged consumer; second, to hold regional hearings for grass roots input from various sections of the country. The representatives of the national organizations met in three different task forces, one concerned with "Definitions and Classifications," one with "Manpower and Training," and one with "Options for Health Care." Each task force met three times over a period of six months, and the entire group met together at the beginning and at the end of this time to integrate their reports and recommendations.

The regional hearings were prompted by the great amount of unsolicited mail received by the Advisory Committee from nurses and others all over the country requesting an opportunity for input into this important task. It was decided to hear testimony in six regions of the country related to the same topics the Advisory Committee was considering. Although the hearings were held in the summer, and with very little lead time the response was gratifying. The hearings were, in my opinion, the most powerful affirmation of widespread concern that the committee could ever hope for, because the themes of what was wrong and what might make it better were similar to the Advisory Committee's findings, whether in Florida, Montana, or Massachusetts. With that kind of reenforcement from citizens, professionals, and consumers all over the country, concerns and recommendations of the committee cannot be written off as ivory tower thinking.

The intent, in both the work of the Advisory Committee and of the regional hearings, was not to merely list the inadequacies of the present system, but to offer some solutions. We feel that our report will offer some sense of direction for the future and provide some useful concepts to legislators, who have the formidable task of translating ideals of the society into programs that will work.

The American Nurses' Association is grateful to the Subcommittee for the invitation to submit information and opinion about the important issue of long-term care in this country, since the nursing profession realizes well that long-term care demands more of the human service known as nursing than any other helping profession. Thus the fate of long-term care and the fate of the nursing profession are closely related. We feel this relationship was recognized by your subcommittee and we thank you for challenging us to deepen our commitment by this endeavor.

Sister Marilyn Schwab, R.N.,
Chairperson, Committee on Skilled Nursing Care,
American Nurses' Association.

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Cooperating State Nurses' Associations for Hearings:

California

Colorado

Florida

Massachusetts

Michigan

Montana

Caroline Brooks, Editor

NATIONAL ORGANIZATIONS WHOSE REPRESENTATIVES SERVED ON TASK FORCES OF ANA'S COMMITTEE ON SKILLED NURSING CARE

American Association of Homes for the Aging
American Association of Retired Persons—National Retired Teachers Association
American College of Nursing Home Administrators
American Geriatric Society
American Health Care Association (formerly, American Nursing Home Association)
American Hospital Association
American Medical Association
American Public Health Association
Association of State and Territorial Directors of Nursing
Gerontological Society, Inc.
Gray Panthers
National Association of Home Health Agencies
National Association for Practical Nurse Education and Service, Inc.
National Caucus on the Black Aged
National Council on Aging, Inc.
National Council for Homemaker—Home Health Aide Services, Inc.
National Council of Senior Citizens, Inc.
National Federation of Licensed Practical Nurses
National League for Nursing, Inc.
National Student Nurses' Association
National Union of Hospital and Nursing Home Employees
Veterans Administration

SYNOPSIS

Care of the aged is frequently inadequate and/or inappropriate, failing to meet the needs of America's older population because facilities and services as well as funds are insufficient.

Although long-term patients have unique problems resulting from the aging process, the fact remains that each person continues as a vital, worthy, changing human, with needs best met on an individual basis.

An older person seeking assistance finds a dearth of institutions, services, and personnel trained to provide the help that is needed. If the level of care desired is different than that available in nursing homes with acute care (or skilled care) facilities, the remaining choices are few or nonexistent. This group of aged people must choose between no care or overcare.

The availability of in-home services, day care centers, foster home programs, funding for home care services, and similar options would not only allow the elderly person to remain at home, but would allow him to do so at a lower cost than possible in acute or skilled care facilities.

Reimbursement systems currently encourage the overuse of institutional facilities and discourage home care services through the payment mechanism. Broadening coverage to allow for care in homes and noninstitutional settings would not only reduce the problem but would also provide a broader and better range of services in the appropriate settings.

Health services for this group of people should focus on the attainment and maintenance of a balance of their physical, mental, or social well-being, and not merely on attaining the improved control of diseases or infirmity. Every chronically ill and older person has the right to strive or to be assisted in striving to achieve maximum health potential.

The term "skilled nursing" as it currently exists in the Federal regulations is restrictive and task-oriented and is not descriptive of professional nursing practice. Not only does the term fail to describe good professional practices, it does not describe the services the patients need.

There is an inherent contradiction in the term "skilled" when it is applied to human services which are provided by responsible institutions or by individuals, whether in public or private agencies. The term implies limitations and exclusions in areas of service which are central to standards of competence and to the achievement of excellence in the quality of care. When discussing the quality of any health care service, the use of skills is axiomatic, and therefore the word "skilled" should be removed from the nomenclature describing long-term nursing care.

Of the 815,000 employed registered nurses in the nation, only 65,235 are found in nursing homes, representing an understaffing situation in long-term care facilities. Since a major portion of the professional nurse's working time in these institutions is occupied with administrative duties, from 80 to 90 percent of the care in these facilities is provided by aides and orderlies who have little or no educational preparation for their jobs. Most of the more than 280,000 aides and orderlies are grossly overworked and underpaid; and these positions generally experience a turn-over rate of 75 percent a year.

One reason for the small number of registered nurses in nursing homes is that present staffing standards are unrealistic in relation to the overwhelming needs of the patients. Another reason for the fewer nurses in these institutions is the low status and low pay of these positions when compared to positions for nurses in other areas.

Basic and graduate educational programs for registered nurses need to emphasize gerontology and geriatric nursing care, not only in the classroom but in clinical facilities, so that the graduates understand problems of patients in this area and can plan and supervise both the physical and social care required.

Work standards, pay schedules, and benefits of both professional and nonprofessional staff need to be examined and altered so as to become competitive in the job market. This, combined with improved training, would raise the capabilities of these employees of long-term facilities and would reduce the expense of high turn-over rate.

The rapid increase in America's aged population indicates that a national health policy is needed immediately and that long-term care should properly be considered within the context of national health insurance plans.

On a national basis, the present provision of health services is fragmented, uncoordinated, and incomplete. The current high costs of health care services stand in the way of effective delivery of health services to large numbers of people in the country. This is especially true and has more disastrous effects on the elderly.

If a national health insurance plan is to provide comprehensive health care services, more recognition must be given to the nurse's role in the delivery of primary care. Appropriate preparation and utilization of the nurse practitioner in the primary care role is one important way to extend health services and use health manpower more effectively. Funding for training programs for nurse practitioners is needed.

The Federal government should make provisions for national standards governing health insurance coverage so that each citizen is assured equal benefits, regardless of age.

SUMMARY OF RECOMMENDATIONS

The following recommendations are made by the American Nurses' Association's Committee on Skilled Nursing Care based on the results of efforts, research, and recommendations of three task forces composed of representatives from all areas of the health field. In addition to the work of task forces, six hearings on long-term care were held throughout the country, and information from witnesses' testimony was used in compiling not only these recommendations, but also the document which follows. Complete task force reports are included in the appendixes of this volume.

I. A national policy on care of the aging should be developed, within which should be provision for care of the elderly in any kind of setting, the right to high quality care, and the right of the elderly to decision-making in regard to their own care. The national policy on care of the aging should be built on the fact that the aged are vital, dynamic persons who have made and who continue to make contributions to society.

II. Because high costs of essential health care services, coupled with the present provision of fragmented, uncoordinated, and incomplete health services stand in the way of effective delivery of health services to the aged, a plan for national health insurance should be developed to insure that health care services are provided for all citizens, guaranteeing coverage for the full range of comprehensive health services. The national health insurance plan should clearly recognize the distinctions between health care and medical care, and provide options in utilization of health care services.

III. In considering options or alternatives for care, the Committee on Skilled Nursing Care recommends that a range of health and supportive services be made available to all elderly citizens. Thus, whether a person chooses to live in his own home and have services brought to him, to go to the services in a day care setting, or to move to a nursing home, he would have assurance that the needed services would be available.

IV. The word "skilled" should be deleted from the phrase "skilled nursing care" as it currently exists in the Federal standards and as the term is generally applied in actual practice, because it is not measurable nor can it be defined when related to the needs of a patient.

V. Because quality health care will depend primarily upon the competency of the persons providing direct care, all professional persons and workers involved in long-term health care in any setting should have a background in the basic care of the aging. These gerontological concepts should be taught at the educational levels of the individuals in the depth and detail each can understand and use. Preparation in gerontological nursing should be within an open educational system which promotes career mobility. The educational program of registered nurses at all levels should be developed and strengthened to correct specific deficiencies in the area of gerontological nursing.

NURSING AND LONG-TERM CARE: TOWARD QUALITY CARE FOR THE AGING

The population of America is growing increasingly older, with more than 10 percent of all people now age 65 years old or older. And as their numbers increase, the elderly will play an even more prominent role in the nation's economic and social life.

By the end of this decade there will be more than 24 million senior citizens in the nation. The over-65 population will increase at a rate of approximately 11 percent, as compared with the national population gain of little more than 5.5 percent.[1]

While health care costs continue to rise for all Americans, for the older person, the problem is compounded. This individual has approximately half the income of those under age 65, and even with Medicare his payment for needed health services is more than twice as much. The aged person is twice as likely to have one or more chronic diseases than young people, and much of the care required is of the most expensive kind. While medical costs escalate, services available under Medicare and Medicaid go down, a process which was accelerated considerably in 1971.[2]

Yet even with this information at hand, this country has failed to develop a national health policy, failed to meet the long-term care needs of the elderly, and failed to instigate or maintain any sort of national health insurance program which would assure dignity, comfort, and help to each American as he and members of his family become among the country's aging.

Long-term health care is especially important to this age group, as it is to other groups, including the chronically ill and the mentally and physically handicapped. This report, while recognizing long-term care needs of these other special groups, will focus on the long-term care needs of the elderly in particular.

In considering the unique needs of long-term patients, emphasis must be placed on the fact that the chronically ill or elderly person is a vital, worthy, changing human being, who is in constant dynamic, mutual interaction with those surrounding him and with his total environment.

These people in need of long-term health care find a dearth of institutions, services, and personnel trained to provide the help they need without traumatic interruption of their lives. Indeed, these people seeking long-term care frequently find only hospitals and skilled nurs-

[1] Jackson W. Goss (President and Chief Executive Officer of Investors Mortgage Insurance Company of Boston), reported by the Associated Press and printed in the *Kansas City Star*, November 1974.

[2] *A Pre-White House Conference on Aging Summary of Developments and Data;* a report of the Special Committee on Aging, United States Senate, November 1971, p. 17.

ing facilities available. There are no real options available in a large number of communities in this country.[3] Because of the lack of alternatives to institutional care, many older Americans must either live in skilled nursing homes, where the level of care is often higher than their needs, or try to remain in their homes, where care may be inadequate or nonexistent and where insurance rarely covers their health needs and services. As a result, the patient/consumer, as well as the taxpayer, suffers because of costly unnecessary institutionalization, which also results in the temporary breaking up of families.

Elderly people needing health care or rehabilitative services can be found in many settings—homes, nursing homes, hospitals, and other settings between home and hospital, such as boarding homes, congregate residences, and extended care facilities. The setting varies with both the preferences and means of the individual and the level of care needed. One elderly individual with a good deal of disability and dependency may reside in his own home or apartment, while another elderly individual with relatively good health may be found in the acute setting of the hospital for diagnostic tests, minor treatments, or major surgery.

The individual requiring long-term care is one who suffers from one or more chronic conditions which have resulted in a physical and/or mental impairment of normal activities, and which require prolonged and supervised care or treatment, necessitating at least, but not only, professional nursing assessment, evaluation, monitoring, judgment, and coordination of services and environmental support systems appropriate to the individual's health needs.

It is the intention of this report to suggest some different directions in health care services, especially in terms of nursing care needs, which constitute the largest portion of those services.

Level of Care

Under the current Federal system of patient classification, and subsequently of reimbursement, emphasis is placed on who is providing services for how many hours per week rather than on the needs of the residents of health care facilities.

The committee strongly recommends the deletion of the phrase "skilled nursing" from Federal regulations and the corresponding "levels of care" concept.

Understanding basic human needs, developmental tasks of all ages, and dynamics of behavior are crucial to the delivery of long-term care. Technical procedures fail when they do not include and consider behaviors and feelings of the long-term care client. Long-term care should not interrupt the natural patterns of individuals' lives.

The present classification of intermediate and skilled nursing care facilities overlooks personal needs, resulting in undesirable restrictions on care for patients needing varying levels of attention and medical services. It is only through a flexible classification of patients and a system of matching services to needs that an acceptable delivery of health care for the elderly can be provided.

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[3] Brahna Trager, paper presented at the opening session of the Committee on Skilled Nursing Care, "The Concept of 'Skill' in Community Care," American Nurses' Association, Kansas City, Mo., May 13, 1974.

For example, an individual who has a stroke may need multiple rehabilitation services (speech and hearing, occupational, recreational, and physical therapy; and restorative nursing) although he may be able to manage his own personal hygiene, eating, and dressing with minimal assistance. Another individual who has had a stroke may require assistance and instruction in self-care and may be progressively moving toward active rehabilitation, while still another person may need to be maintained at a minimal level of rehabilitation. These three different patients need different nursing services provided in different settings, and with different frequency and intensity of care.

Active programs for restorative care demand that there will be coordination of the different components of health services and provision for continuity in the absence of the specialty therapist. For example, when the physical therapist isn't present, the nursing staff must continue to carry out the care designated by the therapist. A patient care plan must be continuously evaluated. This demands the clinical judgment of a professional nurse.

Since an individual's conditions change from day to day, there is a need for continuous evaluation, especially of a dependent person, in order that signs of change are noted. The long-term needs of the individual, constantly affected by his changing state, can be seen only on a continuum. His status may reflect variances in his ability to ambulate, the degree or extent of disability, his ability to communicate, his mental alertness, or his level of orientation. Nursing services in long-term care must be flexible in responding to the constantly fluctuating needs of those individuals who are receiving care. Focusing upon the individual's needs is in direct contrast to the present vertical hierarchy of levels of care, which is based on the numbers and/or kinds of isolated, individual procedures required. The kind, complexity, frequency, and duration of nursing care needed by an individual patient within any given time may vary considerably.

Joan S. Guy, executive director of the Michigan Nurses Association, explains:

> Our members have long been concerned with the confusion and distress for recipients and providers of health care services which have been caused by the current terminology of "skilled nursing care" and "intermediate care." Focus of these classifications has not always been on needs of recipients nor on the skills required for competent nursing care and have often ill served the people they were designed for.[4]
>
> *The all important interpersonal element is compassion . . . humane treatment. . . . quality of care (These) are in reality "where it is all at" and "what it is all about."*
>
> *Please don't continue to allow the patient to become lost in the shuffle. Even though for some of our patients the physical shell seems useless we must remember that there is still a human person inside that body and we must treat them as such even though we have no tangible signs of response. Nursing is not an exact science. There are so many variables, and they are not uniformly measureable.*[5]

[4] Joan S. Guy, testimony presented to the Committee on Skilled Nursing Care hearing, East Lansing, Mich., September 5, 1974.

[5] Testimony presented by Yvonne White, Health Care Association of Michigan, at the hearing on Skilled Nursing Care, held in East Lansing, Mich., September 5, 1974.

Rather than levels of care under which Medicare and Medicaid programs now function, a system should be developed which would allow individuals to receive the kind and degree of nursing and other services required in the appropriate setting, as their changing health status and needs dictate. Such a plan would allow a person in or out of a long-term care facility to obtain required services without having to be relocated. This would eliminate the trauma presently involved when a person must be transferred from his familiar surroundings—his home—to a new setting because of a change in the "level" of care he requires.

Under such a plan, hospitalization or discharge to the community would become the only occasions which require that the individual be relocated.

The present definition, under Medicare, is so rigid and restrictive that in New York State, for example, only three to four percent of the total skilled nursing facility patients are eligible for benefits. This definition is certainly inadequate for the long-term care patient.[6]

Thousands of nursing home patients could face serious illness and even death because of a narrow and restrictive government definition of skilled nursing care which could force the transfer of about 100,000 patients from skilled nursing facilities to intermediate care facilities. Studies show that relocation causes stress resulting in disorientation which could cause illness or even death.

> *It seems to me that if we needed to experiment with such a serious matter as implementing a Federal skilled care program we could have at least started with a segment of the population much younger, that would have better tolerated and adjusted to the serious abuses and misuses of the current program. I have seen discharges of many patients from my own facility to local nursing homes that were dead the next week due to transitional shock.*[7]

The government definition which provides that only skilled nursing home patients who are recovering from acute illnesses are entitled to skilled nursing care denies skilled nursing care to patients who are chronically ill and requires that they be transferred to intermediate care facilities where a different type of care less suited to their needs is available.

It is customary practice of the fiscal intermediary for the Medicare program to require the cessation of Medicare benefit in an extended care facility when a patient's condition has become stabilized, irrespective of the degree of skilled nursing care required by the patient. This means that suddenly, during the course of treatment, the patient must be transferred to another nursing home or moved to another bed in the same facility if a bed is available.

In a typical case where such a chain of events occurred, the patient lost her extended care benefit and subsequently developed complications requiring re-admission to the hospital, where the patient died.

Decreasing the necessity of moving a patient from one setting to another reduces for him the risk of "transfer shock" which is inherent

[6] Ruthie L. Hunt, "Statement of the New York Nurses' Association," testimony presented to the Committee on Skilled Nursing Care hearing, Newton, Mass., September 9, 1974.

[7] Testimony presented by Constance M. Mugent, Administrator, National Medical Care of Portland, Inc. (a 100-bed skilled nursing care facility), at a hearing on Long-Term Nursing Care held in Newton, Mass., September 9, 1974.

in such moves. It also increases the efficiency and appropriate utilization of services. Any patient transfer or discharge should be carefully planned on the basis of the patient's therapeutic needs, with the patient and/or his family involved in the planning. Prime consideration needs to be given to careful patient assessment in relation to transfer and placement criteria.

Placement and Transfer Mechanism

In discussing the evaluation of patients and classifications of patients in terms of needed levels of care, Tucker Trautman, Director of the Senior Citizens Law Center in Denver, Colorado, representing Gray Panthers, a nationwide organization working against all forms of age discrimination and for radical social change, has stated:

> There is no doubt that this is a medical determination which requires the input of that profession. However, it is our position that the patient has a role in those determinations within the nursing home community. However, under present Federal law and regulations, the patient has little if any input into those decisions. You might ask, "Why should a patient have input?" I think the question perhaps answers itself, but one prime reason is that as in any field, reasonable medical persons may disagree. Having patient input would provide a natural check on that medical decision-making process. However, the most important reason to allow such input is that it gives the older person some say in his own destiny. It is purely a matter of human dignity.
>
> Under current Federal regulations, a patient is admitted to a nursing home *only* upon the recommendation of a physician. Once the patient is admitted, the nursing home is required to provide a written plan of care and where appropriate a written plan of rehabilitation. Federal regulations also require periodic inspections by medical review teams at least once a year and with no more than 48 hours notice. That medical review team, which is composed of one or more physicians and other appropriate health and social service personnel, establishes personal contact with the patient and reviews the medical charts and upon that information makes recommendations to the state. Under those regulations there is no mechanism to allow the patient to object to his admission or to identify whether his plan of care is appropriate. The regulations contemplate a pure medical decision made only by physicians and other health and social service personnel.
>
> The medical review team, upon its inspection, determines among other things "the necessity and desirability of continued placement . . . and the feasibility of meeting health care needs through alternative institutional or noninstitutional services." Once again, that decision is a medical one lacking input whatsoever from the patient. If it is determined that a transfer of the patient is appropriate, that transfer—

need only be accomplished by written notice to the patient. Again, there is no mechanism to dispute the decision even if the patient feels that it is inappropriate.

Perhaps the most tragic effect of the present lack of any dispute mechanism prior to transfer is the growing body of medical evidence which demonstrates that older persons, more than most segments of our society, become very dependent on their immediate environment. Often family and friends have passed away or they may have been abandoned by family, thus their immediate surroundings become very important to their existence. Transfer of these elderly patients from one nursing home to another can have detrimental effects. . . . A study in the Stockton State Hospital located in Stockton, California, examining the effects on transfer of elderly patient from wing of that hospital to another agency showed that the mortality rates of transferred persons went up when compared with a similar group who were not relocated. In the group of transferred patients who were non-ambulatory the mortality rate was nine times that of the control group while the ambulatory group had a mortality rate of almost five times that of the control group. That study and other similar studies have concluded that safeguards must be taken to prevent the death or deterioration of the transferred patient unless the transfer is absolutely necessary. A plan of preparation can be utilized to slowly integrate the person into the new environment. Again, the Federal law makes no provision for such a plan.[8]

Misnomered Nursing

Another problem related to the difficulties of classification involves the controversial definition of skilled nursing.

As it currently exists in Federal standards, skilled nursing is a misnomer which cannot be measured and cannot be defined when related to the total needs of a chronically ill or long-term care person.

Additionally, there is an inherent contradiction in the term "skilled" when it is applied to human services which are provided by responsible institutions or individuals, whether these are public or private. The term seems to imply limitations and exclusions in those areas of service which are central to standards of competence and to the achievement of excellence in the quality of care—most particularly in the quality of health care which is an essential need in the whole population.[9]

Brahna Trager, Home Health consultant and author of Home Health Services in the United States, raises the following issues:

It is impossible to avoid the question, "When is it appropriate for any human service, and most particularly for any health care service to be *unskilled*?"

The term "skilled" touches on other questions. Is it possible to single out certain facilities and services from the entire range of health care resources and make valid distinctions concerning "skill"?

[8] Tucker Trautman; testimony presented to the Committee on Skilled Nursing Care hearing, Denver, Colo., September 16, 1974.
[9] Trager, *op. cit.*

Is there such a facility, for example, as an "unskilled" acute care hospital?

Is it valid to select from the various categories of health care personnel, certain professions and to make distinctions which are intended to be specific only to that profession?

Is there an official designation in physician services which singles out certain aspects of his activities which can be considered "skilled" or "unskilled"?

Can the training and competence which lead to a total approach to health care, based upon judgment, experience and broad knowledge, be separated from the tasks related to all of these for the purposes of labeling and consequently of reimbursement? [10]

> *The major component of service needed and provided in home health agencies is nursing. With the enactment of Medicare legislation the designation, "skilled," was unfortunately attached to nursing as a reimbursable service provided by home health agencies. The practice of nursing is an art, a science and a skill as is practice of medicine, physical therapy or occupational therapy. Fortunately, these latter disciplines escaped the "skilled" label and Medicare regulations do not refer to skilled medical care, skilled physical therapy, or skilled social worker as a requirement of reimbursement.*
>
> *The attachment of the label "skilled" to nursing has become a major barrier to the delivery of care to the aged. The definition has resulted in great variance in interpretation.*[11]

The long-term care patient requires prolonged and regular supervision, care, or treatment, necessitating professional nursing assessment, evaluation, monitoring, judgment, and coordination of services plus environment support systems appropriate to his health needs. This is professional nursing.

The contribution of nursing is to meet the needs of the long-term client. These include providing for a high quality of life, an acceptable life style pattern, and some power or control over his life. This is professional nursing.

Professional nursing requires sound judgment and technical skills based on a thorough knowledge of scientific principles and the ability to apply these principles in assisting people to cope with real or potential health problems which may be physical, biological, social, emotional or intellectual in nature. And this is professional nursing.

Whether such assistance is provided continuously or at intervals, whether in a home setting, in an institution setting, or in other community or public health facilities, the registered nurse must be responsible for appropriate utilization of her skills and those of other nursing personnel.

Hence the professional nursing component must be present in all long-term nursing care, and the artificial designation of "skilled nursing" is meaningless. Worse, it is detrimental to patient care.

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[10] *Ibid.*

[11] Testimony presented by Jayne Tapia, Director of the Arlington-Lexington Visiting Nurse Association, representing the Council of Public Health Services of the Massachusetts League for Nursing, at the hearing on Skilled Nursing Care held in Newton, Mass., September 5, 1974.

Role of the Nurse

Nurses constitute the largest single group of health professionals involved in patient care today. Nursing constitutes the major health component now provided within long-term facilities. While nursing services within these facilities vary in the intensity and amount required and received by eligible recipients, the fact remains that adequate nursing care requires planning, direction, and supervision by registered nurses. All patients should have the right of immediate access to the judgment and skills of registered nurses, who should function as providers of primary care. This should be recognized in government programs, policies, and reimbursement systems.

The difference between professional and non-professional nursing care is often the difference between therapeutic and custodial care.

To illustrate, a resident with loss of bowel and bladder control needs to be kept clean and dry. This is custodial care. There is no such thing as a custodial patient, only custodial care. Understanding why control has been lost, planning a training program with the resident and staff, understanding the feelings of both the resident and staff in coping with the unpleasantness is therapeutic nursing care. The registered nurse is responsible for the quality of nursing care in the facility regardless of who gives that care.

The emerging roles of the registered nurse need to be more widely utilized in long-term care. In the profession, these emerging roles are referred to as the expanded role of the nurse and/or the extended role. The nurse in an expanded role may go by various titles, such as nurse practitioner, clinical nurse specialist, or nurse clinician. Nurses with advanced preparation are equipped to function with a higher degree of independence than is usually attributed to nurses. They are more skilled in assessment, planning, and evaluation of patients. Some isolated instances of their use in geriatric long-term care do exist, but the potential is far greater than any current experience.

The commitment and contribution of nursing to the large number of chronically ill and elderly persons includes assessment of the patient's health status and identification of his specific nursing problems, formulating a nursing diagnosis, planning with him and his family for his care and implementation, and evaluation of the plan with appropriate modifications when indicated to meet this patient's needs. Nursing's commitments and contributions also include teaching health care principles and practices to the patient and his family, assuming accountability for defining and validating all levels of nursing activity in terms of therapeutic effectiveness, increasing the sophistication of personal care services as health delivery systems expand, and accepting management responsibilities in providing nursing care to the patients.

Nursing contributes an understanding of the developmental stages of the life cycle, the effects of varying settings upon a person's life style, and the effects of chronicity upon a person. Nursing likewise attempts to decrease the regimentation imposed by health care in any setting, and to prevent, diminish, or restore the numerous losses associated with chronicity.

Specifically, the commitment and contribution of nursing to promoting delivery of quality health care services to chronically ill and elderly persons include:

- Active nursing participation at the planning level in both the determination and the systematic evaluation of the delivery of health services for these persons;
- The delineation and assumption of appropriate nursing responsibilities for coordinating health services within the health care systems and sub-systems so that chronically ill and older patients may have accessible movement into the system and receive continuing, high quality care;
- The provision of direct, humanistic nursing care services which are based on the personal health needs of chronically ill and older patients. This includes health assessment, health maintenance, and consultative and restorative nursing care in primary acute and long-term care circumstances both in and out of the hospital environment;
- Demonstration of accountability for appropriate and effective use of human and material resources in the nursing management of patient care services in the home and in institutional and other community health care facilities.

Role of Licensed Practical Nurses and Nurses' Aides

The nursing team includes the registered professional nurse, the licensed practical nurse, and the nurses' aide. Licensed practical nurses assist the professional nurse to carry out nursing functions which require special technical skills. Nurse practice acts in every state distinguish between the scope of practice of the registered nurse (RN) and the licensed practical nurse (LPN). Yet Federal standards contain statements such as "a licensed nurse" to mean either RN or LPN, and thus fail to make this distinction.

Nurses' aides form the largest group of nursing personnel in long-term care facilities, and much attention has been directed to their low status, low pay, and lack of training. More short-term training and higher pay for these people will not, of itself, improve patient care. Attention must focus on the entire team, increasing the proportion of and education of the RN and the LPN in their respective roles and, through these leaders, improving the education and status of the nurses' aide.

Each member of the nursing team makes a contribution to nursing care and, as with any team, each member is dependent on the other to achieve the goal—good patient care.

Regulations should recognize that nursing personnel have different competency levels and that effective round-the-clock nursing care involves an appropriate blend of the competencies of nursing personnel and the needs of patients.

Options for Long-Term Health Care

The health care industry has experienced tremendous growth in recent years, with total national health care expenditures rising to $80 billion in 1974. The cost of acute hospital care and institutional long-

term care has contributed significantly to the rise, and the trend seems certain to continue.

Of the more than 20 million Americans over 65 years of age, 80 percent report one or more chronic illnesses that require medical supervision. However, only five percent require long-term institutionalization, such as in acute care or nursing facilities. Studies show that there are patients in institutions who do not need to be there, and would not be there if alternative services were available.

The advent of the Medicare program in 1966 provided home health care as a significant alternative to hospital or nursing home care. The number of institutional visits covered by the Medicare regulations are generally adequate for an episode of acute illness if they are judiciously used by the provider and the patient. However, little provision has been made to provide for visits for care of chronic illness or preventive care. There is no incentive to keep the patient well in the present system.[12]

There is a consensus among health care authorities that a significant number of the patient population are treated in facilities equipped for care beyond those patients' needs. The health care system is oriented primarily toward treatment of the acute phase of illness and does not offer a complete spectrum of health care by providing available alternatives to acute care, financing the alternatives, and educating physicians and patients in use of the acceptable alternatives. This problem becomes even more significant for the elderly.

In considering options or alternatives for care, the committee recommends that the national goal be to make available a range of health and supportive services for all elderly citizens. Thus, whether the individual chooses (1) to live *in his own home* and have services brought to him, (2) to go to the services *in a day-care setting*, or (3) to move *to a nursing home*, he would have some assurance that the needed service would be available.

1. IN-HOME SERVICES

It is the right of every individual to live his life in circumstances which enable him to make the fullest use of his capacities. This right is protected when the society in which he lives provides safeguards which ensure basic economic security in a decent environment and services which are necessary to promote his physical, mental and emotional health. These services are only effective when they are available in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health.[13]

In-home services are a major component in this system. They utilize the home and the family as a valuable resource; they prevent the unnecessary displacement of persons which occurs when services are lacking; they guarantee the right of the individual to remain in the place of his choice. In the absence of in-home services, no system may be considered either comprehensive or effective and must, therefore, be

[12] M. Delora Cotter (representing the Colorado Association on Home Health Agencies), "Statement on Options for Health Care Services," testimony presented to the Committee on Skilled Nursing Care hearing, Denver, Colo., September 16, 1974.

[13] Brahna Trager, *Home Health Services in the United States: A Working Paper on Current Status*, Washington, D.C., July 1973, p. 6.

an integral part of this system. Top national priority must be given to the development of a rational system of comprehensive in-home services for the whole population.[14]

In spite of the increased verbal interest in home-health care, the necessary impetus toward implementation of a national policy with respect to home-health services is still absent.

This delay and this denial has begun to affect our national economy significantly in terms of dollars. Even more significantly, however, it affects the health, the personal freedom, and to a serious extent the future well-being of the whole population.

It has been said that home care is respectable, but it is not yet fashionable. It should be made fashionable. Home care is not second best, and it is not "cut-rate." It provides the best modern medical care, it makes it possible for the chronically ill and certain selected convalescent cases to be looked after in their homes, and it provides patients with a wide range of professional services which are not easily secured through the physician alone.

Coordinated home care has proven its worth and applicability to many medical care problems. Many patients with conditions requiring only a short period of general hospital care would welcome the opportunity to return home at an early date. At home, under proper supervision, a coordinated home care program can successfully provide a continuity of care for these patients.

Any group or agency within a community that has the skill, ability, and drive to set up and operate a home care program is encouraged to do so. Home care is a valuable and essential addition to the totality of medical resources for many patients.

In-home services must be developed as a part of a network of many community services, health, social, and supportive, some of which are provided directly, and others which are coordinated with an agency's services rather than provided directly. The network must allow freedom of movement back and forth between facilities, hospital, and home. One phone call to the umbrella agency should assure any kind of service available and appropriate transfers as a person's needs change. Services should be developed to promote maximum utilization of resources and to prevent costly duplication of existing services, in collaboration with the area comprehensive health planning agency.

Need for service should be authorized by any professional person involved in the program, rather than limited to authorization by physician only, and the service should be authorized without the requirement for prior hospitalization.

The services which should be provided include those which are necessary to the rehabilitation and recovery of the patient, those which are necessary to prevent deterioration, and those which sustain the patient's current capacity even when full recovery or medical improvement is not expected. Nursing constitutes the major service required to meet such needs of patients in their homes. Nurses should be given more responsibility to determine patients' in-home service needs, for

[14] Report of the Council on Medical Service, *Home Health Care,* American Medical Association, 1973.

the purpose of better patient planning and better utilization of health personnel.

> *I believe the nurse's knowledge and judgment in assessment of the patient's condition, establishment of the plan of care and supervision of the personal care given by the home health aide must be part of the accepted definition for nursing care. It is clear that good professional assessment and reassessment of care are key factors in the delivery of appropriate home health services for as long as they are needed and not longer.*
>
> *Most hospital bills are paid by some third party mechanism, but to hospitalize must not be a substitute for home health care. Community agencies accept a financial responsibility for part pay or free services to meet patient needs but this is extremely limited. There must be a better reimbursement for home care.*[15]

In-home services should not be fragmented because of funding, and therefore coordination of governmental and private resources at all levels is necessary. This principle needs to be applied to the development of regulations, eligibility requirements, data collection, and billing requirements. Reasonable uniformity in all these areas will go a long way toward assuring humane services to people in a cost-effective manner.

The agencies providing in-home services should meet standards as established by national standard setting bodies (i.e. National League for Nursing, American Public Health Association, and National Council for Homemaker-Home Health Aide Services). Efforts should also be made to combine surveys for multi-service agencies so they are not besieged with service and financial surveys and audits by many different groups. Such combinations will achieve cost reductions and coordination of the review of an agency.

A management information system should be developed for all in-home service agencies so that comparable data may be collected nationwide for the purpose of analyzing trends and studying specific problems, as well as providing reliable information on costs and statistics for health planning and national health insurance.

The range of services could include a variety of services such as audiologic, handyman, legal, nursing, nutrition, and physical therapy.

An adequate number and variety of staff should be maintained to meet the needs of the community, with innovative patterns of staffing needed to utilize all personnel to provide maximum service.

> *To assure quality, the homemaker-home health aide's services must be appropriately supervised by a professionally prepared person who need not be a nurse. But periodically the patient's condition, home situation and care needs should be assessed by the professional nurse to assure that the help pro-*

[15] Testimony presented by Carol Winkler, Executive Director of Community Homemaker Service, Inc. (a nonprofit Mile High United Way affiliate) and homeeconomist, at the hearing on Skilled Nursing Care held in Denver, Colo., September 16, 1974.

vided in the home continues to be appropriate to the patient's needs.

In Wyoming patients are cared for at home with varying degrees of incapacity. In the home health agencies, nursing services and home health aides, if needed, are provided for years to the stable incapacitated. The State pays for the service to those no longer "medically eligible" by Medicare definition. Many families are keeping members at home to death.[16]

The use of nurse practitioners, nurse clinicians or clinical specialists should be encouraged, developed and expanded to provide leadership and to teach other workers and volunteers and to give a variety of services which are greatly needed by disabled people.

2. DAY CARE

The recent surge in interest in lowering health care costs and enabling long-term disabled persons to live in their homes rather than becoming institutionalized has resulted in intensive efforts to develop a program of day care for aged and long-term disabled persons. A viable day care program for the aged and long-term disabled has economic as well as social, rehabilitative, and preventive advantages.

In Great Britain day care programs for the elderly began in 1962 because of a serious lack of beds in hospitals and long-term care facilities. These programs have been highly successful in maintaining the aged in their homes and as independent as possible. According to testimony presented before the U.S. Senate Subcommittee on Aging in June of 1971, only one percent of the population over 65 in the United Kingdom lives in long-term care facilities. In the United States, five percent of the population over 65 are in long-term care facilities.

The day care is being one link in a chain of services offered the aged and disabled. Day care programs have enormous potential for meeting the long-term care needs of individuals, while delaying or avoiding the need for full-time institutionalization. These programs offer the opportunity for nursing care, monitoring of medications, dietary care, socialization, rehabilitation and social services. They provide a means of helping the aged and disabled to maintain and re-establish their ability to care for themselves. Because of the therapeutic programs offered in such facilities, they may be accurately described as a form of preventive medicine.

Examples of successful day care programs in Great Britain, Canada, and isolated examples of programs in the United States can serve as models for expansion of a coordinated system of day care programs geographically constructed and operated throughout the United States and available to all our elderly and disabled citizens regardless of where they live or their ability to pay.

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[16] Testimony presented by Elta M. Kennedy, Home Health Nursing Consultant, Nursing Services, Department of Health and Social Services, Cheyenne, Wyo., at the hearing on Skilled Nursing Care, Denver, Colo., September 16, 1974.

Experience with the Center for Adults Plus in New York City led Milton Berger to write:

> Day centers can allay the feelings of uselessness, depression, isolation, alienation, helplessness and hopelessness which are so prevalent in this age group. Fear of dependency and of not being needed or wanted, and feelings of loneliness and abandonment can be alleviated in a therapeutic community setting. This setting can provide for nonverbal as well as verbal communication; for spiritual, emotional and physical interaction; and for dialogue and communion in a spirit of mutual interest, trust and intimacy. In an active process of involvement in giving as well as receiving, men and women can find the strength to accept what needs to be accepted existentially while enjoying the excitement and search for self-fulfilling new options or solutions to conflicts and problems that seemed unsolvable.[17]

There are two major types of day care centers. The first type is health-care oriented, usually situated within the confines of a long-term care facility and functioning under the same administration. Elderly and chronically disabled persons may come, or be transported, to the center in the morning and spend the entire day, or part of a day, in therapeutic activity. They return on the same day to their homes. Comprehensive services which are available in the institution are available to persons in the day care program. The services offered are determined by assessment of individual needs of each person.

> *The goal of the Amherst Adult Day Center is to provide viable alternatives to institutional living and enable individuals to remain within the community, who for one reason or another are unable to utilize other community resources such as the Senior Center.*
>
> *The concept (of the Amherst Adult Day Center) will permit an individual to participate between peer groupings, offering the advantages of family and day center associates, and will provide an alternative to institutionalization by maintaining the individual at the highest level of physical, social and mental functioning possible.*[18]

Socially oriented day care programs exist outside of hospital or licensed long-term care facilities. Their goals are toward social rehabilitation and maintenance. Activity programs, both group and individual, provide a means of socialization and prevention of physical disability from disuse and mental disability caused by loneliness and isolation. Although socialization through activity is the primary focus, other services, such as nursing consultation, dietary instruction, educational and vocational classes, social services, personal care services, and health education, should be available on a part-time basis.

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[17] Milton M. Berger and Lynne Flexner Berger, "An Innovative Program for a Private Psychogeriatric Day Center," *Journal of the American Geriatrics Society*, April 1971, p. 333.

[18] Testimony presented at the hearing on Skilled Nursing Care held in Newton, Mass., September 9, 1974.

Experience with a day care program at Maimonides Hospital and Home for the Aged in Montreal, Quebec, Canada, has shown it to be a cost-saving program. Of a total of 250 persons cared for in the program, only six percent over a four year period have had to be institutionalized. Ninety-four percent have been able to continue maintaining themselves in the community. Administration attributes this to diminution of social isolation, improved nutrition, and continuous health supervision and treatment.

Day care facilities must be accessible to the population they intend to serve. Time needed for transportation from the furthest point should not exceed one hour, if at all possible. The facilities should provide a safe environment with sufficient room for a variety of meaningful and stimulating activities to the group to be served, as well as helping maintain orientation and continued learning.

There should be space to provide opportunity for both group and individual activity, for action, and for rest.

The minimum staff in a day care center would be an administrator who might also provide another professional service in a small center; a nurse clinician with gerontological and/or rehabilitation background; a social worker; a physician; a secretary and attendants or aides. The amount of time worked and kind of input of each staff member would depend on the program needs of the center. For instance, the physician may be hired on a consultant basis and not be physically in the center.

The most common staffing pattern is based on 45–50 day care clients and includes an administrator (usually a nurse), two registered nurses, two social workers, a part-time physician, and four attendants. An occupational and physical therapist are usually available for program development and consultation and are desirable on the basic team.

The nurse clinician could provide the original and ongoing health assessment of day care participants with medical input when necessary. The nurse social worker team could also do family and social assessment and work with both family and client. On the basis of these assessments and input requested from other professionals, the day care program for both the group or individual could be planned.

Other basic staffing that would be necessary for day care centers is food preparation and service personnel with dietician consultation, housekeeping personnel and bus drivers or other transportation providers.

> *Today I want to describe a little publicized, modest, success story of a program providing an array of health maintenance services for older adults. The program has been conceived and designed by, organized by, and implemented by community health nurses in county community health nursing services and in organized local health departments in Colorado. . . .*
>
> *The community health nurse conducts the program in settings wherever older adults congregate. The programs are conducted in church basements, community centers, kitchens of senior citizen centers, retirement homes, and occasionally in overloaded health department clinics. . . .*

We are in great need of funding at the State level for assistance with rational planning, documenting findings, and evaluating the cost-effectiveness of such programs. . . .

Funding is needed at the local level not only for providing services but for planning and evaluation. . . . No charge is made to consumers in any of the programs. Third party payments through insurance mechanisms should be provided as a mechanism to avoid expensive institutionalization.[19]

Because of its importance as a major option for care of the elderly, day care should be adequately financed and recognized by reimbursement mechanisms. Among the several possible major financing alternatives to providers of day care services are Medicare, Medicaid, private pay, national health insurance, revenue sharing, Federal and state grants and union health plans.

We recommend that consideration be given to restructuring the Medicare and Medicaid programs in a way which would allow reimbursement of full costs to providers of both institutional and non-institutional day care services to the aged and long-term disabled persons. Eligible costs should include but not be limited to those costs now eligible for reimbursement under the Medicare program. We recommend, further, that for the purpose of financing a day care program, requirements of prior hospital stay be eliminated, and self-admission to day care services be implemented.

We recommend, further, that the benefit eligibility requirements be extended to all persons in need of day care services who do not have the personal ability to pay.

Financial incentives should be given to existing long-term care facilities to encourage use of available space within these facilities for day care services. This alternative would require little restructuring or revision of existing Title XIX rules and regulations, and would decrease significantly expenditures for long-term care. National health insurance proposals must give serious consideration to the importance of day care with the program designed to include it.

Careful study and consideration should be given to the possibility of capital assistance grants to non-profit providers for day care services through revenue sharing.

3. NURSING HOMES

Contrary to the popular belief that long-term care facilities are "dumping grounds" where children can dispose of unwanted parents, long-term care facilities are needed to provide care for people who cannot be cared for elsewhere and should be an integral part of the care system.

The health care system has been predominantly medically oriented—that is, related to cure of disease. Long-term care, on the other hand, has to be of a broader scope, including psycho-social needs, as well as medical needs of patients.

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[19] Testimony presented by Audrey J. Ostberg, Adult Health Nursing Consultant, Community Nursing Section, Colorado Department of Health, at the hearing on Skilled Nursing Care held in Denver, Colo., September 16, 1974.

The medical model, while appropriate in the hospital setting, is inappropriate to meeting the total needs of the person in a long-term care setting. The Federal standards must be adapted to recognize this fact. Facilities care for individuals of all ages, with all kinds of problems, and while some may live out their lives in this setting, others may require such services temporarily until they are well enough to return to live in the community. A long-term facility may, in fact, serve as a point of entry to the health care system, and it certainly plays an important role in the delivery of health care by caring for those not in need of hospitalization but unable to remain in their home settings because of extreme disabilities or failure of the system to meet their needs.

Other settings should be considered to meet individual needs and services, including day or night care centers, homemaker services, retirement resident centers, foster homes, boarding homes, and group care facilities.

A setting that is virtually non-existent is one that provides for the care of an individual who is in a terminal phase of illness, who is severely disabled, or who is in a transitional phase of illness. This person requires a complete complement of equipment and/or services as well as a concentration of professional and other staff services to live out his days in relative comfort and dignity. The acute care hospitals at one time provided such care as was needed and desirable. Although some hospitals are continuing to provide such care, many others with a waiting list for beds will not admit terminally ill, chronically disabled, or persons in a transitional phase, stating that their needs do not require hospital care since there is nothing more that can be done to help them.

Even so-called "skilled" nursing homes are reluctant or refuse to accept terminally ill patients, contending that they do not have the services, personnel, or equipment to meet the needs of these people. Thus a gap exists in options being considered for the continuous care of a patient whose needs cannot be met in the existing health care system.

If the options described as in-home services and day-care services were available in every community, the nursing home would become the appropriate setting for the person who needs continuous nursing care. Thus, with appropriate utilization of other settings, the utilization of the nursing home would become more appropriate and the classification question less significant.

Supportive services, as needed, should be available in whatever setting is most suitable to the individual, his family, and his needs. There are many planning agencies in communities but few action agencies coordinating services, utilizing what is available, and also arranging for the development and provision of services not currently available. An umbrella agency offering services, or contracting for additional services as needed, could be established under the sponsorship of a public or private community group such as a home health agency, a hospital, or an agency with nursing staff available. This umbrella agency, building on what is available in the community, would provide or arrange for the provision of all needed services.

Nursing Manpower and Education

Quality health care will primarily depend upon the competency of the person providing the direct care. As important as attitudes and personality traits of workers are, if those persons are untrained, uninformed, and inadequately supervised, recipients will receive minimal quality care. Competence denotes an educational process of attainment of knowledge, understanding, attitude, and skill.

> *It is well known that geriatric nursing as well as rehabilitative nursing are specialties and need special training. In-service must be provided to bring continuity of care to all areas of a facility, but the knowledge or education must start in the schools of nursing for professional staff and in the vocational schools of LPN's and aides/orderlies. We must have continuing education in the forms of workshops and seminars for staff. The public also must be educated in the aging process through most media.*[20]

A first step in upgrading care is effective utilization of all types of nursing personnel, and expansion of nursing skills through education, including pre-service and in-service training.

There is a need for an expanded training program for registered nurses in chronic and long-term care and for certification and reimbursement which will legitimize and encourage an expanded role for all involved in long-term care.

> In perhaps no other area of health care delivery has the charge nurse more responsibility for patient care unassisted by a physician than in long-term care. In the nursing home where a physician may visit a patient approximately once a month, the nurse must monitor patient progress, detecting signs of abnormality and establishing the treatment regimen. . . . In the home care setting the visiting nurse may be the only frequent contact with a professional that a patient has. As such the nurse is required to monitor and correctly identify clinical symptoms, and often act as social worker, guidance counselor, an advocate of patient and family.[21]

> *To effectively define skilled nursing we must remove the emphasis from care that is medically-oriented to care that is health care oriented. This includes the identification and provision of health services as determined by the collaborative efforts of health care professionals as opposed to the need for skilled services being determined largely by the physician.*[22]

Nurse educators providing basic education of nursing personnel must recognize the fields of chronic disease, adult health, and aging,

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[20] Testimony presented by Hebe Chestnutt, at the hearing on Skilled Nursing Care held in Helena, Mont., September 18 1974.

[21] C. Patrick Babcock (Director, Michigan Office of Services to the Aging), testimony presented to the Committee on Skilled Nursing Care hearing in East Lansing, Mich., September 5, 1974.

[22] Testimony presented by Eldonna Shields, a clinical nurse specialist in gerontological nursing and Director of Nursing at Shields, Nursing Clinic, Inc., Lorain, Ohio, at the hearing on Skilled Nursing Care held in East Lansing, Mich., September 5, 1974.

and accept them on the same level as other skilled fields of nursing. Graduate programs leading to advanced degrees in nursing care of the aged and chronically ill should be promoted and funded.

Only by education and exposure to these areas will well prepared health care professionals enter and remain in the field of long-term care. Long-term care facilities should be used more for field practice for all levels of nursing students, to expose them to this area of nursing.

All professionals and workers being prepared for long-term health care in any setting should have exposure to the following basic concepts. Concepts should be taught at the educational level of the worker and in the depth and detail he can understand and use.

Concepts include:

- Process of normal aging—biological, psychological, and sociological;
- Attitude toward aging, including respecting the value and dignity of each individual and the patient's rights;
- Concepts of disease prevention and maintenance of health;
- Concepts of rehabilitation, both mental and physical, to the highest functioning level, to include re-motivation and reality orientation;
- Chronic diseases and the meaning of chronicity;
- Nutrition as applied to long-term care;
- Pharmacology and long-term care;
- Administrative environment or climate in which care is given;
- Death and dying;
- Interaction with families;
- Human sexuality—sexual needs of aged and long-term patients;
- Mental health.

Funds need to be made available in the development of a basic curriculum for training all disciplines in long-term care, a responsibility that could be assumed by a coalition of national health organizations in the field.

Federal and other public funds should be made available to help national health organizations finance their own programs of continuing education in long-term care. Reasonable fees could be charged to help defray the costs of such programs.

National health organizations should be encouraged to offer financial incentives to their state and local constituent groups for conducting continuing education programs in long-term care.

> *In-service education and ongoing staff development programs should be an essential requirement for all long-term care agencies. There should be more adequate enforcement of the requirements in licensing rules and regulations. The option of a consortium approach and shared services of an in-service educator should be implemented by smaller agencies.*[23]

Publicly financed training centers in long-term care should be required to earmark a portion of their resources to assist long-term

[23] Testimony presented by the Michigan Nurses' Association representative during the hearing on Skilled Nursing Care held in East Lansing, Mich., September 5, 1974.

health care facilities in organizing and conducting in-service education programs.

Federal and other public funds should be available to colleges, universities, and vocational schools through project grants and capitation grants for developing and implementing basic educational offerings in the field of long-term care.

Federal and other public funds should be available through traineeships, grants, and loans for students to receive basic and graduate education in long-term care.

Auxiliary Nursing Education

Every health care facility should provide a planned program of in-service education for all levels of personnel. To encourage this type training, the cost of in-service education provided by health care facilities should be a reimbursable item under publicly funded programs.

Conditions of employment in long-term health care facilities should include financial incentives for participation in in-service and continuing education programs for all employees.

> *The training programs available for these ancillary persons varies all the way from nothing except "buddy system" on the job training to a maximum of four weeks in a vocational technical school program which is planned to meet the needs of acute hospital nurse aides. . . .*
>
> *There is currently a pilot project being started in the Portland area the purpose of which is to develop a curriculum for the training of geriatric aides. Even if such a curriculum is developed unless it can be made a part of some tax supported educational institution and funded with tax monies on an ongoing basis, it will have little lasting value. . . . In my facility during the past year I have had 143 persons on the staff to fill 45 positions. This tremendous turn-over is costly in terms of dollars and also in continuity of patient care. This added cost is reflected in higher rates for nursing home care. I believe this turn-over could be reduced if job satisfaction could be increased through better preparation for the job and through elevating the status of the geriatric aide.*[24]

Acceptance of a career ladder concept could serve to interrupt the high rate of turnover, particularly among persons hired as nurses' aides, allowing for vertical movement which is not now available to them.

In order to make education for aides relevant, accessible, and acceptable, the Redwood Health Consortium has developed "Care of the Geriatric Patient," a course for the training of Nurses' Aides in Skilled Nursing Facilities. The course is designed primarily for newly hired aides who have already begun working in the facility or for aides who have been hired and are waiting for permanent placement. In addition, plans have been made to accommodate aides who need review.

[24] Testimony presented by Virginia Bundy, director of nursing at the Jewish Home for Aged, Portland, Maine, at the hearing on Skilled Nursing Care held in Newton, Mass., September 9, 1974.

Focus is placed on the basic skills for the aide in the geriatric facility. In addition, there is emphasis on the psycho-social aspects of caring for the geriatric patient. The course is offered through Santa Rosa Junior College, and each participant who completes the 16 weeks of training receives three units of college credit as well as a certification issued by the Redwood Health Consortium.

More well-planned programs such as this must be coordinated with nursing home employment process and policies in order to make a difference in training results.

Emphasis needs to be given to job satisfaction, especially at the nurses' aide level, with recognition of the contributions of the aides stressed. The registered nurse remains the leader of the nursing team as well as the role model and teacher of other levels of nursing personnel.

Salaries and working conditions for personnel providing long-term health care service must be competitive in order to recruit and retain qualified staff, with employee involvement becoming a part of the decision-making process concerning employment conditions.

National Health Policy

While health care is considered a right of all people, barriers exist that prevent equal access to equal health services, especially for the elderly. Major barriers are the present fragmented delivery system, the uneven distribution of health manpower, the improper utilization of health manpower, and the spiraling costs of health care.

The proposals for national health insurance before Congress deal with from one to all of these barriers—from more money to pay for care to more money available through the Social Security system and general tax funds plus suggestions for coordinating the delivery system, increasing health manpower, expanding career opportunities, incentives for redeployment of health manpower, utilization control of services, and control of quality through peer review.

Contributing to the inflationary costs of health insurance are the failure of health insurance to provide coverage for diagnostic measures and health maintenance services when done outside the hospital and the overcontrol of home health benefits under both private and public health insurance systems.

When planning legislation for a national health policy, it must be remembered that the methods of reimbursement will bear directly on the quality of care. Nurses are concerned that any national health plan be truly economical with proper utilization of services. Quality care can be both economical and effective.

For example, if insurance benefits were to be expanded, nursing in the home and homemaker home health aid services could maintain individuals in their own homes, thus avoiding crisis situations and serious breakdowns that lead to need for the most expensive care.

Any system of national health insurance that is adopted should provide payment for comprehensive health care—preventive, maintenance, diagnosis and treatment, restorative, and protective.

If a national health insurance plan is to provide comprehensive health care services, more recognition must be given to the registered nurse's role in the delivery of primary care. Appropriate preparation

and utilization of the advanced nurse practitioner in the primary care role is one important way to extend health services and use health manpower more effectively.

Provisions must be made to permit payments for certain health services in addition to those provided by physicians or arranged and directed by physicians. Payment mechanisms should be such as to facilitate effective and efficient use of the knowledge and skills of qualified professional nurses as providers of primary care services.

On a national basis the present provision of health services is fragmented, uncoordinated, and incomplete, with high costs of essential health care services standing in the way of effective delivery of health services to large numbers of people in the country, although Americans spend more on health care ($83.4 billion in fiscal 1972; an estimated $100 billion between July 1, 1973 and June 30, 1974) than the population of any other country.

The average American works approximately one month of the year to support the health industry. And still, ten percent of the adult population suffers from undiagnosed hypertension. Millions of American children have never seen a dentist. An estimated 60,000 persons suffering from cancer will die needlessly this year because the disease was not diagnosed early enough to be successfully treated.

That working Americans are assured of adequate health care is questionable. Whether the elderly, the retired American is receiving adequate health care is an even more disturbing question. The retired person most often is faced with reduced income with little or no adjustment to meet inflationary monetary changes. At the time in life when medical needs increase, the ways and means of meeting this need decreases irrespective of Medicare and Medicaid.

The Denver Gray Panthers have made the statement:

> What is needed, as a matter of national policy, is not only a clear statement that older Americans are entitled to quality institutional care, but an accompanying statement establishing the entitlement of older persons to reside and function outside of institutions and to receive a spectrum of non-institutionalized services which will maximize their ability to remain in alternative living situations. What is needed are specific and categorical legislative mandates and appropriations for the range of services which will support a non-institutional care system for older persons. And it is needed now.[25]

This report has presented some directions for shaping national health policy, especially in terms of long-term care and the elderly.

[25] Duane Gall, testimony presented to the Committee on Skilled Nursing Care hearing, Denver, Colo., September 16, 1974.

PART 3

RECOMMENDATIONS

The Subcommittee on Long-Term Care subscribes to the recommendations presented by the American Nurses' Association Committee on Skilled Nursing Care (number 1–5 below) as well as offering its own recommendations designed to improve the quality of nursing care in nursing homes.

1. A national policy on care of the aging should be developed, within which should be provision for care of the elderly in any kind of setting, the right to high quality care, and the right of the elderly to decision-making in regard to their own care. The national policy on care of the aging should be built on the fact that the aged are vital, dynamic persons who have made and who continue to make contributions to society.

2. Because high costs of essential health care services, coupled with the present provision of fragmented, uncoordinated, and incomplete health services stand in the way of effective delivery of health services to the aged, a plan for national health insurance should be developed to insure that health care services are provided for all citizens, guaranteeing coverage for the full range of comprehensive health services. The national health insurance plan should clearly recognize the distinctions between health care and medical care, and provide options in utilization of health care services.

3. In considering options or alternatives for care, a range of health and supportive services should be made available to all elderly citizens. Thus, whether a person chooses to live in his own home and have services brought to him, to go to the services in a day care setting, or to move to a nursing home, he would have assurance that the needed services would be available.

4. The word "skilled" should be deleted from the phrase "skilled nursing care" as it currently exists in the Federal standards and as the term is generally applied in actual practice, because it is not measurable nor can it be defined when related to the needs of a patient.

5. Because quality health care will depend primarily upon the competency of the persons providing direct care, all professional persons and workers involved in long-term health care in any setting should have a background in the basic care of the aging. These gerontological concepts should be taught at the educational levels of the individuals in the depth and detail each can understand and use. Preparation in gerontological nursing should be within an open educational system which promotes career mobility. The educational program of registered nurses at all levels should be developed and strengthened to correct specific deficiencies in the area of gerontological nursing.

6. The Federal Government and its 13 agencies presently providing training for nursing personnel should make a greater effort to encourage nurses to consider careers in geriatric and gerontological nursing.

7. Schools of nursing should place greater emphasis on geriatrics and gerontology in their curricula. Graduate programs offering advanced degrees in nursing care of the aged and the chronically ill should be established.

8. The MEDEX program should be continued and expanded to channel discharged medical corpsmen trained in geriatrics into nursing homes and the care of geriatric patients.[1]

9. Grants should be provided to colleges and universities to provide for the training of physician's assistant in geriatrics and the needs of nursing home patients.[2]

10. Grants should be provided to colleges and universities to provide for the training of nurse practitioners to provide primary health care in nursing homes.[3]

11. Grants should be provided to schools of nursing to establish short-term in-service training programs for nursing home personnel, particularly aides and orderlies.[4]

12. Representatives of various professional organizations in the health care field should explore the feasibility of establishing a career ladder to increase the possibilities for advancement and financial reward for nursing home personnel.

13. The Congress and the Department of Labor should examine the feasibility of a program wherein able-bodied elderly could seek employment in nursing homes with the resulting earnings exempt from the social security retirement test.

14. Federal standards for nursing homes should be raised. Nursing homes participating in Federal programs as skilled nursing homes should be required to employ the minimum of one registered nurse around the clock. Intermediate Care Facilities should be required to have the minimum of one licensed practical nurse on duty at all times.

15. HEW should promulgate nurse staffing ratios which provide the minimum of 2.25 hours of nursing time per patient per day in Skilled Nursing Facilities.

16. HEW should promulgate regulations to correct the current situation wherein registered nurses and licensed practical nurses spend most of their time with administrative duties rather than caring for patients.

17. Nurses should make greater use of the Williams-Steiger Occupational Health and Safety Act of 1970. If a nursing home fails to provide a safe living environment, nurses may notify the Department of Labor and ask for an inspection. If the employer is found in violation, a citation and a penalty will be issued.[5]

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[1] See S. 1158 introduced by Senator Moss on March 12, 1975.
[2] S. 1159 introduced by Senator Moss is intended to accomplish this purpose.
[3] S. 1160 introduced by Senator Moss on March 12, 1975, added as an amendment to S. 66 on April 10, 1975.
[4] See Moss bill S. 1155, added as an amendment to S. 66 on April 10, 1975.
[5] See *Federal Register*, May 29, 1971, for details on OSHA regulations.

APPENDIXES

APPENDIX 1

REPORT AND RECOMMENDATIONS FROM THE AMERICAN NURSES' ASSOCIATION'S COMMITTEE ON SKILLED NURSING CARE

TASK FORCE ON CLASSIFICATIONS AND DEFINITIONS

The purposes of this task force are:

To define the level of care now known as "skilled nursing" so that such definition can be used by regulatory and reimbursement agencies. This definition must be in terms of the unique needs of long-term patients and the unique contribution of nursing to meeting those needs. The definition must be in language clear enough for the public to understand, be in measurable terms, and be reimbursable.

To develop criteria for classification and grouping of patients in long-term care settings according to their needs.

To recommend more efficient and less traumatic methods than the prevailing one of moving the patient to find the service.

The Task Force on Classifications and Definitions takes the position that health services for the chronically ill and elderly should focus on the attainment and maintenance of as dynamic a balance as possible in their physical, mental, or social well-being, and not merely a focus on attaining the improved control of diseases or infirmity, and that every chronically ill and older person has the right to strive, or to be assisted in his striving, to achieve his maximum health potential. This philosophy is the basis for the following position statements and recommendations.

It is the decision of the Task Force members to delete the word "skilled" from the term "skilled nursing." The rationale for this decision is based on the following:

1. The term "skilled nursing" as it currently exists in the Federal standards and as the term is generally applied in actual nursing practice, in our opinion, is not measurable, nor can it be defined when related to the needs of a patient.

2. "There is an inherent contradiction in the term 'skilled' when it is applied to human services which are provided by responsible institutions or individuals, whether these are public or private. It seems to imply limitations and exclusions in those areas of

service which are central to standards of competence and to the achievement of excellence in the quality of care—most particularly, in the quality of health care which is an essential need in the whole population." It is impossible to avoid the question: "When is it appropriate for any human service, and most particularly for any health care service, to be 'Unskilled'"?[1]

3. Recent state nurse practice acts have recognized and provided clear legal authority for the continually expanding roles and functions of nursing. Under these definitions, nursing is "skilled" in all its aspects and settings.

4. Professional nursing requires sound judgmental and technical skills based on a thorough knowledge of scientific principles and the ability to apply these principles in assisting people to cope with real or potential health problems which may be physical, biological, social, emotional, or intellectual in nature. Whether such assistance is provided in the home, in an institution, or in other community or public health facilities, the registered nurse must apply these principles to ensure the appropriate utilization of other nursing personnel whose preparations may represent several varying levels of training. In addition to utilizing them appropriately for the tasks for which they have been trained, the registered nurse must provide, also, the supervision and guidance required to ensure that the patient is receiving quality care.

5. The Task Force members, in considering the unique needs of long-term care patients, and the unique contribution of nursing to meet these needs, cannot reconcile these with a philosophy which dictates classification and grouping of patients in any setting. Members find contradictions, also, between the need to classify and group patients according to their needs, and the need to find less traumatic methods to move patients to find needed services.

In considering the unique needs of long-term care patients, emphasis must be placed on the fact that the chronically ill or elderly person is a vital, worthy, changing human being, who is in constant, dynamic, mutual interaction with those surrounding him and with his total environment. He has the same multifaceted human needs as all other individuals, including the need to express some options and control in regard to his life. In addition, he may require compensation for diminished function and sensory deprivation.

The individual requiring long-term care is one who suffers from one or more chronic conditions which has resulted in a physical and/or mental impairment of normal activities requiring prolonged and supervised care or treatment, necessitating at least, but not limited to, professional nursing assessment, evaluation, monitoring, judgment, and coordination of services and environmental support systems appropriate to the individual's health needs.

The commitment and contribution of nursing in promoting the delivery of health services to the large number of chronically

[1] Brahna Trager, "The Concept of 'Skill' in Community Care," paper presented at opening session of the Committee on Skilled Nursing Care, American Nurses' Association, Kansas City, Mo., May 13, 1974.

ill and elderly persons in our society includes assessment of the patient's health status with concurrent identification of his specific nursing problems, planning with him and his family for his care, implementation of that plan of care, and evaluation of the plan's effectiveness in terms of the patient's progress (or lack of it) with appropriate modifications as indicated to meet more effectively this patient's needs. Nursing's commitments and contributions include, also, teaching health care principles and practices to the patient and his family, assuming accountability for defining and validating all levels of nursing activity in terms of therapeutic effectiveness, increasing the sophistication of personal care services as health delivery systems expand, and accepting management responsibilities in providing nursing care to patients.

Nursing contributes an understanding of the development stages of the life cycle; the effects of varying settings upon a person's life style; and the effects of chronicity upon a person. Nursing likewise attempts to decrease the regimentation imposed by health care in any setting, and to prevent, diminish, or restore the numerous losses associated with chronicity.

6. Specifically, the commitment and contribution of nursing to promoting delivery of quality health care services to chronically ill and elderly persons include:

a. Active nursing participation at the planning level both in the determination and the systematic evaluation of the delivery of health services for these persons.

b. The delineation and assumption of appropriate nursing responsibilities for coordinating health services within the health care systems and sub-systems so that chronically ill and older patients may have accessible movement into the system and receive continuing, high quality care.

c. The provision of direct, humanistic nursing care services which are based on the personal health needs of chronically ill and older patients. This includes health assessment, health maintenance, consultative and restorative nursing care in primary, acute and long-term care circumstances both in and out of the hospital environment.

d. Demonstration of accountability for appropriate and effective use of human and material resources in the nursing management of patient care services in the home, in institutional and other community health care facilities.

Understanding the basic human needs, the developmental task of all ages, and the dynamics of behavior care crucial to the delivery of long-term care nursing. Technical procedures fail when they do not include and consider behaviors and feelings of the long-term care client. Long-term care should not be built on the medical care model which tends to interrupt the natural patterns of individuals. Medical care, like nursing care, is one facet of the total health care. Nursing applies medical and related services either prescribed by a physician and/or based on the judgment of a professional nurse.

Since all people change from day to day, there is a requirement for constant evaluation, especially of a dependent person, to recognize

signs of change. The long-term needs of the individual, constantly affected by his changing state, can be seen only on a horizontal continuum. His status may reflect, for example, variances in his ability to ambulate, the degree or extent of disability, his ability to communicate, his mental alertness, or his level of orientation. The horizontal model for the delivery of health care services in long-term care provides a framework for care which responds to the constantly fluctuating needs of those individuals who are receiving care. Focusing upon the individual's needs, it is in direct contrast to the present vertical hierarchy of levels of care which is based on the numbers and/or kinds of isolated, individual procedures required. To meet these human needs, health care must be provided on a similar horizontal continuum, within or outside an institutional setting. The kind, complexity, frequency and duration of nursing care needed by an individual patient with any given time may vary considerably. The concept of the horizontal continuum of health care negates the present procedure-oriented system of fund allocations which is based on the establishment of arbitrarily defined levels of care or detailed patient classification systems. The horizontal concept of delivery of health services also negates the necessity of moving clients to obtain required services.

Services for long-term care should be available to the patient in the setting in which he resides or delivered to him from an outside source. Decreasing the necessity of moving a patient from one setting to another reduces for him the risk of "transfer shock" which is inherent in such moves. It also increases the efficiency and appropriate utilization of services. Any patient transfer or discharge should be carefully planned on the basis of the patient's therapeutic needs with the patient and/or his family involved in the planning. Prime consideration needs to be given to careful patient assessment in relation to transfer and placement criteria.

CONCLUSIONS

Since significant data point to the conclusion that the health needs of the chronically ill and elderly are not presently being met, and since there is both the opportunity and great necessity for some change and some reorganization in the present patterns of health care services for these groups in society, the reorganization and changes which can be made in the pattern of these health services should focus upon:

Increasing the comprehensiveness, continuity, accessibility and quality of these health services, while assuring their reasonable costs.

Recognizing that the health needs of the chronically ill and elderly are concerned less with acute illness than with maintaining health and dealing with long-term and disabling health problems which generally can be met through community-based primary health care services.

Accepting that these primary health care services must be coordinated with home care and institutional health care services to ensure continuity of care.

Recognizing that meaningful health services for chronically ill and elderly persons must be developed and implemented with the participation of these persons as the consumers of such services.

Recognizing that, for institutional and community-based health services to be of high quality and low cost, a prime consideration must be that these services are planned and implemented to utilize fully the skills of all health professions.

Providing for a system of funding which has as its primary concern the health needs of the individual rather than budgetary requirements.

RECOMMENDATIONS

The word "skilled" should be deleted from the phrase "skilled nursing."

Services should be funded and made available in the setting in which the patient resides, or delivered from an outside source.

Funding systems must allow for the individual to purchase services appropriate to his health needs, and be related to a services audit system rather than a budget accountability, after basic shelter and nutritional needs are provided.

Institutional settings should be funded for and encouraged to expand services beyond single purpose, traditional offerings.

Funding, rather than being limited to isolated technical nursing functions, should provide for the full range of professional nursing activities which include:

Assessment of and judgment in relation to patient's specific health needs and problems.

Decision-making and planning for specific methods to assist the patient to meet or cope with his specific needs.

Implementation of specific, identified nursing interventions.

Appropriate delegation of care activities.

Health teaching of the patient and/or his family.

Supervision of patient activities, progress.

Supervising of the manner in which the patient's care is administered.

Evaluation of the therapeutic effectiveness of nursing interventions.

Coordination of health services.

Appropriate and effective use of human and material resources in the nursing management of patient care services to ensure provisions for options and alternatives.

Implementation of preventive nursing measures such as those designed to prevent crippling, cross-contamination with resultant superimposed infections, measures to ensure the safety and comfort of the patient as well as those general care measures related to maintenance of the patient's well-being.

APPENDIX 2

REPORT AND RECOMMENDATIONS FROM THE AMERICAN NURSES' ASSOCIATION'S COMMITTEE ON SKILLED NURSING CARE

TASK FORCE ON OPTIONS FOR HEALTH CARE SERVICES

In considering options for health care we are cognizant of the fact that options at present are limited, due to a variety of factors.

We have given lip service to the individual's right to choose without providing options from which to choose. It is our hope that not only the desires and needs of the individual but those of his or her immediate family will be taken into consideration in planning and providing for the range of services needed in an environment of his/her choice. The objective of services provided would be to enable the individual and his family to function as independently as possible. Long-term care must provide for flexibility in movement within or from one type of setting and services to another setting and services according to needs.

We believe that supportive services as needed should be available in whatever setting is most suitable to the individual, his family, and his needs. There are many planning agencies in communities but few action agencies accepting the responsibility for a community's (or a combined group of communities) coordination of services, both utilizing what is available and also arranging for the development and provision of services not currently available. An umbrella agency offering services, or contracting for additional services as needed, should be established under the sponsorship of a community group such as a home health agency, a hospital or an agency with nursing staff available. This umbrella agency, building on what is available in the community, would provide or arrange for the provision of all needed services.*

The three options studied in depth are in-home services, day care, and residential care.

It is the right of every individual to live his life in circumstances which enable him to make the fullest use of his capacities. This right is protected when the society in which he lives provides those safeguards which ensure his basic economic security in a decent environment and the services which are necessary to promote his physical, mental and emotional health. These services are only effective when

*From testimony presented by Ruth Henig, Michigan Nurses Association, Committee on Gerontology Nursing at the Hearing on Skilled Nursing Care, East Lansing, Mich., September 5, 1974.

they are available in a comprehensive system which includes all of the skills and facilities essential to the promotion and maintenance of optimum health.

In-home services are a major component in this system. They ensure appropriate utilization of all other components in the system: They utilize the home and the family as a valuable resource; they prevent the unnecessary displacement of persons which occurs when services are lacking; they guarantee the right of the individual to remain in the place of his choice. In the absence of in-home services, no system may be considered either comprehensive or effective. They must, therefore, be an integral part of this system, and top national priority must be given to the development of a rational system of comprehensive in-home services for the whole population.

A national policy must provide:

That in-home services which are comprehensive will be available, accessible, and acceptable to every member of the population who needs them.

That they will be available without restrictions as to diagnosis, race, religion, or ethnic origin, age ar sex.

That they will be based on the needs of the consumer rather than the provider.

That they will be provided without financial barriers.

That they will be provided in circumstances which guarantee high quality.

That they will be provided without barriers between health and social services, but as a coordinated blend which promotes and supports optimum health in the broadest sense.

That they will be based upon a philosophy which recognizes the right of the individual to participate with professionals in making decisions about the place, type and extent of care and services he needs and receives.[1]

1. IN-HOME SERVICES

In-home services must be developed as a network of many community services, health, social, and supportive, some of which are provided directly, while others are community services included under the umbrella of services to people but are coordinated with an agency's services rather than provided directly. The network must allow freedom of movement back and forth between facilities, hospital, and home. One phone call to the umbrella agency should assure any level of service and appropriate transfers as a person's needs change. Services shall be developed to promote maximum utilization of resources and to prevent costly duplication of existing services in collaboration with the area comprehensive health planning agency.

The services which shall be provided include those which are necessary to the rehabilitation and recovery of the patient, those which are necessary to prevent deterioration, and those which sustain the patient's current capacity even when full recovery or medical improve-

[1] Trager, Brahna, "Toward A National Policy," Home Health Services in the United States: A Working Paper on Current Status, U.S. Govt. Printing Office #96-867-O, July 1973, pp. 27-28.

ment is not expected. Health care varying in intensity and service components responsive to the individual needs of patients must be available in the home. As patients' needs change, there must be adequate mechanism for service to patients within the varying needs for home care, as well as for transfer to other care settings.

We believe that in-home services should not be fragmented because of funding, and therefore recommend coordination of governmental and private resources at all levels. This principle needs to be applied to the development of uniform regulations, claims review procedures, financial audits, reimbursement formulas, eligibility requirements and data collection. Reasonable uniformity in all these areas will go a long way toward assuring humane services to people in a cost-effective manner.

The agencies providing in-home services should meet standards as established by agency accrediting bodies (i.e., National League for Nursing, American Public Health Association, Joint Commission on Accreditation of Hospitals, and National Council for Homemaker-Home Health Aide Services). Such accreditation of an agency must be accepted in lieu of surveys for other purposes; i.e., Medicare and Medicaid. Surveys for the various services of a multiple-service agency shall be combined or coordinated. Such combination will achieve cost reductions and coordination of the review of an agency.

A management information system should be developed for all in-home service agencies so that comparable data may be collected nationwide for the purpose of analyzing trends and studying specific problems, as well as providing reliable information on costs and statistics for health planning and national health insurance.

Each community will need a care facilitating mechanism to ensure that a continuum of services is organized and that it is used appropriately. This will require a strong communication system for planning each person's care referrals and transfers. Contracts and agreements between hospitals, facilities, agencies, and individuals will be needed to be sure commitments are made, and then followed to be sure service is delivered as expected.

An agency will be expected to develop and provide a variety of services, in accordance with what is possible in a community and what is needed by the patients. Agencies should be required to establish utilization review procedures applicable to all services. Planning for the services should be accomplished by a consortium of the total community: consumers of service, third party payors, providers, planners, industry, and government.[2] The services should include the following, and a consumer should be able to receive any one of them without also being required to need others to be eligible for any.

IN-HOUSE SERVICES

Audiologic Services
Barber-Cosmetology
Dental Care
Education or Vocational Training
Handyman

[2] *Ibid.* p. 29.

Home Delivered Meals
Homemaker-Home Health Aide
Housekeeping and Heavy Cleaning
Information and Referral
Laboratory
Legal
Medical Supplies and Equipment
Nursing
Nutrition and Diet Therapy
Occupational Therapy
Ophthalmologic Services
Pastoral Services
Peripatology
Personal Contact Services (i.e., Friendly Visitor, Telephone Reassurance, etc.)
Physical Therapy
Physician Service
Podiatry
Prescription Drugs
Prosthetics/Orthotics
Protective Services
Recreational Service
Respiratory Therapy
Social Casework
Speech Pathology
Translation Service
Transportation and Escort Service
X-rays

STAFFING

Qualifications

Professional: professional staff shall be required to meet the qualifications as established by their professional organizations.

Sub-professional: these staff shall be required to meet the standards where they have been established. Where none exists standards must be set using related standards especially for pre-service education and training and in-service education.

Volunteers: Volunteers must meet same standards for the task they are expected to perform.

Compensation

Professional: salary and benefits equitable with those provided to other professionals in the area.

Sub-professionals: guaranteed annual wage at level above the Federal minimum wage, with benefits comparable to those provided to professional staff.

Staffing

Adequate numbers and variety to meet the needs of the community. Innovative patterns of staffing are needed to utilize all personnel in a way to provide maximum service.

The use of the nurse practitioner, nurse clinician, or clinical specialist needs especially to be developed and expanded.

Sub-professionals can be trained to give a variety of services which are greatly needed by disabled people.

Volunteers can really expand the services of a program of in-home services if they have good training and a dispatching person.

Sharing of Resources and Discipline

With the rapid expansion of knowledge and technology it is essential that a regular system be developed for personnel to be kept informed so that care is given in the most humane and economic manner. Methods of doing this include in-service education, modern references kept available, and the use of personnel from one setting to another for demonstration, observation, and in-service education. Economic shared use of some specialized personnel from one agency to another may be essential to make the service available and to use the specialist economically. Shared in-service and sometimes pre-service training (i.e., aides) can be developed on a community level. Shared community information and referral services would help to assure that one call would get the right service to the patient.

Eligibility for Service

1. Based on needs of the consumer.
2. Available without restrictions as to race, religion, ethnic origin, age or economic status.
3. Authorization for service, by any professional personnel—not restricted to physician.
4. No requirement for prior hospitalization.
5. Services available singly or in any combination without requirement for ongoing professional service.
6. Needing and able to utilize services within the home setting.

Reimbursement

1. Variety of payment mechanisms should be explored.
   a. Fee for service
   b. Capitation
   c. Reimbursement to client
   d. Part of Health Maintenance Organization
2. Full cost reimbursement with retroactive settlement after audit.
3. Effective financial management and accountability must be assured through the development and use of functional budgeting practice and cost analysis.
4. Development of "incentive reimbursement" plan for home health agencies which meet good business practices and timeliness of reports.

2. DAY CARE

The health care industry has experienced tremendous growth in recent years with total national health care expenditures rising to more than $80 billion in 1974. The cost of acute hospital care and long-

term care has contributed significantly to the rise, and the trend seems certain to continue.

The recent surge in interest in lowering health care costs and enabling long-term disabled persons to live in their homes rather than becoming institutionalized has resulted in intensive efforts to develop options for health care services. One of the options proposed presently is a day care program for aged and long-term disabled persons. A viable day care program for the aged and long-term disabled has economic as well as social, rehabilitative, and preventive advantages.

In Great Britain day care programs for the elderly began in 1962 because of a serious lack of beds in hospitals and long-term care facilities. These programs have been highly successful with emphasis on keeping the aged in their homes and as independent as possible. According to testimony presented before the Subcommittee on aging in June of 1971, only 1% of the population over 65 in the United Kingdom lives in long-term care facilities. In the United States 5% of the population over 65 are in long-term care facilities.[3] Unfortunately, these unnecessarily high figures of long-term facility residents in the United States has not changed significantly over the past few years. The reason is unmistakably clear: alternatives to nursing home care, except in a few isolated geographical locations, are simply not available for the majority of our citizens. It is more and more evident that many elderly and disabled persons are living in nursing homes, not for medical reasons or because they require nursing care on a 24-hour basis, but because there is a lack of essential services that, if available, could maintain these people in their own homes. Surveys throughout the country indicate that nearly one third, and in some instances more than one third, of the residents in long-term care facilities do not require nursing service, and other health care services, on a 24-hour basis, and could indeed manage outside the institution if alternate health care services were available and accessible to them, and if they could afford such services. Although we speak of alternatives and options to institutional care, we do so with tongue in cheek, for we speak of a myth. Except for a few isolated experimental projects, usually funded for a limited period of time, there are no such alternatives to nursing home care for the majority of our aged ill and disabled citizens.

If we are to practice the belief that health care is a right and not a privilege, then we must have options available and accessible for all. A coordinated nationwide program of multiple services should exist with the day care center being one link in a chain of services offered the aged and disabled. Day care programs have enormous potential for meeting the long-term care needs of individuals, while delaying or avoiding the need for full-time institutionalization. Day care programs offer the opportunity for nursing care, monitoring of medications, dietary care, socialization, rehabilitation and social services. They provide a means of helping the aged and disabled to maintain and reestablish their ability to care for themselves. Because of the therapeutic programs offered in such facilities, they may be

[3] Hearings before the Subcommittee on Long-Term Care, Special Committee on Aging, U.S. Senate, June 15, 1971. Trends in Long-Term Care. Major input by L. Cosin, Clinical Director, Geriatric Unit, United Oxford Hospitals, Oxford, United Kingdom.

accurately described as a form of preventive medicine. Mitchell states that "day care not only meets the physical, psychological, sociological, and spiritual needs of its participants but also has proved to be a solution, in part, to the rapidly rising costs of health care, a nationwide problem presently of great concern to us all."[4]

Examples of successful day care programs in Great Britain, Canada, and isolated examples of programs in the United States can serve as models for expansion of a coordinated system of day care programs geographically constructed and operated throughout the United States available to all our elderly and disabled citizens regardless of where they live or their ability to pay.

Experience with the Center for Adults Plus in New York City led Berger to write:

> Day centers can allay the feelings of uselessness, depression, isolation, alienation, helplessness and hopelessness which are so prevalent in this age group (the elderly). Fear of dependency and of not being needed or wanted, and feelings of loneliness and abandonment can be alleviated in a therapeutic community setting. This setting can provide for nonverbal as well as verbal communication; for spiritual, emotional and physical interaction; and for dialogue and communion in a spirit of mutual interest, trust and intimacy. In an active process of involvement in giving as well as receiving, men and women can find the strength to accept what needs to be accepted existentially while enjoying the excitement and search for self-fulfilling new options or solutions to conflicts and problems that seemed unsolvable.[5]

TYPES OF CARE PROGRAMS

Health Care Oriented Programs

Day hospitals are facilities situated within the confines of a hospital and functioning under the same administration. Elderly and chronically disabled persons may come, or be transported, to the center in the morning and spend the entire day, or part of a day, in therapeutic activity. They return on the same day to their homes. Comprehensive services, which are available in the hospital, are available to persons in the day care program. The services offered are determined by assessment of individual needs of each person. Only hospitals that can supply such comprehensive services necessary for maintenance and/or rehabilitation of the elderly and disabled should be considered for day hospitals. The sharing of health services between facilities should be encouraged, especially in small hospitals where the cost of employing personnel to supply comprehensive health services would be prohibitive. The over-all objective of the day hospital is to ease the return of hospital patients to community life, while providing a means of professional monitoring of physical conditions and an opportunity to reach maximum independence through comprehensive, coordinated rehabilitative services.

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[4] Mitchell, Monroe. "Long-Term Care." *Hospitals*, April 1, 1972, p. 123.
[5] Berger, Milton M., and Berger, Lynne Flexner, "An Innovative Program for a Private Psychogeriatric Day Center" *Journal of the American Geriatrics Society*, April 1971, p. 333.

Day care centers are similar to day hospitals. They are situated within the confines of long-term care facilities or they may be isolated from such facilities and function exclusively for persons needing day care only. Comprehensive rehabilitative and/or maintenance services are offered either full-time or through a shared service arrangement. Consolidation of services of existing facilities with renovation of one or more facilities in each community should be encouraged. Cost of renovation should be provided by Federal funds. Nursing homes should be encouraged to use existing facilities and services to include day care programs to maximum extent possible. In areas where neither of the above plans are feasible, new facilities should be built specifically for day care centers, These should be built with geographic distribution in mind in order to be accessible to the greatest number of people. The objectives of such a program would be to provide a degree of care intermediate between out-patient therapy and total institutional care, and to give support to families who are keeping an older, or disabled person, in their homes. The total program should be planned to provide stimulation that is active, rather than passive, and should include sharing with other human beings in group situations with the goal to promote physical and social rehabilitation.

Experience with a day care program at Maimonides Hospital and Home for the Aged in Montreal, Quebec, Canada has shown it to be a cost-saving program. Of a total of 250 persons cared for in the program, only six percent over a four year period have had to be institutionalized. Ninety-four percent have been able to continue maintaining themselves in the community. Administration attributes this to diminution of social isolation, improved nutrition, and continuous health supervision and treatment.

Socially oriented day care programs exist outside of hospital or licensed long-term care facilities, and are goal-oriented toward social rehabilitation and maintenance. Activity programs, both group and individual, provide a means of socialization and prevention of physical disability from disuse and mental disability caused by loneliness and isolation. In our work oriented culture, the older person is faced with multiple losses—loss of a spouse, loss of close friends, loss of good health with the accompanying inability to get around as easily as before, loss of the worker's role because of forced or voluntary retirement, loss of family responsibilities, and loss of income to meet increased cost of living. At present, we have little in the way of supportive services to help these persons cope with the stress produced by these losses. The socially oriented day care center is one way of meeting this need. Although socialization through activity is the primary focus, other services such as nursing consultation, dietary instruction, educational and vocational classes, social services, personal care services, and health education should be available on a part-time basis. Personnel necessary to supply these services should function through a coordinated shared service program. There are presently many good senior citizens programs throughout the country, and existing programs should be used wherever possible. Many of them are in need of enlarged plant facilities. Transportation is rarely available, denying persons that would benefit from attending these centers to do so. Minimal services mentioned above are not always available. One hot meal, preferably at noon, should be offered at cost. This latter

service is available in only a few isolated senior centers throughout the United States. Existing senior citizens programs should be expanded both in plant facility and in service, including noon meal and transportation. Eligibility requirements for membership should be broadened to include the chronically ill and disabled who are under 65 years. Necessary renovation should be Federally reimbursed. Not only should existing facilities be expanded but new facilities should be developed in areas where there are none. Churches, lodges and other such buildings that are customarily used for only part of each week, should be considered as possible location for new centers. Where no such buildings exist, or can be made available for this purpose, new buildings should be constructed specifically for this purpose.[6]

SERVICES

Services will vary depending upon the type of day care program; i.e., health care oriented (hospital, day care center) versus socially oriented centers. Programs should be developed and services provided in accordance with the objectives of the center. In a health care oriented center the following services should be available either full-time, part-time or on a consultant basis (Whenever feasible, services should be shared. This is a cost-saving factor which must not be overlooked.):

Administrative and Secretarial Services
Medical Services:
- For medical assessment of persons, for acceptance into the program
- For availability for consultation and referrals to speciality areas

Nursing Services:
- For nursing assessment of persons for acceptance into the program
- For primary care throughout the person's stay within the program

Social Services:
- For social assessment of persons for acceptance into the program
- For consultation on an ongoing basis

Physical Therapy
Occupational Therapy
Speech and Hearing Services, and Peripatology
Diversional, recreational therapy
Psychological Services
Dietary and Nutrition Services
Educational, Vocational Services:
- Health
- Prevention
- High School, College Courses

Personal Care Services
Information, Referral and Counseling Services (may be combined with social services and psychological services)
Transportation:
- Ambulances cabulances
- Taxis
- Volunteer's cars
- Staff cars

[6] Louis Novick, "Day Care Meets Geriatric Needs," *Hospitals*, November 16, 1973, p. 50.

Bus supplied and maintained by facility
State bus or small mini-bus, with lifts to accommodate persons with wheelchairs
Entertainment—socialization
Podiatry
Comprehensive Record Keeping Service
Guidance and education for families
Orthotics and Prosthetics
Dental
Laboratory services

Additional suggested services are:
Arts and crafts
Religious services
Work therapy (i.e. sheltered workshop)
X-Ray Service (available in day hospital type of program)
Miscellaneous (library, store, beauty shop, barber shop, legal service, etc.)

In a socially oriented center where socialization through activities is the primary focus, the following services are recommended:
Administrative and Secretarial Service
Activity Program Service—with a full-time program director:
Diversional, recreational therapy
Arts and crafts
Entertainment, socialization
Work therapy (optional)
Medical, nursing, and social service on consultant basis, or part-time through sharing of services
Dietary service. At least one hot meal per day
Transportation service
Educational services
Information, referral, counseling and legal services
Guidance and education for families

If such a day care program should also be functioning as the primary rehabilitation facility, such as would be economically more feasible in sparsely populated areas, the following additional services should be provided:
Physical Therapy
Occupational Therapy
Speech Therapy
Vocational counseling
Psychological Services
Orthotics and Prosthetics

SPECIFICS OF DAY CARE FACILITIES

Day care facilities must be accessible to the population they intend to serve. Time needed for transportation from the furthest point should not exceed one hour if at all possible.

The facilities should provide a safe environment.

There should be sufficient room for a variety of activities that will be meaningful and stimulating to the group to be served and will help maintain orientation and continued learning.

There should be space to provide opportunity for both group and individual activity, for action and for rest.

Expansion of existing in-care services to include outcare should be considered. This could provide an enhanced program for people both in and outside institutions. Utilizing current facilities should be fully explored before new ones are developed.

Possible facilities for day care are many and varied. The facility to some extent would determine the kind of service that could be offered. Possible settings are adult care homes, day hospitals, psychiatric or general hospitals, unused college dorms, community rooms in sheltered housing or apartment complexes, senior service centers and convalescent centers. The first four listed should lend themselves to a complete and varied program to meet most day care needs existent in the older population. The other facilities might necessitate a more limited program that would serve only selected people based on the services that could be offered. All alternatives must be considered because of the factor of availability. Old two story frame houses have been suggested, but should be looked at closely for safety factors and considered only if better structures are not available.

Basic accommodations that must be present for a minimal program are facilities for food preparation and dining, resting, toileting and activity. An office for clerical activities and private conferences is also desirable. This would be the place for keeping client records and could also serve as a medication center.

Types of rooms used in now existing day care settings to be considered are arts and crafts, living, multiple activity centers, library, beauty shop, grooming, physical therapy, laundry, bathing, sheltered workshop, and classrooms and storage.

It is desirable that the kitchen be set up in such a way that clients can participate in cooking or preparing snacks. Space for health assessment in or near the day care facility would also be desirable. This space could also be used for emergency or first-aid care.

The furnishings of an adult day care center should be in keeping with older people's tastes. They should be easy to care for and clean; usable with wheelchairs and walkers; demanding of some activity: proper care, and movement; comfortable enough to maintain good orientation, but not so comfortable as to discourage movement. Some beds should be provided for resting, but as few as two for 40 people were observed as sufficient in existing facilities.

In considering furnishings, reality testing should be kept in mind and mirrors, clock and calendars should be in evidence. Some new furnishings which demand proper care are important. Better lighting than for younger people and hand rails at appropriate places in bathrooms, halls and by stairs should installed. Ramps for access to the building by wheelchair and walker should also be considered.

A garden area where day care recipients can actively participate as well as find enjoyment is an asset to a day care facility.

The day care center for older adults should be located within a maximum of a 15 mile radius or one hour travel time of the people to be served. This mileage was the furthest travel found in the literature. However, all existing day care centers seem to be in urban areas and a rural area with a greater raduis would probably not involve more

travel time. Therefore, the maximum travel time of approximately one hour is suggested.

Furnishing of transportation is necessary for a successful adult day care operation. Camper type vehicles offer the broadest possibilities for transporting aged and disabled persons because they can be outfitted to accommodate wheelchairs as well as having seating capacity for persons that are ambulatory. Maintaining the refrigeration unit in these vehicles has also been suggested. Transport units being utilized successfully accommodate 8 to 10 people and have hydraulic lifts. They provide good visibility for both driver and passengers and have safe seating and good heating. Loading and unloading may take a while, hence larger units than those mentioned above are not feasible since the time frame from start to the delivery point would be great.

Transportation may also be furnished by family or friends and should be done to maintain responsibility and interest where at all possible.

STAFFING A DAY CARE FACILITY

The staff should be warm, accepting, empathetic people interested in disabled and aging people.

The kind of staff will depend both on the program to be offered and the constraints of the area in which the center is located. A rural center may need to use more volunteers and consultants to develop a desirable program than would be necessary in an urban area.

The basic professional staff should have good preparation for the role they are fulfilling and be able to work as individual therapists as well as in a team relationship.

The minimum staff in a day care center would be an administrator who might also provide another professional service in a small center; a nurse clinician with gerontological and/or rehabilitation background; a social worker; a physician; a secretary and attendants or aides. The amount of time worked and kind of input of each staff member would depend on the program needs of the center. For instance, the physician may be hired on a consultant basis and not be physically in the center.

The most common staffing pattern in the literature is based on 45–50 day care clients and include an administrator (usually a nurse), two registered nurses, two social workers, a part-time physician, and four attendants. An occupational and a physical therapist are usually available for program development and consultation and are desirable on the basic team if at all possible.

A nurse clinician could provide the original and ongoing health assessment of day care participants with medical input when necessary. The nurse social worker team could also do family and social assessment and work with both family and client. On the basis of these assessments and input requested from other professionals, the day care program for both the group or individual could be planned.

Other basic staffing that would be necessary for day care centers is food preparation and service personnel with dietician consultation, housekeeping personnel, and bus drivers or other transportation providers.

A team relationship and approach is desirable between all staff of the center, and people should be chosen with this in mind in hiring. They should subscribe to the objectives and program plan. A good orientation and communication network will contribute to effective staff participation and input in the program.

Other personnel who could be called on for service to the day care center clientele are professional counselors, religious counselors, financial counselors, speech therapists, chiropodists, hair dressers, barbers, art and music therapists, psychiatrists, dentists, and pharmacists. The more variety of input available, the broader the program possibilities could be for meeting individual health and social needs.

Not all staff will need to be full-time and not all will need to be hired. Volunteer help is very effective, particularly with activity parts of the program and socialization. The clients should also provide any skills they have for the betterment of the program.

Day Care Centers lend themselves to flexible staffing patterns and utilization of part-time staff. Incentive pay has also been used to assure quality staff in some settings.

COSTS OF DAY CARE FACILITIES

Costs of a day care program for aged and long-term disabled persons are affected by a number of variables, i.e., range of services provided, local labor costs, staffing, number of meals served, inflationary trends, etc. It seems evident that a program of day care for aged and long-term disabled persons costs substantially less than long-term care currently provided in health care facilities. It should be emphasized here that this significant difference in costs occurs primarily because the day care program typically operates on a five day basis and for eight or less hours each day, and not because the range and quality of services needed by day care participants are significantly different from services needed by long-term care participants in an institutional setting.

FINANCING ALTERNATIVES

There are several possible major financing alternatives to providers of day care services. Some of these are:

Medicare
Medicaid
Private pay
National Health Insurance
Revenue Sharing
Federal and State Grants
Union Health Plans

None of the alternatives proposed above can be said to be the best way of financing a day care program for aged and long-term disabled persons. Each would vary in terms of eligibility requirements, processing procedures, costs, flexibility, and other factors. Each would have specific advantages and disadvantages. Some would be combined, and should be when such a combination results the most feasible financing method. Each alternative requires study and must be carefully evaluated.

The Medicare financing technique has gained a great deal of popularity and received a great deal of criticism since its advent in 1966. Because it is presently an existing possible alternative we recommend

that consideration be given to restructuring the Medicare program in a way which would allow reimbursement (retroactive) of full costs to providers, both institutional and noninstitutional, rendering day care services to the aged and long-term disabled persons. Eligible costs should include but not be limited to those costs now eligible for reimbursement under the Medicare program. We recommend, further, that for the purpose of financing a day care program requirements of prior hospital stay be eliminated, and self-admission to day care services be implemented.

This financing alternative does not have the capability or flexibility of meeting the needs of all persons requiring day care services and could be, therefore combined with other financial alternatives.

In 1967 the Federal government implemented Medicaid (Title XIX). Through this program health care financing is provided for both institutional and noninstitutional providers of services. Because of its broader coverage and flexibility we recommend serious consideration be given to funding day care for the long-term disabled through existing State agencies responsible for handling Title XIX programs. We recommend, further, that the benefit eligibility requirements be extended to all persons in need of day care services who do not have the personal ability to pay. Reimbursement (retroactive), at full costs, and self-admission as well as referrals, should be integral components of the program.

Financial incentives should be given to existing long-term care facilities to encourage use of available space within these facilities for day care services. This alternative would require little restructuring or revision of existing Title XIX rules and regulations, and would decrease significantly expenditures for long-term care.

Revenue sharing—a new program and possible alternative for financing day care services to aged and long-term disabled persons. Revenue sharing legislation provides that funds may be expended for human service programs. Utilization of this financing technique could provide capital assistance grants to nonprofit providers for day care services. This alternative should receive careful study and consideration.

A national health insurance method of financing a day care program for aged and long-term disabled persons has, probably, the greatest potential. Because of its expected broad coverage of persons and services and its proposed financing mechanism, a national health insurance program is, perhaps, the best alternative to ensure a viable and lasting day care program.

3. RESIDENTIAL CARE

The group unanimously supports the principle that services must be acceptable to both the consumer and the health social professionals prescribing the care; accessible for the person and his family; and appropriate to meet the individual need of the elderly and disabled person.

The members of the group insist that the term "skilled" be deleted since it indicates discrimination (i.e. skilled-unskilled nursing) and further has no real meaning especially in view of the definition used

by Social Security and HEW. By limiting the definition of nursing to specific medical procedures it fails to recognize the broad mission of nursing care which includes a multiplicity of services which together help to maintain the person's life style.

The committee unanimously proposes that terminology be modified to delete levels of care and that in the future two types of facilities be available: (a) Long-Term Health Care Facilities, and (b) Social Care Facilities.

In light of accepted research findings it is crucial to organize institutional services so that the consumer's varying needs may be met in one setting without subjecting him or her to the trauma of frequent geographical moves.

It has also been demonstrated that staff and patients respond better to situations in which there is a mix of patients in terms of functional ability and rehabilitation potential.

Further problems exist in trying to provide adequate appropriate care to a population of elderly and disabled some of whom require protective living and some of whom require varying amounts of health services. Too often the latter group are disadvantaged because the total needs of the population cannot be adequately met by staff. Also, this arrangement too often tends to encourage unnecessary dependence in the group requiring social care because of the fact that the institution is geared to meeting the needs of the "sick."

Our present system has reinforced the trend to institutionalize individuals by providing payment for services provided in an institution and not paying for similar services provided outside the hospital or health care facility. Our present system financially rewards facilities for keeping patients bedfast rather than providing financial incentives for providing rehabilitative services.

Three options in providing health care have been recommended and discussed in depth. Another group of options, however, should be included as vital components in providing comprehensive services. These are: foster homes, boarding homes, group care facilities, sheltered living and others similar in nature. Another category of services to be considered are clinics staffed by nurse clinicians on a 24-hour-a-day basis to provide ongoing health care.

RECOMMENDATIONS

This Task Force recommends:

Provisions for a wide array of alternatives in living arrangements for the elderly and disabled. Monies should be appropriated to investigate concepts of group living.

Provisions for an enlightened welfare system that will increase payments for individuals who remain in their own homes or for individuals who bring the elderly or disabled welfare recipient into their homes.

Provision of decent housing at a cost older and disabled people can afford.

Provision of a satisfactory entry into the health care delivery system other than exclusively through a physician's referral; for example, admission to long-term care facilities could be initiated by a nurse clinician.

Provision of incentives for nursing home based out-reach programs and day care centers. This exposure to the institution could serve to minimize the trauma of adjustment to institutional life at a later date should it become necessary.

Provision of the development of preventative health services and screening programs for the early detection of illness. A preventative health program is financially sound.

Development of concepts of long-term facilities as community centers and the lease for out-patient services. These facilities should be flexible enough to serve the changing needs and circumstances of its patients and clients.

Adoption of an adequate reimbursement system for payment of services rendered by providers of care. A special task force should be charged to study the professional, financial, social, and technical factors involved in establishing an equitable reimbursement system. Our present system rewards sub-standard facilities while penalizing those that are above average. A new system should reward good care and penalize sub-standard care.

Establishment of an Ombudsman program on behalf of nursing home patients to assist them in obtaining needed services, receive and investigate complaints, obtain the necessary corrections, and to assist clients through the complexities of the welfare system and the health care delivery system.

Support of experimental projects to test the feasibility of innovative strategies for meeting the needs of elderly and disabled persons with long-term care requirements. Examples: triage, remotivation, reality orientation and resocialization.

Launching a wide range educational program to dispel myths about old age and long-term care.

Insuring flexibility in government supported programs in order to meet the actual needs of the recipient and to avoid inappropriate utilization of services which too frequently contribute to the spiraling costs of care and at the same time fail to meet patient requirements.

Recognize that unless nursing and social services are expanded and supported, instead of providing payment primarily to cover medical services we will continue to disadvantage the elderly and disabled.

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APPENDIX 3

REPORT AND RECOMMENDATIONS FROM THE AMERICAN NURSES' ASSOCIATION'S COMMITTEE ON SKILLED NURSING CARE

TASK FORCE ON NURSING MANPOWER AND TRAINING

Composition of Nursing Care Team

There needs to be a change in current staffing ratio patterns of professional to auxiliary staff in all options of health care.

Recommend

Nursing administration establish staffing patterns which reflect the quality and quantity of various categories of nursing personnel necessary to carry out the nursing care program.

Research and demonstration on various staffing patterns for 24-hour coverage, 7 days per week for all health care workers to include RN's, LPN's, home care aides (health-homemaker), nurses' aides, medical secretaries, ward clerks, and qualified aides in fields such as physical therapy, recreational therapy, occupational therapy, speech therapy, to determine most effective outcome.

Expansion of the Nurse's Role in Patient Management

Recommend

A. Assessment, implementation, and evaluation of care; the development of protocol with the attending physicians, and the nurses' managing of patient's care with physician as consultant.

B. Patient care plan and patient goals be responsibility of expanded health care team since it is necessary for quality care.

Time and Manpower Spent on Paperwork

Recommend

A. Complete overhaul of record-keeping system required by Federal, state, and third party payors to reduce amount of repetitive paperwork.

B. Qualified personnel be assigned to handle paperwork thereby relieving health care workers, including physicians and nurses to provide health care.

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Education and Training

Recommend

A. Basic concepts for all professionals and workers being prepared for long-term health care in any setting. Basic concepts to include:

1. Process of normal aging, biological, psychological, and sociological.
2. Attitude toward aging including respecting the value and dignity of each individual and the patient's rights.
3. Concepts of prevention and maintenance.
4. Concepts of rehabilitation, both mental and physical, to the highest functioning level; to include remotivation and reality orientation.
5. Chronic diseases and the meaning of chronicity.
6. Nutrition as applied to long-term care.
7. Pharmacology and long-term care.
8. Administrative environment or climate in which care is given.
9. Death and dying.
10. Work with families.
11. Human sexuality, sexual needs of aged and long-term patients.
12. Mental Health.

B. Programs for nurses' aides should utilize the educational system as an open one which permits mobility.

1. Educational programs carried out through high schools, vocational schools, and community colleges.
2. Basic education for aides starting with attitudes toward patients.
3. Fundamental skills and physical care necessary for this group of nursing personnel.
4. Better selection of personnel who work with long-term patients by establishing better methods of screening.
5. Recognizing that not all health workers are suited to work with chronicity.

C. Educational programs should be strengthened to correct specific deficiencies found in the education of RN's at various levels. Basic programs would include:

1. Contact with the "well aged" and adequate content on gerontology.
2. Use of available support systems for the field of geriatric nursing in nursing homes and the community.
3. Additional training in crises intervention and in assessment skills.
4. More education in communication skills, chronicity, and the concept of family relationships.
5. Addition of leadership training.
6. More electives with other disciplines, e.g., social work, psychology, pertaining to care of the elderly and other specialized areas dealing with the aged and aging.

D. The utilization of the American Nurses' Association's *Standards for Nursing Services and The Position, Role and Qualifications of the Administrator of Nursing Services* in defining and preparing persons for these roles.

E. Programs should be developed for nurse practitioners utilizing ANA's *Guidelines for Short-Term Continuing Education Programs Preparing the Geriatric Nurse Practitioner.* Guidelines are needed to direct the preparation of RN's for consulting roles in long-term care facilities. Methods for efficient utilization of nurse consultants need to be developed.

F. All long-term care facilities should develop volunteer programs including various age groups in order to:

1. Educate all segments of society re the aged and aging.
2. Begin to change attitudes re the aged and aging by involving children with old people.

GENERAL RECOMMENDATIONS

1. Long-term care facilities should be used more for field practice for all kinds of nursing students.

2. There be educational experiences for all levels of personnel together, including inspectors/surveyors and review teams, to develop an appreciation of the roles and tasks of each group.

3. Every university that has a center for study of gerontology should have direct links with service agencies.

4. The pooling of educational resources among various facilities to provide orientation programs, and continual ongoing in-service educational programs for all levels of staff should be mandatory.

5. The feasibility of a central community library for acquisition, dissemination and evaluation of multimedia and other teaching tools should be explored.

6. Graduate programs for gerontological nursing should be established (there are presently none available) in various sections of the country.

7. Training programs for aides complete with screening mechanisms for both in-patient and home based needs should be developed. These programs should be provided within the educational system through occupational and preservice training. Supplement with on-the-job training and integration with work experiences. Institutions should be discouraged from setting up their own educational programs except for in-service.

8. Funds should be made available in the development of a curriculum for training all disciplines in long-term care. It is suggested that responsibility for generation of such funds be assumed by a coalition of national health organizations in the field.

9. Federal and other public funds should be available to colleges, universities, and vocational schools through project and capitation grants, for developing and implementing basic educational offerings in the field of long-term care.

10. Federal and other public funds should be available through traineeships, grants, loans, for students to receive basic and graduate education in long-term care.

11. Conditions of employment in long-term health care facilities should specify that employees in all categories be offered financial incentives for participation in in-service and continuing education programs.

12. Federal and other public funds should be made available to help national health organizations to finance their own programs of continuing education in long-term care. Reasonable fees might be charged to help defray the costs of such programs.

13. National health organizations should be encouraged to offer financial incentives to their state and local constituent groups for conducting continuing education programs in long-term care.

14. Every health care facility should provide a planned program of in-service education. The cost of in-service education provided by health care facilities should be a reimbursable item under publicly funded programs.

15. Publicly financed training centers in long-term care should be required to earmark a portion of their resources to assist long-term health care facilities in organizing and conducting in-service education programs.

16. Factors causing high turn-over of nursing personnel in many nursing homes should be studied, considering job satisfaction, especially at the nurse aide level. The contribution of the aide to patient care especially must be recognized.

17. Salaries and working conditions for personnel providing long-term health care services must be competitive in order to recruit and retain qualified staff. The principle of employee involvement in the decision-making process about employment conditions should be fostered.

18. Availability of manpower resources should be considered as a necessary adjunct to local comprehensive health planning.

19. The planning process for meeting manpower needs should consider the multitude of other services in addition to institutional care, such as home care, day care, etc.

20. Individual licensure of qualified personnel (RN and LPN) should be continued.

21. There should be a publicly financed mechanism in every community for the coordination of human services as it contributes to long-term care.

22. Long-term health care needs a larger share of the health care dollar. Large amounts of money are now being spent for hospital care for people who could be maintained in their own homes through ambulatory services, or in nursing homes. This principle of redirecting more money into preventive and maintenance health services should be incorporated into any Federally financed health program, including the anticipated system of national health insurance.

23. Education and inclusion of families in planning nursing home patients' care and program is imperative to facilitate the maintenance of "wellness" in community life, health and homemaking functions are part of the integral whole.

APPENDIX 4

AMERICAN NURSES' ASSOCIATION RESOLUTION ON NATIONAL HEALTH INSURANCE

Whereas, health, a state of physical, social and mental well-being is a basic human right, and

Whereas, government at all levels must act to insure that health care services are provided for all citizens, and

Whereas, there is a need for integrated systems to deliver comprehensive health care services that are accessible and acceptable to all people without regard to age, sex, race, social or economic condition, and

Whereas, there is need for a national program designed to correct serious inadequacies in present health care delivery systems, and

Whereas, nursing care is an essential component of health care; therefore, be it

Resolved, that the American Nurses' Association aggressively work for the enactment of legislation to establish a program of national health insurance benefits, and be it further

Resolved, that the national health insurance program guarantee coverage of all people for the full range of comprehensive health services, and be it further

Resolved, that the scope of benefits be clearly defined so that they can be understood by beneficiaries and providers alike, and be it further

Resolved, that the national health program clearly recognize the distinctions between health care and medical care; and that the plan provide options in utilization of health care services that are not necessarily dependent on the physician, and be it further

Resolved, that nursing care be a benefit of the national health program, and be it further

Resolved, that the data systems necessary for effective management of the national insurance program protect the rights and privacy of individuals, and be it further

Resolved, that the plan include provisions for peer review of services that will protect the right and the responsibility of each health care discipline to monitor the practice of its own practitioners, and be it further

Resolved, that there continue to be a system of individual licensure for the practice of nursing, and be it further

Resolved, that provision be made for consumer participation in periodic evaluation of the national health insurance program, and be it further

Resolved, that the national health insurance program be financed through payroll taxes or payment of premiums by the self-employed, and purchase of health insurance coverage for the poor and unemployed from general tax revenues, and be it further

Resolved, that ANA strongly urge the designation of nurses as health providers in all pending or proposed legislation on National Health Insurance.

APPENDIX 5

A NURSE FIGHTS CORRUPTION*

Armed with evidence the author took direct action to halt thievery in her place of employment

Anonymous**

What does a nurse do when she finds corruption in her place of employment? If she tries to correct the situation, where can she turn for help?

When I was hired as the director of nursing for a skilled nursing care facility, I knew I would encounter many obstacles in improving the existing quality of care. This was not a new experience as I had changed nursing care for the better in other institutions and believed it was possible to do so in this one. After several months, however, I began to suspect that I was facing problems that I had not faced before.

Why was I suspicious? We were on a tight budget and necessary nursing care items could not be purchased. Yet occasionally nursing care items that I did not want or order were delivered and charged to the nursing budget. When I questioned this, the administrator intimated that the budget could be manipulated to suit "needs." When it came time to submit my nursing budget recommendations for the coming year, I was informed this job had been taken care of for me because I was spending so much time and energy in improving nursing care that I would probably appreciate being relieved of some duties. True, I was spending considerable time on the floors, teaching and supervising, but I also was sensing that someone did not want me involved in financial matters. My written job description entitled me to complete control of the nursing department, which included employing personnel, ordering supplies, and providing information to maintain and revise the nursing budget as needed. But a complete financial picture was hard to come by because I could not obtain up-to-date supply order lists and previous budget revisions. Of course, all reasons given for the changes in duties and excuses for the lack of information were friendly and logical.

To improve nursing care, I spent hours developing good working relationships with housekeeping, dietary, maintenance, and office personnel. As their trust and confidence grew, department heads and other co-workers began telling me that they, too, had similar supply-ordering problems. In addition, items that were obviously not for nursing home use were delivered but they disappeared almost immediately.

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*From the American Journal of Nursing, vol. 75, No. 3, March 1975, pp. 440-41.

**The author was director of nursing at the skilled nursing home where the events that she describes in this article took place.

Gathering Evidence

The secretary, who worked very closely with me, confided some financial details she had learned, including the fact that bills for supplies not used at the facility were lumped together with legitimate bills.

Within six months of my employment. I had many suspicions, but no proof. Then a bill for drugs I had neither ordered nor received was put on the monthly log of bills to be paid. I called the pharmacist, who was also the owner of the pharmacy that had billed us, and inquired about that particular bill. He was obviously upset by my questions, gave no explanation, and would only tell me to ask the administrator about the bill. I now felt certain that someone was stealing from the institution.

It was time for me to make a decision. The facts as I saw them were that misappropriation of funds was taking place, it involved my departmental budget and others, and apparently it had been happening for some time. Who was involved? Why hadn't this misappropriation come to the attention of the nursing home's board of governors? What was I going to do about these discrepancies? Even though I had many unanswered questions, I chose to stay and tackle the problem. This decision marked the beginning of the most difficult six months of my life.

Proof of my suspicions soon came, unexpectedly, when I discovered another facet of the situation. The administrator had been handling many patients' personal accounts. Some patients could be termed confused, but I did not consider their behavior totally irrational. They did not accept statements that "you will be taken care of" or "don't worry, you have plenty of money," but wanted a full accounting of their finances. This they were unable to obtain from the administrator. I had hesitated over the loss of corporation money, but the realization that patients' monies might be involved was a stimulus to action.

I approached the state nurses' association for advice and was assured that legal help was available if needed, and encouraged to stay and try to correct the situation. I also told my story to my lawyer, a personal friend, who gladly agreed to help me whenever I needed his services. (Eventually I was threatened with a libel suit and was thankful that I had him to assist me.) In addition I explained my problem to a physician with whom I worked closely at the nursing home. I knew that disruptions might occur there and immediate knowledgeable advice might be required.

Proving Theft

Next I approached the chairman and a member of the board of directors. I did not make accusations, but asked such questions as why nursing equipment could be ordered without my knowledge, why the budget could be altered at will, who checked to see if what was paid for was needed, and whether all goods delivered and paid for were used by the facility? Within a few days a new firm of auditors was employed and the entire bookkeeping system and financial situation were thoroughly examined.

For me a new set of problems now began. The next three months were unbelievably difficult because I had to work with the administrator, who knew exactly what I had done. I did not know what to expect each day as I arrived. The work in the facility was upset in many ways. Employees and patients all felt the tension and knew that something was very wrong. At times the administrator and I could cooperate for the good of the facility. At others, I was physically afraid for myself, even though the situation might have appeared normal to someone not involved. The extreme tension continued until the auditors and the board of directors were convinced that the administrator was misusing funds. She was then fired. No criminal charges were filed as they would have been difficult to prove, due to the unusual bookkeeping system that had been employed. Litigation might have been emotionally damaging to some of the patients whose personal funds were involved. Some restitution was made to the facility and patients, but the total loss probably will never be known.

Although each situation is different, of course, the assets that enabled me to bring about change included my education, previous job experiences, and reputation. Because of these, I could evaluate the problem realistically, set a definite goal of administrative change, and present accurate facts to those who could support me, the nurses' association, lawyer, and physician, and to those who could institute change, the board of directors. Personalities did not become a part of the issue. Other persons working in the facility came forth with required proof once the investigation began. Finally, I did not ignore or leave the situation, but remained to see that change did occur.

My greatest asset throughout the ordeal was my family, whose total support enabled me to withstand the exceptional pressures that were so much a part of resolving a most unpleasant situation.

APPENDIX 6

OCCUPATIONAL SAFETY AND HEALTH LAW SETS WORKING CONDITIONS

(By Elaine E. Cabot, R.D.)

On-the-job safety and health protection in the dietary department is the business of the nursing home, but the Williams-Steiger Occupational Safety and Health Act of 1970 says it is also the business of the federal government.

The purpose of the federal law is to assure safe and healthful working conditions. The Act requires each employer to furnish his employes with a place of employment free from recognized hazards that might cause serious injury or death; further, it requires the employer to comply with specific safety and health standards issued by the Department of Labor.

Employes have responsibilities, too. The Act requires employes to comply with the safety and health standards, rules, regulations and orders issued under the Act.

In general, the standards consist of rules intended to prevent hazardous conditions which have been proved by research and experience to be harmful to personal safety and health. Some of the rules apply to all employes—fire protection standards fall into this category. Others apply to specific activities.

There are many thousands of occupational safety and health standards. These two are typical: (1) "Aisles and passageways shall be kept clear and in good repair, with no obstruction across or in aisles that could create a hazard." Are all dietary aisles always kept clear when employes are receiving or storing food and supplies? (2) "In any operations in which the eye hazards of flying particles or liquid chemicals exist, employes shall be protected by suitable face shields or goggles." Is the day coming when it would be wise to wear eye protection devices when working with the deep fat fryer or when pouring chemicals into the dishwashing machine?

Admittedly, the Act was designed to apply more to heavy industry than to nursing homes, and nursing home dietary departments are not known for their high rate of severe injury or fatal accidents. But it is possible for an employe to be hurt severely or even fatally, and the Act covers nursing homes; the dietary department has its share of hazards (the possibility of electrocution caused by defective wiring when an employe is working around water is real). Therefore, it will pay for employes and employers to become familiar with the applicable standards and to develop a safety posture in keeping with the spirit of the Occupational Safety and Health Act.

Workers have the right to notify the Department of Labor and to request an inspection if they believe that unsafe and unhealthful conditions exist. Further, employes have the right to bring unsafe conditions to the attention of the safety and health compliance officer as he makes an inspection. If the Department of Labor believes that the Act has been violated, a citation of violation and a proposed penalty will be issued to the employer.

Part of the difficulty for nursing home administrators and dietary managers is determining what all the standards are and how they apply. One rule of thumb is to remember that whatever the employe believes is unsafe and unhealthful is subject to scrutiny by the Department of Labor. Have your employes ever complained that the dietary department is too hot to work in or that the ventilation is inadequate? Do you have working areas that are dark? Do you have wet or slippery walking surfaces? It shouldn't be at all difficult to develop a list of conditions that the staff members would consider unsafe or unhealthful; and to start from there. Of course, such a list would not necessarily be a list of violations; the violations may be those conditions which do not comply with the specific health and safety standards issued by the Department of Labor, or recognized hazards that might cause serious injury or death.

The Occupational Safety and Health standards were based on two existing sets of standards: National Consensus Standards and established federal standards.

The National Consensus Standards are occupational safety and health standards adopted and promulgated either by the American National Standards Institute (ANSI) or by the National Fire Protection Association (NFPA). The National Consensus Standards contain only mandatory provisions of the standards, but the adoption of the advisory provisions is encouraged.

The established federal standards are operative occupational safety and health standards established by the Department of Labor, and went into effect in April 1971. A listing of the Occupational Safety and Health Standards can be found in the *Federal Register*, Vol. 36, No. 105, Part II, dated May 29, 1971. A booklet, "Occupational Safety and Health Regulations," is the companion piece to the general industry standards published in the *Federal Register*. By combining the listing published in the aforementioned issue of the *Federal Register* and the contents of the Regulations booklet, a complete text can be obtained of the Safety and Health Regulations for general industry through January 1, 1972.

As examples of the types of standards involved, a few of the Occupational Safety and Health Standards set out in various sections of the Act are listed below:

Walking and Working Surfaces

The floor of every workroom shall be maintained in a clean and, so far as possible, a dry condition. Where wet processes are used, drainage shall be maintained, and false floors, platforms, mats or other dry standing places should be provided where practicable.

Fire Protection

Portable fire extinguishers. (a) General requirements: (1) Operable condition. Portable extinguishers shall be maintained in a fully charged and operable condition, and kept in their designated places at all times when they are not being used. (2) Location. Extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. They shall be located along normal paths of travel. (3) Marking of location. Extinguishers shall not be obstructed or obscured from view. In large rooms, and in certain locations where visual obstruction cannot be completely avoided, means shall be provided to indicate conspicuously the location and intended use of extinguishers. (4) Marking of extinguishers. If extinguishers intended for different classes of fire are grouped, their intended use shall be marked conspicuously to ensure choice of the proper extinguisher at the time of a fire.

Special Industries

Bakery equipment. Open fat kettles: The floor around kettles shall be maintained in a no-slip condition; Fire-extinguishing devices suitable for class B fire shall be provided; Goggles or face shields shall be provided to prevent injuries from hot fat splashes. Slicers: When it is necessary to sharpen slicer blades on the machine, a barrier shall be provided leaving only sufficient opening for the sharpening stone to reach the knife blades. General requirements: All safety devices on ovens shall be inspected at intervals of not less than twice a month by an especially appointed, properly instructed bakery employe and not less than once per year by the representative of the oven manufacturer.

Safety is not a new consideration in the operation of a dietary department, but the emphasis is new. Many potential hazards exist in every operation; it is up to the administrator and the dietary manager to see that employes are safety-oriented; that the working area is well-maintained, clean, well-lighted, and adequately ventilated; that equipment is maintained in a good state of repair, and that housekeeping is a matter of safety as well as of sanitation.

GLOSSARY

1. *Clinical Nurse Specialists* are primarily clinicians with a high degree of knowledge, skill and competence in a specialized area of nursing. These are made directly available to the public through the provision of nursing care to clients and indirectly available through guidance and planning of care with other nursing personnel. Clinical nurse specialists hold a master's degree in nursing preferably with an emphasis in clinical nursing.

2. *Nurse Clinicians* have well-developed competencies in utilizing a broad range of cues. These cues are used for prescribing and implementing both direct and indirect nursing care and for articulating nursing therapies with other planned therapies. Nurse clinicians demonstrate expertise in nursing practice and insure ongoing development of expertise through clinical experience and continuing education. Generally minimal preparation for this role is the baccalaureate degree.

3. *Nurse Practitioners* have advanced skills in the assessment of the physical and psychosocial health-illness status of individuals, families or groups in a variety of settings through health and development history taking and physical examination. They are prepared for these special skills by formal continuing education which adheres to ANA approved guidelines, or in a baccalaureate nursing program.

4. *Primary Care* has two dimensions: (a) A person's first contact in any given episode of illness with the health care system that leads to a decision of what must be done to help resolve his problem; and (b) the responsibility for the continuum of care, i.e., maintenance of health, evaluation and management of symptoms, and appropriate referrals.

5. *Roles in Practice.* Practitioners of professional nursing are registered nurses who provide direct care to clients utilizing the nursing process in arriving at decisions. They work in a collegial and collaborative relationship with other health professionals to determine health care needs and assume responsibility for nursing care. In the course of their practice they assess the effectiveness of actions taken, identify and carry out systematic investigations of clinical problems, and engage in periodic review of their own contributions to health care and those of their professional peers.

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