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The Advanced Practice Registered Nurse Leadership Role in Nursing Homes

Leading Efforts Toward High Quality and Safe Care

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KEYWORDS

• Nurse practitioners • Clinical nurse specialists • APRNs • Leadership
• Nursing homes • Skilled nursing facilities • Long-term care

KEY POINTS

- APRNs are knowledgeable and skilled in the care of older adults.
- There is abundant evidence that APRNs in nursing homes improve resident outcomes.
- The literature strongly supports that APRN leadership is needed and that policies must be revised to enable APRNs to lead in nursing homes.

INTRODUCTION/HISTORY/DEFINITIONS/BACKGROUND

This article provides evidence for the critical role of advanced practice registered nurse (APRN) leadership in the care of older adults living in the nursing home (NH). The older adult population in the NH is one of the frailest, marginalized, and often neglected in American society. Looking back at the impact of the COVID-19 pandemic on older adult NH residents reveals a stunning number of infections and subsequent deaths in long-term care facilities (659,617 confirmed resident cases and 133,443 confirmed deaths as of July 11, 2021).[1] This is a shameful reminder of the many challenges and gaps in the long-term care industry including inadequate staffing, high staff turnover, improper isolation technique, and lack of fundamental knowledge of how to adequately implement infection control and prevention processes.[2]

Long-term care includes a wide variety of health care facilities outside of acute care hospitals that offer different levels of care, depending on the needs of the patients. Skilled nursing facilities or NHs provide postacute and long-term care to patients and residents that includes 24-hour skilled nursing care and regular visits by physicians and advanced practice providers and are the focus of this article.

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There are four core roles for APRNs in the United States: nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife, and certified registered nurse anesthetist.[3] APRN practice scope and standards vary by state and are governed primarily by the individual state boards of registered nursing. NPs and CNSs are certified based on the APRN consensus model, which addressed the regulatory inconsistencies in the United States; identified the four core APRN roles; and further delineated six population foci including family, adult-gerontology, neonatal, pediatrics, women's health/gender-related, and psychiatric-mental health.[4] Long-term care settings primarily involve family, adult-gerontology, and psychiatric-mental health foci; however, there are pediatric long-term care facilities as well.

NPs and CNS have some core clinical roles and responsibilities in common; however, there are some differences in their education, licensure, and practice. NPs are autonomous and collaborative in their approach to care. The main role of the NP in the NH is to improve access to care by providing direct clinical care to individual patients.[5,6] In this role, they assess residents, order diagnostic tests, diagnose, order treatments, prescribe medications, and perform procedures within their scope of practice. NPs provide care to long-stay residents overall, for acute exacerbations of chronic conditions, and for residents with neuropsychiatric (dementia, depression, anxiety) diagnoses when compared with physicians.[7] The quality of NP care is similar to, or in some cases better, than that of physicians in several studies.[8–13]

CNSs in NH have often acted more in a consulting role to the organization to improve overall quality of care versus providing individual care to residents.[14,15] CNSs focus on guiding the overall management of the frail, complex older adult population, educating and supporting the NH staff to provide optimal care using the best available evidence, and facilitate a supportive culture of safety in the organization. This role has been driven by research and quality improvement efforts, led by CNSs with gerontologic expertise.[14,16]

Over the years there have been increasing questions about how to differentiate the roles of NPs and CNSs with some studies finding confusion, ambiguity, and lack of clarity in the two roles.[17,18] Some authors have advocated for the blending or combining the role of NPs and CNSs indicating the roles have more in common than differences,[19–21] whereas others have supported that the roles are distinct and should remain as two separate, important roles that address different needs.[22,23]

COMPETENCIES

NPs and CNSs core competencies include a similar focus of expertise in direct patient care, education, research, ethical, and leadership. However, there are several differences. NP competencies in the care of older adults are driven by National Organization of Nurse Practitioner Faculties and include nine broad categories of competence:[24]

1. Scientific foundations
2. Leadership
3. Quality
4. Practice inquiry
5. Technology and information literacy
6. Policy
7. Health delivery system
8. Ethics
9. Independent practice

In addition, the competencies are further delineated along populations, with family and adult-gerontologic primary care NPs having competencies in the care of older adults. CNS competencies in the care of older adults include[25]

1. Direct care
2. Consultation
3. Systems leadership
4. Collaboration
5. Coaching
6. Research
7. Ethical decision-making, moral agency, and advocacy

To work in a primary care environment, CNSs can obtain a CNS core certification or an adult-gerontology CNS certification through the American Nurses Credentialing Center. Alternatively, they can also obtain certification as an adult-gerontologic acute care NP through the American Association of Critical Care Nurses.

An important area of commonality between NPs and CNSs is in leadership, and both professions have a stated core competency in leadership. The focus of leadership is slightly different.

NP leadership competencies are the same for family and adult-gerontology primary care NPs and include:

1. Assumes complex and advanced leadership roles to initiate and guide change.
2. Provides leadership to foster collaboration with multiple stakeholders (eg, patients, community, integrated health care teams, and policy makers) to improve health care.
3. Demonstrates leadership that uses critical and reflective thinking.
4. Advocates for improved access, quality, and cost-effective health care.
5. Advances practice through the development and implementation of innovations incorporating principles of change.
6. Communicates practice knowledge effectively, orally and in writing.
7. Participates in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus.

CNSs have a core set of leadership competencies that tend to focus more on health systems and populations. The competencies listed next are specific to adult-gerontology population primary care NPs because these are most relevant to NH care:

1. Integrates information technology into systems of care to enhance safety and monitor health outcomes.
2. Creates therapeutic health-promoting, aging-friendly environments.
3. Promotes health care policy and system changes that facilitate access to care and address biases.
4. Provides leadership to address threats to health care safety and quality in the adult–older adult population.
5. Participates in development, implementation, and evaluation of clinical practice guidelines that address patient needs across the adult age spectrum.
6. Advocates for access to hospice and palliative care services for patients across the adult age spectrum.
7. Promotes system-wide policies and protocols that address cultural, ethnic, spiritual, and intergenerational/age differences among patients, health care providers, and caregivers.
8. Implements system-level changes based on analysis and evaluation of age-specific outcomes of care.

This article focuses on the leadership role of NPs and CNSs in NH.

NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS LEADERSHIP IN NURSING HOMES

The complexity of care has expanded in NHs over the past few decades with the rise of postacute care discharges; in response, APRNs have developed five distinct roles in NHs including[5]

- Direct, ongoing primary care management for long-term care residents
- Acute care to short-stay patients and long-stay residents
- Education to staff, residents, and family members
- Consultation to NH staff on system-wide patient care clinical issues including care coordination, discharge planning, and care transitions
- Consultation to organizations on improving patient safety and quality systems within the facility

Based on the NP and CNS competencies, there are leadership responsibilities in each of these roles, with NPs having greater roles and responsibilities in providing individual care to NH residents[8,9,26] and CNSs carrying out more of the consulting role.[15,27,28] However, the literature shows that NPs have provided consultation to NH staff and organizations in areas of quality improvement and patient safety.[29–31] For example, geriatric NPs were used as consultants in education and quality improvement in the Wellspring project to improve the quality of care in 11 freestanding NHs.[32] Both NPs and CNSs work to improve patient safety and the quality of care for residents in NHs.

Leading in Patient Care

APRNs, particularly NPs at the patient care level, have assumed increasing responsibilities for leading the individual care of residents in NHs. Multiple studies have shown that NPs provide equivalent or better care in NHs, often at a lower cost.[8,9,26,29–31] From the perspective of APRN leadership in NHs, this may mean leading the clinical care teams working closely and collaborating with directors of nursing, directors of staff development, quality leaders, infection preventionists, and other clinical staff. NPs provide leadership when they engage staff in “on the spot” or “just in time” education.

One example of a best practice is to conduct rounds with the certified nursing assists (CNAs) and or charge nurses on patients, engage in discussion of specific patient care issues, and look for opportunities to reinforce knowledge, which has been shown to be highly successful in hospitals.[33] These are great opportunities to reinforce clinical issues, particularly related to areas that the CNA or licensed nurse are responsible for. For example, in the process of helping a CNA to turn a resident, the APRN can model examining the skin for rashes or signs of pressure injury and talk about what to look for or ask the staff what they would be looking for, always keeping the discussion on a positive note and commending staff for a job well done when appropriate. An opportunity with the staff nurse would be initiating walking rounds to review diagnoses, medications, and discuss whether medications and treatments are working as intended and look for any potential patient safety concerns. These leadership practices elevate the entire team in the NHs by extending knowledge and reinforcing competence and confidence in the staff.

CNSs do not typically provide direct resident care themselves, although that does happen in some cases. More importantly, CNSs can greatly influence the staff and how they interact with patients. For example, a best practice for the CNS could be

to work with licensed nurses and certified nursing assistants to teach them how to do walking rounds at change of shift or rounding with the CNAs to assess for pain.[34] These opportunities might include piloting rounds on a specific group of residents or by working with the nurses and CNAs to determine what data should be exchanged during walking rounds and end with conducting a class where the process is demonstrated with a simulated patient.

Advanced Practice Registered Nurse Leadership at the Organizational Level

One of the key messages in the 2011 Institute of Medicine (now National Academies of Medicine [NAM]) report: *The Future of Nursing: Leading Change, Advancing Health*[35] and the 2021 NAM report *The Future of Nursing 2020 to 2030: Charting a Path to Achieve Health Equity*[42] is that nurses, in partnership with other health professionals, must be strong leaders to ensure a transformed health system. Specifically, the reports call on nurses to be full partners and to lead in the design, implementation, evaluation, and advocacy reforms in future health systems. This requires an even greater focus on strong nursing leadership at all levels within the profession of nursing and interprofessionally through collaborative efforts with other health professions. Nowhere is this more urgent than in NHs, were team-based care is essential.

There are many long-standing systems-level problems in NHs that should be addressed and APRNs certainly have the knowledge, skills, and ability to lead many of the reform efforts. These issues vary depending on the context, time, and perspective. In 2006, the Commonwealth Fund highlighted the booklet, *20 Common Nursing Home Problems—and How to Resolve Them* (https://www.commonwealthfund.org/publications/other-publication/2006/jan/twenty-common-nursing-home-problems-and-how-resolve-them). The 20 problems included such issues as resident rights and honoring resident preferences, but also clinical issues, such as appropriate use of medications, avoiding the use of restraints, minimizing the use of feeding tubes, frequent readmissions, and refusal of medical treatments.

In the past two decades, other significant areas of concern have included inadequate staffing,[36–38] excessive antipsychotic use,[39] high staff turnover,[40] and poor NH culture.[41] In response to the many quality issues, Centers for Medicare and Medicaid Services (CMS) launched a demonstration project on quality assurance performance improvement (QAPI) as an outgrowth of the Affordable Care Act. QAPI integrates two components of quality: quality assurance ensures that minimum standards are met, and performance or quality improvement focuses on constant improvement processes. APRNs have been shown to be natural leaders of these efforts.

More recently, the issue of institutional racism has been identified as a key national and health system problem. The NAM recently published *The Future of Nursing 2020 to 2030: Charting a Path to Achieve Health Equity*, which provides a framework for how nurses can see their role in acknowledging and addressing the significant challenges in health and health care and the impact on patients.[42] The report included nine recommendations for system-wide changes to support nurses in their work to positively influence health equity. Disparities in US NHs have existed for many years, Feng and colleagues[43] reported on the growth of people of color in NHs because of the increased growth of older minority populations. Rahman and Foster[44] found that families of color preferences for NHs that are close to family and with racial homogeneity foster racial segregation in communities of color and contribute to disparities in quality. Despite this knowledge, little has been done to address these disparities.[43–48] In fact, a 2015 study of Medicare and Medicaid dual eligible residents identified quality disparities between access to CMS publicly reported five-star NHs and

NHs with lower quality ratings. In 2020, the COVID-19 pandemic revealed significant racial and ethnic disparities with greater numbers of residents of color becoming infected and dying from the disease. In one study, NHs with higher numbers of racial and ethnic minority residents had 61% more COVID-19-related deaths compared with NHs without racial and ethnic minorities.[46] APRNs are well positioned to lead the work of reducing disparities in NHs by devising and leading quality improvement projects that address deficiencies and areas of low quality as identified in CMS NH Compare Web site.

Advanced Practice Registered Nurse Leading Quality Improvement

In the first decade of the twenty-first century, there were a variety of studies examining APRNs leading quality improvement in NHs that revealed higher quality in homes with APRN consultant leaders compared with NHs that lack the APRN consultant.[14,49–51] Using an APRN, whether a consultant or an employee, has consistently shown positive outcomes through APRN-led quality improvement projects.

Building on the positive outcomes of early quality improvement efforts, the Advancing Excellence in America's Nursing Homes campaign, which is now known as the National Nursing Home Quality Improvement initiative, formed in 2007 to enhance quality improvement in NHs at a national level.[51] The original Advancing Excellence campaign focused on an interdisciplinary group of national leaders coming to consensus on a set of quality measures that encouraged participating NHs to set achievement goals and submit measures over time. APRNs held several leadership positions in the campaign and were key participants in this process.[52] The campaign relied on local area networks of excellence to create learning collaboratives to assist NHs to establish goals and processes and to enter data in a national database.[53] The campaign was active for several years and provided a strong foundation for the subsequent work on the QAPI process.

The QAPI framework involves five elements: (1) design and scope; (2) governance and leadership; (3) feedback, data systems, and monitoring; (4) performance improvement projects; and (5) systematic analysis and systemic action and requires multiple steps to implement.[54] The complexity of the process has been challenging at times for some NHs to initiate and sustain,[55,56] partially because of minimal nurse leader staff. Registered nurse leaders including the director of nursing and APRNs have been essential in the successful implementation of QAPI in NHs,[57] particularly those with gerontologic nursing knowledge who can lead the interdisciplinary team.[52] Early studies of QAPI implementation revealed that many NHs were not ready to implement QAPI; they lacked skills needed to identify, measure, and remedy deficiencies in the NH.[58] APRN Leaders can gain from the lessons learned from the Advancing Excellence Campaign and from QAPI implementation to use their leadership skills and knowledge of the quality improvement process to assist NHs to implement QAPI programs.

A Quality Improvement Leadership Exemplar

One of the most informative studies of the leadership role of APRNs in improving NH care came from the Missouri Quality Improvement Initiative (MOQI) study where APRNs working full time were embedded in 16 NHs; the study aimed to reduce potentially avoidable hospital transfers from NHs to acute care hospitals.[59] The role of the APRNs (15 NPs and 1 CNS) was to work with the existing NH staff and leadership to manage sick residents and to affect changes in NH systems that would improve resident outcomes. The APRNs were supported by a variety of experts including an INTERACT/Quality Improvement coach, care transitions coach, health

informatics coordinator, MOQI medical director, and project supervisor along with the research team. APRNs kept diaries to document how they interacted in the home.

Based on the APRN notes, the key areas of impact include taking care of basics, such as improving hydration, mobility, preventing falls, and managing medications; improving team discussions about implementing comfort care and limiting treatments, such as advance directives, cardiopulmonary resuscitation orders, and hospice; and improving communication about treatments, such as counseling families, working with staff and families, and obtaining assistance from social work staff. APRNs used root cause analysis to help staff understand the causes of poor outcomes, initiated huddles to identify issues and develop solutions, and to affect changes in medications by reducing polypharmacy and ensuring best practices were followed. APRNs were instrumental in improving discussions about key issues in quality of care and in improving communication with residents and family. The MOQI project is an excellent exemplar in how APRNs can lead quality improvement and practice transformation in NHs.

A later report on this work showed statistically significant reductions in all-cause hospitalizations (40%; $P < .001$), avoidable hospitalizations (45.2%; $P < .001$), all-cause emergency department visits (50.2%; $P < .001$), and in avoidable emergency department visits (59.7%; $P < .001$). Medicare costs were also reduced, as were outcome measures, such as falls, incontinence, and immobility.[59] The authors emphasized that the APRN primary focus was on the geriatric clinical management of residents. APRNs emphasized the importance of discontinuing harmful or ineffective care and instead to focus on evidence-based practices and held direct care staff accountable for their care processes.

Findings include that there are essential elements in the APRN role in the areas of leadership, direct resident care, and education including:

- Leadership: APRNs must lead and advocate for evidence-based practices and be part of the facility leadership team
- Direct resident care: early recognition of changes of condition and management of acute and chronic illness
- Education: educate staff, residents, and family on goals of care, health management, and planning for end-of-life care

These three areas are competencies for NPs and CNSs. These reports also acknowledge the importance of the context and tools that enabled the success of the APRNs in this project including the use of the INTERACT II (https://pathway-interact.com/) tools, such as Stop and Watch and SBAR (situation, background, assessment, recommendation). When the leadership remained engaged and the APRNs were supported in this work, the improvements were sustained over time.[60]

Advanced Practice Registered Nurses Improving Nursing Home Outcomes

Several studies have shown that APRNs can reduce the cost of care and improve important resident outcomes, such as resident satisfaction, emergency room visits, and hospitalizations.[8,61–63] In a 2005 systematic review, Christian and Baker[11] found that when NPs were part of the team, there were lower rates of emergency department transfer and shorter hospital lengths of stay. A later study using Medicare claims data found that NP visits were associated with fewer emergency department visits overall and fewer hospitalizations when compared with physician-only visits.[64] APRNs are instrumental in improving a variety of other quality outcomes, such as resident falls, urinary incontinence, depression, pressure injuries, and behaviors.[51,65]

Another successful role for APRNs is in improving NH outcomes through the change management process. In a study of NPs and CNSs as change champions in implementing an evidence-based pain protocol, Kaasalainen and colleagues[34] reported that APRNs used multiple strategies to promote changes in pain management including education of team members, staff reminders highlighting the pain protocol, chart audits, feedback, staff meetings, NPs using advanced assessment skills, and other quality improvement initiatives. By using interactive educational meetings and encouraging the entire interdisciplinary team to participate in discussions around the pain protocol, staff were empowered to initiate practice changes. The study authors conclude that APRNs can improve the quality of care in NHs by leading staff through knowledge transfer and exchange to achieve positive outcomes.[34]

A third major way in which APRNs have shown significant success is in leading transitions of care, where APRNs facilitate care as patients leave the acute care setting and transition to other settings including NHs. A major goal of Mary Naylor's transitional care model is to reduce rehospitalizations in vulnerable populations including older adults. The transitional care model used APRNs because they are uniquely qualified to work with other members of the interdisciplinary team on complex issues, such as medication reconciliation, geriatric syndromes, and management of high-risk residents.[66,67] The transitional care model includes such processes as engaging the resident and caregiver, managing symptoms, educating residents, promoting self-management, collaborating with the team, coordinating care, and maintaining relationships; practices that APRNs are already skilled at providing in NHs.[68]

There are two other models that are applicable to NHs. The first is the GRACE model (geriatric resources for assessment and care of elders), which is focused on care of older adults with care provided primarily by a NP and social worker who collaborate with an expanded GRACE team that includes a geriatrician, geriatric pharmacist, physical therapist, and mental health case worker.[69] This is an integrated care model that targets mostly dual-eligible (Medicare and Medicaid) patients with chronic diseases. Care begins with a comprehensive in-home assessment by an NP and social worker, who then consult with the expanded team. A randomized controlled trial that studied the model found that patients enrolled in GRACE had fewer emergency room visits, hospitalizations, readmissions, and lower costs compared with a control group.[70,71] This is particularly effective in caring for older adults with multiple chronic diseases and mental health and psychosocial challenges. Many of these patients have conditions that are well managed by nurses, such as common geriatric syndromes including pressure ulcers, incontinence, and functional decline. This model is highly effective during transitions of care.

The second model is the NICHE-LTC (Nurses Improving Care for Healthsystem Elders-Long-Term Care) program. This program is an education and consultation model with the aim to improve health care at the organizational level. Key components of the program include the geriatric resource nurse along with the geriatric certified nursing assistant, who work together as champions for frontline staff as organizations work to implement evidence-based processes into the workflow.[71] APRNs often play an important role in leading this program in NHs with goals of improving mobility, reducing falls, preventing avoidable emergency department visits and hospitalizations, preventing pressure injuries, and other resident outcomes.

BARRIERS TO ADVANCED PRACTICE REGISTERED NURSE LEADERSHIP

There are several organizational barriers to the ability of APRNs to impact quality outcomes. A recent systematic review identified facilitators to an optimal practice

environment, which included an autonomous/independent practice environment and positive relationships with physicians.[72] Organizational barriers included poor physician and administrator relationships, a lack of understanding of the APRN role, along with various policy and regulatory barriers to practice. The authors stress that organizations must explain and promote the APRN role, implement policies that support APRNs, and communicate these with members of the organization to ensure a positive practice environment.

The most prominent barriers to APRN leadership are the disjointed scope of practice regulations in the United States,[73] inconsistent and confusing insurance practices, and the consistent opposition of the American Medical Association,[74] who insist that increased scope of practice is a patient safety risk, despite all evidence to the contrary.[75] As discussed throughout this article, there are many studies that have shown that NP care is safe, results in similar outcomes to physicians, at lower cost, and often with greater patient and family satisfaction. One of the most relevant studies was undertaken by the Institute of Medicine Report in 2010.

The 2011 Institute of Medicine Report, *The Future of Nursing: Leading Change, Advancing Health*, called for removing practice barriers for APRNs as one of their key messages.[35] Subsequently, other national organizations have published statements of agreement with these recommendations. The National Governors Association published their own review of the evidence, advocating for expanded use of APRNs and for states to consider changing their scope of practice restrictions.[76] The Robert Wood Johnson Foundation published a comprehensive overview of the scope of practice and other regulatory barriers to APRN practice in *Charting Nursing's Future*, which discusses misconceptions, barriers to APRN practice, recent breakthroughs, and remaining barriers.[77] The report can be downloaded from the Web site at https://www.rwjf.org/en/library/research/2017/03/the-case-for-removing-barriers-to-aprn-practice.html. This report makes a strong case for removing these barriers to APRN practice.

The newest NAM report, *The Future of Nursing 2020 to 2030: Charting a Path to Achieve Health Equity*,[42] reinforces the need for APRN full scope of practice in Recommendation 4: all organizations, including state and federal entities and employing organizations, should enable nurses to practice to the full extent of their education and training by removing barriers that prevent them from more fully addressing social needs and social determinants of health and improving health care access, quality, and value. These barriers include regulatory and public and private payment limitations; restrictive policies and practices; and other legal, professional, and commercial (contracts and customary practices) impediments.

OPPORTUNITIES FOR ADVANCED PRACTICE REGISTERED NURSE LEADERS IN POLICY CHANGE

Gutchell and colleagues[78] discuss the rationale and best practices for removing practice barriers through health policy changes using Kingdon's theoretic framework of agenda setting and emphasize the importance of taking advantage of the window of opportunity that arises when a problem, policy, and political streams come together to create an opportunity for policy change. The authors describe various strategies that are effective in changing health care policies related to APRN scope of practice. Some of these strategies are understanding the political climate, coalition building, choosing an influential sponsor, conducting letter writing campaigns, meeting with and developing relationships with legislators and staff, raising public awareness, and developing fact sheets, among other activities.

SUMMARY

There is strong evidence that APRNs provide high-quality care in NHs and that they play an important leadership role at many levels. At the individual care level as clinicians, APRNs lead the clinical care of residents and engage with NH staff to improve individual resident quality of care that results in improved resident outcomes. They also play an important role in leading resident, family, and staff education and facilitate communication among the team.

At the organization of system level, APRNs act as consultants and lead QAPI efforts. In this role, they lead teams of staff to work together to set goals, implement improvement processes, measure the improvements, and put systems in place to reinforce and sustain improvements. They use their skills in communication, coordination, collaboration, and education to work with the staff to achieve the established goals.

There are barriers to APRN practice that interfere with optimization of these efforts. APRNs must use their leadership skills to reduce these barriers. APRN leadership efforts should initiate the published evidence-based practices as a call to action to address the various barriers to APRN scope of practice so that additional progress is made in improving the care of older adults in the NH setting. It is clear that there is more than enough evidence to support the need for APRN leadership; it is critical that APRNs use this evidence and their leadership to influence NH owners, operators, and policy makers to strengthen the APRN role in long-term care.

CLINICS CARE POINTS

- APRNs bring advanced clinical knowledge to nursing homes that improves patient outcomes.
- APRN leadership enhances nursing home processes of clinical care, which also contibute to improved resident care.
- Nursing homes should be mandated to hire APRNs to achieve improved resident outcomes, improve resident and staff satisfaction, and improve patient safety.

DISCLOSURE

The author has nothing to disclose.

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