It is with deep sadness that I inform readers that this is the last contribution we will receive from Jackie Stolley, who died unexpectedly January 17, 2010. At the time of her death, Jackie was a Professor at Trinity College of Nursing and Health Sciences in Rock Island, Illinois, and a gerontological clinical nurse specialist at Genesis Medical Center. She was a very giving person: a superb educator and mentor, a champion of evidence-based practice, and a tireless advocate for vulnerable populations and older adults in particular.

I had the privilege of serving as chair of both Jackie’s master’s thesis and doctoral dissertation committees at The University of Iowa College of Nursing, and she served as my research assistant during all of the years of her graduate education. Together, we published 26 articles and book chapters, and I was a frequent guest lecturer in her classes at Trinity.

Beyond our professional relationship was a satisfying personal one. It was hard not to enjoy being around Jackie. She was funny, forthright, and devoted to her family and her three grandchildren in particular. She loved to garden and to read, and for years we exchanged books on tape—a habit she acquired while commuting from the Quad Cities to school over many years. We were frequent visitors in each other’s homes and had regular “girls’ nights out,” which featured good food, passionate political discussions, a movie or two, and an occasional casino trip.

I will miss Jackie both professionally and personally, as well as her many and sustained contributions to gerontological nursing research, education, and practice, and to the *Journal of Gerontological Nursing*.

~ Kathleen C. Buckwalter, PhD, RN, FAAN, Editor

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**Caring for Hospitalized Older Adults**

With the graying of America and the aging of the Baby Boomer generation, hospitals and hospital nurses must develop knowledge and skills that enable them to provide quality care. Thirty-four percent to 50% of older adults experience some kind of functional decline from the time they are admitted to the hospital to the time they are discharged, which has a significant impact on the quality of life of these individuals (Inouye, Bogardus, Baker, Leo-Summers, & Cooney, 2000). In the United States, adults older than age 65 use 48% of hospital days, tend to have longer lengths of stay, and have multiple comorbidities (Mezey, Quinlan, Fairchild, & Vezina, 2006). Thus, the aging of America has an enormous affect on the health care system, as well as the quality of life of each older adult.

Even with the prevalence of older patients in hospitals, few RNs have had formal courses in care of geriatric patients (Mezey et al., 2006). Schools of nursing are working diligently to include information dedicated to care of older adults, but time constraints inhibit the depth of this information. In addition, nurses who were educated before this emphasis on care of geriatric patients have not been updated.

Although The Joint Commission (2009) requires age-specific education and care across the life span, its requirements do not always address the specific needs of older adults, which can result in poor outcomes and extended lengths of stay. Despite its efforts, without specific instruction and ongoing mentoring,
care of older adults will continue to result in negative sequelae. Highly prevalent problems identified in the hospitalized geriatric population are delirium, dementia, medication problems, depression (Lyons & Landefeld, 2001), skin breakdown, falls, incontinence, and sleep deprivation (Inouye et al., 2000). Other common problems in hospitalized older adults are changes in mental status (e.g., delirium, dementia), immobility, and malnutrition/dehydration (Palmisano-Mills, 2007). Many nurses have received no formal education regarding the conditions, such as acute or chronic confusion, that most frequently occur in older patients (Berman et al., 2005).

PROGRAMS THAT ADDRESS CARE OF HOSPITALIZED OLDER ADULTS

Several programs have been developed to address care of hospitalized geriatric patients. These include the Hospital Elder Life Program (HELP) (2002), developed in Connecticut to prevent delirium in hospitalized older adults; Acute Care of Elders (ACE) units, developed at University Hospitals in Cleveland (Panno, Kolcaba, & Holder, 2000), which create an environment friendly to older adult; and the Nurses Improving Care for Health System Elders (NICHE) program, developed at New York University to support hospital staff to deliver superior health care (Hartford Institute for Geriatric Nursing, n.d.). The NICHE program provides educational materials and a tool to assess readiness to begin the educational program.

Although the NICHE program provides education and guidance, it does not impose a specific model of care on hospitals. One program that has been developed is the Geriatric Resource Nurse (GRN) model. The GRN program was initiated at Boston’s Beth Israel Hospital with the underlying premise that not all nurses have the necessary understanding and skills to deliver satisfactory care for older adults. The model involves substantial organizational backing and includes an ongoing educational series, the development of GRNs on all shifts on all units, consultation with an expert in care of older adults, and the use of evidence-based practices.

GRN models have been initiated at 63% of NICHE hospitals (N = 42). More than half of the providers (69%) have reported that the model is excellent or good (Mezey et al., 2004) but requires strong administrative support. Hospitals reported that the GRN program is valuable for providing good care for older adults but that without institutional support and physician acceptance, the durability of the model is uncertain. Similarly, a program at New York University Medical Center found that the GRN model has been effective in caring for older adults, especially in identifying those patients with high-risk geriatric syndromes (Lopez et al., 2002). Parke, Ross, and Moss (2003) reported on a comparable model, the Geriatric Enrichment Program for Acute Care, which succeeded in initiating a “cultural shift” in caring for older adults. While evaluation is ongoing, they cite that education and administrative support were essential to implementing and continuing the program.

The most problematic attitude seen in the health care arena has been a mindset that signs and symptoms are due to “being old,” and thus, they are not properly assessed and treated. I was able to provide a comprehensive educational program to four nurses who worked different shifts on a busy medical unit. There was little budget, but the enthusiasm of the nurses made up for the lack of money.

The purpose of the program was to prepare GRNs who are available for assistance and consultation. As a result of having this education, the nurses became more alert to problems that arose with older patients, and their coworkers readily consulted them for their expertise. Although no formal patient care outcome statistics were gathered, the staff on the unit reported much greater confidence in caring for older adult patients and appreciated having “experts” to consult. They have learned that even though a patient is “old,” it does not mean the situation is hopeless, and staff continue to intervene in ways they did not know prior to the educational program. For example, they are particularly aware of nutritional problems and investigate reasons for acute confusion. They are also making careful efforts to provide the proper environment for patients with chronic confusion.

One of the biggest impediments to implementing an educational program as described above is economics and, thus, administrative support. In the current economic downturn, financial aspects are stressed even more. Although a program may be cost effective in the long term, programs initially cost money that frequently is not there.

SUMMARY

Care of hospitalized older adults is an important aspect of nursing that has been poorly addressed in nursing schools and by ongoing inservice programs. As a result, negative outcomes have occurred, including increased lengths of stay related to preventable complications. By ensuring that nurses have the latest information on care of older patients, these negative outcomes can be eliminated and costs to patients and hospitals reduced. We can do it—one nurse or nursing unit at a time.
REFERENCES


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