


Case Study:

Dying with a Stage IV Pressure Ulcer

*An analysis of a nursing
home's gross failure to
provide competent care.*



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Overview: This case study of the care received by a terminally ill nursing home resident in his late 80s describes the many organizational and clinical factors that led to the progression of his pressure ulcer from stage II to stage IV. The patient suffered weight loss, an increase in tissue load, and deterioration of the wound and finally died in pain with a large stage IV pressure ulcer that exposed his coccyx. The authors examine the ethical aspects of the case and explore the ways in which inadequate staffing, staff education, and supervision contributed to insufficient help with meals, infrequent and improper repositioning, and unrelieved pain. To hear *AJN* editor-in-chief Diana J. Mason's audio interview of Jeanie S. Kayser-Jones, in which the coauthor discusses the ethical dilemmas she encountered while conducting research in this case, go to www.ajnonline.com and click on "Podcasts." 

“Oh, that hurts! You're hurting me. Please, please, just leave me alone. Please stop.” These were the words of Louis Daly, a friendly, cognitively alert African American man in his late 80s, as nurses were changing the dressing on his stage IV pressure ulcer two days before he died. (This is a real patient; his name and other identifying details have been changed.) In nine months Mr. Daly's pressure ulcer progressed from stage II to stage IV, increasing from $1 \times 1 \times 0.1$ cm in length, width, and depth to $2.5 \times 2 \times 2.5$ cm by the seventh month and $10 \times 7 \times 6$ cm, with tunneling from 8 o'clock to 4 o'clock, by the eighth—or in the words of one certified nursing assistant (CNA), “from the size of a dime to the size of a grapefruit.” His entire coccyx was exposed. During this time, he lost 29 lbs., more than 20% of his body weight. Although a physician had prescribed morphine to be given orally 30 minutes prior to each dressing change, on that day Mr. Daly had been given the analgesic less than five minutes before the nurses began. No one suggested waiting for the medication to take effect before starting the dressing change.

Illustrations by Denny Bond

HOW DID THIS HAPPEN?

Mr. Daly's case came to our attention while we were conducting a study on the multiple factors that influence the quality of the care received by terminally ill nursing home residents. In the course of this study, we extensively observed participants; interviewed residents, their families, physicians, and nursing staff; and observed and documented the care of residents from the time they were identified as being terminally ill until they died.¹

We met Mr. Daly 40 days before he died. During this period we spoke with him and his wife and observed his care in 30 bedside visits. Mr. Daly's frail wife visited him every other day despite reporting pain in her legs that made it difficult for her to walk. As his condition declined, she tried to come daily. “I'd like to be able to see him more,” she said. “It's hard for me to get over to see him with the public transport and all. I'm not too well myself.” (Editor's note: the first person singular in this article refers to coauthor Jeanie S. Kayser-Jones.)

Nine and a half months before his death Mr. Daly was discharged from a hospital after an above-the-knee amputation of a gangrenous left foot. He was admitted to the nursing home with diagnoses of peripheral vascular disease and end-stage renal disease with an order for hemodialysis three times a week. He had been in a different nursing home before his hospitalization; since we didn't have access to his previous records, it was unclear whether the pressure ulcer developed at the first

The Dilemma of Intervention

How can a researcher do the most good? There's no easy answer.

Conducting this study was very difficult for my research team and me. Nearly every day we saw residents being cared for inadequately. Residents often weren't assisted with meals. They asked (and sometimes begged) us for water, needed their bedding changed after being incontinent, didn't receive oral care, and were left in bed when they could and should have been out of bed. Staff frequently ignored call lights. They also said that, given the number of patients they had to care for, they simply didn't have time to administer pain medication when it was needed.

One of my research assistants told me that it was so painful for her to observe the patients' suffering that she could no longer collect data. We intervened as much as we could without jeopardizing our position in the nursing home. However, we couldn't even begin to address the innumerable problems. When I think about the residents in our study who died hungry, thirsty, and in pain, I begin to cry and wonder what more I could or should have done.

The question of when to intervene has been a problem for me during the nearly 30 years that I have been conducting research in nursing homes. I have published extensively on the problems in nursing homes and have presented my findings to the U.S. Senate Special Committee on Aging. The findings of my research have been published in more than 60 newspapers and magazines. Yet today, far too many nursing home residents continue to receive poor-quality care.

In applying to the National Institutes of Health for a grant and submitting to the University of California Committee on Human Research the study that produced this case study, I stated that if a resident were in pain we would feel ethically bound to intervene. In such cases, we approached the RN or LVN in charge of the patient's care, told her or him that the resident was in pain, and asked that pain medication be administered.

I also had an oral agreement with the director of nursing that I would immediately report to her any care we observed that we believed was unsafe or problematic in any way so she could discuss it with the staff member in question. If the director of nursing was not on duty—as was the case in the evening, for example—I would explain the problem to the charge nurse and describe it in a memo that I left in the mailbox of the director of nursing.

Besides the interventions noted in the article, we helped residents many other times. I took apples and bananas to residents who were hungry for fresh fruit, and we refilled water pitchers and gave water to residents who were thirsty. When residents were dying, we supported and comforted their families.

There were also many times when we didn't intervene. If we had intervened each time we saw a problem, we would have been so busy providing care that we could not have been "objective research scientists." In qualitative research, the goal is to observe the "natural situation." If we had intervened constantly, it would have changed the situation we were observing.

Over the years, I have discussed the question of intervention with numerous people, including lawyers, physicians, nurses, and ethicists, and with their advice I have concluded that it is more important for me to be able to continue to collect and report data that could have a wide impact than to try to improve care on a case-by-case basis. When I do intervene because I see no ethical alternative, I risk being asked to leave if the facility's administration thinks I am being too intrusive or "seeing too much." For example, I took a risk in asking if my colleague could come to the nursing home to look at Mr. Daly's pressure ulcer. The administrator and director of nursing were pleased to have her, but others might not have responded in the same way.—*Jeanie S. Kayser-Jones, PhD, RN, FAAN, professor emerita, University of California, San Francisco, School of Nursing*

nursing home or the hospital. Although we didn't witness Mr. Daly's care during the first eight or so months of his stay at the second nursing home, we were able to observe his care closely during the final 40 days of his life. At times we felt we had no option but to step out of our roles as researchers and intervene. (For more detail on the ethical challenges posed by this study, see *The Dilemma of Intervention*, above.)

Nutrition. Mr. Daly had a good appetite, enjoyed food, and preferred to feed himself. However, his hands were tremulous and he was often in a semi-reclining position at mealtime, which made it difficult for him to eat fast. (On none of the 30 visits we

made was he ever in a chair. Another man, a 60-year-old who was dying of a brain tumor, wanted to go out on the sundeck. Twice I asked the staff to please get him out of bed, into a wheelchair, and to the sundeck; they never did so.) Mr. Daly and his wife said that the staff "rushed" him to finish his food; when he ate slowly, the CNAs "shoveled" the food into his mouth. Not wanting to be rushed, he would refuse to eat. Upon admission to the nursing home, Mr. Daly's medical record indicated, he had only a few remaining teeth. Although his wife told the staff he didn't have dentures and needed soft food, he was kept on a regular diet for nine months and dentures were never obtained. During

that time he ate only the food he was able to manage with his few remaining teeth. Two weeks before he died, he was at last placed on a pureed diet.

During the last month of his life, Mr. Daly became unable to feed himself. During this period some of the staff, and one CNA in particular, fed him slowly and carefully. "He's a nice man," she said. "He's my favorite one here." Although she thought she was feeding him slowly, at one meal he cried out, "Slow down. Don't rush me. I don't like to eat too fast." "I'm sorry. I didn't mean to rush you," she replied. "Just tell me when you're ready. Say 'ah' when you're ready." After a few moments Mr. Daly said "ah" and she gave him another bite of food. He ate 85% to 90% of the food on his tray. "Great job tonight, Mr. Daly," said the CNA. "You did very well. See why he's my favorite? He's so nice." Mr. Daly smiled, thanked her, and said that he liked her as well. This was one week before he died.

The CNA remarked that she had 11 residents to care for; six of them had to be fed. She explained that she went from room to room, feeding several residents simultaneously so as not to rush them. "It's tiring running back and forth," she said, "but it's the best way for them. I wouldn't want to get all this food shoved down my throat in five minutes, so why would they?"

Not all of the staff were as sensitive. One CNA brought the tray into the room, placed it on the bedside table, and left. Later, he returned and scooped a large spoonful of mashed potatoes into Mr. Daly's mouth. Mr. Daly held up both hands, indicating that it was too much. He ate two additional small bites of food and then said, "That's it." The CNA asked if he was finished eating, but before Mr. Daly could respond, the CNA began to take the tray away. We asked the CNA to leave it in case Mr. Daly was hungry later. The CNA said he would return. A few minutes later, when we asked Mr. Daly if he wanted any more food, he pointed to a cup of pudding. One of us (RLB) fed him slowly, and he ate the entire cup and about 60% of the other food on his tray. The CNA never returned.

When visiting one day, Mr. Daly's wife said, "If I'm here, I feed him. Then at least I know that he eats. I wish I could come more often to feed him. I'd feel better knowing that he was eating and not being rushed. I wish they would spend more time with him. I never see anyone in here but to drop a tray off and ask me to feed him. . . . I wonder what happens when I'm not here."

Three days before Mr. Daly's death, a CNA came into the room with the tray. She handed it to Mrs. Daly and asked, "You feed him?" "Yes, I'll feed him," she replied.

The CNA began to pour milk all over the pureed food. "No, no," Mrs. Daly cried. "Don't put milk on that." "It's to help him," the CNA replied. "He

The CNA was stirring all of the food, along with the cranberry juice, into an unidentifiable pile.



needs milk to make it easier for him to swallow." Then the CNA accidentally spilled a glass of cranberry juice all over the tray and onto the pureed food. Mrs. Daly was visibly upset; she went into the bathroom to get some paper towels. When she returned, the CNA was stirring all of the food, along with the cranberry juice, into an unidentifiable pile.

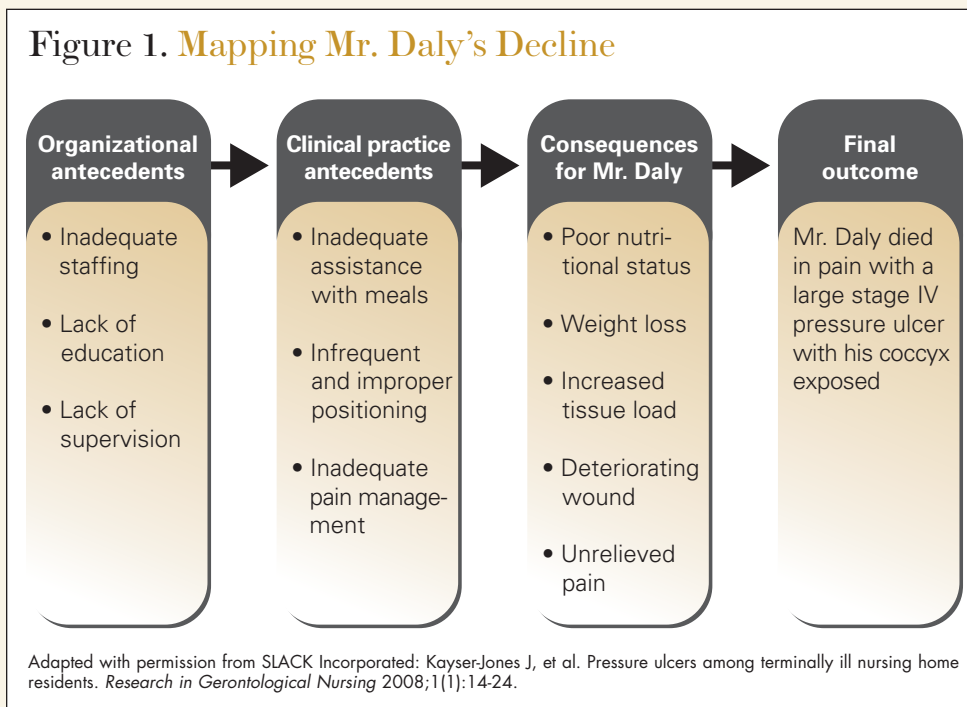
Mrs. Daly became angry. "I told you I would feed him. What are you doing?" The CNA left the room. Mrs. Daly tried to separate the types of food on the plate. With each bite, she attempted to identify the food and tell Mr. Daly what she was giving him. He ate nearly all of his lunch.

The pressure ulcer. When we first met Mr. Daly, his pressure ulcer had already progressed from stage II to stage IV. The staff were concerned; many of them said they didn't understand how it had become so large. One CNA said she had been transferred to another unit for a month, and when she returned, the pressure ulcer had grown dramatically. "When I was last with him it was so small, and now it's huge. It's awful, absolutely awful." When asked how this had happened, she replied that she wasn't sure. "I don't want to say it was neglect, but I don't know what it could be." The staff nurse in charge of treatments said that Mr. Daly had diarrhea and that feces were always in the wound. She suggested this was part of the reason the wound was not healing, but the cause of the diarrhea was never identified, and no medication was ordered for its treatment.

We were concerned, and I asked the director of nursing what she thought of Mr. Daly's condition. "He has to be off his back," she said. "He has to be on his side." However, during our visits, except for one occasion when he was correctly positioned on his left side and several others when he was partially lying on his left side, he was always flat on his back, with the head of the bed elevated at a 30°-to-90° angle.

When I next approached the administrator, who was an RN, and the director of nursing to express

Figure 1. Mapping Mr. Daly's Decline



the head of the bed and pulled him up.)

My colleague advised the director of nursing that Mr. Daly needed to be seen by a wound care team so a wound-healing program could be put in place. The pressure ulcer could heal, she said, but it would take two to three months. We don't know whether the director of nursing told Mr. Daly's physician about my colleague's visit or her recommendation.

I didn't see the physician between September 7, the date of my colleague's visit to examine and debride the wound, and September 16, the day Mr. Daly died, but on September 12 the physi-

cian wrote the following brief note on the chart to indicate that he had discussed discontinuing dialysis with the nephrologist, Mr. Daly, and his family: "Discussion with the family and they agreed to stop dialysis as the burdens outweigh the benefits."

On September 15, RLB spoke with Mrs. Daly. "The doctor said we might as well take him off because it ain't doing any good." Mrs. Daly said. "The wound ain't healing." She went on, "He's just laying there without talking. I figure he done suffer enough. The poor man has suffered so much."

Mr. Daly died three days after stopping dialysis. **Pain.** During the last weeks of his life Mr. Daly suffered greatly. "His pain is terrible," a CNA said. "He cried this morning when I tried to move him onto his side. He jumped and screamed when I touched him. He cries often. He has a bad sore on his back." When asked what the sore was from, the CNA replied that he didn't know.

Although the physician had prescribed an analgesic to be given 30 minutes before dressing changes, it wasn't always given. Two days before Mr. Daly's death, the treatment nurse, a CNA, and a per diem RN entered the room to change Mr. Daly's dressing. "We need some morphine for him," the treatment nurse said. The per diem nurse left the room, returned, and gave Mr. Daly the pill. Three to four minutes later, they began to change the dressing. "In all the years I have been doing this," the nurse said, "I have never seen anything like this. There is always poo-poo in the bandage. There's nothing we can really do for him. It's so bad. All I do is try to keep it clean and dry." When he was turned on his side so they could remove the dressing, Mr. Daly screamed in pain. The treatment nurse spoke kindly. "Okay, okay, we're just going to change your bandage, just one

concern about Mr. Daly's pressure ulcer and care, the director of nursing said, "It's just awful. And it's so painful, and it's dangerous because my glove and the gauze [used to pack the wound] catch on his coccyx bone when I change the dressing."

I asked if they would like one of my colleagues, a wound care specialist, to evaluate Mr. Daly's pressure ulcer. They agreed that this would be a good idea, and Mr. Daly gave his consent. He was given his pain medication in time for it to take effect before she began. My colleague then debrided the wound, packed it with saline-soaked gauze, and applied a dressing. She recommended that an enzymatic debriding agent be obtained, and the director of nursing said she would ask the physician to order it. Nine days later, when Mr. Daly died, the debriding agent still had not been obtained.

The tunneling, my colleague explained to the staff, was a classic example of shearing and had probably occurred because the staff were small in stature and Mr. Daly was a relatively large man, which made it difficult to reposition him. "No," the director of nursing replied, "to be honest, it's because we don't have enough staff. It's hard to get another CNA to help move him. So his CNA stands at the head of the bed and pulls him up in the bed." The CNA agreed that this was so and expressed frustration, saying, "There's a charge nurse who won't help me, even to pull a patient up in bed. She'll say, 'I'm just about to give these meds, and I have to do it now.' Then you have to adjust people all by yourself, and it's very bad." (On one occasion I saw this technique in action: Mr. Daly had slipped down in bed and his leg was caught in the bedside rail. I found his CNA and asked if she could help me reposition him. However, to my amazement, she quickly went to the railing at

the head of the bed and pulled him up.)

minute.” The treatment nurse carefully and thoroughly cleansed the wound and packed it with gauze. Mr. Daly cried the entire time. “Oh, that hurts. You’re hurting me. Please, please just leave me alone. Please stop!” Tears were streaming down his face.

After changing the dressing, they rolled Mr. Daly onto his back. The treatment nurse patted him on the arm and said, “It’s okay now. We’re done.” When leaving the room, she said, within range of Mr. Daly’s hearing, “I can’t imagine he’ll live much longer with a sore like that.” (RLB, who was observing without my supervision that day and is not a nurse, didn’t feel qualified to intervene, though she attempted to comfort Mr. Daly during and after the procedure.)

Mr. Daly also experienced pain in the stump of his left leg. His physician had ordered oral morphine be given every hour as needed, adjusting the dosage according to the severity of the pain, but Mr. Daly’s requests for medication were often ignored. As Mrs. Daly put it, “Sometimes it takes a really long time for them to come.” Mr. Daly died at 12:15 PM on the 16th of September. On the 13th and 14th, he had complained of moderate-to-severe pain but received no analgesia. On the 15th and 16th, he received only one dose of morphine at 9 AM each day.

WHAT’S ETHICS GOT TO DO WITH IT?

Mr. Daly’s is not an isolated case. According to a study recently released by the U.S. Department of Health and Human Services, 94% of for-profit nursing homes and 88% of nonprofit nursing homes were cited for violations of federal health and safety standards in 2007.² In the two for-profit nursing homes in which we conducted this study, 64 of the 117 terminally ill residents were either admitted with or acquired a pressure ulcer after admission; of these, 52 died with a pressure ulcer.¹

Given the systemwide failure to provide adequate care, what do ethical questions have to do with what happened to Mr. Daly? His case is shocking, tragic, and disturbing, but aren’t changes in the system required, which will enable changes in practice, rather than a discussion of abstract ideals? Someone reading this case study could conclude that no single person or group of people is entirely responsible. After all, many actions and inactions contributed to the outcomes of pain, weight loss, loss of dignity, worsening pressure ulcer, and death. Should we focus on the for-profit corporation that owned the nursing home, the administrator, the director of nursing, the treatment nurses, or the CNAs? Should we consider the fact that understaffing resulting from cost-cutting measures led to the demoralization of staff and poor outcomes? What about the fact that lobbying by the corporations that own many nursing homes today undermines the enforcement of the numerous federal regulations intended to protect patients like Mr. Daly? How relevant are our

When he was turned on his side so they could remove the dressing, Mr. Daly screamed in pain.



dismay and outrage at the insensitivity and lack of knowledge shown by many of the CNAs caring for Mr. Daly?

The danger in health care is that sometimes people begin to accept the way things are and feel helpless to make changes. Perhaps this is why ethics are not given much emphasis in nursing schools and are often considered too abstract for practical application. Resources are limited; you can’t change the system and might actually get in trouble if you try to do so. In metropolitan areas, the fact that there are thousands of places to work may make it easier for individual nurses to challenge the status quo. In some less-populated areas, however, there may be only one or two possible employers within commuting distance of many nurses’ homes.

What would you have done differently for Mr. Daly if you had been the director of nursing, one of the treatment nurses, or the administrator who was also an RN?

First, let’s look at whether Mr. Daly’s care violated any of the provisions of the 2001 code of ethics for nurses set out by the American Nurses Association (ANA).³

Provision 3 states: *The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.*

The accompanying interpretive statement notes that the nurse has a responsibility to implement and maintain standards of professional nursing practice and, as an advocate for the patient, “must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system . . . that places the rights or best interests of the patient in jeopardy.”

The nurses didn’t promote and protect Mr. Daly’s health, safety, or right to pain relief. Prevention and treatment of pressure ulcers requires nutritional assessment and support, management of tissue load (how pressure is distributed on tissue), and ulcer and infection care. Pain management is also crucial.

Even when he was given analgesia prior to dressing changes, inadequate time was allowed for it to take effect.



Nutritional assessment and support. A person with a pressure ulcer needs adequate nutrients to promote healing. The form for the Minimum Data Set (the clinical assessment process that must be followed by all nursing homes receiving Medicare or Medicaid), which must be completed within 48 hours of admission to a nursing home and quarterly thereafter, has a section on assessing oral and dental status. Mr. Daly wouldn't have lost 29 lbs. if the staff had assessed him adequately, obtained dentures for him or served him foods that he could eat, and assisted him properly at mealtimes.

Tissue load management. The corporation that ran this for-profit nursing home didn't staff it adequately. The director of nursing had said of Mr. Daly's pressure ulcer, "He has to be off his back." She knew that pressure relief and proper repositioning were important principles of pressure ulcer care, but she didn't ensure that they were adhered to. She also said that because of inadequate staffing it was difficult for the CNAs to get someone to help them when residents needed repositioning. On only one occasion during our 30 visits was Mr. Daly positioned properly. Lying on his back at a 30°-to-90° angle placed great pressure on the ulcer, resulting in pain and additional damage. Furthermore, the tunneling might have been prevented if there had been a mechanical lift to assist the CNAs in repositioning him. The CNAs were not instructed to ensure that two staff members, rather than one, carefully lifted him up in bed to prevent shearing. Shearing can cause distortion in the blood vessels in the sacral area, causing tissue to become ischemic and necrotic. Improper repositioning undoubtedly contributed to the extensive tunneling and the exposing of Mr. Daly's coccyx, which caused him great pain.

Ulcer care. Because of the pressure ulcer's location, protecting the wound from fecal matter would have been challenging. But Mr. Daly's diarrhea was not treated, and no attempt was made to prevent feces from entering the wound. Although necrosis was evident, a debriding agent was not obtained.

Lack of attention to these problems contributed to the pressure ulcer's failure to heal.

Pain management. Although Mr. Daly often complained of pain, he received inadequate pain medication—despite its having been ordered. When he requested medication, he sometimes had to wait a long time before it was given, and even when he was given analgesia prior to dressing changes, inadequate time was allowed for it to take effect.

Provision 4 reads: *The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.*

The interpretive statement notes that when delegating nursing care activities to others, the nurse must assess "the knowledge, skills, and experience of the individual to whom care is assigned" and monitor and evaluate the quality of care provided.

Federal regulations require certified nursing homes to have a director of nursing (an RN) on duty for only eight hours a day, and one licensed nurse (an RN or LVN) on duty during the evening and night shifts.⁴ At this nursing home the director of nursing usually worked from 8 AM to 5 PM. Therefore, much of the residents' care was delegated to CNAs who had limited knowledge and may also have been responsible for more patients than they could safely care for, since federal regulations allow nursing homes considerable staffing flexibility, stating only that they must provide "sufficient numbers" to care for residents.⁴

Training and supervision of staff are paramount in nursing homes. The director of nursing knew that Mr. Daly wasn't being turned in bed but did nothing to either teach the staff about its importance or supervise them to make sure they did it. And while she knew that the CNAs didn't ask for assistance in repositioning Mr. Daly, she didn't tell them that it was imperative that they seek help to do so. Pressure ulcers are a major problem in nursing homes; however, during the 30 months that we collected data, we never heard about a single in-service education program on preventing and managing pressure ulcers. One CNA said she didn't understand how the pressure ulcer had become so large. Another said, "He has a bad sore on his back" but didn't know what had caused it. If the CNAs don't understand the reasons for relieving pressure over bony prominences and providing adequate nutrition, and if they are not properly supervised and held accountable for doing so, the quality of the care they provide will be compromised, especially if they are overburdened.

Staffing. Many of the nursing home staff worked double shifts, even when they preferred not to do so. An RN confided that she had worked 90 hours in one week, and a CNA stated that he had worked 50 days without a day off. For the daytime shift the

licensed nurse–resident ratio was 1:15; in the evening, it was 1:22; and at night, 1:45. If someone called in sick, the ratio worsened. On one occasion, one LVN was responsible for the care of some 40 residents on the day shift, and when staff didn't report for work on the evening shift, one RN and two CNAs had to care for them.

It is the duty of administrators and directors of nursing to ensure that enough professional nurses are available to provide the necessary care. Although nurses may be reluctant to ask for additional staff for fear of repercussions, it is our professional responsibility to do so. During this study, an administrator at another facility closed a unit and refused to admit patients because he didn't have adequate staff. He was not fired, as some of his staff expected would happen, but instead gained the respect of the facility's upper management. Nurses should refuse to tolerate a work environment that prevents the delivery of high-quality care. The ANA and the American Academy of Nursing should take a position on this problem and provide leadership and support to nursing home staff, who now feel that they are battling it on their own.

Provision 2 says: *The nurse's primary commitment is to the patient.* Section 2.2 of the interpretive statement continues, "Nurses are frequently put in positions of conflict arising from competing loyalties in the workplace, including . . . conflicting expectations from patients, . . . physicians, colleagues, . . . health care organizations."

Reporting. Nurses have an ethical responsibility to intervene in all health care settings when the environment contributes to unsafe, inadequate, or unethical care. Researchers and staff can report unsafe conditions to the state department of health and to the state or local ombudsman. The National Citizens' Coalition for Nursing Home Reform is an advocacy organization that can provide help and information; see their Web page at www.nccnhr.org/static_pages/ombudsmen.cfm for links to every state's ombudsman.

Provision 1 states: *The nurse . . . practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.*

The interpretive statement notes that "the measures nurses take to care for the patient enable the patient to live with as much physical, emotional, social, and spiritual well-being as possible. . . . This is particularly vital in the care of patients and their families at the end of life to prevent and relieve the cascade of symptoms and suffering that are commonly associated with dying."

Mr. Daly's care lacked compassion and respect. In the final days of his life he was allowed to overhear statements such as "There is always poo-poo

in the bandage" and "I can't imagine he'll live much longer with a sore like that."

Nor did he receive the pain control that was his right. A recent study found that a lack of knowledge, inadequate staffing, and poor nurse–physician communication contribute to inadequate pain management in nursing homes.⁵ While these factors suggest that pain management is a systemic problem, it is difficult to understand why Mr. Daly was not medicated properly by those who heard him crying out in pain.

GOOD CARE IS EVERYONE'S BUSINESS

After Mr. Daly died, his wife told us about the last days of her husband's life. The night before he was to have dialysis, he had always told her to get his clothes out for him so he could dress for it. "Just the day before I gave the okay to stop the dialysis," she said, "I asked him if he wanted me to lay out his clothes, and he said no, he didn't want me to get the clothes out. I figured, he just don't want it no more."

It is by now widely accepted that when nurses work long hours and don't get adequate sleep, they and their patients are at risk for injury. Mr. Daly's case drives home the often-repeated point that increasing staff-to-resident ratios is imperative. Inadequate staffing in nursing homes has been a problem for decades, and numerous studies have documented its importance in both the processes and outcomes of nursing home care.⁶⁻¹⁰ Elsewhere, colleagues and I have described how inadequate staffing contributed to malnutrition, dehydration, weight loss, and pressure ulcers.^{11, 12} What are the consequences for nursing home residents if nurses and CNAs are fatigued, overburdened, and frustrated? And what are the consequences for the caregivers of knowing that they are unable to provide a high standard of care? When stressed, does their ability to be compassionate and caring decline?

Fowler states that prior to the 1960s the emphasis in nursing ethics was on "virtue ethics," which focused on the character of the moral agent rather than on rules or duties.¹³ Nurses were expected to possess characteristics such as benevolence, care, compassion, kindness, and trustworthiness. We need to ask whether the ANA's code of ethics for nurses is a part of every nursing student's curriculum and taught in a way that makes it relevant to everyday patient care. When nurses think about ethics, they tend to focus on dramatic issues such as whether or not to prolong life-sustaining treatment. We may neglect the everyday ethics of care, as illustrated in the case presented here. We do not contend that the nurses in this facility were intentionally unethical. But were they—and are nurses working in nursing homes, acute care facilities, and other health care settings—aware of the code of ethics for nurses, and is it integrated into their daily practice?

Fowler also makes clear that these virtues don't exist in a vacuum: the environment in which nurses provide care needs to nurture them and allow them to flourish. Nurses and other professionals such as physicians, dietitians, social workers, administrative staff, and the management of the corporations that own the nursing homes must collectively take responsibility for providing ethical care and engage in collaborative efforts to prevent the problems seen in this case. ▼

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