Nursing Notes

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November 2008 ***Tess Kwiatkowski, MS, RN, Editor***

CLINICAL CORNER

Cost Analysis Gives Nod to Advanced Wound Dressing

Treatment of stage II pressure ulcers with a self-adhesive polyurethane foam dressing was more cost effective than was treatment with standard saline-soaked gauze, in a randomized trial. "The current wound care practice in the United States is still dominated by the traditional methods such as saline-soaked gauze or wet-to-dry gauze," Wyatt G. Payne, MD, said in a poster presented at the annual meeting of the Wound Healing Society. "The increased cost per dressing of advanced wound care products leads to the perception that they are expensive, when they may actually be a more cost effective alternative because they need changing less often," he wrote.

For the study, Dr. Payne of the Bay Pines VA Healthcare System in St. Petersburg, Fla., and his associates randomized 36 patients with stage II pressure ulcers to receive Allevyn Thin self-adhesive polyurethane foam dressing (Smith & Nephew) or saline-soaked gauze. Each patient was assessed each week for 4 weeks, unless the ulcer closed before this time. Mean patient age was 73 years, and 61% of participants were men.

The mean cost of dressing and other materials for patients in the polyurethane foam dressing group was $32 per week, compared with $58 per week for those in the saline-soaked gauze group. "This implies that a switch from gauze to polyurethane foam would make it possible to treat 80% more patients with the same materials budget," the researchers estimated.

Overall mean treatment cost per week was also lower for patients in the foam-dressing group, $91, compared with a mean of $209 for the saline-soaked gauze group. The savings of $118 per patient "is consistent with a saving in the cost on nursing time of $92 per week," Dr. Payne reported at the meeting, which was held in conjunction with a symposium on advanced wound care. "This represents more than 3 hours of nursing time per patient per week (assuming a median wage of $28 per hour for a registered nurse)," he wrote.

Dressings were changed a mean of 5 times per patient per week in the foam-dressing group, compared with a mean of 13 times per week in the saline-soaked gauze group. At the end of 4 weeks, 50% of the wounds in the foam-dressing group were closed, compared with 38% of those in the saline-soaked gauze group, but there was no evidence of a difference between the two groups in time to wound closure.

Total per patient costs over the 4-week evaluation period ranged from $265 to $315 in the foam-dressing group and from $691 to $781 in the saline-soaked gauze group. The number of days free of ulcer was 9 vs. 7, respectively.

Smith & Nephew funded the study. Dr. Payne said that he has no financial interest in the company.
Source: Caring for the Ages, August 2008

Oral Hygiene Curbs Pneumonia Risk in Elderly

Among nursing home residents, having a nursing aide help them maintain good oral hygiene lowers the odds of them dying from pneumonia, a study suggests.

Pneumonia is the leading cause of death in elderly nursing home residents, Dr. Carol W. Bassim and colleagues point out in the *Journal of the American Geriatrics Society*. "Several studies have shown that poor oral hygiene or inadequate oral care are also associated with pneumonia," they add.

Researchers with the National Institute of Dental and Craniofacial Research, Maryland, studied four groups of patients at a nursing home in Florida. Two of the groups received enhanced oral hygiene care, while the other two did not. Initially, there was no difference in the mortality rate from pneumonia between the two groups. However, patients in the oral care group were older and more disabled than those who did not receive oral care, and once this was taken into account the risk of dying from pneumonia was more than three times higher in patients who did not receive oral care.

Pneumonia in the elderly is often triggered by aspirating saliva or food. It is likely that the risk of pneumonia "depends on the quality and the quantity of the oropharyngeal contents of a patient at the time of respiratory inoculation or introduction," Bassim and colleagues explain. "The quantity of saliva inhaled and a predisposition to gross aspiration events may not be modified through oral care," they add, "but this study indicates that oral care may be involved in significantly reducing the harmful quality of the intra-oral environment, reducing the risk of a patient dying from pneumonia."
Source: Journal of the American Geriatrics Society, September 2008

Study Shows One-on-One Attention at Mealtime Reduces Undesired Weight Loss

Extra attention at mealtime has been found to help reduce the occurrence of unintentional weight loss among long-stay nursing home residents, according to the Journal of the American Geriatrics Society.

Over the course of a 48-week trial, researchers at Vanderbilt University assessed the unintentional weight loss of 76 nursing home residents. During the first 24 weeks, half of the group received additional attention during mealtime while the other half served as a control group. For the second 24 weeks, the groups switched roles. Researchers noticed that 52% of residents maintained their weight when they were part of the extra attention group. That compares with 28% of residents in the control group.

During the study, "extra attention" constituted one-on-one sessions of 42 minutes per resident per meal and 14 minutes per resident per snack. Researchers suggest that groups of three or four residents per staff member during mealtimes are more practical and just as effective as one-on-one care.
Source: McKnights.com Daily Update

Elderly Dementia Residents on Antipsychotic Drugs have Soaring Stroke Risks, Researchers Find

New study results further underscore scientists' warnings about the risks of stroke involved with giving elderly patients antipsychotic drugs. There is an increased risk of stroke with both typical and atypical antipsychotics, said study author Dr. Ian Douglas, a research fellow at the London School of Hygiene and Tropical Medicine. Similar findings date back at least six years, according to other researchers.

"This risk is substantially higher in patients with dementia than those without. These findings need to be factored into prescribing decisions made by doctors caring for patients with often-distressing and difficult-to-treat psychiatric symptoms," Douglas said.

Douglas and a colleague studied nearly 6,800 individuals who were taking antipsychotic drugs and had suffered a stroke. Those taking the drugs were 1.7 times more likely to suffer a stroke. The rate more than doubled, to 3.5 times more likely, for dementia patients taking antipsychotics. Study findings were published in the British Medical Journal online.
Source: McKnights.com Daily Update

MDR Gram-Negative Bacterial Colonization Common in Long-Term Care Facilities

Colonization with multidrug-resistant gram-negative bacteria (MDRGN) is common in residents of long-term care facilities, according to a report in the July Journal of the American Geriatrics Society. "MDRGN are an important problem in long-term care facilities," Dr. Erika M. C. D'Agata from Beth Israel Deaconess Medical Center in Boston told Reuters Health. "Physicians and all healthcare workers should strictly adhere to the infection control precautions and know the antibiotic resistant profiles of gram-negative bacteria at their institution so that they can prescribe the optimal antibiotics."

In 84 residents of a long-term care facility, Dr. D'Agata and colleagues quantified the prevalence of MDRGN, methicillin-resistant Staphylococcus aureus (MRSA), and vancomycin-resistant enterococci. Just over half the residents (43/84, 51%) were colonized with MDRGN, the authors report, compared with colonization rates of 28% with MRSA and 4% with vancomycin-resistant enterococci. "The most common resistance pattern was three-drug resistance to ampicillin/sulbactam, cefazolin, and ciprofloxacin," the report indicates.

On multivariable logistic regression analysis, advanced dementia and nonambulatory status were the only independent risk factors for MDRGN colonization. "We are currently completing a one year prospective study to determine if there are increasing trends in MDRGN in long-term care facilities and to determine the main mechanism of spread," Dr. D'Agata said. "We have also submitted an NIH grant to study this issue in 21 Boston nursing homes." "MDRGN are increasing worldwide throughout all healthcare institutions, not only long-term care facilities," Dr. D'Agata added. "Physicians are being increasingly faced with situations whereby they do not have effective antibiotics to treat infections."
Source: J Am Geriatrics Society 2008;56:1276-1280.

Infectious Diseases the #2 Killer Worldwide

Infectious diseases are the second most dangerous killer, leading to 16.2 percent of worldwide deaths, according to the World Health Organization (WHO).

Heart disease, infectious diseases, and cancer remain the world's top three killers, the WHO said in a report, released October 27, on the global burden of disease. Only heart attacks and related problems kill more people than infectious diseases, claiming 29 percent of people who die each year, reported the Associated Press (AP). Cancer claims 12.6 percent of global deaths.

The death rate from infectious diseases actually dropped from 2002, when they accounted for 19.1 percent of the world's deaths. This drop was partially due to estimates for AIDS deaths being revised downward last year, said Colin Mathers, the lead author of the report. Deaths from malaria are also lower and the number of deaths from measles dropped as a result of the wider use of vaccination, the AP reported.
Source: Infection Control Monitor

STRATEGIES FOR QUALITY AND SAFETY IMPROVEMENT

APIC Steps Up Efforts to Ensure Healthcare Workers Receive Flu Shots

In a push to increase influenza immunization among healthcare workers, APIC has released new recommendations for healthcare personnel.

In addition to its support for required flu shots for healthcare workers, APIC has recommended facilities obtain informed statements from employees who decline the vaccine for other-than-medical reasons. Such forms should acknowledge the risk to patients posed by this refusal.

These new recommendations apply to physicians, nurses, therapists, and other health workers in hospitals, physician's offices, dental offices, nursing homes, urgent care centers, outpatient settings, and home health settings. For APIC's free toolkit to help healthcare facilities improve their vaccination rates, click here.
(http://www.apic.org/AM/Template.cfm?Section=Influenza&Template=/CM/ContentDisplay.cfm&ContentID=10135)
Source: Infection Control Monitor

"Nine Patient Safety Solutions" Launched by World Health Organization

In an effort to curb medical errors and prevent healthcare mistakes, the World Health Organization (WHO) has launched a new global program called "Nine Patient Safety Solutions." According to the WHO, medical errors affect one in 10 patients worldwide, and at any given time more than 1.4 million people suffer from hospital-acquired infections. Experts believe that simple steps can reduce the number of mistakes made by medical professionals worldwide.

The nine solutions are based on patient-safety strategies and best practices that were identified by WHO's World Alliance for Patient Safety and Collaborating Center. They were drafted with feedback from more than 50 experts in patient safety from more than 100 countries. The strategies come under nine general headings and are being made available to WHO member states. The intention is that the strategies will be used to re-examine patient care processes to improve safety.

Dr. Liam Donaldson, chair of the alliance and chief medical officer for England, headed the agency's campaign, and unveiled the nine solutions. The headings are:

1. **Look-alike, sound-alike medication names**--Confusing drug names are a worldwide concern and one of the most common sources of medication errors.
2. **Patient identification--**Incorrectly identifying patients leads to medical, transfusion, and testing errors.
3. **Communication during patient handovers--**Gaps in hand-off communication between units and teams can lead to inappropriate treatment and possible harm to the patient.
4. **Performance of correct procedure at correct body site--**This preventable mistake is the result of miscommunication and incorrect or unavailable communication.
5. **Control of concentrated electrolyte solutions--**Concentrated electrolyte solutions used in injections are dangerous if administered improperly or not handled correctly.
6. **Assuring medication accuracy at transitions in care--**Medication errors most commonly occur at patient transition points, and medication reconciliation is designed to prevent these errors.
7. **Avoiding catheter and tubing misconnection(s)--**Patient harm can be caused through the misconnection of syringes, tubing, and catheters.

8. **Single use of injection devices--**The reuse of injection needles, which contributes to the spread of Human Immunodeficiency Virus (HIV) and other viruses, is one of the biggest health concerns worldwide.
9. **Improved hand hygiene to prevent healthcare-associated infections--**Effective hand hygiene is a preventive measure to avoid hospital-acquired infections.

The solutions were based on actions and interventions that have been working in some countries to improve overall patient safety while reducing the number of medical mistakes made.
Source: World Health Organization, Joint Commission International Center for Patient Safety, All Headline News, and Yahoo! News

Fall Prevention in Long-term Care: Practical Advice to Improve Care

Authored by Mara Ferris, MS, RN, GCNS-BC, CPHQ, FASCP
Topics in Advanced Practice Nursing eJournal. 2008;8(3) ©2008 Medscape Posted 09/10/2008

Three days ago, Ms. P fell in her home and suffered a Colles' fracture of her right arm. The wrist was surgically repaired and, following a brief hospitalization, Ms. P has now been admitted to a skilled nursing facility. Her medical history includes early dementia, paroxysmal atrial fibrillation, hypertension, diabetes, peripheral neuropathy, osteoarthritis, glaucoma, urge incontinence, and history of falls. In addition to this most recent episode, Ms. P has been hospitalized 4 other times in the past 18 months for diagnoses, including dehydration, pneumonia, and twice for delirium due to medications. She has also been seen in the local emergency department 3 more times in the past 5 months after having fallen.

At her baseline, Ms. P is fully oriented but has difficulty in new situations and has some short-term memory deficits. Prior to admission, she had lived in senior housing where she was independent with activities of daily living and simple household tasks, but was assisted by her daughters with shopping, strenuous household chores, and her finances.

Falls are common among older adults. One third of adults over 64 years old, living outside of institutions, fall each year, and the likelihood of falling continues to rise with older age.[1] Among the elderly, falls cause significant morbidity and mortality, and often contribute to functional decline, depression, social isolation, and nursing home admission. Compared with community-dwelling elders, nursing home residents generally have more comorbidities and advanced disease, including dementia. It is not surprising then that nursing home residents are nearly 3 times more likely to fall than elders living in the community.[2] In a 100-bed facility, there will generally be 100-200 falls each year, and many residents will fall more than once.[3] No nursing home will be able to prevent all falls, but there is a great deal that can be done to reduce fall risk and thereby the total number of falls and injuries.

Fall Prevention

Risk Assessment

The first step to preventing a fall is to determine the risk. Although there are many fall risk assessment tools in the literature, no single tool is valid in all practice settings and most are not well validated.[2,4,5] Nevertheless, the logic of identifying elders at risk for falls is undeniable because many risk factors are well documented. An assessment should be completed so that risk factors can be minimized, if not eliminated. Selecting the most appropriate tool for nursing home residents should be based on 2 criteria: The tool should address the most common risk factors, and it should be simple and practical to use.

The Minimum Data Set (MDS) is an interdisciplinary assessment tool required by federal regulations for use in nursing homes. The MDS identifies some of the risk factors for falls, including a history of falls, dizziness, wandering, restraint use, and use of drugs in high-risk classes. As its name implies, the MDS is not a comprehensive assessment tool, and yet it is too lengthy for quick fall risk assessments. So in addition to the MDS, many nursing homes use 1-page tools that are commercially available, posted on the Internet,[6,7] or that have been created within the facility. At a minimum, any quick tool should include the following:

- A history of falls;
- Cognition, including fluctuating mental status;
- Impulsivity;
- Vision;
- Ambulation;
- Continence;
- Use of high-risk medications (eg, antihypertensives, diuretics, and hypoglycemics);
- Use of assistive devices for transfer or ambulation;
- Attached equipment (eg, catheters, intravenous lines, and oxygen); and
- Familiarity with the environment.

Considering these 10 risk factors, Ms. P is clearly at high risk for falls.

For residents with a history of falls, it is helpful to determine the circumstances of previous falls, although this information may not be available. In Ms. P's case, her daughters may be able to provide some information about previous falls even if the falls were unwitnessed -- where, when, and how she fell. Despite her cognitive deficits, Ms. P may provide more information than might be expected if she is asked directly. Are there common characteristics to the falls? For example, have the falls happened when she was using the bathroom, at the same time of day, when her blood sugars were low, or when she was wearing her high heels or not wearing her glasses?

When Ms. P arrives at the nursing home, she is pleasant and cooperative, and she is introduced to her new room and roommate, Ms. L. She eats lunch in the main dining room with Ms. L and seems to be quietly "settling in." About 4:30 pm, the roommate goes to an activity that Ms. P chooses not to attend. A few minutes later, a staff member finds Ms. P sitting on the bathroom floor in a puddle of urine.

Fall Prevention Planning

Any plan to prevent falls for elderly residents of extended care facilities is a precarious balancing act. Two conflicting goals must be met: promoting the greatest level of independence and mobility while simultaneously preventing falls and injuries. Although Ms. P's risk for falls may have been anticipated, designing an individualized care plan within the first days of admission to long-term care to prevent falls is very difficult. Even so, in Ms. P's case there is some information that, if gathered in the first few hours of admission, might have prevented this fall. For example:

- Were her blood sugars stable during the hospitalization?
- When and what was the last hypoglycemic medication administered?
- How well did she eat at lunch?
- In addition to vital signs, is she orthostatic?
- Was her drug regimen changed while she was hospitalized?

Every fall warrants a postfall assessment to determine the cause or causes of the fall. Unfortunately, there are no comprehensive postfall assessment tools in the literature,[8] and most facilities develop their own. Besides identifying any physical trauma, the physical assessment following a fall must include factors that might have contributed to the fall (for example, orthostasis, low blood sugar, and signs of infection). This postfall assessment should include a history of the fall and the events and circumstances preceding it. The history is gathered with a combination of the patient's report (if possible), witness observations (if any), and consideration of the patient's position and physical environment when found.

In Ms. P's case, it would be helpful to note:

- Was the bathroom light on and was it sufficient for her?
- Did she fall as she approached the toilet or as she tried to lower her panties?
- Have staff assisted or cued her to toilet since arriving this morning?

Interventions to Prevent Falls

Because falls are due to many causes and often more than 1 cause, no single intervention will prevent all elders from falling. A comprehensive assessment to determine the fall risk factors for each individual resident is essential. Only with such an assessment can a care plan be developed that addresses the individual's unique risk factors, needs, and preferences.

In Ms. P's case, the nurse practitioner found that she needed to lower the doses of the antihypertensive and hypoglycemic medications. The nursing staff recognized that Ms. P was especially stiff and uncomfortable first thing in the morning and late in the day, making it difficult for her to get to the toilet "in time." With some suggestions from the pharmacist, the schedule of her arthritis medications was changed to provide more consistent relief. The pharmacist also suggested adding vitamin D and calcium to Ms. P's drug regimen to strengthen her bones, and because vitamin D has been shown to reduce falls.

The nursing assistants cued Ms. P to use the toilet more frequently during the day, which reduced both her episodes of incontinence and the number of times that she had to "run" to the toilet. The occupational therapist posted signs in Ms. P's room to provide visual cues to help independent mobility in her room (eg, picture of a toilet on the bathroom door). Ms. P accepted physical therapy and learned to use a rolling walker, but, to the staff's dismay, she was unwilling to give up her stylish high heels for something more practical and to her mind "ugly."

The Bottom Line

Falls are the cause of significant injury and disability among older adults. In the long-term care setting, residents are likely to have more than 1 risk factor for falls. Only by assessing the unique strengths, risks, and preferences of each individual can falls be reduced. By providing a safe environment for all residents and developing individualized care plans, many falls can be prevented. As with every patient, needs will change over time. Continuous observations for even subtle functional changes should guide revision of the fall prevention or injury prevention care plan. Reassessment of fall risk should be done at least every 3 months for long-term care residents. When falls occur, the postfall assessment will often identify new risk factors and will suggest new interventions to prevent the next fall. Every care plan should accommodate the individual elder's preferences while balancing the safety goals with the goal of maintaining the highest level of independent function and mobility.

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2008 Update on Consumers' Views of Patient Safety and Quality Information

An updated examination of consumers' views on health care quality information reveals major challenges remain in providing the public with comparative quality information and encouraging its use.

The *2008 Update on Consumers' Views of Patient Safety and Quality Information* (http://www.kff.org/kaiserpolls/upload/7819.pdf) finds that three in 10 (30%) Americans say they have seen health care quality comparisons of health insurance plans, hospitals, or doctors in the past year. Not all people make health care choices or decisions in a given year that would call for the use of quality information, but this is a downward trend from surveys in 2006 (36%) and 2004 (35%) and roughly equivalent to the level in 2000 (27%). Further, just one in seven (14%) Americans report that they "saw" and "used" comparative health quality information for health insurance plans, hospitals, or doctors in the past year, again down from roughly one in five in both 2006 (20%) and 2004 (19%).

The report of consumer views on quality information was conducted in August as part of the Kaiser Health Tracking Poll: Election 2008 series. The report draws on data from a set of questions related to consumer quality information that the Kaiser Family Foundation has asked since 1996, at times in conjunction with partners. The report also examines public opinion on the coordination of health care among different health care providers and steps the public has taken to better organize their own care.

The survey was conducted by telephone from July 29 to August 6, 2008, among a randomly selected nationally representative sample of 1,517 respondents 18 years of age and older. The margin of sampling error for the overall survey is plus or minus three percentage points. For results based on subsets of respondents the margin of error is higher.
Source: The Henry J. Kaiser Family Foundation

Creating Unique Health ID Numbers Would Facilitate Improved Health Care Quality and Efficiency

Creating a unique patient identification number for every person in the United States would facilitate a reduction in medical errors, simplify the use of electronic medical records, increase overall efficiency and help protect patient privacy, according to a new RAND Corporation study. (http://www.rand.org/pubs/monographs/MG753/) Although creating such an identification system could cost as much as $11 billion, the effort would likely return even more in benefits to the nation's health care system, according to researchers from RAND Health.

Federal legislation passed over a decade ago supported the creation of a unique patient identifier system, but privacy and security concerns have stalled efforts to put the proposal into use. As adoption of health information technology expands nationally and more patient records are computerized, there have been increasing calls to create a system that would make it easier to retrieve records across varying systems such as those used by doctors and hospitals.

RAND researchers examined the costs of creating a unique patient identification system, compared the error rates of such a system and its alternatives, and examined the operational advances and disadvantages of the technology. The RAND study concluded that one of the primary benefits created by broad adoption of unique patient identifiers would be to eliminate record errors, and help reduce repetitive and unneeded care.

In the absence of unique patient identifiers, most health systems use a technique known as statistical matching that retrieves a patient's medical record by searching for attributes such as name, birth date, address, gender, medical record numbers, and all or part of a person's Social Security Number. Reviewing past research studies, RAND researchers estimated that statistical matching returns incomplete medical records about 8 percent of the time and exposes patients to privacy risks because a large amount of personal information is exposed to computer systems during a search. The study also concluded that many of the privacy concerns related to a unique patient identification system could be addressed through the creation and enforcement of laws that severely punish those who misuse information retrieved with a health ID number.

One way to deal with privacy concerns might be to allow to people to voluntarily enroll in a unique patient identification system, researchers say. Such an approach would allow a unique health identifier system to demonstrate that it can be used without compromising patient privacy and can be more accurate than current statistical matching systems. Some proposals have suggested using patients' Social Security Numbers as a medical identifier. But the RAND study found Social Security Numbers are a poor option because they are so widely used and they pose risks of identify theft.

A genuine unique patient identification system would be more secure because it could include safeguards such as check codes that allow numbers to be easily screened for input errors. Such check codes are mathematical combinations of the other digits in the number and are commonly used in other digital IDs such as those in the product bar codes scanned at checkout counters.

Support for the study was provided by a consortium of health information technology companies. They include Cerner Corporation, CPSI, Intel, IBM, Microsoft, MISYS, Oracle and Siemens.
The study, "Identity Crisis: An Examination of the Costs and Benefits of a Unique Patient Identifier for the U.S. Health Care System," (http://www.rand.org/pubs/monographs/MG753/) is available at www.rand.org. Other authors of the report are James H. Bigelow, Basit Chaudhry, Paul Dreyer, Michael D. Greenberg, Robin C. Meili, M. Susan Ridgely, Jeff Rothenberg and Roger Taylor. RAND Health, (http://www.rand.org/health/) a division of the RAND Corporation, is the nation's largest independent health policy research program, with a broad research portfolio that focuses on quality, costs and health services delivery, among other topics.
Source: RAND Corporation

ENHANCING HEALTH CARE DECISION MAKING

Frailty in Elderly Can Be Proactively Managed: An Expert Interview With Renee Roberts, MSN, RN, NP-C

Author: Laurie Barclay, MD

October 21, 2008 — Editor's note: The concept of frailty has recently emerged as a crucial facet of the care of older adults. This clinical syndrome can include loss of muscle mass, generalized weakness, and poor endurance, often resulting in adverse outcomes, such as hospitalization, decline in functioning, and even death. Nurse practitioners are uniquely positioned to proactively identify frailty and to help determine whether it can be reversed or stabilized.

To find out more about the role of nurse practitioners in helping to reduce complications and healthcare costs of frailty in the elderly, Medscape interviewed Renee Roberts, MSN, RN, NP-C, about her presentation at the National Conference of Gerontological Nurse Practitioners (NCGNP), held from September 25 to 27 in St Louis, Missouri. Ms. Roberts, a board-certified adult nurse practitioner, is a clinical team leader of Evercare Georgia and a member of the National Black Nurses Association, the American Academy of Nurse Practitioners, the National Conference of Gerontological Nurse Practitioners, the American Geriatric Society, and the Georgia Medical Directors Association. She is also a board member of the Atlanta Black Nurses Association and a 2007–2008 American Health Insurance Plans Fellow.

Medscape: How widespread is frailty in the elderly, and what are its causes or underlying mechanisms?

Ms. Roberts: Researchers estimate that 3% to 7% of 65- to 75-year-olds are frail, as are about 20% of those older than 80 years. This proportion reaches a third for those in their 90s. Life expectancy today is around 78 years, unlike in 1900, when it was 47 years. As you can see, individuals are living longer with long-term or chronic illnesses. By 2020, 20% of the population, or an estimated 12 million people, will be older than 65 years. If you think that is astonishing, by 2050, 80 million people will be older than 65 years. With this shift in demographics, the problem of frailty will only escalate.

According to Dr. Linda Fried, an expert in this area, "frailty is a stage of age-related physiologic vulnerability, resulting from impaired homeostatic reserve and a reduced capacity of the organism to withstand stress." It is also characterized as a syndrome that involves a progressive physiologic decline of multiple body systems. Before the age of 75, individuals have efficient reserves to tolerate stressors or to maintain homeostasis. After the age of 75, individuals need compensation around diminishing reserves to preserve function and well being.

The presence of 3 or more of the following elements identifies an individual as being frail: weakness, as measured by grip strength; unintentional weight loss of 10 pounds or more in a year; slow gait or walking speed; low levels of physical activity; and general feeling of exhaustion or poor endurance. Sarcopenia, osteopenia, malnutrition, and depression are also common among frail older adults.

Medscape: What are the consequences of frailty in the elderly in terms of medical complications and healthcare costs?

Ms. Roberts: Frailty can occur after an acute event or as the end stage of a chronic condition, such as atherosclerosis, infection, cancer, depression, or other long-term illnesses. It is a predictor of negative outcomes or adverse health outcomes, including disabilities, institutionalization, falls, dependency, injuries, acute illnesses, hospitalizations, and mortality. Once frailty is established, and if measures are not implemented to slow down or prevent its progression, there is often a rapid decline toward death. It is important to rehabilitate these individuals early to minimize the harmful effects on illness and on their physical functioning.

According to the Medical Expenditure Panel Survey of 2001, healthcare spending more than doubles for people with chronic illnesses and activity limitations. This can lead to inappropriate hospitalizations and emergency department transfers of frail individuals. The cost to manage and care for these older adults is steadily increasing, which continues to stress our current healthcare system.

Medscape: What can be done to identify and reduce risk factors for development of frailty?

Ms. Roberts: There is clearly an opportunity for nurse practitioners to deliver quality care, improve health outcomes, and provide cost-effective care for frail individuals. In **nursing homes** and in **community settings**, nurse practitioners can proactively identify early changes in conditions to reduce risk factors and determine reversibility or stabilization potential in the development of frailty, which is of paramount importance and could save our nation money. Nurse practitioners are skilled at identifying and stratifying elderly at risk for frailty. This includes those without advanced-care plans, and those with cognitive and functional declines, behavioral problems, depression, weight loss, recurrent infections, inappropriate hospitalizations and emergency-department visits, polypharmacy, dysphagia, falls, chronic diseases, and exacerbations. Intervening early in these conditions would help reduce risk factors for the development of frailty.

Medscape: What role should nurse practitioners play in preventing, diagnosing, and managing frailty?
Ms. Roberts: It is important for nurse practitioners to design a plan of care that is highly individualized and to coordinate services that will ensure successful implementation. This includes providing evidence-based interventions while preventing, diagnosing, and managing frailty. Treating any underlying disease processes or any medical condition that can cause frailty must be the first consideration. This includes recognizing and treating depression, which is undertreated in the elderly population.

Nurse practitioners, when developing a clinical pathway and plan of care for frailty, understand specific health–illness trajectories, and they know that not everything can be reversed. This is important when determining goals and priorities of care, which can include comfort, function, and longevity.

It is important that this individualized plan of care be established on the basis of a comprehensive advanced-care plan and communicated to all providers. Successful intervention includes identifying early changes in conditions, being proactive with prompt assessment and treatment, educating patients and caregivers about key triggers of decline, and developing contingency plans for possible complications. Barriers should be identified and addressed appropriately. Care should be provided in the least invasive manner and least intensive setting.

Preventative strategies and supportive services include medication management, balance, gait, strength and exercise training, depression recognition and management, pain assessment and management, management of undernutrition, immunizations, fall prevention and injury control, and environmental safety assessment and management.

In preventing frailty, food intake should be maintained with a balanced diet that includes protein, fruits, vegetables, fiber, and fluids. Resistance exercises build muscle and help to reduce joint stiffness and pain. There is evidence that tai chi can reverse the cycle, restoring balance in the community setting.

Avoiding isolation and keeping the mind active as long as possible is important for older adults. Socializing, playing games, reading, and working on crossword puzzles are great ways to maintain mental sharpness.

Medscape: Describe the take-home message and clinical implications of your research regarding frailty in the elderly.
Ms. Roberts: The syndrome of frailty in the elderly can be challenging for clinicians because it is often subtle or asymptomatic. The degree to which these individuals — whether robust, highly independent, vulnerable, or frail — respond to medical treatment or stressors during an acute event or at the end stage of a chronic condition makes some more vulnerable to poor or adverse health outcomes than others.

Reversing, preventing, and slowing down the adverse effects of frailty takes a multidisciplinary team approach. Proactively identifying frailty and intervening early can make a difference in the outcomes of these individuals. I cannot stress this enough.

Medscape: What new data presented at NCGNP most captured your attention regarding frailty in the elderly, and how are these findings likely to affect management?
Ms. Roberts: Many of the causes of frailty are treatable and even reversible with early identification and a comprehensive treatment plan, but there may be a point where a palliative-care approach is appropriate for frailty. We must take the whole-person approach to function, independence, comfort, and quality of life.
Source: Medscape Medical News

SYSTEM DESIGN & ORGANIZATIONAL CHANGE

Meeting the Leadership Challenge: *MDS 3.0 Implementation Strategies for the Nurse Executive*

By Rena R. Shephard, MHA, RN, RAC-MT, C-NE, AANEX Executive Editor

Significant changes in assessment philosophy that reflect current clinical practice standards and a focus on resident-directed care are at the core of the next generation Minimum Data Set, the MDS 3.0 Implementation is scheduled for October 2009, but plenty of preparation will be needed leading up to that date. Changes in key operational and clinical systems and processes will help to pave the way to successful implementation – and to improvements in quality of care and quality of life for residents.

How a facility implements the MDS 3.0 will affect all of the critical aspects of nursing home operations: it will determine how accurate the resulting care plans and the data the surveyors see will be, how representative of the quality of care in the facility the Quality Indicators and Quality Measures will be, and whether Part A reimbursement will be consistent with the intensity of care the facility provides. (*Editor's Note: In Illinois, MDS coding also determines Medicaid reimbursement. LSN will be providing plenty of education on MDS 3.0 beginning with a December 9th audio call and continuing with sessions at the Annual Convention and ongoing throughout the Spring and Summer of 2009 in partnership with CMS and IDPH)*.

Effective leadership is the key to success in making this change in the facility, just as it is with any change. An effective and dynamic leader develops a vision for what must be accomplished and shares that vision in a clear and positive manner that leaves no question about the goal—and the worthiness of the goal—that everyone will work toward together. A great leader entices others to follow. As leaders, administrative team members have the central leadership role in this.

Make a *plan*

A critical first step is to make a plan for implementation well in advance of the October 2009 start date. Involve the entire team in the facility, and, as a leader, be the facilitator throughout the process - leave no doubt that this project has the full support of the facility's administrative team.

Provide *formal training*

Ensure that all staff members who will participate in the assessment receive formal training from recognized experts. As the leader, be sure to remove obstacles that might prevent them from receiving the training and support they will need. Also, ensure they have the most up-to-date instruction manual at all times. Affiliation with the American Association of Nurse Assessment Coordinators (AANAC) and the American Association of Nurse Executives (AANEX) can be instrumental in meeting these needs.

Create a team of individual *section specialists*

Solicit volunteers among the staff to become the experts on the various new items, one person/one item (or section). Each of these specialists would provide additional mentoring and support to other team members with regard to the item specialty and would act as a resource person on that item on a continuing basis.

Find out about *your software vendor's transition plan*

The Centers for Medicare & Medicaid Services (CMS) has published a timeline for providing to the software vendors the information they will need to develop the MDS 3.0 software in time for implementation. But beyond that, each vendor will develop its own process and timeline for software development and testing. It is critical that your facility be aware of your vendor's plan well in advance and that a joint plan for integration of the new software into your facility, including plenty of time for staff training, be developed.

Recognize that the *MDS is a complex process*

The nursing home industry can learn a lot about what NOT to do from implementation of the original MDS in the early 1990s. In many ways, the complexities of the process were not recognized and accounted for at that time, and to this day, the ripple effect of consequences continues in inaccurate assessment data that may be attributed to inadequate training, lack of priority from administrative team members, and a job description for MDS nurses that in many ways cannot be accomplished.

Understand the MDS 3.0 yourself

Make sure you have a clear understanding of the processes of the MDS 3.0 - how it works and how it can be used to improve quality of care, quality of life, and outcomes for your residents – how it can be the foundational tool for culture change for your facility.

Understanding the MDS 3.0 yourself is important also so you can assist the interdisciplinary team by removing obstacles to success, providing needed resources, and monitoring to identify training needs and to recognize successes.

Administrative team members in many organizations have never really understood their key role in the MDS 2.0 in this context and to this day may have significant problems with MDS accuracy and effectiveness as a care planning tool, whether they know it or not, despite the critical role this instrument plays in the survey process, reimbursement, and quality monitoring. Unless you will be completing some portion of the MDS 3.0, that doesn't mean that you have to know how to fill out every item on the MDS. But it does mean that you must know enough about it to ensure that the team responsible for completion of the form gets it right.

Empower a team to *analyze and revise processes*

The team should study current MDS-related processes in the facility; flowcharting the processes can be very helpful in analyzing what works and what doesn't work. Brainstorm with them what will be needed in terms of processes for the team to be able to do their work efficiently and effectively. This team should then flowchart the proposed new process step by step in order to be able to identify and remove barriers to success – and to be able to know when aspects of the proposed processes should be altered.

Put together a team to analyze the facility's *staffing patterns and job designs*

Too often, job descriptions evolve into task lists that have little relationship to their purpose. This may be a good time to restructure or redesign jobs to meet the needs of the facility and residents.

***Experiment* with the interviews yourself**

Go out there and sit down with a resident and complete the scripted interviews that are an integral part of the MDS 3.0 – get comfortable with the process. Don't forget to take your cues from the instruction manual that will accompany the MDS 3.0. It will provide you and your team with the script to use, but also with some tips on how to help a resident stay focused and to narrow their answers.

Also, it would be wise to time the interviews you do, so you can begin to have an idea of how long they are going to take – this will really help when your staff needs support and guidance about these interviews. And this doesn't have to wait until the 3.0 is implemented. These scripted interviews can be very valuable right now – not for use with the MDS 2.0 – but as an assessment tool for care planning purposes outside of the MDS process.

Incorporate *staff practice time* into the facility transition plan

With phasing in of the scripted interviews long before MDS 3.0 implementation and providing ample time for staff to practice completing the new form, October 1, 2009, will not have to be a frantic time.

Develop a *quality improvement plan* for MDS 3.0 activities
Include practice in auditing the accuracy of the MDS 3.0 and related documentation, and implement routine monitoring of accuracy as part of the facility's Quality Assessment and Assurance activities.

***Be prepared for resistance* – but be undaunted by it**
Resistance to change is inevitable. Prepare for it. Learn from it. Harness the energy and use it toward change.

Be a cheerleader for this change
Change is very difficult, even at best. Be a leader in this transition – be an example for others to follow. You can do this by presenting this MDS upgrade as a very positive change for residents. The interview process gets to the core of what the resident wants and what is important to him or her – it is the basis for resident-directed care and for culture change.

And you can also do this by presenting this change as a positive one for the facility. The improvements in quality of care and quality of life that can result from fully implementing the MDS 3.0 approach will shine through at survey time and in staff and resident satisfaction.

Making change happen takes time and vision, patience, and leadership. What seems clear is that providers with effective and dynamic leadership in an atmosphere of resident-directed care will be the ones to experience a smooth, successful transition. The investment of passion for the residents, commitment to interdisciplinary team members, and clear articulation of vision and expectations from a dedicated leader will help to pave the way for full and successful implementation of the MDS 3.0.

About AANEX
AANEX is a non-profit professional association representing nurse executives working in the long-term care industry. AANEX is operated by nurses for nurses and is dedicated to providing members with the resources, tools and support they need in their specialized role of leader and manager in long-term care.

AANEX offers the nurse executive:

- The opportunity to discuss common challenges and problem-solve with peers and experts from across the country via the Executive Town Hall and online discussion groups.
- Quick and easy access to current long-term care news, regulatory updates, manuals and publications.
- Weekly email reminders about important dates, deadlines and current events.
- Educational programs and CEs encompassing the essential job functions of the long-term care nurse executive.
- *ExecExpress*, a weekly newsletter addressing tough issues and frequently asked questions posed by AANEX members.
- AANEX is the organization chosen by successful leaders in long-term care. To join or get more information about AANEX, visit **www.aanex.org** or call (877) 457-7208.

Stayin' Alive

Authored by Jay Moore, managing editor, HealthLeaders Media
The e-mail subject line reads: "Pop song *Stayin' Alive* helps people perform chest compressions for CPR."

Skeptical, am I. Quality is a weighty matter, not one to be addressed with gimmick solutions. We have thousands dying from healthcare-associated infections every year. We have wrong-site surgeries, fatal drug errors. We have hospitals struggling with the costs of improving patient safety. In short, we have serious challenges. Someone is actually spending the time to study the effects of disco music?

My cynicism aside, the report is from a credible source—the American College of Emergency Physicians—so I read on. The Bee Gees' *Saturday Night Fever* anthem, I learn, has 103 beats per minute, which is almost exactly the rate at which compressions should be administered. Physicians and medical students at the University of Illinois College of Medicine who were trained to do chest compressions while listening to the song were able to maintain the ideal compression rhythm weeks after their training. Apparently the song creates a sort of mental metronome that sticks in the brain.

I reflect that maybe there's something to this. But then again, the study involves just 15 participants—10 physicians and five medical students. How can anyone expect to draw meaningful conclusions from that? Training caregivers with the Bee Gees? Come on.

A few days later, I read a *New York Times* piece about how teaching literature to medical residents can make them more empathetic, compassionate physicians who are more adept at evaluating patients. The story describes residents gathering to read short stories and poems together, then reflecting upon how the themes and situations detailed in the readings apply to their clinical experiences.

Again, I am leery. Using literature to supplement medical students' curricula is not a new phenomenon. But residents? They're extraordinarily busy, and the scope of their training is immense. Now we're going to squeeze "narrative medicine training" into their 80-hour weeks?

But then I read this quote from Benjamin Kaplan, MD, a second-year resident at Saint Barnabas Medical Center in Livingston, NJ, about the issue of committing time for such things amid a sea of priorities: "It does get pretty busy. But if you want to make time for it, you can," Kaplan told the *Times*. "Spending a half hour a day to remember that we are all human, not just doctors or pharmacists or nurses or patients, is important enough that I think you should do it."

And there it is. Kaplan is right. Time may be at a premium, but it's there. The trick, of course, is deciding which training, which initiative, which solution justifies the time. When it comes to improving the quality of care that healthcare organizations provide to patients, I'm still not convinced that every obscure study or program is time well spent. For the most part, we cannot nickel-and-dime our way through healthcare's minefield of enormous challenges, and the issue of quality is no exception. But we—and that we includes me—also shouldn't automatically dismiss nontraditional ideas as trivial. **The industry push for quality demands legitimate solutions—and it also demands fresh thinking.**

The Bee Gees and classic literature aren't exactly typical quality solutions. But we need all the solutions we can get.

MANAGEMENT FORUM

Help New Nurses Keep Patients in Focus while Completing Tasks

Expert **Kathleen Bartholomew, RC, RN, MN,** shares some tips to help your staff balance their busy workloads and build better relationships with patients.

Q: How can I help my new nurses multitask and focus on communicating with our patients effectively?

A: By its nature, nursing involves a tremendous amount of multitasking. Nurses can be found simultaneously assessing the color and quantity of urine in the Foley catheter, while hanging an IV, talking to patients, and trying to listen for a physician they just paged. Being attentive to a patient these days is challenging for even the most experienced of nurses. Here are some tips you can relay to your nurses, which they can practice every time they enter a patient's room:

Jot down as much as you possibly can in your notes (especially the easily-forgettable little things, such as replacing a box of tissues). Don't try to keep a "to-do" list in your head. Trying to remember everything will take your attention away from everyone.
Stop at the doorway and take two or three long, deep breaths to give yourself a moment to clear your head. It will allow you to feel as though one project is completed before you start on the next one.
Be keenly aware of your body language and behavior. The most important communication happens within the first minute of walking into a patient's room-whether anyone speaks or not. Before you speak, look patients directly in the eye and touch them lightly on the hand or leg-or touch the bed covers (depending on your comfort level and the patient's receptiveness). Nonverbal cues can speak volumes.
Source: Nurse Manager Weekly

Put on Your Best Performance Review

A performance review gives a nurse manager and an employee a chance to take a step back and assess how the employee's performance is measuring up to the requirements of his or her position. It is a time to communicate, a time to set goals, and a time to strengthen the manager-employee relationship. But they are often challenging for both parties.

Regardless of how challenging the task may be, it is necessary. And luckily, there are steps nurse managers can take to ease the process and make it as effective as possible.

To conduct the most productive and painless performance reviews, follow these tips:
Remove the shock. The feedback given in a performance review shouldn't be a surprise. Make sure you communicate and provide staff members with constructive criticism throughout the year, instead of springing it on them all at once. Also, never miss an opportunity to let staff know when they set a positive example for your facility. For example, if you notice a staff member has done well during the past few months, pull him or her aside and tell them how much their good work is appreciated. In doing so, you will minimize the chance of the employee getting defensive when you discuss areas that need improvement and they will know their hard work is not going unnoticed.
Give them time. Performance reviews are most effective when both the nurse manager and the staff member prepare for them. Inform employees of their performance evaluation at least two weeks ahead of time so they can organize their own materials, such as an informal evaluation of their performance or a list of goals they wish to achieve in the future. Employees will arrive for their review collected and more open to discussion.
Run a performance observation tab. Keeping track of the work performance of each staff member—whether it is good or bad—is nearly impossible without making written record of it. As events happen, make note of them. Consider creating a file where you store notes regarding any immediate recognition or constructive feedback you gave to staff so at the end of year you have specific examples to discuss with each employee. For instance, you may want to record the number of times you had to confront a staff member for acting unprofessionally around a patient and the advice you gave to help them improve this behavior.
Open with the goods. Start off with the positives. Many employees fear performance reviews because they think their managers will spend the session nitpicking every mistake they made during the past year. Presenting the positives first is a good way to calm this fear, while making it easier for them to accept the negatives later. Remember to be specific when discussing the positives; don't just congratulate the staff member for working well with patients, point out a particular incident. Also, take some time prior to the meeting and make a list of the employee's positive traits, backing them up with specific examples.
Look into the future. If you want to retain your staff, you need to give them the chance to grow within your facility. Goals should be set during every performance review, but many managers overlook this step in exchange for a simple "thank you" and a pat on the back before sending them back onto the floor. Make it a priority before the review to outline goals you wish staff to accomplish during the next 6-12 months and bring them up with the employee.
Source: Strategies fore Nurse Managers.com

RESOURCE REVIEW

AHRQ Health Care Innovations Exchange Current Issue Focuses on Improving the Health and Care of the Elderly

The **Health Care Innovations Exchange** (http://www.innovations.ahrq.gov/) is an Agency for Healthcare Research and Quality (AHRQ) program designed to support health care professionals in sharing and adopting innovations that improve the delivery of care to patients. You should explore this site to find innovative strategies and quality-related tools, learn how to improve your organization's ability to innovate and adopt new ideas, and interact with innovators and adopters. The current issue focuses on meeting the complex health care needs of a rapidly expanding elderly population.

The US Census Bureau has projected that nearly one in five Americans will be age 65 or older by 2030, which will increase the demand for health care services. The **featured innovations**, by providing outreach to the elderly, preventive services, and care management, may reduce the need for intensive and expensive health care services.

The featured innovations describe unique programs--from storytelling to fall prevention--designed to increase functioning among the elderly.

- The featured QualityTools describe useful resources for organizations that care for the elderly.
- In the Spotlight:
    - Expert Commentaries on Caring for the Elderly:
    - Care Networks Smooth Transition from Hospital to Nursing Home
    - Innovations Improve Complex Care for Seniors
    - The Story Behind an Innovation:
    - A Doctor Uses Care Coordinator to Improve Patient Health

Free Publication Available on Pan-Flu Preparedness

The American Health Lawyers Association (AHLA) has made a new 96-page publication available free of charge. "The 'Community Pan-Flu Preparedness: A Checklist of Key Legal Issues for Healthcare Providers,' (http://www.healthlawyers.org/panfluchecklist) is a scalable tool designed to assist providers along the continuum of care, as well as the broader healthcare and public health communities, in taking concrete steps to prepare for an influenza pandemic."

"The checklist was informed by a [May 2, 2008] public interest dialogue session convened by the American Health Lawyers Association, Office of Inspector General (OIG) of the U.S. Department of Health and Human Services, and the U.S. Centers for Disease Control and Prevention (CDC). Participants from federal and state agencies, the provider and payer communities, academia, and other stakeholders discussed the role of the healthcare sector in community panflu preparedness."

AHRQ Updates Long-Term Care Internet Site

The Agency for Healthcare Research and Quality (AHRQ) has recently updated the Long-Term Care section of their website. Click here (http://www.ahrq.gov/research/ltcix.htm) to view this page of links as well as to sign up for Long-term Care E-Mail Updates from this Agency.

OTHER ITEMS OF INTEREST

Good Nurse, Bad Nurse: Movie Portrayals of Nurses have Changed Over Time, Study Finds

There is Florence Nightingale. Then there is the loathsome Nurse Ratched from "One Flew Over the Cuckoo's Nest." Depictions of nurses on the silver screen have shifted dramatically over the last century, according to a new study. And those portrayals have affected nurses in real life.

Australian researchers watched more than 280 films made over the last 100 years, and reviewed the plots of another 36,000 to learn how nurses have been depicted on the silver screen. Starting at the dawn of the film era, nurses were generally seen as the heroine or love interest, someone who selflessly cares for others, according to the report. During the women's liberation movement in the 1960s, nurses began cropping up in psychological thrillers and as sociopaths, according to the report authors.

Modern films tend to depict nurses as self-confident and powerful-a much better view than had earlier been taken. Still, authors warn that nurses need to be aware of how they're being portrayed in the cinema. With roughly 26% of the 280 some films featuring an overtly sexual characterization of nurses, study author Dr. David Stanley from the Curtin University of Technology in Perth says there are negative implications for the nursing profession.

The full report, titled "Celluloid angels: a research study of nurses in feature films 1900-2007," was published in the October issue of the Journal of Advanced Nursing.

Source: McKnights.com Daily Update