

Nursing Notes



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Tess Kwiatkowski, MS, RN, Editor

HOT TOPICS

Information Regarding DEA Enforcement Actions against Long-Term Care Pharmacies

The Drug Enforcement Administration (DEA) recently stepped up enforcement action against several long-term care pharmacies in Ohio. Pharmacies are being cited for common practices that have evolved in long-term care to meet the needs of patients.

The agents are focusing on several areas of concern including:

- Dispensing CII, III, IV and V drugs based upon a chart order faxed by the facility to the pharmacy. DEA does not consider a chart order to meet the legal requirements of a valid prescription order under 42 CFR 1306.21. DEA also does not recognize the LTC nurse as the agent of the prescriber.
- Dispensing III, IV and V drugs upon the oral orders of the LTC nurse, after the nurse has received the order from the physician. Again, the DEA does not recognize the LTC nurse as the agent of the prescriber.
- Using the exception for emergency orders for non-emergencies, including situations where the need for the drug could have been anticipated by the prescriber/pharmacy but the prescriber/pharmacy failed to obtain timely a new prescription.
- Drugs dispensed from an e-box without a valid prescription.

The American Society of Consultant Pharmacists (ASCP) has been working with Senior Care Pharmacy Alliance (SCPA) and members from Ohio to help develop a multi-pronged strategy to respond to the DEA. First, they developed fact sheets and background materials and immediately scheduled a series of meetings for a delegation from Ohio with key Senators and members of the Congress. They helped engage members of Congress who in turn, have now initiated several contacts with the Agency. Senator Sherrod Brown took ASCP's summary of the issues and sent his own letter to DEA expressing his serious concerns regarding DEA's recent actions.

In addition to the above, they have reached out to American Medical Directors Association (AMDA), American Association of Homes and Services for the Aging (AAHSA), American Health Care Association (AHCA), National Hospice and Palliative Care Organization (NHPCO), and others to educate them on recent DEA actions and to engage them in their response.

On April 7, 2009 the ASCP and the SCPA met with the DEA to seek clarification of the scope of these investigations, to clarify questions regarding the use of chart orders and whether the nurse in the long term care facility can act as the agent of the prescriber and

to obtain assistance in helping educate pharmacists and practitioners about DEA regulations.

Here is a summary of what was discussed:

1. They do not know what triggered any of the current investigations. But DEA did state that they are not targeting long-term care pharmacies.
2. DEA interprets the Controlled Substances Act very narrowly and when violations are found, they will enforce the law
3. Chart orders in long-term care facilities do not constitute valid prescription orders unless they contain all the information that is required under the Controlled Substances Act. As a general rule, chart orders do not contain the required elements.
4. DEA has been considering ASCP's long-standing request to change its interpretation of the law to recognize chart orders and the nurse as agent of the prescriber. DEA does not appear likely to make any changes in policy with respect to Class II controlled substances. However, DEA said they would get back to the ASCP in 90 days regarding Class III-V controlled drugs.
5. They informed the DEA that long-term care pharmacies will comply strictly with the law, but strict compliance entails changing many Standards Operating Plans (SOPs) that have been the standard of practice for 30 years. It also affects the entire long-term care system, including hospitals and the physician community
6. They explained to them the likely consequences of strict compliance:
 - Some residents will not get their medications at all, or not get them in a timely manner; nursing facilities may be out of compliance with federal requirements for pain management.
 - Physicians likely will be very resistant to complying with the changes needed to strictly comply with the law. Physicians who do not wish to comply may decide not to work in the LTC environment -- this may exacerbate the existing shortage of qualified physicians working in the LTC environment.
 - Nursing facilities and will need to retrain staff.
 - Pharmacies and nursing facilities will have to revise SOPs.
 - They asked the DEA to send a Dear Registrant letter to help inform physicians and other health care providers about the need for strict compliance. DEA agreed this would be helpful and will consider our request.

ASCP and the entire LTC pharmacy community has worked for years to change DEA's interpretation of law to accommodate long-term care pharmacy practice. ASCP will continue to advocate for policy changes, and will work to seek changes in law and regulation at both the federal and state levels to reflect the needs of LTC pharmacies and the residents served by them.

The ASCP will continue monitoring this situation closely. Suffice it to say, until they are able to change the Controlled Substances Act, DEA's regulations, and the Agency's policy interpretations, every long-term care pharmacy, long-term care facility, and prescriber must comply with existing law and regulations.

It was agreed by all parties to schedule another meeting in 90 days to discuss the decision on the handling of CIII-Vs. In the meantime, the ASCP urges its members to review their pharmacy procedures to ensure compliance with the law. **LSN urges its members to check with your pharmacy provider to get more details.**

Source: American Society of Consultant Pharmacists

CMS Releases New MDS 3.0 Draft

An updated version of the [MDS 3.0 Draft Item Set](http://blogs.hcpro.com/mdscentral/wp-content/uploads/2009/05/mds30draftitemset.pdf) (<http://blogs.hcpro.com/mdscentral/wp-content/uploads/2009/05/mds30draftitemset.pdf>) appeared on CMS' Web site Thursday, May 7. CMS has noted that the MDS 3.0 is a draft version of the data set and it should not be used for any training purposes at this point. Although items may be added, revised, or dropped before the final MDS 3.0 is released, the updated MDS 3.0 draft gives providers a good indication of what the final version will include.

CMS has noted that the MDS 3.0 is a draft version of the data set and it should not be used for any training purposes at this point. According to the recently released [timeline](http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS302010ImplementationTimeline.pdf), (<http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS302010ImplementationTimeline.pdf>) CMS will issue a final publication of MDS 3.0 in October 2009 with the goal of making it fully operational and begin reporting in October 2010.

The initial analysis of the new draft revealed significant changes from the previous draft and the MDS 2.0. Some key changes featured in the updated MDS 3.0 draft include:

- The MDS 2.0 two-column coding format for ADL self-performance and support provided, which was omitted from the previous draft, is included in the updated version
- Changes to section T. The updated MDS 3.0 draft revises the manner in which therapy services are reported. The updated MDS 3.0 draft requires the start and end dates of therapy to be recorded. This allows an Other Medicare Required Assessment (OMRA) to be completed closer to the start or end date of therapy services, adjusting the resource utilization group category so the payment rate is more accurate.
- The requirement that the Brief Interview for Mental Status, Resident Mood Interview (PHQ-9), Interview for Daily Preference, Interview for Activity Preference, and Pain Assessment Interview be conducted the day before, day of, or day after the assessment reference date is omitted from the updated MDS 3.0 draft.
- The look back period for active diseases was reduced from 30 days to 7 days.
- The updated MDS 3.0 draft clearly states the reverse staging of pressure ulcers should not be used.
- Section N, Medication, of the updated MDS 3.0 draft includes a section for insulin.
- The revision to the look-back period under RUG-IV, which will exclude certain preadmission services from RUG calculation, necessitates changes to the way these services are reported on the MDS. Section O of the updated MDS 3.0 draft includes a two-column format indicating which special treatments and procedures provided in the 14-day look-back period were administered "while not a resident" and "while a resident." The services provided "while a resident" will be used in RUG calculation and care planning, while the services provided "while not a resident" will only be used in care planning.
- The updated MDS 3.0 draft includes a section for the Care Area Trigger (CAT) Summary (Section V). CATs will replace Resident Assessment Protocols (RAP) as the new tools for organizing MDS information about a resident's health problems and functional status.

Source: CLTC Weekly & HCPro MDS 3.0 Update

Stakeholders will have a chance to provide comments on the MDS 3.0 through the recently released Skilled Nursing Facility (SNF) Prospective Payment System (PPS) [proposed rule](http://edocket.access.gpo.gov/2009/pdf/E9-10461.pdf). (<http://edocket.access.gpo.gov/2009/pdf/E9-10461.pdf>) All comments are due on June 30, 2009. Any additional questions regarding MDS 3.0 should be directed to MDS30Comments@cms.hhs.gov. Look for updates from LSN on MDS 3.0 in future issues of Weeks News. For more general information on the MDS 3.0 [click here](http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp): (http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp)

MDS 3.0 a Focus of the Open Door Forum

CMS officials reviewed the changes included in the latest MDS 3.0 Draft Item Set and addressed callers' concerns about the new assessment tool during the SNF Open Door Forum on May 28. Two areas of focus were the new Care Area Triggers (CAT) and ensuring the MDS 3.0 will work efficiently with Resource Utilization Group, Version Three (RUG-III).

Karen Schoeneman, of CMS' division of nursing homes, clarified the differences between the Resident Assessment Protocols (RAP) on the MDS 2.0 and the CATs on the MDS 3.0. The CAT process will be basically the same as the RAP process, but instead of using a set framework for the additional assessment (a RAP), facilities will be able to choose the clinical process guideline they wish to use (a CAT).

According to Schoeneman, RAPs are not comprehensive and do not cover every condition or issue a resident may have. "The Internet contains countless resources related to clinical practice guidelines for any particular issue that might be triggered by the MDS assessment process," Schoeneman said. "CMS decided that it was time to let the providers be free to choose and use the clinical practice guideline or authoritative source material they wish to complete that in-depth assessment process."

The updated *RAI User's Manual* will include a list of government Web sites with free clinical practice guidelines that have been researched and are authoritative, which providers can use. Providers will still have the option of using CMS' clinical practice guidelines, as the updated manual will also include RAP outlines as they are in their current state.

Since states are not required to implement RUG-IV for their Medicaid processing, CMS has been working to ensure that the MDS 3.0 data will work with RUG-III without changing the distribution of patients who classify into the different categories. "So far, we have crosswalked items from the MDS 3.0 to the RUG-III system and have been able to work that there is no impact overall to how patients categorize," said CMS official Ellen Berry. Information about this analysis is expected to be posted on the MDS 3.0 page of CMS' Web site within the next two weeks.

CMS official Thomas E. Dudley, MS, RN, confirmed that MDS 3.0 implementation efforts remain on track and said that CMS does not anticipate any major changes between this draft and final version to be released in October.

Source: HCPro MDS 3.0 Update

Long-Term Care could Emerge as an Important Player in HIT

Author: Emily Beaver

Few nursing homes are using electronic health records that allow them to share information with other healthcare providers—a standard known in the technology world as "interoperability." But more nursing homes could begin using more interoperable EHRs soon, thanks to incentives provided by the American Recovery and Reinvestment Act (ARRA) and a push to certify long-term care health IT products.

The Certification Commission for Healthcare Information Technology (CCHIT) announced recently that it aims to begin certifying long-term care Health IT products by July 2010.

CCHIT has created a volunteer task force full of industry players representing skilled nursing facilities, assisted living, home care, and hospice services, according to the CCHIT. The task force will advise a CCHIT work group creating the Long Term Care Spectrum certification.

Although certification is voluntary, the marketplace is starting to request it, said John Morrissey, communications director for CCHIT. A certification would ensure buyers that certified long-term care HIT products would work seamlessly with other certified HIT products, said Majd Alwan, PhD, director for the Center for Aging Services and Technologies (CAST).

The ARRA is putting a lot of emphasis on standards-based interoperable health IT to guarantee every American has a health record that is portable or can allow the exchange of information, Alwan said. The certification is an indication that the investment in this product is somewhat protected and the system will not become obsolete because it is not compliant with national standards for interoperability, he said.

Achieving interoperability in HIT products is especially important in long-term care because the sector serves seniors who often have multiple chronic conditions and multiple care providers, such as physicians and pharmacists, Alwan said. The population also tends to move across the several care settings. For example, if a senior who falls suffers from a broken hip, he or she may move from a hospital to a skilled nursing facility for rehab before transitioning to an assisted living facility within in relatively short period of time, Alwan said.

Also, sharing electronic records may be useful because seniors in long-term care facilities may have a primary care physicians or geriatricians who work outside of their facilities. "The benefits of interoperable HIT across settings would be maximized in this segment," Alwan said.

The long-term care industry has adopted electronic records at a rate that is comparable, if not higher, than acute care and private physician practices, he said. However, many nursing homes are not using fully integrated or interoperable electronic records, he said. "This implies the long-term care sector is not only ready for this, but stands in a position where it could leap-frog other sectors" in adopting electronic records, Alwan said.

Source: Health Leaders Media

STRATEGIES FOR QUALITY & SAFETY IMPROVEMENT

Evidence-Based Guidelines to Monitor Patients Post Falls

As a general rule, a physician should examine any indication of injury as soon as possible, and a physician should immediately evaluate any head trauma. Other injuries, such as suspected or obvious fractures also require rapid treatment, as do symptoms of cardiac or neurological crisis.

Nurses must be especially alert to possible injuries for several days after a fall. Delayed discovery of a hip or other fracture is a common occurrence. Slow internal bleeding into the brain from trauma to the head may not cause symptoms for days, and the outcome of such slow bleeds can be fatal.

Watch for the following indications that anything is different about the patient:

- Altered gait or limp
- Unusual hesitation or slowness when moving
- Verbal complaints of pain
- Nonverbal indications of pain, such as facial grimaces
- Loss of appetite
- Serious bruising of any part of the body
- Redness or warmth to any part of the body
- Favoring of an appendage, such as not using an arm or hand
- Unusual sleepiness or lethargy
- Changes in behavior or cognition

Nurses should never assume a patient's complaint of pain or signs of injury are simply the minor effects of taking a tumble and don't indicate anything serious. Just because a physician evaluates someone and declares him or her uninjured does not rule out an undetected insult to some part of the body with symptoms that may surface later.

A patient's plan of care following a fall should include additional checks or monitoring of the patient's status for several days. The frequency of those checks depends on the individual patient and the circumstances, but in many cases, twice a shift for three or four days is sufficient.

Source: Carole Eldridge, DNP, RN, NEA-BC, dean, campus director and associate professor at St. John's College of Nursing and Health Sciences at Southwest Baptist University via Nurse Manager Weekly

Exercise Is Safe Bet to Prevent Falls in Older People

Exercise programs that lend strength, flexibility and balance might be one of the best ways to prevent falls among people age 65 and older, according to a Cochrane review of more than 100 studies. A variety of other measures from pacemakers to vitamin D supplements might be useful in preventing certain individuals from falling, but exercise appears to be the most widely effective strategy for reducing both the risk of falling and the overall number of falls among older people.

"It may not be possible to prevent falls completely, but people who tend to fall frequently may be enabled to fall less often," said Lesley Gillespie, an orthopedic trauma specialist at the University of Otago in New Zealand and lead author of the review. The review appears in the latest issue of *The Cochrane Library*, a publication of The Cochrane Collaboration, an international organization that evaluates medical research. Systematic reviews like this one draw evidence-based conclusions about medical practice after considering both the content and quality of existing medical trials on a topic.

Each year, about 30 percent of people over age 65 who live outside of assisted care facilities experience a fall. Poor balance, diminished eyesight, the side effects of medications and dementia are among the reasons older people sometimes fall. One in five of these falls could require medical attention, but even without causing serious injury, falling can make individuals fearful of leaving their homes or participating in activities, the Cochrane researchers noted.

"Falling puts a strain on the family and is an independent predictor of admission to a nursing home," Gillespie said. Gillespie and colleagues examined 111 studies of falling prevention measures, which included more than 55,000 people from 15 countries. The studies suggest that group exercise programs, Tai Chi and home exercise programs all reduce the risk of falls and the rate of falling.

"Effective exercise programs for reducing falls focus on balance, strength and flexibility, and challenge the older adults to improve in all of these components," said Bonita Lynn Beattie, a physical therapist and vice president for injury prevention at the Center for Healthy Aging. She suggested that older adults should check in with their primary doctor before beginning an exercise program, especially if they "have significant weakness, balance issues or dizziness."

Other preventive measures might only be effective for small, targeted groups. For instance, "taking vitamin D supplements probably does not reduce falls, except in people who have a low level of vitamin D in the blood," Gillespie said. Similarly, cataract surgery and insertion of a pacemaker can help specific groups of people with poor eyesight or certain blood pressure conditions fall less often.

Anti-slip devices worn on shoes during icy conditions and reviewing medications regularly are also effective in reducing falls. In some cases, gradually reducing the dosage of sleep aids and depression medicines can reduce the number of falls experienced by an individual, the researchers found. Behavioral changes can also make a difference, Beattie said. "An older adult should probably reconsider climbing on a ladder to clean gutters or using a chair to change a light bulb or reach high shelves," she said.

Gillespie said that the findings "may not be applicable to older people with dementia," since most of the studies in the review "specifically excluded them from participation."

The Cochrane Collaboration is an international nonprofit, independent organization that produces and disseminates systematic reviews of health care interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions.

Source: Health Behavior News Service

Ensure Hand Hygiene Compliance

On April 14, The Joint Commission released a free monograph (http://www.jointcommission.org/PatientSafety/InfectionControl/hh_monograph.htm) intended to help healthcare organizations target their efforts in measuring hand hygiene performance. The monograph is designed to address "everything you ever wanted to know about hand hygiene measurement but were afraid to ask". The aim of the monograph is to broaden understanding of the issues and provide practical solutions for strengthening measurements and improvement activities.

"Measuring Hand Hygiene Adherence: Overcoming the Challenges"

(http://www.jointcommission.org/NR/rdonlyres/68B9CB2F-789F-49DB-9E3F-2FB387666BCC/0/hh_monograph.pdf) is also designed to help healthcare workers understand the importance of hand hygiene and provide ways for hospitals (and other healthcare organizations) to measure and improve compliance among frontline staff members.

This tool is a product of two-years of collaboration among major infection prevention organizations such as APIC, the CDC, the Institute for Healthcare Improvement (IHI), the National Foundation for Infectious Diseases (NFID), the Society for Healthcare Epidemiology of America (SHEA), and the World Health Organization (WHO).

The Perils and Pitfalls of Nursing Documentation

By Judi Kulus, NHA, RN, MAT, RAC-MT, AANAC Master Trainer

Imagine that it is the year 2013 and you have just been promoted to your dream job at the top-rated care center in town, making more than you ever imagined possible. Life is good! As soon as you settle into your office, you receive a phone call. The call isn't congratulating you on your promotion, but a call to inform you that you have been named as a defendant in a law suit against the care center you were working for in 2009 – four years ago. Instead of celebrating your promotion, you are being asked to remember what you did (or did not do), on Friday, May 8, between 2:00 and 10:00 p.m. The only information that you have to rely on is the documentation on the resident that you completed that consisted of three general sentences. What do you do?

In today's litigious environment the lawsuit will likely take 11 years of your life, countless hours, untold stress and sleepless nights, and personal costs in time and money. According to national trending reports, nursing home litigation is now widely recognized as one of the fastest-growing areas of health care litigation. This means that charting the care you provide to your residents is critical to showing the high quality care you provide. But this is easier said than done, isn't it?

If I could boil down the job of charting to a few key thoughts, it would look like this:

- **Charting effectively *IS* resident care.** Don't separate the two in your mind.
- **Hurried charting is poor charting.** Slow down and reduce your risk.
- **Avoid being sued for negligence by implementing the three *W's*.** What happened, what did you do about it, and what was the resident's response.
- **Resist practicing beyond the "scope of practice" permitted by law for your credentials.** Know your state law! LPNs don't do or chart RN duties. RN's don't do or chart MD duties.
- **Time charting to as close to the events as possible.** Don't wait until the end of your shift. Chart as you go!

Henry Ford once said, "Thinking is hard work, that's why so few do it." In nursing practice, it's easy to rush, be careless, make illogical and unreasonable assumptions, and to just simply not chart the care we provide. Take a moment to reflect on the nursing discipline of "critical thinking."

Picture the entire body of nursing process that includes the standards of clinical practice, regulations, ethics, and reimbursement is covered with the umbrella of "critical thinking." GateWay Community College's nursing educator, Margi J. Schulz, RN, MSN, describes critical thinking as, "The art of thinking about your thinking while you are thinking in order to make your thinking better: clearer, more accurate, or more defensible."

Whether you've been a nurse for six months or 26 years, your charting skills can be honed in and improved upon. Take time to improve your critical thinking skills and enhance your ability to put that thinking into the medical record!

Source: Pathway Perspectives Newsletter

SYSTEM DESIGN & ORGANIZATIONAL CHANGE

Strange Bedfellows: The Improbable Romance of Accounting and Nursing

Authors: Jill Smoller RN, Administrator, Glen Cove Center for Nursing and Rehabilitation and Anthony Morrone CPA, Partner, Horan, Martello, Morrone, PC

It is odd to think that a profession born from the power of compassion and concern could join hands with an occupation filled with number crunching and the bottom line. But, like many love stories, there is often no explanation for the chemistry.

There are few nursing homes that really understand and reap the rewards that a thoughtful accounting firm can have on a nursing facility. Many nursing homes use such firms on a monthly basis to close the books and create the spreadsheets that identify operating and other costs. Clearly, this is an important function of an accounting firm. But, it is only the beginning. An accounting firm that has already taken the time to understand the day-to-day workings of a nursing home can then offer guidance and analysis in the many other facility operations that take place on a daily basis. We are not suggesting that accountants can or should run nursing homes, but it is prudent for all nursing facility administrators and department heads to understand the monetary impact of their decisions and to be able to discuss creative, cost-effective alternatives for achieving positive outcomes. Making use of an accounting firm's overall financial acumen is a simple way to accomplish this. Look for an accounting firm that has some background in healthcare and lots of experience with operational reviews. The Internet is a great resource to find these types of accountants, or consult your state association for a referral to a firm that specializes in operational studies.

There are skeptics who insist that increasing the profitability of a nursing home inevitably reduces the quality of care given to the residents. This does not have to be the case. In fact, there are nursing homes that provide exceptional care to residents and still remain extremely profitable facilities.

Building a Partnership

So, what is the secret? It is all about creating a bond between care and cost; it is making sure every decision-making team member thinks about the bigger picture; it is knowing what decisions will lead to which outcomes; it is about sharing financial knowledge and responsibility. Facilities can earn more money, not by sacrificing care, but by slashing inefficiencies. This practice may seem obvious, but many facilities still operate without careful consideration of the financial implications of their procedures. For instance, in an informal meeting with the director of nursing and director of admissions, an involved accountant will discuss the admissions process and how the facility should consider cost and staffing concerns when making admission decisions.

Facilities that can approximate the additional costs related to tracheostomy care, extensive wound care, and numerous other factors will be better prepared to make informed decisions regarding admissions. Sometimes, in a hurried attempt to fill beds, the admissions or nursing departments spend little, if any, time determining if the admission would actually be beneficial for the facility. Some patients with excessive drug costs are discharged from hospitals to nursing homes without so much as a second thought. But such indifference is unwise for a facility that wants to avoid spreading its resources too thinly to adequately address patient needs. There is no handy chart that will easily make sense of the options, yet certain considerations should be addressed when deciding whether to admit a patient. In cases like these, facilities would benefit from the advice of an accountant, an invaluable resource for understanding such dilemmas.

Likewise, facilities that take the time to determine which potential admissions may require increased assistance with care (professional or nonprofessional) are facilities that can consistently offer great care without compromising attention to residents. For example, if an admissions coordinator working with the director of nursing accepted one resident who requires two- and three-person assists with all ADLs, the certified nursing assistants (CNAs) on a unit would likely be able to accommodate them. If, however, six residents required such labor-intensive care, the increased demand on the CNAs would likely compromise the quality of

medical attention. The nursing home's decision to admit a resident is an important one that must be made repeatedly throughout the day. Nursing home employees involved in the admission process must balance the amount of care required and available with the costs associated with each case. It is an astute accounting firm that can assist the facility in creating an individualized game plan for making sense of these important decisions. When these details are thought out in advance, the bottom line improves for both the owner and the residents.

Staffing

Finding the ideal admission mix, however, is not the only strategy for financially savvy nursing facilities. Facilities should scrutinize their personnel practices as well. There are staffing issues everywhere. In almost every nursing home, if you ask most workers, they will tell you that they could use more help. So what is the magic number for nurses and nursing assistants on any given nursing unit? With the help of a knowledgeable accountant, a simple formula based on the actual needs of residents (for direct care) and nursing care (professional) is just a meeting or two away. Residents who wander or who have behavioral problems take additional time for nursing assistants but probably require no additional assistance from nurses. Therefore, units designated for residents with behavioral issues may need additional CNA assistance but might do fine with less licensed staff. Residents who are medically complex may require additional nursing time but perhaps not as much CNA help. Rather than staffing all 40 bed units with the same canned staffing pattern, a wise accountant can discuss the combinations and permutations of staffing alternatives that result in better care for the residents and a more cost-efficient arrangement for the facility.

Another important aspect of daily operations that is frequently overlooked or inadequately addressed by administration is the use of overtime. In the nursing home industry, 75% of cost is labor intensive. The percentage of overtime in any given facility, if kept unchecked, is enormous. Using an accounting firm's expertise and familiarity with census and staffing, the director of nursing and the scheduling coordinator can learn to relate occupancy to the staffing pattern. For instance, when a unit is functioning at full capacity, an agreed-upon staffing quota would apply. But when a 40-bed unit, which usually functions with five nursing assistants, is now only 50% occupied, there would be a conscious shift of staff from that unit. It is true that any facility should be committed to providing full-time employment for full-time employees, as per union contracts. But the work time for part-time employees can be adjusted depending on demand. A very basic part of reducing costs during decreased occupancy would be not to replace sick calls. If these basic concepts are not a part of routine staffing decisions, the facility loses opportunities to reduce its costs and loses opportunities to increase the bottom line.

What is most difficult for an accountant, an administrator, or a director of nursing, is trying to alter a staffing pattern that has existed for years. Just because a 40-bed nursing unit has functioned adequately with two nurses and five or six CNAs for years doesn't necessarily mean that this is the ideal arrangement. An analysis of the acuity of the patient population can determine more realistically what the unit may need. If staff reduction is a consideration, the staff members should be participants in that conversation. With an accountant at the helm, the CNAs can discuss whether their services may be of better use elsewhere in the building. The inclusion of staff in decisions that directly affect them is an enormously powerful tool for reaching mutually agreeable decisions. An accountant's explanation and ongoing dialogue with healthcare workers is an ideal way to effect positive change within a facility. Workers and residents alike will reap the benefits of a more sensible staffing system and the profits that come with it.

Optimizing Reimbursement

Yet another powerful role that knowledgeable accounting firms can play is to strategically embrace the entire concept of RUGs III with the rehabilitation director and MDS coordinator.

Facilities that have not been guided regarding optimizing reimbursement or have not had the chance to become savvy with the MDS tool invariably give away thousands of dollars because of dates entered a day late or a day too soon. With a nursing department that is aware of increased reimbursement for IV therapy (and other such things) prior to admission, and a rehab department that is aware that placing residents on therapy at the time of admission (and not a day or two later), the resident places into a higher category—which translates into significant revenue for a facility. Administrators should not assume that their rehab department or their nursing departments are aware of all the intricacies of the ominous MDS. A roundtable discussion, replete with informed accountants, pertinent facility staff, and donuts, should take place at least quarterly. The purpose of the meeting would be to familiarize and reacquaint key personnel with tactics and strategies that can be used to legitimately bolster the revenue via RUGs-III methodology. This is not a matter of gaming or manipulating the system, but rather it is about being smart enough to capture, document, and be correctly reimbursed for care that is actually provided.

Conclusion

Healthcare professionals of all levels can participate in a facility's efforts to increase efficiency as a means of improving care. Workers who are aware of operating costs are also aware of how much they improve a facility's performance when they work according to well-conceived plans informed by the wisdom of both nursing and accounting. From CNAs to staffing coordinators, admissions officers, and administrators, thinking about how a facility's resources work together to support the residents and the workers ensures that working will be sensible and according to a plan that benefits everyone instead of running a disordered, random, and costly operation. Insight from an accountant will actually improve the nursing and care aspects of a facility, not only the financial element. Because accountants are financially oriented, it is only through their collaborations with clinical people (e.g., nurses, dietitians, and others) that bring their efforts into focus. Accountants, in spite of their backgrounds in the impersonal world of numbers, actually bring a great romance into the compassionate field of nursing, proving that there can be a great and long-lived affair between the business of nursing and the nursing business.

Source: Long-Term Living Magazine

Quality of Life Survey Highlights Need for Holistic Approach in Elderly Residential Care

Choice, privacy and a sense of identity are just some of the things that older people living in residential care need to maintain a good quality of life, according to research in the May issue of the *Journal of Advanced Nursing*.

Researchers from the National University of Ireland (NUI), Galway, spoke to 101 older people living in 12 long-stay care homes, including small and large facilities, well-established and recently built homes and those provided by the public, private and voluntary sectors. They found that four key themes had an impact on the subjects' quality of life: the ethos of care provided by the home, the residents' sense of self and identity, how connected they felt and the activities and therapies they got involved in.

"It was clear from our research that practitioners and policy makers need to take all these factors into account if they are to provide older people with the sort of residential care that enhances their quality of life" says lead author Dr Adeline Cooney, from the School of Nursing and Midwifery at the University. "We also found that residents tended to be happier if they had been involved in the decision to move into residential care, as they were more likely to make the best of it, getting involved in activities and making friends. People who were not involved in the decision tended to withdraw into themselves and were more likely to be lonely, unhappy and keen to return home."

Two-thirds of the residents who took part in the study were male. All were 65 or over and the majority of residents (45 per cent) fell into the 75-84 age group and had been in residential care for two to four years (37 per cent). Key findings included:

- Participants said choice was important when it came to their daily routine. "I can go to bed anytime I like" one said positively, while another complained that "you're woken at six and breakfast isn't until ten past eight."
- People valued the opportunity to make their surroundings more familiar. "This is my own furniture" said one, while another complained she was unable to have her computer with her because "there is no space".
- Privacy was also important and even people who had their own rooms said staff tended to barge in without knocking. Others felt it even more acutely. "There's nowhere to get away on your own" said a resident in a shared room.
- Residents liked it when they felt valued by staff and their expertise or skills were drawn on. Some facilities formally involved residents in collective decision making, but not all. One resident spoke about how she loved gardening and had joined the committee to set one up at her residential home.
- Feeling connected to family, the community and the outside world was also important. "If I couldn't keep in contact with the outside world where would I be?" said one participant, while another said of fellow residents "it's not like your family, but you make them your family."
- Residents who were not provided with regular and varied activities often felt frustrated and disengaged. One resident said it was "just the same thing, the same day in and day out...it's boring".
- Residents valued the chance to get out and keep in touch. This could be a simple shopping trip, a visit to family or an event such as a day trip or barbecue. But lack of independence and mobility often restricted how often they were able to go out.
- Previous life experiences also shaped how well people settled in. For example, one resident didn't want to make friends because the other residents were from a "poorer class" and regarded her as too "swanky" for them.
- Health status also had an important effect on quality of life and some residents said their health had deteriorated since they moved in. Important therapies were not always available. "The physiotherapy I was getting just stopped" said one participant.
- Other factors that affected quality of life included the physical condition and homeliness of the facility, the friendliness of the staff, the openness of the visiting policy and strong links with the local community.

"This study highlights the importance of providing a holistic, person-centred approach that goes beyond satisfying the technical and procedural aspects of care" concludes Dr Cooney. "Care staff should regard the quality of life of residents as an integral part of their role and residents and their families should have significant input into how services are structured and delivered. "Although this study was carried out in Ireland, the basic principles of how the quality of life of older people in residential care can be enhanced are universal."

The study, which was funded by the National Council for Ageing and Older People, was led by Professor Kathy Murphy from the School of Nursing and Midwifery and Professor Eamon O'Shea from the Irish Centre for Social Gerontology, both at NUI Galway.

*Source: Resident perspectives of the determinants of quality of life in residential care in Ireland. Cooney et al. **Journal of Advanced Nursing**. 65.5, 1029-1038. (May 2009).*

CLINICAL CORNER

Review: Do Feeding Tubes Help or Harm in Advanced Dementia?

Family members grappling with the decision to allow a feeding tube for a relative with advanced dementia will find little comfort from a new review of evidence. Poor food intake is common in individuals with dementia for a variety of reasons. In advanced dementia, health care providers might intervene by feeding patients artificially, usually by inserting a feeding tube through the stomach. This decision is emotional, controversial and influenced by complex ethical issues.

But do feeding tubes actually help people with degenerative dementia? In a new Cochrane review from London, doctors searched for evidence that this intervention was beneficial. "We found that there is no research evidence that tube feeding prolongs survival or improves the quality of life for people with advanced dementia," said lead author Elizabeth Sampson, M.D. "In fact, some studies suggest that tube feeding may have an effect opposite to the desired and actually increase mortality, morbidity and reduce quality of life."

The review appears in the current issue of *The Cochrane Library*, a publication of The Cochrane Collaboration, an international organization that evaluates research in all aspects of health care. Systematic reviews draw evidence-based conclusions about medical practice after considering both the content and quality of existing trials on a topic.

At first glance, it appears counterintuitive that individuals fail to benefit from tube feeding, but the way that the body utilizes food is complex, Sampson said. With some forms of dementia, the body might be unable to metabolize food properly.

Especially worrisome for families is the pain typically associated with prolonged hunger and thirst. "In a study with patients terminally ill with advanced cancer and unable to eat, however, few experienced painful feelings of hunger and thirst," Sampson said. "If they did, this pain was alleviated by simple measures, such as pain relief or small sips of water. Compassionate nursing and medical care similar to that which underlies the philosophy of the hospice movement can alleviate a great deal of suffering and should be available to people with dementia, too." Sampson and colleagues are at the Marie Curie Palliative Care Research Unit, Royal Free and University College Medical School.

This research encompassed a review of 452 studies in seven health care databases, five from the United States. Overall, the studies included 1821 people, 409 of whom received some form of tube feeding and 1467 who did not. The researchers found no randomized controlled studies, considered the gold standard of studies.

"Just because we found insufficient evidence of benefit does not mean that for some individuals with advanced dementia, tube feeding is the wrong decision," Sampson said. "Each case needs to be considered individually. We would hope that family members will feel better informed about the pros and cons of tube feeding in persons with advanced dementia because of this paper."

Artificially feeding individuals with dementia is a relatively new phenomenon that evolved after development of the percutaneous endoscopic gastrostomy tube, or feeding PEG, in the early 1980s, said Stephen Post, Ph.D., a professor of preventive medicine at Stony Brook University. Their intent was to nourish seriously ill children until they got well, but by 1985, PEGs became widely used as a cost-saving measure in nursing homes, which lacked sufficient staff to do assisted oral feedings.

"As Dr. Sampson found, there is no evidence that the feeding tube benefits patients with advanced dementia," Post said. "Indeed, as she details in this paper, there are all sorts of considerations for not using feeding PEGs. The most serious reason, perhaps, is physical restraint, which is terrible. One study shows, in fact, that 71 percent of persons with advanced dementia, who receive feeding tubes, are physically restrained." It is important to realize, he adds, that the gastrointestinal system of patients close to death often shuts down and a feeding tube can cause considerable suffering.

The choice is not either a feeding PEG or nothing, said Post, who is also president of the Institute for Research on Unlimited Love, and the author of a book on moral issues in Alzheimer's disease. He said there is a third option that people have been using since the beginning of time: assisted oral feeding. "My grandmother had Alzheimer's disease in the 1970s and I regularly helped feed her soft foods like applesauce and gave her something to drink."

Post said the most important thing a loved one can do is to routinely stop by the nursing home on the way to or from work, and spend a half an hour doing assisted oral feeding. There is also an emotional connectedness that goes on, he believes, and countless benefits of giving for the giver. "The most humane thing is assisted oral feeding," he said. "There is almost a sacred quality to it in my mind."

The Cochrane Collaboration is an international nonprofit, independent organization that produces and disseminates systematic reviews of health care interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions.

Sampson EI, Candy B, Jones L. Enteral tube feeding for older patients with advanced dementia. Cochrane Database of Systematic Reviews 2009, Issue 2.

Source: Health Behavior News Service

Pain in the Cognitively Impaired Elderly: Guidance for Clinicians

Mara Ferris, MS, RN, GCNS-BC, CPHQ, FASCP, President, Association for Gerontologic Education, Exeter, New Hampshire

For many years, healthcare professionals have been taught that "pain is what the patient says it is." A pain assessment should always begin by eliciting the patient's self-report of comfort or pain. Cognitive or functional deficits can impede self-reporting, making pain assessment much more difficult. Older patients are certainly not unique in receiving inadequate pain assessments and pain management, but they are among the most vulnerable. The elderly are more likely to experience pain and have difficulty communicating their level of pain to caregivers.

How should pain be assessed in confused, cognitively impaired, or nonverbal elders? The American Society for Pain Management Nursing (ASPMN) has published practice guidelines to assess pain in the nonverbal patient with advanced dementia. The first step is the same as that used for most other patients -- ask.

Step 1: Ask the Patient About Pain

Obtaining the older patient's self-report of pain is essential, even if cognitive or functional deficits are present. Numerous studies have demonstrated that despite the presence of significant cognitive impairment, many patients can reliably report their pain if asked directly. Whether or not the patient is cognitively or functionally impaired, simple strategies can obtain detailed and accurate information:

- When asking about pain, use words like "hurt," "ache," and "feel OK." If the patient uses specific words to describe discomfort, document and use these words to reassess pain and comfort level.
- Establish the patient's primary diagnosis and medical history. Ask hip fracture patients about the affected hip and leg, but don't stop there. Touch or point to the body part of concern while asking about pain to focus attention and clarify where any pain is located.
- Elderly patients, like all patients, have a fundamental right to have their pain assessed. A pain assessment tool that has been validated by research is appropriate for this purpose. Commonly used tools include the Numeric Rating Scale and the Visual Analog Scale. These can be used both with patients who are cognitively intact and for some patients who are impaired.

Although these tools have not been validated for use with elders with dementia, it is worth trying to use a pain assessment tool because only the patient can rate his or her level of pain. Several tools to assess pain in patients who are unable to reliably report their pain have been developed and validated, but each tool has limitations and none of these tools rates pain severity.

Step 2: Search for Potential Causes of Pain

- Consider chronic conditions, especially musculoskeletal disorders and neuropathies.
- When a patient has limited mobility, consider the need for repositioning.
- Look for sources of discomfort in addition to pain -- for example, new skin irritation, constipation, recent falls, environmental conditions (too cold, too warm, too much glare, too noisy).

Step 3: Observe Behaviors

- In the absence of self-report, observation of behavior is a valid approach to assess pain. However, behaviors do not always accurately reflect pain intensity, and in some cases, the observed behavior indicates another source of distress.
- Behaviors that are likely to be signs of pain include guarding a body part, reluctance to move or be moved, decreased mobility, and crying out or wincing when touched, with movement, or during procedures.
- Nonspecific distress behaviors that may or may not be caused by pain include restlessness, vocalizations, irritability, and decreased appetite. In a setting where longer contact fosters familiarity, the clinician may be better able to identify a patient's unique pain behaviors.
- Snow and colleagues suggest the mnemonic "BODIES" to improve the assessment of pain and pain management in demented and nonverbal elders (Table 2).

Step 4: Seek Surrogate Reports of Pain

- In the absence of a patient's self-report of pain or comfort, family, friends, and other caregivers can function as surrogates to assist in identifying a patient's pain. Family members are often able to describe lifelong or recent patterns associated with pain such as changes in effect, mood, appetite, or activity.
- Clinicians should be aware that surrogates' perceptions of patients' pain are not consistently reliable. Numerous studies have found discrepancies between reports of pain by patients and family members and other surrogates (whether lay or professional). Using surrogates should not be the sole strategy used to assess a patient's pain, but their familiarity with the patient can contribute to better pain assessment.

Step 5: Do an Empiric Analgesic Trial

- If pain has been identified or is suspected because of diagnoses, behaviors, or surrogate reports, an empiric trial of analgesics is warranted.
- For pain that is thought to be mild to moderate, a trial of around-the-clock acetaminophen might be successful. If pain behaviors subside, pain can be confirmed and analgesia should be continued.
- If the patient is already receiving analgesia, evaluate the drug choice, dose, and frequency and make appropriate changes to include more effective agents that will provide more consistent pain relief.
- In a study of demented patients, scheduled administration of acetaminophen significantly reduced disruptive behaviors. Titrate analgesia upwards slowly by drug choice, dose, or schedule until relief is achieved.

Pain Assessment Tools

Assessing pain in confused patients is difficult but not impossible. There are several pain assessment tools in the literature that were developed specifically for patients with cognitive and/or functional deficits. Each has strengths and limitations. The American Geriatrics Society has published a guideline for the assessment of chronic pain in older adults but does not endorse any single assessment tool. Similarly, in its guideline, the ASPMN does not identify a preferred assessment tool for this special population. The ASPMN strategies described above are effective but not perfect. It can be difficult to assess pain in patients who cannot verbalize their pain, but we must make every effort to do so, because the elderly, like all patients, have a right to relief of their pain.

Source: Topics in Advanced Practice Nursing eJournal

AGS Guidelines Advise Seniors to Avoid NSAIDs and COX-2 Inhibitors

By Megan Rauscher

Revised practice guidelines on the management of persistent pain in the elderly issued by the American Geriatrics Society (AGS) advise physicians to have their patients avoid non-steroidal anti-inflammatory drugs (NSAIDs) and COX-2 inhibitors and consider the use of low-dose opioid therapy instead.

"For a lot of elderly patients with multiple medical problems and who are at high risk for complications from NSAIDs, they may be better off in the long run taking low-dose opioids," Dr. Bruce Ferrell, chair of the AGS Panel on Pharmacological Management of Persistent Pain in Older Persons, noted in a telephone interview with Reuters Health.

The updated guidelines, which were presented at the AGS's annual meeting in Chicago, focus primarily on patients with chronic pain who are 75 years of age or older; this group tends to be frail and have multiple chronic illnesses that cause persistent pain, Dr. Ferrell explained. The panel concluded that the risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, usually outweigh the benefits and the revised guidelines reflect this, he added.

In addition, "NSAIDs have a lot of drug-disease interactions," Dr. Ferrell noted. For example, "with hypertension and congestive heart failure and for patients who have a little bit of renal insufficiency, NSAIDs are a little bit dangerous in these groups."

Based on the most recent clinical trial data, as well as clinical observations, the panel recommends that NSAIDs and COX-2 inhibitors be considered rarely, and with extreme caution, in highly selected individuals, a statement from AGS notes. Instead, all patients with moderate to severe pain or diminished quality of life due to pain should be considered for opioid therapy, which may be safer in the long-term.

"Although we are saying that opioids are a reasonable choice for a lot of patients," Dr. Ferrell pointed out that "a lot of physicians are frightened sometimes to start down that road of giving opioids for chronic pain, especially noncancer-related pain, so in some circles it is controversial." The guidelines will be published in the August issue of the Journal of the American Geriatrics Society.

In a prepared statement, Dr. Cheryl Phillips, president of the AGS, said: "Persistent pain isn't a 'normal' part of aging and should not be ignored. As seniors become susceptible to more complex health ailments, the need for a clear and precise pain management plan is key."

Source: Reuters Health

The Difficulties of Early Identification of Dementia

Source: Elin Lindstrom Claessen University of Gothenburg

If grandma seems to forget things, will she end up demented? These days, memory loss is one of the very few symptoms that may signal which 70-year-olds risk developing dementia. This is shown in a doctoral thesis at the Sahlgrenska Academy at the University of Gothenburg, Sweden.

Several of the tests previously used to predict which elderly individuals risk developing dementia do not seem to work any longer. The thesis shows that memory loss is the only factor that can still be used to indicate who is at risk, although not among the very old.

The study compared non-demented 70-year-olds examined in the early 1970s with non-demented 70-year-olds examined in the year 2000. The results show that those who were examined in 2000 scored much higher on psychological tests than those examined 30 years

earlier. This finding clearly indicates that such tests can no longer be used to predict future dementia. In the early 1970s, several different tests could be used to predict people's risks of developing dementia, but today it seems like psychiatric evaluation of the memory is the only useful test. In addition, it is more difficult to predict dementia the higher the person's level of education, says physician PhD Simona Sacuiu, the author of the thesis.

The follow-up of the 70-year-olds five years later showed that 5% had developed dementia. Those with memory problems showed an increased risk of developing dementia, although not everybody with poor memory developed dementia. Consequently, the link between forgetfulness and future dementia is more complex than commonly thought. Memory loss among elderly individuals may, but doesn't have to be, an early sign. In order to effectively detect dementia at an early stage, we need a useful tool that includes several types of tests, but the tests need continuous adjustments since the elderly of today perform much better at standardized psychological tests than previous generations, says PhD Sacuiu.

Examinations of a group of non-demented 85-year-olds show that the link between memory problems and dementia is not as clear in this age group. The 85-year-olds' ability to find words, to copy a geometric figure and to take quick decisions were some qualities that were evaluated in a psychiatric assessment. More than 300 individuals participated in the study, of which 17% had developed dementia three years later.

"We can't say that memory loss is the only meaningful sign of future dementia among 85-year-olds, since other symptoms, such as difficulties finding words or drawing a geometric figure, were needed for their risk of developing dementia to increase," says Sacuiu.

The H70 study

H70, short for Health 70, is a unique population study at the Sahlgrenska Academy. The study was started in 1971 with an assessment of 70-year-olds. The individuals were followed up regularly for 30 years. A new H70 study was started in the year 2000. Its participants will be followed up again during 2009 at age 79. The study includes data on over 2000 residents of Gothenburg, Sweden. The participants have been examined both physically and mentally, and have made it possible for several research teams to pinpoint various trends in physical and mental health in the ageing population.

Source: Medical News Today

Revealing a Surprising Link between Diabetes and Alzheimer's Disease

Blindness, heart disease, nerve damage, and kidney failure are not the only complications facing the nation's estimated 24 million people with diabetes. Although not widely known, those with the disease face up to double the risk of developing Alzheimer's disease (AD) than non-diabetics, according to an article in the May 18th issue of *Chemical & Engineering News*, the American Chemical Society's weekly newsmagazine.

C&EN senior editor Sophie Rovner explains in the article that people with diabetes tend to have a higher risk of getting AD, and possibly get it at an earlier age, than the general population. Five million people in the United States have Alzheimer's, a brain disorder that causes severe memory loss. Diabetes results from the body's inability to produce or use insulin. Newer research now suggests that insulin is critical for healthy nerve cells in the brain. As the hormone declines in the brains of people with Alzheimer's, so does their memory.

Some research even suggests that diabetes and Alzheimer's are part of the same disease process that affects different parts of the body and that Alzheimer's may be considered "Type 3" diabetes. If so, then doctors might treat Alzheimer's in the same way as diabetes, which includes giving patients insulin or other medications - including so-called "insulin sensitizing" drugs - the article states.

Source: Medical News Today

MANAGEMENT FORUM

The Six Key Elements of Employee Motivation and Performance

As a nurse manager, part of your job is keeping employees motivated and working to the best of their abilities. This results in reduced turnover and higher patient satisfaction. Following are six key elements that make up the framework for employee motivation and performance:

Element #1: Purpose. The first task a manager or supervisor should undertake is to align the individual's purpose with that of the organization. says **Dan Strakal, EdD**, an expert speaker on workplace issues and president of Capable-Performance-Solutions, a consulting firm in Albuquerque, NM.

Element #2: Expectations. Communicating exactly what's expected of each employee improves motivation. "Clear expectations promote longer periods of sustained effort to achieving desired outcomes," Strakal says. Take a few minutes to speak with employees one on one, he recommends. Ask the employee to share with you any barriers or challenges he or she faces on a daily basis.

Element #3: Competence. One way that effective managers build competence is to create opportunities for others to be challenged, to grow, and to develop their skills without causing employees to become overly frustrated, Strakal says.

Element #4: Feedback. "Effective feedback shapes performance, builds confidence, and encourages sustained effort," Strakal says. Managers can achieve effective feedback in several ways, such as:

- Creating an atmosphere that encourages the free flow of performance feedback
- Giving feedback that is specific, accurate, objective, and focused on behavior
- Trying not to soften a message by mixing positive feedback with reprimands
- Providing timely feedback immediately after desired behavior is demonstrated

Element #5: Support. Respect is another important factor that affects employee motivation, says **Jacqueline Coates, MA**, practice administrator at Apple Hill Eye Center in York, PA. "With my former employer, we implemented a gazillion different promo ideas to motivate staff. They all worked for a brief period of time, then the newness would wear off and motivation would decline," she says. "Through a closer assessment of the programs, we learned that supervisors were the direct link to a weak or solid foundation to build motivation. If the relationship between the supervisor and staff was not a positive one, the motivational ideas and techniques were futile."

Element #6: Rewards. After a respectful relationship has been established, find out what incentives are most influential to your staff, Coates says. "Our ideas might seem grand, but may be less stimulating to staff. Seek out the informal leaders and get them involved."

Source: *The Doctor's Office*, HCPro, Inc., April 2007

Recognize your Rising Nurse Leader!

The Institute for the Future of Aging Services (IFAS) is pleased to announce a call for nominations for the 2009 Joan Anne McHugh Award for Leadership in Long-Term Care Nursing. This award, open to all AAHSA member organizations, recognizes nurses who provide excellent clinical care, while demonstrating leadership and a commitment to the field of long-term care nursing. Nurses working for AAHSA member organizations and meeting other eligibility criteria may be nominated. The winner receives a \$1,000 professional development award and national recognition at AAHSA's 2009 Annual Meeting in Chicago. All entries must be postmarked by July 10, 2009. Download the Award Nomination Brochure for complete details. For more information, contact Alisha Sanders, 202-508-1211.

OTHER ITEMS OF INTEREST

News Spotlight: Proposed 2010 Fiscal Year Budget Increases Nursing Incentives

President Barack Obama's proposed healthcare workforce development funding for fiscal year 2010 could bring incentives to nurses in the field and in the classroom.

Of the \$1 billion in the budget devoted to strengthening healthcare professions, \$125 million is allocated to the Nursing Education Loan Repayment Program (NELPN) (<http://bhpr.hrsa.gov/nursing/loanrepay.htm>) —an \$88 million increase from the 2009 budget. The program contracts RNs with the federal government to work full-time in a healthcare facility with a nursing shortage in return for repayment of qualifying educational loans.

Funds for the Nurse Faculty Loan Program (NFLP) (<http://www.hrsa.gov/grants/nflp/>) would also increase by 40%, which support eligible schools of nursing offering advanced education programs to prepare graduates to serve as nursing faculty.

In addition, the budget may increase diversity in the workforce, due to funds allotted to Title VII and VIII of the Public Health Service Act health professions training, which are federal programs geared toward training healthcare providers in interdisciplinary settings to care for underserved patient populations, as well as increasing minorities in the profession.

Source: U.S. Department of Human Health and Services (<http://www.hhs.gov/news/press/2009pres/05/20090507b.html>) and National League for Nursing (http://www.nln.org/newsreleases/pres_budget_050809.htm)