

# Nursing Notes



*Providing insights on leadership, management,  
and clinical innovations for nursing  
professionals in aging services*



Forward

Subscribe

Unsubscribe

Archives

**August 2009**

**Tess Kwiatkowski, MS, RN, Editor**

## HOT TOPICS

### **What does License-Pending Mean under the Current Nurse Practice Act?**

In response to several questions regarding the employment of license-pending nurses, LSN feels it is important to clarify what is written on this issue in the Nurse Practice Act (NPA) that became effective January 1, 2008. Since regulations implementing the Act have still not been published, we must read the ACT itself to answer this question.

The sections that refer to the issue of license pending are 60-10 (d-e) for RNs and 55-10 (d-e) for LPNs. Under the last NPA, a nurse that had taken the State Boards could be hired as license pending until they found out they failed the test, at which time they could no longer work. **Under the new NPA, an applicant for licensure can work as license-pending under an RN or an APN only after they have passed the Department approved licensure exam but before they receive their actual license.**

LSN encourages members to print the new [Nurse Practice Act](http://ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1312&ChapAct=225%20ILCS%2065%2F&ChapterID=24&ChapterName=PROFESSIONS+AND+OCCUPATIONS&ActName=Nurse+Practice+Act%2E) (<http://ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1312&ChapAct=225%20ILCS%2065%2F&ChapterID=24&ChapterName=PROFESSIONS+AND+OCCUPATIONS&ActName=Nurse+Practice+Act%2E>) and keep on hand in order to be able to refer to it.

Hopefully this answers your questions on this issue. Please contact [Tess Kwiatkowski](mailto:tessk@lsni.org) ([tessk@lsni.org](mailto:tessk@lsni.org)) if you have other concerns.

### **DEA Targets Long-Term Care Pharmacies and Facilities in Two New States**

Recently, LSN's Nurse Leadership Committee had a lengthy and spirited discussion on the changes in interpretation and enforcement that the Drug Enforcement Agency (DEA) has taken towards the prescribing of controlled substances II-IV in the LTC and hospice settings. (See Nursing Notes June 15th). Our special thanks to Denise Wassenaar of Alliance Pharmacy Services and Michelin Taylor of Resurrection LTC Pharmacy for the information in the article from American Society of Consultant Pharmacists (ASCP). Also to Evvie Munley and Jennifer Hilliard of AAHSA for the information on AAHSA's role in the coalition of stakeholders.

On April 7, American Society of Consultant Pharmacists (ASCP) met with the Drug Enforcement Agency (DEA) in Washington, D.C. ASCP left with two commitments. First, DEA said they would let them know within 90 days whether they would make any changes to their policies regarding "nurse as agent" and "chart order." Second, they agreed to issue a "Dear Registrant" letter advising prescribers and dispensers of their obligations under the Controlled Substances Act.

90 days have passed and DEA has not issued the "Dear Registrant" letter (though "it is in process"), and they have not yet been able to schedule a follow-up meeting or clarify their policy positions (although "they still intend to do so"). In the meantime, on July 22 DEA hit four more pharmacies and the nursing facilities served by them in two additional states, signaling that DEA has every intention of strictly enforcing current law and regulations regarding prescribing and dispensing of controlled drugs in **all** classes. It is now clear that until the law is changed, DEA will continue to treat nursing facility and hospice nurses differently than nurses in hospitals and will not accept chart orders in nursing facilities as valid prescription orders.

In the wake of these actions, ASCP, in partnership with other DEA Task Force members, has reached out to several key federal legislators and has already received assurances of assistance. On July 24 ASCP convened an emergency meeting of the DEA Task Force and agreed to a two-pronged action agenda. The first prong is education - making sure that every long-term care and hospice pharmacist and all other health professionals in long-term care and hospice understand DEA's current interpretations of law and have the information and tools to help them comply. The second is advocacy. Their first goal (already in process) is getting DEA to issue the "Dear Registrant" letter. Their second goal is a legislative fix. ASCP has already drafted proposed legislative changes and are vetting them widely among their industry and clinical partners. They will be working with staff from the Senate Judiciary Committee in August to finalize this language. Their goal is to get a bill introduced in the Fall. In the mean time, to help implement these tactics, they have decided to formally turn our DEA Task Force into a multi-stakeholder coalition. This coalition (as yet, unnamed) currently consists of national organizations and individuals representing a broad spectrum of long-term care and hospice professionals.

AAHSA is part of this coalition effort with ASCP. AHCA; AMDA, and a variety of other pharmacy and health professional groups are also members.

Several letters and/or contacts have been made to explain the LTC perspective, but DEA is the immovable object in this situation. The ideal scenario, of course, would be for DEA to permit facilities / the DON position to become an "agent of the physician", but they seem very disinclined to do that at this point. The DEA is stuck on the fact that [unlike, e.g., hospitals] nursing homes are not DEA registrants.

The stakeholder group is also working with the FDA on the definition of "emergency situation." This is the trigger for allowing telephone orders for Schedule IIs in an emergency situation. Under the law, it is HHS and not DEA that gets to define this. According to ASCP, DEA does appear willing to accept FDA's interpretation of this. Given DEA's rigidness in interpretation, it's a far cry & certainly doesn't address all that's needed in terms of changes, but would give some degree of interim leeway on Schedule IIs until this situation can be resolved.

The regulations currently define an emergency situation as:

(1) immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user; (2) no appropriate alternative treatment is available, including administration of a drug which is not a controlled substance under Schedule II, and (3) it is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance, prior to dispensing.

The definition would seem to apply to frequent circumstances encountered in LTC, but DEA interprets this definition narrowly and doesn't like, e.g., using telephone orders routinely when residents run out of medications, instead of having a system in place to reorder medications in advance – DEA really doesn't seem to understand LTC at all in terms of how quickly residents' conditions, responses to different meds, etc., can change. Although DEA has authority over the rules governing prescribing and dispensing, the Controlled Substances Act gives HHS the authority to define emergency situations.

In addition to approaching the respective agencies, the coalition is seeking legislative relief. ASCP recently met with Senator Whitehouse's (D-RI) staff and Senator Sherrod Brown's staff (D-Ohio). Staff indicated that Senator Whitehouse would likely be interested in helping given his interests in pain management, the elderly and DEA. It was agreed that September would be good timing because all are now really consumed by healthcare reform. Sen Brown's office was reportedly supportive, saying they would be willing work with Whitehouse's office on this.

Legislative action is, as you know, never an overnight process. Most recently, the group also decided to work on education and outreach. AMDA is working with one of the doc groups to develop questions from the physician and nurse perspective. These will be turned into one-pagers that all can disseminate. ASCP is also working to develop some quick tools to help pharmacists, facilities and doctors make changes in workflow to meet DEA rules for CIII-Vs.

LSN advises members to be in communication with your pharmacy provider for guidance on this issue. Although there are rumors that the DEA may even go beyond controlled substances, AAHSA feels that DEA's jurisdiction is limited to "scheduled" drugs. As a result, the problem with chart orders will not affect medications that are not on Schedules II-IV.

### **CMS Releases FY2010 SNF PPS Final Rule, RUG-IV Payment System**

The Centers for Medicare & Medicaid Services (CMS) released the final rule for fiscal year (FY) 2010 payment updates to skilled nursing facilities (SNF) on July 28.

A major component of the final rule is the recalibration of the case-mix indexes (CMI), which will reduce Medicare payments to SNFs by \$1.05 billion, or 3.3%. The CMI recalibration will correct a FY 2006 projection error, which resulted in an unexpected increase in Medicare payments, and will better align reimbursement with the resources used to care for a resident. Fortunately, this significant cut in Medicare payments will be partially offset by the SNF market basket update for FY 2010, which will result in a \$690 million, or 2.2%, increase. Thanks to the market basket update, the total reduction in Medicare payment to SNFs in FY 2010 will be \$360 million, or 1.1% lower than FY 2009 payments.

Another important component of the final rule is the finalization of the Resource Utilization Group, Version Four (RUG-IV) for implementation in FY 2011. In the final rule, CMS addressed many comments they received about RUG-IV and provided responses and explanations. Ultimately, CMS plans to implement RUG-IV as it appeared in the proposed rule, with a few minor modifications, such as:

- Fever with feeding tube will be added to the Special Care High category
- CMS clarified that dehydration has been deleted as a qualifier in any category, including the Special Care and Clinically Complex categories
- Respiratory failure in combination with oxygen therapy while a SNF resident will be added to the Special Care Low category
- Oxygen therapy while a SNF resident will be moved to the Clinically Complex category

A patient will also qualify in the Special Care Low category if one of the following is present along with two or more skin treatments:

- Two or more venous/arterial ulcers; or
- One Stage 2 pressure ulcer and one venous/arterial ulcer.

*Source: HCPro*

## CLINICAL CORNER

### Should Healthcare Workers Colonized with MRSA Avoid Patients?

*Response by Kimberly K. Scarsi, PharmD, MS, Assistant Professor, Research, Division of Infectious Diseases, Northwestern University, Feinberg School of Medicine, Chicago, Illinois; Clinical Pharmacist, Northwestern Memorial Hospital, Chicago, Illinois*

Preventing transmission of drug-resistant organisms such as methicillin-resistant *Staphylococcus aureus* (MRSA) is a high priority for infection control and prevention. Although studies have demonstrated that patients colonized with MRSA are at a higher risk of subsequent MRSA infection due to their own flora, colonized healthcare workers (HCWs) are rarely the source of MRSA transmission to patients. In fact, 1 literature review found that only 1.6% of 191 MRSA outbreaks in a nosocomial setting were associated with asymptomatic HCWs.<sup>[1]</sup> Routine screening of asymptomatic HCWs for MRSA colonization is thus not warranted. Of note, when HCWs are implicated in MRSA transmission, this is more likely due to poor hand hygiene resulting in patient-to-patient transmission.<sup>[2]</sup>

Routine decolonization of HCWs who are asymptomatic MRSA carriers is not recommended. However, if a HCW is identified as the source of a MRSA outbreak, then decolonization is considered in combination with a full infection control management plan. In this situation, the HCW should avoid direct patient care activities until culture results are negative.<sup>[2]</sup> In situations where decolonization is necessary, the optimal pharmacologic regimen has not been firmly established. Options include topical decolonization of the nares alone; topical nasal and whole body decolonization; and topical decolonization plus oral antimicrobial agents.

Mupirocin (Bactroban<sup>®</sup>) remains the only medication approved by the US Food and Drug Administration for nasal decolonization. However, other topical products such as bacitracin are under investigation for mupirocin-resistant MRSA strains. Mupirocin is commonly used with antiseptic body washes such as chlorhexidine, with or without oral agents such as rifampin, tetracyclines, or trimethoprim-sulfamethoxazole. Two recent reviews provide a detailed discussion of the evidence for each therapy and are useful resources.<sup>[3,4]</sup> Importantly, investigations to date have not addressed key areas such as the long-term effect of decolonization on infection recurrence, rates of re-colonization after a pharmacologic intervention, or the effect of decolonization on drug resistance.<sup>[2]</sup>

In summary, given that asymptomatic MRSA-colonized HCWs rarely transmit MRSA to patients, US guidelines do not recommend routine screening of or decolonization for asymptomatic HCWs. Similarly, guidelines do not recommend restricting work activities unless colonized HCWs are found to be the source of MRSA transmission. Although pharmacologic decolonization is an important tool in clinical management of MRSA colonization in certain situations, it cannot replace the importance of consistent hand hygiene.

#### References

1. Vonberg R, Stamm-Balderjahn, S, Hansen S, et al. How often do asymptomatic healthcare workers cause methicillin-resistant *Staphylococcus aureus* outbreaks? A systematic evaluation. *Infect Control Hosp Epidemiol*. 2006;27:1123-1127. [Abstract \(http://www.medscape.com/medline/abstract/17006821\)](http://www.medscape.com/medline/abstract/17006821)
2. Siegel JD, Rhinehart E, Jackson M, Chiarello L, for the Healthcare Infection Control Practices Advisory Committee. Management of multidrug-resistant organisms in healthcare settings, 2006. Available at: <http://www.cdc.gov/ncidod/dhqp/pdf/ar/MDROGuideline2006.pdf> Accessed March 24, 2009.
3. McConeghy KW, Mikolich DJ, LaPlante KL. Agents for the decolonization of methicillin-resistant *Staphylococcus aureus*. *Pharmacotherapy*. 2009;29:263-280. [Abstract \(http://www.medscape.com/medline/abstract/19249946\)](http://www.medscape.com/medline/abstract/19249946)
4. Simor AE, Daneman N. *Staphylococcus aureus* decolonization as a prevention strategy. *Infect Dis Clin North Am*. 2009;23:133-151. [Abstract \(http://www.medscape.com/medline/abstract/19135919\)](http://www.medscape.com/medline/abstract/19135919)

Source: *Medscape Nurses MedPulse*

## **Study Shows even Moderately Elevated Cholesterol Level Boosts Dementia Risk**

*Emily, Schwartz.Golin/Harris International*

Elevated cholesterol levels in midlife - even levels considered only borderline elevated - significantly increase the risk of Alzheimer's disease and vascular dementia later in life, according to a new study by researchers at Kaiser Permanente's Division of Research and the University of Kuopio in Finland. The study appears in the journal *Dementia & Geriatric Cognitive Disorders*.

The four-decade study of 9,844 men and women found that having high cholesterol in midlife (240 or higher milligrams per deciliter of blood) increases, by 66 percent, the risk for Alzheimer's disease later in life. Even borderline cholesterol levels (200 - 239 mg/dL) in midlife raised risk for late-life vascular dementia by nearly the same amount: 52 percent. Vascular dementia, the second most common form of dementia after Alzheimer's disease, is a group of dementia syndromes caused by conditions affecting the blood supply to the brain. Scientists are still trying to pinpoint the genetic factors and lifestyle causes for Alzheimer's disease.

By measuring cholesterol levels in 1964 to 1973 based on the 2002 Adult Treatment Panel III guidelines (the current practice standard) when the Kaiser Permanente Northern California members were 40 to 45 years old, then following the participants for 40 years, this study is the largest long-term study with the most diverse population to examine the midlife cholesterol levels and late-life dementia. It is also the first study to look at borderline high cholesterol levels and vascular dementia, rather than just Alzheimer's disease.

This study, funded by the National Institutes of Health, adds to other research emphasizing the importance of addressing dementia risk factors in midlife, before an underlying disease or symptoms appear, the researchers said.

The study tracked members of Kaiser Permanente's Northern California Medical Group from 1967 to 2007 by using the multiphasic testing records pioneered by Kaiser Permanente founding physician Morris Collen, MD, who is widely regarded worldwide as a health care informatics pioneer. Of the original 9,844 participants, 598 were diagnosed with Alzheimer's disease or vascular dementia between 1994 and 2007, when the participants were between 61 and 88 years old. This epidemiological study did not examine the mechanism of the link between cholesterol levels and dementia.

This study is part of an ongoing body of research at Kaiser Permanente to better understand the risk and protective factors for dementia. Dr. Whitmer recently authored two dementia-related studies: one that found a larger abdomen in midlife increases risk of late-life dementia, and one that showed that low blood sugar events in elderly patients with type 2 diabetes increase their risk for dementia. Another Kaiser Permanente study, led by Valerie Crooks of Kaiser Permanente in Southern California, found that having a strong social network of friends and family appears to decrease risk for dementia.

Other authors on this study include: Miia Kivipelto, MD, Ph.D., Department of Neurology, University of Kuopio, Finland, and the Aging Research Center, Karolinska Institutet, Stockholm, Sweden; Benjamin Wolozin, MD, Ph.D., Department of Pharmacology, Boston University School of Medicine; and Jufen Zhou, MS, Kaiser Permanente Division of Research. Additional funding for the study was provided by Kaiser Permanente Community Benefit, the Academy of Finland Marie-Curie EST Program, the Gamla Tjänarinnor Foundation, and Stiftelsen Dementia, Sweden.

*Source: Medical News Today*

## **On-Time Pressure Ulcer Healing Project**

The On-Time Quality Improvement for Long-Term Care Program is funded by the Agency for Healthcare Research and Quality (AHRQ), generally in collaboration with a State Department of Health, a Quality Improvement Organization (QIO), or a trade association, to improve nursing home care. The focus is on prevention and timely treatment during routine care. New tools to document pressure ulcer healing and treatments and reports to help monitor the healing process have been developed as part of the expansion of the On-Time Quality Improvement Program.

### **Background**

Currently, there is a large amount of documentation and reporting in long-term care facilities related to pressure ulcer risk, pressure ulcer assessment, and treatment. But facilities have no standardized set of data elements to document weekly skin assessments and treatments provided. In addition, there are no easily accessible decision support tools. Existing tools consume large amounts of staff time but do not assist wound nurses and frontline clinicians in monitoring resident and pressure ulcer status and providing treatment based on best practice.

On-Time Pressure Ulcer Healing focused on monitoring pressure ulcer healing, risk factors that may be specific to the rate of healing, and best practices for treatment. The goal is to improve clinical information and integrate that information into facility daily workflow. Improved communication between certified nursing assistants (CNAs), dietary staff, Minimum Data Set (MDS) coordinators, social workers, and nurses should result in more timely referrals, treatments, and changes in care plans.

With the help of quality improvement consultants who conducted regular working phone meetings, facility staff work in multidisciplinary teams. Teams consolidate and standardize CNA documentation and ensure the completeness and accuracy of documentation. They use a set of reports and tracking tools to identify high-risk residents, improve information flow among team members, improve documentation of preventive care, and make more timely referrals and treatments. Reports can be accessed at least weekly and provide summary trend information.

Multidisciplinary On-Time implementation team members typically consisted of the nursing director, Quality Improvement Organization (QIO) coordinator/staff development director, nurses from the Skin Team, wound nurse, MDS nurse, and dietitian. Facility teams also participated in program phone meetings to share experiences with workflow transformation with other participating facilities. To foster learning, facilities also received educational opportunities that involved interaction with clinical experts via onsite visit and conference calls.

**Click here** (<http://www.ahrq.gov/research/pressureulcerhealing/>) to download resources, from the AHRQ site, such as a Literature Review, Wound assessment documentation descriptions and calculations, Prototype clinical report description and calculations, Health information technology specifications, and Educational materials for using standardized forms.

## **Commonly Used Medications May Produce Cognitive Impairment in Older Adults**

Many drugs commonly prescribed to older adults for a variety of common medical conditions including allergies, hypertension, asthma, and cardiovascular disease appear to negatively affect the aging brain causing immediate but possibly reversible cognitive impairment, including delirium, in older adults according to a clinical review now available online in the *Journal of Clinical Interventions in Aging*, a peer reviewed, open access publication.

Drugs, such as diphenhydramine, which have an anticholinergic effect, are important medical therapies available by prescription and also are sold over the counter under various brand names such as Benadryl®, Dramamine®, Excederin PM®, Nytol®, Sominex®, Tylenol PM®, and Unisom®. Older adults most commonly use drugs with anticholinergic effects as sleep aids.

While it is known that these medications do have an effect on the brain and in the case of sleeping pills, are prescribed to act on the brain, the study authors suggest the amount of cognitive impairment caused by the drugs in older adults is not well recognized.

"The public, physicians, and even the Food and Drug Administration, need to be made aware of the role of these common medications, and others with anticholinergic effects, in causing cognitive impairment. Patients should write down and tell their doctor which over-the-counter drugs they are taking. Doctors, who often think of these medications simply as antihistamines, antidepressants, antihypertensives, sleep aids or even itching remedies, need to recognize their systemic anticholinergic properties and the fact that they appear to impact brain health negatively. Doing so, and prescribing alternative medications, should improve both the health and quality of life of older adults," said senior study author Malaz Boustani, M.D., Indiana University School of Medicine associate professor of medicine, Regenstrief Institute investigator, and research scientist with the IU Center for Aging Research.

Dr. Boustani and colleagues conducted a systematic evidence-based analysis of 27 peer reviewed studies of the relationship of anticholinergic effect and brain function as well as investigating anecdotal information. They found a strong link between anticholinergic effect and cognitive impairment in older adults.

"One of the goals of our work is to encourage the Food and Drug Administration to expand its safety evaluation process from looking only at the heart, kidney and liver effects of these drugs to include effects of a drug on the most precious organ in human beings, our brain," Dr. Boustani said.

"Many medications used for several common disease states have anticholinergic effects that are often unrecognized by prescribers" said Wishard Health Services pharmacist, Noll Campbell, Pharm.D., first author of the study, noting that these drugs are among the most frequently purchased over the counter products. "In fact, 50 percent of the older adult population use a medication with some degree of anticholinergic effect each day."

"Our main message is that older adults and their physicians should have conversations about the benefits and harms of these drugs in relation to brain health. As the number of older adults suffering from both cognitive impairment and multiple chronic conditions increases, it is very important to recognize the negative impact of certain medications on the aging brain," said Dr. Boustani.

The brain pharmacoepidemiology group of the IU Center for Aging Research currently is conducting a study of 4,000 older adults to determine if the long term use of medications with anticholinergic effects is linked to the irreversible development of cognitive impairment such as Alzheimer's disease.

Authors of the JCIA study are Noll Campbell, Pharm.D., Wishard Health Services; Malaz Boustani, M.D., MPH; Tony Limbil, M.D., MPH, of University of Illinois; Carol Ott, Pharm.D. of Wishard and Purdue University; Chris Fox, MRCPsych and Ian Maidment, B.Pharm., of Kent Institute of Medicine and Health Sciences University of Kent and Medway NHS Trust, United Kingdom; Cathy C. Schubert, M.D. of the IU School of Medicine; Stephanie Munger, B.S., of Regenstrief and IUCAR; Donna Fick, R.N., Ph.D., of Pennsylvania State University; David Miller, M.D., of the IU School of Medicine and Rajesh Gulati, M.D., of IU Medical Group - Primary Care. The study was funded by the John A. Hartford Foundation, the Atlantic Philanthropies, the Starr Foundation, and the National Institute on Aging.  
*Source: Cindy Fox Aisen, Indiana University*

## WORKFORCE WISDOM

### **Improve Nurse Satisfaction in a Time of Uncertainty**

Improving nursing satisfaction is tough in bad economic times. But the state of the economy doesn't need to bring your nursing satisfaction scores down—there are ways to boost morale immediately.

For example, you can:

- Begin nursing staff meetings by asking, “What was the best thing that happened to you today or during your last shift?” The meetings should focus on improving care and team-building.
- Focus on improving the image of nursing by gathering a group of nurses to volunteer with a community or organization project.
- Ask creative nurses to develop banners or posters that showcase nursing excellence and hang them around the unit or facility.
- Thank nurses for their fortunate choice of profession. In Gallup’s annual honesty and ethics professional survey, nursing has been rated No. 1 for the past seven years.
- Ask a nurse to create helpful hints on how to deal with stress and print them in your nursing or facility newsletter.
- Arrange time for the DON to visit each nursing unit to listen and discuss why he or she is encouraged and hopeful about the future. Now is the time for leadership to paint an accurate but hopeful picture for nurses.
- Keep up the budget-friendly celebrations and recognitions for staff nurses. You can celebrate by handing out coffee coupons or recognizing a staff nurse during every unit meeting for his or her excellent patient care.

Source: *Nurse Manager Weekly*

## **Five Factors Can Keep Nurses on the Job**

Satisfaction, organizational commitment, autonomy, opportunities for promotion, and fewer outside job opportunities: these 5 factors can help stop new nurses from leaving their jobs and, in turn, save money for health systems.

In studying 1933 newly licensed registered nurses working in hospitals nationwide, researchers learned that nurses' intent to stay at a job is influenced by their perceptions of their working conditions, specific workplace attributes, their own personal characteristics, and available job opportunities.

Understanding the factors that affect whether a new nurse will stay at a healthcare setting can help hospital managers better direct their resources and keep their workforce stable, and is particularly important in the face of the shortfall of 500,000 nurses expected by the year 2024, according to Christine Kovner, PhD, RN. “If nurses stay in their jobs, hospitals and the healthcare system will realize significant savings on costs associated with replacing nursing staff,” said Dr Kovner, a professor at New York University's College of Nursing and the lead author of the study, which was published in the March/April issue of *Nursing Economics*.

As much as 5% of a hospital's budget may be eaten up by costs associated with nursing turnover.

“More important,” continued Dr Kovner when announcing her team's findings, “patient outcomes are at stake because when the nursing staff is destabilized by frequent resignations and high turnover, the disruption and inconsistency of service can have a negative impact on patient care and safety.”

Dr Kovner and her colleagues identified the following characteristics as increasing the likelihood that new registered nurses would be satisfied with their job and committed to their organizations:

- variety
- autonomy
- supervisory support
- workgroup cohesion
- procedural justice (rights are applied universally to all employees)
- promotional opportunities
- collegial relations between doctors and nurses.

Variables that reduced nurses' commitment to their jobs included a high workload, organizational constraints, and mandatory overtime.

From the June 2009 Issue of Oncology Nursing News

<http://www.oncologynursingnews.com/issue/June/15/2009/1696/>

Source: *Nursing Economics*

## **Nurse Salaries Remain on the Rise**

Nurse salaries are climbing considerably across the nation, according to recently released employer survey data.

The 2009 *Compensation Data Healthcare* results compiled by Compdata surveys show wages for RNs increased by 9.2% over the last three years - which translates to an average of \$61,300 per year. Previous year-to-year salary increases for nurses have been between \$2,000 and \$3,000.

Researchers gathered the data among more than 320,000 nurses from nearly 900 healthcare organizations across the U.S. through questionnaires. These included hospitals, long-term care and rehabilitation facilities, homecare agencies, and physician clinics. Results shows nurses on the coasts of the country have the highest salaries; nurses in the Western region will take in an average \$75,300 in 2009; and those in the Northeast will make about \$67,400.

The findings illustrate the healthcare industry has yearly pay increase budgets running around 3%, while other businesses have pay increases around 2%. The average nursing salary jumped up by 5.3% from 2008 to 2009 alone.

"Many of the positions within the healthcare industry continue to be in high demand and nursing positions continue to lead the pack," says **Lane Odle**, product marketing manager at Compdata Surveys. "The position's yearly increase of 5.3% is indicative of that."

And, based on the survey data, it appears that nurses' pockets will continue to grow.

"At this time, there is no indication that pay increases for nurses will slow down," says Odle, adding that the consistent, annual salary gains suggest nurses' pay will continue to rise. "Also, HR professionals in the industry are projecting the same pay increase budget for 2010, which means they expect the industry to be stable in the coming year."

Compdata Surveys has yet to set estimates for how much nurse' salaries will increase next year, but Odle anticipates the aging population with further drive them up.

"The Baby Boomers in the [nursing] field are nearing retirement, which will leave a number of vacant positions," she says. "Additionally, longer average life spans are expected to cause the number of individuals seeking medical care to increase exponentially. These factors will increase the demand for healthcare workers."

Source: *Nurse Manager Weekly*

## **ENHANCING HEALTH CARE DECISION MAKING**

### **Advance Care Planning: Preferences for Care at the End of Life**

Research can help physicians and other health care professionals guide patient decision-making for care at the end of life. Findings (<http://www.ahrq.gov/research/endliferia/endria.htm#NeedMore>) resulting from research funded by the Agency for Healthcare Research and Quality (AHRQ) are discussed. This research can help providers offer end-of-life care based on preferences held by the majority of patients under similar circumstances.

### **Patient Preferences Are Often Not Known**

Predicting what treatments patients will want at the end of life is complicated by:

- The patient's age.
- The nature of the illness.
- The ability of medicine to sustain life.
- The emotions families endure when their loved ones are sick and possibly dying.

When seriously ill patients are nearing the end of life, they and their families sometimes find it difficult to decide on whether to continue medical treatment and, if so, how much treatment is wanted and for how long. In these instances, patients rely on their physicians or other trusted health professionals for guidance.

In the best of circumstances, the patient, the family, and the physician have held discussions about treatment options, including the length and invasiveness of treatment, chance of success, overall prognosis, and the patient's quality of life during and after the treatment. Ideally, these discussions would continue as the patient's condition changed. Frequently, however, such discussions are not held. If the patient becomes incapacitated due to illness, the patient's family and physician must make decisions based on what they think the patient would want.

### **Research Can Help Guide Decision-making**

The Agency for Healthcare Research and Quality (AHRQ) has issued a [report](http://www.ahrq.gov/research/endliferia/endria.htm#NeedMore) (<http://www.ahrq.gov/research/endliferia/endria.htm#NeedMore>) that is intended to show how physicians and other health care professionals can help their patients with advance care planning and assess patient preferences for care at the end of life.

Section 1 (<http://www.ahrq.gov/research/endliferia/endria.htm#Discussion>) discusses research findings from studies funded by the Agency for Healthcare Research and Quality (AHRQ), as well as those from other research. For readers who want more detailed information, [Section 2](http://www.ahrq.gov/research/endliferia/endria2.htm#Preferences) (<http://www.ahrq.gov/research/endliferia/endria2.htm#Preferences>) contains charts and tables showing the quantitative results of the studies supported by AHRQ. While no one can predict exactly what patients will want or need when they are sick or dying, this research can help providers offer end-of-life care based on preferences (both real and hypothetical) held by the majority of patients under similar circumstances.

### **Making a Difference**

- Patients need more effective advance care planning
- Patients with chronic illness need advance planning
- Patients value advance care planning discussions
- Opportunities exist for advance planning discussions
- Physicians can use a structured process for discussions
- Patient preference patterns can predict other choices
- Invasiveness and length of treatment affect preferences.
- Treatment patterns are based on prognoses.
- Advance planning helps physicians provide care that patients want
- AHRQ funds studies to improve end-of-life care

### **Terms Patients Should Understand**

Advance directives are also known as living wills. These are formal legal documents specifically authorized by State laws that allow patients to continue their personal autonomy and that provide instructions for care in case they become incapacitated and cannot make decisions. An advance directive may also be a durable power of attorney.

A durable power of attorney is also known as a health care proxy. This document allows the patient to designate a surrogate, a person who will make treatment decisions for the patient if the patient becomes too incapacitated to make such decisions.

## SYSTEM DESIGN & ORGANIZATIONAL CHANGE

### **Core Competencies in Nursing Supported by The Commonwealth Fund**

The [Hartford Institute of Geriatric Nursing](http://hartfordign.org/policy/position_papers_briefs/) ([http://hartfordign.org/policy/position\\_papers\\_briefs/](http://hartfordign.org/policy/position_papers_briefs/)) (HIGN), The Coalition for Geriatric Nursing Organizations (CCGNO), and the Pioneer Network have long recognized that nurses need to be a stronger partner, and more appropriately even, leaders in the culture change movement. However, to date, nurses have felt marginalized and, in fact, have not been active participants. This initiative will augment the work of the Hartford Centers for Geriatric Nursing Excellence in Nursing Homes Collaborative in identifying the principles and characteristics of a nursing practice model that includes role definition and culture change competencies of all members of the nursing service (i.e., directors of nursing, supervisors, managers, RNs and LPNs, certified nurse assistants, advanced practice nurses).

To further explore and make recommendations about the role and competencies for nurses with regard to nursing home culture change, in 2008 the Hartford Institute for Geriatric Nursing at NYU College of Nursing, in collaboration with the Coalition for Geriatric Nursing Organizations and the Pioneer Network, convened an interdisciplinary Expert Panel of leaders in culture change and in gerontological nursing for a one-and-a half-day meeting. The purpose of this meeting was to foster dialogue, to identify facilitators and barriers to nurses' involvement in culture change, and to identify actions that the culture change movement and the broad nursing community might consider in order to promote competencies for nurses in a resident-directed care environment in nursing homes.

The [Issue Paper \*Nurses' Involvement in Culture Change: Overcoming Barriers, Advancing Opportunities\*](http://www.pioneernetwork.net/Data/Documents/CultureChangeNursesIssuePaper.pdf)

(<http://www.pioneernetwork.net/Data/Documents/CultureChangeNursesIssuePaper.pdf>) summarizes the Expert Panel discussion and frames the competencies that need to be developed for nurses involved in culture change and resident-directed care. The paper encompasses five sections: culture change and research supporting culture change; nursing in nursing homes; culture change, nursing practice, and nursing education; recommendations; and next steps. The paper includes the following recommendations pertaining to the practice and the academic training of nurses in culture change:

- Develop and distribute a Statement of Goals for Practicing Nurses in Culture Change Nursing Homes.
- Develop competencies for nurses practicing in culture change nursing homes.
- Conduct a comprehensive review of culture change content in pre-licensure (associate degree and bachelor of nursing) nursing programs.
- Disseminate existing tools/resources on culture change and nursing's role in culture change to academic nursing programs, including strategies for incorporating this content into the curriculum.
- Create new tools/resources based on the competencies for nurses in nursing homes.
- Identify research priorities for examining the role of nurses in nursing home culture change.

As next steps, HIGN and the CGNO will partner with Pioneer Network to develop core competencies and quality indicators in nursing that are guided by culture change principles and a cross-disciplinary approach to care. It is expected that the process and model developed through the work with Medical Directors are transferable to the development of core competencies for person-centered care in nursing. The transfer will assure consistency in core competencies within care teams.

Click [here](#)

(<http://www.pioneernetwork.net/Data/Documents/CultureChangeNursesIssuePaper.pdf>) to download the *Issue Paper Nurses' Involvement in Culture Change: Overcoming Barriers, Advancing Opportunities* and [here](#)

([http://www.pioneernetwork.net/Data/Documents/CultureChangeNursesExecutive\\_Summary.pdf](http://www.pioneernetwork.net/Data/Documents/CultureChangeNursesExecutive_Summary.pdf)) to download the Executive Summary.

## The Role of Nurses in Culture Change

The Hartford Institute for Geriatric Nursing provides an issues paper on this vital topic. Click here ([http://lsni.informz.net/lsni/data/images/nursing\\_notes/theroleofnursesinnursinghomeculturechange.doc](http://lsni.informz.net/lsni/data/images/nursing_notes/theroleofnursesinnursinghomeculturechange.doc)) to download this paper.

## RESOURCE REVIEW

### Twittering Nurses Connect Us All

[Twitter](http://twitter.com/), (<http://twitter.com/>) the social networking site that allows users to keep friends, family, and colleagues up-to-date on everything that is happening in their lives, is taking the world by storm. Healthcare providers are commenting on surgeries in real time, nurses are reaching out for experts on the latest clinical care best practices, and there is a constant flow of information and advice.

The information you can share is never ending and Twitter is starting to become a useful tool in the nursing world. Here are some ways nurses and nurse managers are using Twitter:

- **Posting information and updates:** Most healthcare organizations use e-mail to send important announcements to nursing staff about changes in policy and procedure or to let them know about an upcoming in-service, but some nurses don't check their work e-mails regularly. However, most people with Twitter or Facebook (another form of social media) check those accounts more often. By posting updates to Twitter or Facebook, the information can be received quickly and efficiently.
- **Sharing general information:** Whether you want to tell nursing colleagues about a great wound care product you used, or that there is a job opening in your facility, Twitter is a great way to do just that, and allows you to get the news out to multiple people.
- **Asking for advice:** No matter how big or small the question is, Twitter subscribers will be more than happy to lend a hand in answering the question themselves, or finding someone to help.

*Contemporary Long-Term Care Weekly* recently issued their top informative Twitter feed recommendations related to long-term care. This list is in no particular order. Each includes a brief description:

- [Donnawcei](http://twitter.com/donnawcei) (<http://twitter.com/donnawcei>) – Tweets about wound care
- [SeniorsResource](http://twitter.com/SeniorsResource) (<http://twitter.com/SeniorsResource>) – Tweets about providing care information for seniors and their caretakers
- [Medpac](http://twitter.com/medpac) (<http://twitter.com/medpac>) – Tweets about health care reform
- [payersproviders](http://twitter.com/payersproviders) (<http://twitter.com/payersproviders>) – Tweets about the health care industry and business policy
- [consultdoc](http://twitter.com/consultdoc) (<http://twitter.com/consultdoc>) – Tweets about health care finance and patient quality
- [choiceeldercare](http://twitter.com/choiceeldercare) (<http://twitter.com/choiceeldercare>) – Tweets about long-term care options and insurance issues
- [lbramly](http://twitter.com/lbramly) (<http://twitter.com/lbramly>) – Tweets about caring for those with Alzheimer's disease and/or dementia
- [AMDALTCMedicine](http://twitter.com/AMDALTCMedicine) (<http://twitter.com/AMDALTCMedicine>) – Tweets about long-term care medicine news and health care reform
- [agooddaughter](http://twitter.com/agooddaughter) (<http://twitter.com/agooddaughter>) – Tweets about long-term care management
- [ElderCareRN](http://twitter.com/ElderCareRN) (<http://twitter.com/ElderCareRN>) – Tweets about providing care for seniors and the long-term care industry
- [AlzheimersInfo](http://twitter.com/AlzheimersInfo) (<http://twitter.com/AlzheimersInfo>) – Tweets about caring for those with Alzheimer's disease and/or dementia
- [aarpbulletin](http://twitter.com/aarpbulletin) (<http://twitter.com/aarpbulletin>) – Tweets for AARP, covering health care reform and other related topics
- [mjimenez13](http://twitter.com/mjimenez13) (<http://twitter.com/mjimenez13>) – Tweets about Medicare

- [nih\\_gov \(http://twitter.com/nih\\_gov\)](http://twitter.com/nih_gov) – Tweets for the National Institutes of Health about medical technology, research, and advances
- [NewHealthDialog \(http://twitter.com/NewHealthDialog\)](http://twitter.com/NewHealthDialog) –Tweets about health care reform, particularly regarding cost, quality, and coverage
- [WSJHealthBlog \(http://twitter.com/WSJHealthBlog\)](http://twitter.com/WSJHealthBlog) – Tweets for the Wall Street Journal Health Blog about health news, analysis, and business
- [ALZHEIMERSread \(http://twitter.com/ALZHEIMERSread\)](http://twitter.com/ALZHEIMERSread) – Tweets for the Alzheimer’s Reading room about resources available in caring for individuals with Alzheimer’s disease and/or dementia
- [daccarte \(http://twitter.com/daccarte\)](http://twitter.com/daccarte) – Tweets about enhancing the quality of life for seniors

Source: CLTC Weekly

## **Robert Wood Johnson Foundation Initiative on the Future of Nursing at the Institute of Medicine**

A new initiative to study the future of nursing in America and help address the growing nursing shortage, was launched in July by the Institute of Medicine and the Robert Woods Johnson Foundation. The initial cornerstone of the program would be conduct of a major study whose goal would be to produce a transformational report on the future of nursing.

Nursing faces a number of challenges that must be overcome to fulfill the promise of health care reform and meet the nation’s health needs. The future of health care is closely tied to the future of nursing, and it is critical to ensure that the nursing workforce has the capacity in numbers and skill competencies to meet present and future needs.

An ad hoc committee will examine the capacity of the nursing workforce to meet the demands of a reformed health care and public health system. It will develop a set of bold national recommendations, including ones that address the delivery of nursing services in a shortage environment and the capacity of the nursing education system. In its report, the committee will define a clear agenda and blueprint for action including changes in public and institutional policies at the national, state and local levels. Its recommendations would address a range of system changes, including innovative ways to solve the nursing shortage in the U.S.

The committee may examine and produce recommendations related to the following issues, with the goal of identifying vital roles for nurses in designing and implementing a more effective and efficient health care system:

- Reconceptualizing the role of nurses within the context of the entire workforce, the shortage, societal issues, and current and future technology;
- Expanding nursing faculty, increasing the capacity of nursing schools, and redesigning nursing education to assure that it can produce an adequate number of well prepared nurses able to meet current and future health care demands;
- Examining innovative solutions related to care delivery and health professional education by focusing on nursing and the delivery of nursing services; and
- Attracting and retaining well prepared nurses in multiple care settings, including acute, ambulatory, primary care, long term care, community and public health.

Click [here \(http://www.iom.edu/?ID=64233\)](http://www.iom.edu/?ID=64233) to view the IOM Initiative website or [here \(http://www.rwjf.org/pr/product.jsp?id=45713\)](http://www.rwjf.org/pr/product.jsp?id=45713) for the Robert Wood Johnson Foundation site.

## **REGULATORY UPDATE**

### **Five-Star Quality Rating System – Expect Further Refinements**

*Authored: Carolyn Davis*

The Five-Star Quality Rating System was the hot topic at the July 9 Skilled Nursing Facility/Long-term Care Open Door Forum. CMS has been implementing refinements to the Five-Star System on an ongoing basis – and plans for additional near-term and long-term changes are in the works, noted officials.

In January the agency updated risk adjusters for the Quality Measures (QMs) performance score, as well as devising a system to eliminate duplicate deficiencies from the survey data (i.e., ensuring that a single deficiency identified in both a complaint investigation and a nearly simultaneous standard survey is not reported twice).

In February CMS revised the case-mix adjusters for the Staffing performance measure so that the system uses the case mix that was present in the nursing home for the quarter nearest to when the staffing data was reported. That particular case mix will be maintained until new staffing data is reported. Then the case mix will be updated using the new quarter's data. CMS also refined some staffing edits in February "because we found that the edits to ensure quality were suppressing staffing values for some nursing homes," said officials.

Additional potential refinements currently under consideration include:

**1. Changing the Health Inspections performance measure from the current percentile distribution to a fixed numeric value.** Some nursing homes believe that a fixed healthcare efficiency survey score would be more beneficial than percentile rankings for quality improvement purposes because a facility wouldn't have to improve relative to all other nursing homes in its state. "There are pros and cons each way," said CMS officials. While fixed numeric scores could benefit quality improvement, percentile distribution tends to work better for nursing homes when average annual deficiencies increase, which has been the case since 2004, they added.

**2. Improving the collection, verification, and case-mix adjustments of the Staffing measure.** "A preferable way of reporting staffing in lieu of the current once-a-year, two-week period rating that is self-reporting would be to go to a quarterly reporting system that is electronically based on payroll information and that would allow us to compute other variables such as turnover rates and retention rates," said officials. CMS is working to make this happen, as well as looking at the definition of labor categories to determine the feasibility of collecting information on therapists and other staff.

**3. Further separating out the QMs of facilities with high levels of short-stay residents (e.g., hospital-based SNFs).** Many nursing home associations believe that these facilities should be compared against each other rather than against all nursing homes because they have distinct characteristics, pointed out officials. CMS also will investigate which additional QMs should be developed so that more aspects of care are measured, particularly with the short-stay measures, and what additional risk adjusters can improve the existing QM reporting.

**4. Adding resident and family satisfaction survey information to Nursing Home Compare.** CMS has identified three possibilities. First, the agency could simply report whether or not a nursing home uses a resident and family feedback system. Second, CMS could develop criteria characteristic of effectively working feedback systems. Then the agency would identify which nursing homes have systems that meet those criteria. The third option would be a national, single resident and family feedback survey system that is objectively administered by third parties. "We will be talking about the various approaches, the pros and cons, and the costs involved," said officials.

### Questions?

CMS will continue to provide nursing homes with a 12- to 14-day window to preview the Five-Star updates each month before they are posted on Nursing Home Compare. The agency will maintain its telephone help line on a quarterly basis to coincide with the quarterly updates of the quality measures. In other words, providers will be able to call (800) 839-9290 and speak with CMS experts during specific time periods in July, October, January, and April. However, they also can use the e-mail box: [bettercare@cms.hhs.gov](mailto:bettercare@cms.hhs.gov) to communicate at any time with CMS officials about Five-Star technical issues or ideas for refining the system.

*Source: LTC Leader (AANAC), Caralyn Davis, freelance author/editor/researcher*

## **CATs versus RAPs**

The latest MDS 3.0 draft introduced the long-term care industry to Care Area Triggers (CAT), which will replace the Resident Assessment Protocols (RAP) of the MDS 2.0.

Although the *RAI Users' Manual, Version 3.0*, which will contain the MDS 3.0-related changes, is not scheduled for release until October, CMS recently released an example of what Chapter 4 of the updated manual and a CAT will resemble. According to this document, CATs will serve the same purpose as RAPs – “to guide the interdisciplinary team toward a comprehensive assessment of a resident’s functional status.”

Like RAPs, CATs will be triggered by certain responses to MDS items. These triggers identify potential health and functional problems that require additional assessment. However, RAPs limit facilities’ options regarding the type of additional assessments they can perform by spelling out specific guidelines.

CATs are designed to give facilities more options when performing additional assessments. Instead of providing limited guidelines, the *RAI Users' Manual, Version 3.0*, will list resources and Web sites with free clinical practice guidelines that facilities can use in performing the additional assessments for each CAT. Ultimately, CATs will help facilities move toward a resident-centered model of care by allowing them to choose the most appropriate resources for each resident and particular situation.

*Source: MDS 3.0 Update, July 27, 2009*

## **MDS 3.0 a Focus of Recent 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 soon.

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*

## OTHER ITEMS OF INTEREST

### **Older Volunteers' Perceived Benefits Vary with Program Traits**

The advantages of volunteering reported by adults aged 55 and older are largely dependent upon the characteristics of the activities in which they participate, according to a recent article appearing in *The Gerontologist* (Vol. 49, No. 1). The lead author is Nancy Morrow-Howell, PhD, of Washington University in St. Louis.

She and her colleagues document the benefits of volunteering as identified by older adults - a departure from many previous studies, which have focused on the benefits observed by researchers. They also compare reported benefits with information about the volunteer program, such as volunteer training, support, and stipends. "These findings suggest that characteristics of volunteer programs can be strengthened to maximize the benefits of volunteering to older adults," the authors state.

Morrow-Howell's team sampled 401 people aged 55 and older from 13 volunteer programs. The volunteer activities included teaching, tutoring, mentoring, policing and public safety work, conservation efforts, and supportive counseling. More than 30 percent of participants said they were "a great deal better off" because of the service they contributed, and almost 60 percent identified a benefit to their families. Twenty percent reported improved overall health.

The reported benefits depended upon the participant's demographics as well as the type and characteristics of activity. For example, among those who received compensation for their work, the positive relationship between stipend and perceived advantages was weaker for the oldest of the 55+ sample, for non-white older adults, and for those with lower education and lower income.

Women and lower-income volunteers also reported more benefit than others from participating in public security programs. The researchers speculated that those older adults who traditionally had less authority thrived in roles involving law enforcement.

Support for this research was provided by the MetLife Foundation and the Longer Life Foundation.

*Source: Todd Kluss; The Gerontological Society of America*

### **Having a Higher Purpose in Life Reduces Risk of Death among Older Adults**

Possessing a greater purpose in life is associated with lower mortality rates among older adults according to a new study by researchers at Rush University Medical Center.

Patricia A. Boyle, PhD, and her colleagues from the Rush Alzheimer's Disease Center, studied 1,238 community-dwelling elderly participants from two ongoing research studies, the Rush Memory and Aging Project and the Minority Aging Research Study. None had dementia. Data from baseline evaluations of purpose in life and up to five years of follow-up were used to test the hypothesis that greater purpose in life is associated with a reduced risk of mortality among community-dwelling older persons.

Purpose in life reflects the tendency to derive meaning from life's experiences and be focused and intentional, according to Boyle.

After adjusting for age, sex, education and race, a higher purpose of life was associated with a substantially reduced risk of mortality. Thus, a person with high purpose in life was about half as likely to die over the follow-up period compared to a person with low purpose. The association of purpose in life with mortality did not differ among men and women or whites and blacks, and the finding persisted even after controlling for depressive symptoms, disability, neuroticism, the number of medical conditions and income. During the study period, 151 participants died.

"The finding that purpose in life is related to longevity in older persons suggests that aspects of human flourishing particularly the tendency to derive meaning from life's experiences and possess a sense of intentionality and goal-directedness contribute to successful aging," said Boyle.

Significant associations with mortality were found with three specific items on the purpose of life questionnaire to determine the study participants' agreement with the following statements: "I sometimes feel as if I've done all there is to do in life;" "I used to set goals for myself, but that now seems like a waste of time;" and "My daily activities often seem trivial and unimportant to me."

The researchers note that knowledge of the relationship of purpose of life with other demographic characteristics is limited and future studies are needed to examine whether the association of purpose of life with mortality might be modified by other variables not measured in this study, such as how religious a participant may be. In addition, researchers suggest that future studies should examine whether purpose in life can be enhanced in older persons with interventions. "Although we think that having a sense of purpose in life is important across the lifespan, measurement of purpose in life in older persons in particular may reveal an enduring sense of meaningfulness and intentionality in life that somehow provides a buffer against negative health outcomes," said Boyle.

The Rush Memory and Aging Project, which began in 1997, is a longitudinal clinical-pathological study of common chronic conditions of aging. Participants are older persons recruited from about 40 continuous care retirement communities and senior subsidized housing facilities in and around the Chicago Metropolitan area. More than 1,200 older persons are enrolled in the study. The Minority Aging Research Study began in 2004 and is a study of risk factors for cognitive decline in older Blacks. Participants are recruited from community-based organizations, churches, and senior subsidized housing facilities in and around the Chicago Metropolitan Area. More than 350 older persons are enrolled in the study.

This study was funded by the National Institutes on Aging. The authors thank the NIA for supporting this work and are indebted to the participants of the Rush Memory and Aging Project and the Minority Aging Research Study for their invaluable contributions to aging research.

Boyle is a neuropsychologist in the Rush Alzheimer's Disease Center.

*Source: Rush University Medical Center and Medical News Today*

## **The Emotional Cost of Nursing**

*Keri Mucci, for HealthLeaders Media, July 7, 2009*

Nurses cure the sick, heal the wounded, and comfort the dying, but are they doing so at their own cost?

Jenny Watts, researcher and psychology PhD student at the [University of Leicester](http://www2.le.ac.uk/) (<http://www2.le.ac.uk/>) in Leicester, England aims to find out in a new project examining the emotional toll of nursing. The project, which follows a large scale methodical review of published literature Watts conducted last year, will explore how exposure to patient suffering and empathizing with patients influence nurses' experiences of distress.

"The [previous] review revealed certain nurse characteristics may predict a specific form of distress," says Watts. "There appear to be many moderating variables, but the literature suggested more empathetic nurses showed greater vulnerability to what had been labeled as burnout and secondary traumatic stress."

Watts' findings indicate nurses who empathize and identify with their patients can share patients' emotional reactions, thus nurses with highly distressed patients can develop similar symptoms. In addition, dealing with patients' concerns can lead to draining of emotional resources. Such distress can significantly affect nurses' personal and professional lives, resulting in flashbacks of traumatic events, sleeping difficulty, emotional detachment, and increased feelings of work-related dissatisfaction.

"There is evidence that caring for others can have negative implications for their career, in terms of physical health and professional functioning. However, we need to determine a more precise understanding of nurse distress to enable suitable interventions," Watts says. According to Watts, one of the major findings of her review implicates age is a predictive factor of distress. For instance, younger, less experienced nurses report greater distress.

"This project aims to test these apparent relationships and determine how much variance in distress—in the form of burnout, for example—can be determined by factors, such as empathy and social support," Watts says.

Pending approval of the NHS Research Ethics Committee in the U.K., Watts will start the first stage of the project with the university's School of Psychology. A qualitative pilot study will involve nursing staff employed in long-term care facilities and hospital wards for older adults. Watts wants to study the nurses due to the U.K.'s aging population and adults older than 70 being the largest consumers of hospital care. Nurses witnessing death and deterioration in older adults have reported distress and may suffer from anxiety and depression as a result.

The project will include the use of qualitative tools to first gather nurses' experiences of patient care and then apply quantitative measures, such as questionnaires to assess the variables (i.e., social support or staff characteristics). "Using the results, we aim to construct predictive models of the nurses' distress," Watts says. "These models may reveal sources of vulnerability, enabling education and training to be tailored more effectively." She adds, "This strategy may also reveal sources of resilience, such as a negative relationship between social support and burnout, and these more positive findings could also be applied in strengthening occupational policy." Fortunately, working in the profession doesn't and won't take a large emotional toll on every nurse. "Not all nurses will experience significant distress as a result of exposure to patients' suffering. However, for those that do, the consequences can be far-reaching." It is because of this that more knowledge is needed and more measures be taken to prevent nurses and patients from suffering the effects of distress.

"It is increasingly important to maintain the health and wellbeing of healthcare providers," says Watts. "In addition, there is evidence within the literature that compassionate care can have a positive impact on patient outcomes."