

# Nursing Notes



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**April 2009**

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

## HOT TOPICS

### **Nurse CE Requirements Clarified**

Here is a clarification of the CE requirement in the new Nurse Practice Act since LSN continues to get calls and inquiries. The 20 hours of continuing education will be required and noted on the renewal form **for the first time in 2012** for RNs and **2013 for LPNs**. When RNs renew in 2012 (2013 for LPNs), there will be a statement about continuing education and you will need to certify (probably by check mark) that you have had at least 20 hours of approved continuing education during the previous 24 months.

So you do not need to "keep track" of your hours now but need to begin in June of 2010 saving certificates, logging CE, keeping a portfolio or other documentation as proof of the CE you attend or complete. The Department will conduct some random audits of CEs so although you won't be required to send your portfolio with your renewal, you may be asked to produce it if you are part of the audited sample. There will be specific descriptions of the type of CE that will "count" or meet the requirement in the final rules (which hopefully will be published soon).

## REGULATORY UPDATE

### **CMS Delays MDS 3.0 Implementation**

During the Skilled Nursing Facility/Long-Term Care Open Door Forum on Thursday, March 5, the Centers for Medicare & Medicaid Services (CMS) announced that the release of the MDS 3.0 will be delayed until October 2010. Rather than rushing to meet the original October 2009 implementation date, Sheila Lambowitz, director of the division of institutional postacute care at CMS, said the agency wants to take its time and ensure that all stakeholders and systems can be updated to work efficiently with the MDS 3.0.

CMS is currently working on revising the timeline, which should be released in the next couple of months. But according to Tom Dudley, a CMS official, the data specs and final draft won't be released until October 2009. The implementation delay stems from concerns that the original start date did not provide enough time for software vendors, state agencies, and other systems to properly prepare for the MDS 3.0.

“The delay until October 2010 is a positive thing – this gives the states, software vendors, and other stakeholders the time they need to prepare for implementation,” says Rena R. Shephard, MHA, RN, RAC-MT, C-NE, founding chair and executive editor of the American Association of Nurse Assessment Coordinators and president of RRS Healthcare Consulting Services in San Diego. “But this is also a positive for providers – it gives them the time they will need to develop and carry out a plan for training and implementation. I hope they will use it well – this advance preparation can be very important to successful implementation.”

*Source: MDS 3.0 Update - HCPro*

## **STRIVE Technical Expert Panel Meets**

*Authored by Carol Job, RN Consultant, Myers and Stauffer for NAC News*

The Staff Time and Resource Intensity Verification Evaluation (STRIVE) Technical Expert Panel (TEP) met in Baltimore 3.11.09. The STRIVE time study was completed in 15 states, 207 nursing facilities and 9,271 study residents. The new time study data will be used to recalibrate the Resource Utilization Groups case mix weights and determine if care practices have changed. It is important to reflect practice changes in the assessment tool and the classification system. I was hoping we might get a peak at the new RUG IV classification system, but since they are in the rule making process they could not share a draft of the proposed system. Brant Fries walked through some of the analysis that was done and gave out some hints on some of the considerations.

I am pretty certain that the RUG IV will look very similar to RUG III with a few changes. They studied the Extensive items and what effect it would have to count them only after admission to the nursing facility. There might be some changes to the Extensive Count but no details were provided. Some items from Clinically Complex may move up to Special Care. The Behavior group and Impaired Cognition Groups continue to be an issue. There are not a lot of residents classifying into these categories and the variance explanation has not changed dramatically since the last time studies. The ADL scales might change some as well and they are considering adding staff support for eating. They did try to add a pain item but it just did not show a good explanation of resources and it could create some quality of care issues.

The above items are still under consideration; and we will not have the final RUG IV until the proposed rule is published in the Federal Register sometime in May. At that time, there will be a 60 day comment period. The final rule will be published sometime in July with an October 1, 2009 implementation date. Remember this rule will affect Medicare PPS only. Case mix states will not have to implement RUG IV for Medicaid until they have had time to study the impact of the new classification system, make decisions, update rules and set an effective date.

*Source: NAC News*

## **WORKFORCE WISDOM**

### **Hone your Hiring Skills**

*Authored by: Shelley Cohen, RN, BS, CEN, president and founder of Health Resources Unlimited in Hohenwald, TN,*

Selecting new staff to add to the team is one of the most important roles nurse managers play in relation to recruitment and retention, yet their interview skills are typically lacking. In order to improve the interview and hiring process, nurse managers must be educated and provided with the right resources:

- Discuss interview scenarios in your monthly management meetings
- Share what you feel is the most effective interview question at the meeting and ask other nurse managers to do the same
- Ask management for reference materials that can help you improve your interview techniques and approaches
- Demonstrate the importance of hiring for character versus hiring for skill through your own interview techniques

- Work with other nurse managers at your facility to address interview options that involve staff
- Request sample interview questions from management that prompt prospective hires to verbalize their skills, rather than having them show a certification card
- Consult the human resources department for education on liability concerns during the interview process, such as those related to discrimination

Source: *Nurse Manager Weekly*

## Improve the Nursing Image with Professional Communication

Every interaction that we have with another person at work is a communication. Even if we never speak, our body language portrays whether we are interested or disengaged, caring or aloof. More than anything, we communicate what we think of ourselves.

Therefore, if we feel like a long-suffering martyr for healthcare, this image comes through. And if we feel like a skilled expert who can compassionately deliver excellent patient care, everyone who comes within five feet of us knows it without us ever saying a word.

Ensure you and staff communicate professionally by modeling the following behaviors at your facility:

- Always stop and look people in the eye when you are speaking to them
- Never stand by listening while one staff member puts another one down
- Never criticize in public; always speak to the person directly in private
- Keep confidences
- Work cooperatively, despite feelings of dislike
- Be willing to help when help is requested (or you notice a staff member is overwhelmed)
- Don't participate in gossip

Source: *Nurse Manager Weekly*

## Old, but Not Out: The Aging Nurse in Today's Workplace

Author: Laura A. Stokowski, RN, MS *Medscape Nurses*. 2008; ©2008 *Medscape*

### Age and Nursing

Nearly every article or opinion piece about the nursing shortage recommends the important strategy of retaining our older and most expert nurses. The fact that we must even articulate the need to retain nurses speaks to the sad state of affairs we are facing in the nursing profession. Why are qualified nurses leaving nursing for other careers, cutting back their work hours, or retiring early? And can anything be done to persuade nurses to return to nursing?

The age of the average nurse steadily inches upwards. In 2004, the average nurse was age 46.8 years (up from 45.2 in 2000).<sup>[1,2]</sup> The age at which a nurse is considered *old* varies according to different experts. Some define "older" as anyone over the age of 40 years, while others consider workers to be old when they are 55 to 64 years of age. In an interview with Susan Letvak, PhD, RN, from the School of Nursing, University of North Carolina at Greensboro, who has written extensively on the subject of the mature nurse, the older nurse was defined as one who has reached 50 years of age.

The largest cohort of nurses working today consists of those born from 1955 to 1959. We are now experiencing an aging workforce, as this cohort is entering their fifties. By 2010, 40% of nurses will be over the age of 50 years. In about 10 years, as these nurses begin to retire, the nursing workforce will shrink considerably as this large cohort is replaced by smaller cohorts of nurses.<sup>[3]</sup> The loss of these older, expert nurses could have a disproportionate impact on patient safety and quality of care.<sup>[4]</sup>

## **The Older Nurse**

The older nurse wants to feel welcomed, accommodated, appreciated, and effectively used.<sup>[4]</sup> Older nurses tend to be concerned about benefits and retirement plans as well as the quality of the work environment.<sup>[4]</sup> They want a work environment that supports nurse autonomy in practice and participation in operational decision making. Nurses are sensitive, and they are aware when their skills and contributions are not valued by the organization. Devaluation of experience and a lack of respect for nurses are leading factors in nurse attrition. Nurses work long hours under stressful working conditions but rarely receive the same acknowledgment of their contributions accorded to other professionals.<sup>[4]</sup>

Managers may assume, wrongly, that older nurses are all empty nesters with few responsibilities outside the workplace. "Many older nurses are caring for their ailing parents or their grandchildren," explains Susan Letvak. "They need flexible work schedules."

Although not all nurses may remain in active practice primarily for the financial rewards,<sup>[5]</sup> pay is important. Older nurses are unhappy with flattened wage structures that fail to recognize years of service.<sup>[6]</sup> When these nurses see new recruits being lured with huge sign-on bonuses, and travel or agency nurses receiving large hourly salaries for the same work, they wonder if the organization values commitment and longevity at all.

Older nurses often admit to slowing down, as though this is a bad thing. Slowing down can make the nurse more thoughtful, more careful, more patient, and more safe. There is more time to think, and, analogous to the pre-procedural pause, more time to focus and perhaps prevent an error from occurring.

## **Generational Differences**

In today's multigenerational work setting, nurses from as many as 4 different generations are working side by side.<sup>[7]</sup> Each generation's core values, created by the era in which they were born and by their life experiences, can influence work ethic, perceptions of others' work ethic, and communication styles.<sup>[8]</sup>

Letvak points out that the generation gap in nursing is real. Younger nurses view older nurses as being resistant to change, lacking enthusiasm, and stuck in the past, with a "been there, done that" attitude. Older nurses may think younger generations of nurses don't have the same work ethic that they do, that younger nurses are less committed to their jobs and, perhaps, less respectful to authority.<sup>[9]</sup> Generational conflict can lead some older nurses to choose retirement over adaptation.

The myths about older nurses -- that they are slow and resistant to change, that they are less motivated or creative than their younger counterparts -- have been debunked by research.<sup>[4]</sup> It is commonly believed that older workers use more sick time, but in despite having more chronic disease, older nurses have fewer short-term illnesses.

However, some differences between the generations are real. Compared with younger nurses, older nurses express greater satisfaction with their jobs and with nursing as a career choice.<sup>[10]</sup> Although older and younger nurses report similar relationships with other nurses and physicians, older nurses report a higher quality of relationship with nurse management and hospital administration.<sup>[11]</sup> Self-reported work productivity declines with age and years worked in nursing.<sup>[12]</sup>

## **What Will It Take to Keep Our Older Nurses?**

One third of nurses over the age of 50 years plan to leave their nursing positions in the next 3 years.<sup>[10]</sup> Given the high cost of replacing a nurse, it seems inconceivable that healthcare organizations aren't bending over backwards to keep these nurses.

Letvak describes a "magic window" during which it is critical to retain nurses before they are lost to early retirement. As they reach their fifties, many nurses have been working steadily for 30 years or more, and the work is becoming more physically challenging than mentally challenging. Developing strategies to retain this large segment of the nursing workforce requires an understanding of the needs of older nurses.<sup>[10]</sup> It is also important to focus on retaining nurses who are approaching their forties. Nurses entering their fourth decade are highly likely to shift employment into non-acute care settings.

Improving the work environment may delay widespread early departure from the workforce. Reducing job stress and improving the ability of nurses to deliver high quality care by providing adequate staffing are 2 factors important to retaining older nurses.<sup>[12]</sup>

A big part of keeping nurses on the job is preserving their health and preventing work-related injuries. Diminishing strength and muscle mass create more stress on the hip and knee joints, making the older nurse vulnerable to occupational injury. Ergonomics, a discipline that adjusts the work environment to fit the individual, should be used by healthcare organizations to improve the workplace and minimize work-related physical stress. The goal should be a work environment that is ergonomically favorable and safe.<sup>[4]</sup> For example, one hospital introduced a dedicated patient-lift team and new lift equipment to reduce musculoskeletal injuries among its staff. New technology aimed at streamlining tasks and improving efficiency should ease the nurse's burden, not add to it.<sup>[4]</sup>

Mature nurses are far more likely to extend their work life if they are able to participate in decision-making and receive recognition for their work from their supervisors. Encouragement and positive feedback are often directed at younger rather than older nurses. Supportive workplaces, the ability to socialize with peers, time to talk to patients, and control over the work setting are important to older nurses. Older nurses may be persuaded to continue working if they are offered less strenuous jobs or innovative new roles in which they can still use their knowledge and experience, and which have more favorable work schedules. No one is tempted to put off retirement to continue working in a setting that expects nurses to work harder and longer to compensate for short staffing and economic cutbacks.

The older nurse's vast experience, skill, and knowledge can be acknowledged by asking the nurse to serve as a mentor or preceptor to younger nurses and new graduates. "Precepting and mentoring can help the older nurse become enthusiastic about nursing again," maintains Letvak. Research also suggests that veteran nurses could play a valuable role as "emotional mentors" to prevent agitation and burnout in their younger colleagues.<sup>[13]</sup>

Employers should offer retirement planning to older nurses, or make existing financial planning resources more visible and accessible. Retirement plans should be restructured to allow nurses to keep working after age 65 if they choose. Benefits offered to younger nurses, such as child care, should be offered to older nurses who need elder care. Hospitals should shift their focus to retention by offering longevity bonuses to long-term employees rather than big sign-on bonuses to nurses who work only a year.

### **Best Practices to Retain Aging Nurses**

The nursing workforce is often an afterthought for healthcare executives, who rank reimbursement issues, government regulations, quality of care, and uncompensated care as more important than the nursing workforce.<sup>[14]</sup>

A white paper from the Robert Wood Johnson Foundation titled, "Wisdom at Work: The Importance of Retaining the Older and Experienced Nurse in the Workplace," outlines 12 best practices that hold the greatest promise for resolving issues contributing to job dissatisfaction in older nurses:

- Boost 401(k) participation, redefine pensions, and provide financial advice.
- Provide caregiver and grief resources. Workers over the age of 45 often have caregiver responsibilities in the home.
- Develop a corporate culture that values the mature worker.
- Provide flexible work options, including scheduling and worksite location. Options may include job sharing or compressed work schedules.
- Pair knowledge transfer with phased retirement. The soon-to-retire nurse trains a replacement, so the experienced nurse's knowledge and skill are transferred to the novice.
- Achieve magnet status, which is important to retention.
- Start a mentoring program to increase opportunities for knowledge transfer.
- Allow phased retirement, wherein older workers can leave the workforce gradually by reducing hours worked while still accruing benefits.
- Provide retirement planning. Nurses are often unprepared for retirement.

- Manage your talent by assessing the impact of projected demographic and labor market changes, and develop an understanding of the institution's current talent base and the potential for a talent gap, or "brain drain," when older nurses leave.
- Provide lifelong learning and professional development.
- Redesign the workplace and make ergonomic improvements, focusing on working conditions that contribute to turnover and burnout.<sup>[4]</sup>

Unless healthcare facilities take a hard look at the conditions that would help older nurses continue to work beyond the usual retirement age, many of these nurses will be retiring at the exact time that they are coping with the healthcare needs of a growing elderly population.<sup>[4]</sup> A culture of retention is the key to a stable workforce.<sup>[14]</sup>

### **Returning to Nursing**

Keeping our older nurses working is one way to alleviate the nursing shortage. The other side of the coin is how healthcare organizations can encourage nurses who have already left to return to the workforce.

### **Inactive Nurses**

Of our nation's 2.9 million nurses, 17% hold inactive licenses, amounting to nearly a half-million nurses.<sup>[1]</sup> Among nurses no longer employed in nursing, 45% cited stress or burnout as one of the reasons they left nursing.<sup>[1]</sup> Other explanations were low salaries (cited by 34%), inadequate staffing (33%), excessive work hours or shifts required (41%), lack of communication or collaboration (21%), and a lack of opportunities for advancement (17%). The physical demands of the job were judged too difficult by 28% of nurses who left nursing. On the whole, workplace and career factors far outweighed family or personal reasons for leaving. One fifth of inactive nurses believe that their skills are out of date.<sup>[1]</sup>

Langan and colleagues<sup>[15]</sup> also explored the reasons that nurses are inactive, and what would entice them to return. They found that 30% of nurses left because of working conditions such as workload, 12-hour shifts, insufficient time for patients, excessive paperwork, and new technologies. A large percentage (42%) of nurses surveyed stated that greater financial rewards (higher salaries, sign-on bonuses, improved benefits) would be necessary to entice them back to professional practice.<sup>[16]</sup> Respondents also valued flexible working hours, part-time opportunities, consideration for personal and family life, adequate staffing, and positive relationships with supervisors and administrators.<sup>[15]</sup>

Family demands or a tempting career change can induce nurses to take a break from nursing. Others may retire early, but after a period of time, rethink this decision and consider returning to practice. If the break is a short one, the nurse who retains his or her license can return to nursing with a short reorientation to the clinical setting. Nurses who have been away for years, however, may find that even if they have kept their license active with fees and continuing education, an employer will require a refresher course before offering a position.

Nurses returning to acute-care nursing are often filled with self-doubt.<sup>[16]</sup> Their greatest fears usually revolve around equipment, medications, using computers, and physical assessment skills.<sup>[17]</sup> Patient safety and fears of making mistakes are additional concerns of re-entry nurses.<sup>[16]</sup> Returning nurses may experience anxiety and a loss of confidence in their abilities to regain their nursing skills.<sup>[18]</sup> These nurses are usually reassured to find that despite technological advances, the foundations of nursing -- comfort and compassion -- hasn't changed.<sup>[19]</sup>

How easy or difficult it is to re-enter nursing may depend on how long the nurse has been inactive clinically. When it comes to re-employment, length of "time off" refers to how long the nurse has not practiced nursing, not how long the license has been inactive. The requirements for reinstatement of licensure vary from state to state. Some states, such as Delaware, require the completion of an approved refresher program within 2 years before submitting an application for reinstatement if the nurse has been inactive in nursing for 5 or more years.<sup>[20]</sup> Other states, such as Alaska, provide the option of completing an approved refresher course or successfully completing the National Council Licensing Examination (NCLEX).<sup>[21]</sup> Some states require both.

Consult your state's board of nursing for the regulation that applies in your state. (To locate your board of nursing, visit the [National Council of State Boards of Nursing](https://www.ncsbn.org/515.htm).) The refresher course requirements also vary from state to state. Each state's nurse practice act will specify how many total hours of instruction are required, along with how many hours must be didactic and how many hours must be clinical instruction. It is essential to check your state's requirements before taking a refresher course.

### **Refresher Courses**

Refresher courses are offered in many different locations and formats. Courses incorporate both didactic and clinical instruction; some also have a laboratory requirement with opportunities for simulation training. Online courses are convenient, and include both theoretical and clinical components. Learning is self-paced, but there is usually a minimum time period for completion of the course. Learner support is often available online as well. The clinical experience portion of an online course can often be completed in the nurse's local community, and the nurse must arrange his or her own clinical training. The nurse who holds an active license but desires to take a refresher course before returning to work can often opt to take only the didactic portion of the course.

Courses are offered through colleges and universities or hospitals. Hospital-based courses are usually the basis for a "re-entry program," offered to nurses who have been hired for a nursing position in the hospital. The main drawback of refresher courses is that they concentrate primarily on adult medical-surgical nursing, and do not offer sufficient preparation for some specialty areas. Nurses who wish to return to a specialty area must negotiate for an adequate orientation program upon hiring.

A partial list of nurse refresher courses available in the United States can be found at [Nurse.com](http://Nurse.com). Another place to look for refresher courses in your area is the Web site of your state nurses' association.

The prerequisites for acceptance into a refresher course vary. Most require the prospective student to take cardiopulmonary resuscitation training for health professionals before enrolling. Many require a criminal background check and drug screen. Some require proof of a physical examination within the past year, including proof of tuberculosis testing and immunizations.

### **Barriers to Returning to Nursing**

Admittedly, it isn't always easy for the older nurse to find a position that suits his or her skills and career desires.

Jenny is a 57-year-old nurse with a master's degree in nursing. She began her long nursing career in 1972, and throughout subsequent years worked at a veterans hospital, as a hospital float, at a home care agency, at a home infusion agency, and in several other settings. She last worked in an inpatient setting in 1990, but while working in home care, she became skilled in taking care of oncology patients, including pain management and palliative care.

In 2001, Jenny decided she wanted to return to bedside nursing. She missed the contact with patients in the hospital, providing total care, and looking for ways to improve quality in nursing. She interviewed for several positions, but was turned down by nurse managers because of her 11-year break from hospital nursing. "You need to take a refresher course," she was told by the manager of an oncology unit, who completely ignored the skills in oncology that Jenny maintained in her home care experience.

Jenny's financial situation precluded taking time off to go back to school. She interviewed for a position in palliative care, and was astounded when she was told, "We aren't in the business of helping nurses make a midlife career change."

Jenny has not given up looking for the right nursing position for her because she believes she has a lot to give. The search, however, is very frustrating. Most of the time, when she puts in applications, she doesn't even get a call back. Most positions are full-time only, with no provision for the older nurse to work part-time. It's hard for her to believe there is really a nursing shortage.

Jenny's experience illustrates the difficulties faced by some nurses trying to return to the workplace. These nurses often find themselves on their own, with no one to guide them. They may be unable to get past human resource personnel to even have the opportunity to sell themselves to a nurse manager. New graduates do not experience this level of difficulty getting a job in nursing.

### **Advice From an Expert**

If you are considering returning after an extended time away from nursing, take the advice of expert Susan Letvak on re-entering the workforce with confidence. Don't hesitate because you think you will be the oldest nurse on the unit. You are likely to find enough contemporaries to make you feel comfortable. Begin by verifying the status of your nursing license. Your state board of nursing can tell you what you need to do to reactivate a lapsed or inactive license.<sup>[19]</sup>

Letvak suggests taking a refresher course to make certain that you have the requisite skills and clinical competence. Refresher course instructors may also be willing to write references for the student to aid in the job search. Prepare a professional resume that includes all of your related experience, including volunteer work and participation in professional societies. When you get to that job interview, you need to sell yourself, without overstating your abilities. If you are offered a position, request the same level of orientation and mentoring that a new graduate would receive.<sup>[19]</sup>

### **Conclusion: Growing Old**

I like poet TS Eliot's reflection on growing old:

*"The years between fifty and seventy are the hardest. You are always being asked to do things, and yet you are not decrepit enough to turn them down."*

Nurses between 50 and 70 years of age are capable, knowledgeable, and experienced. In most cases, these nurses have many productive years left in the nursing profession. What older nurses want and need to keep working is not a big mystery -- they want to be valued and they need to contribute. Whether these nurses remain in nursing will depend on how nursing treats them. Employers can either continue to spend millions on nurse turnover, or they can wake up to what they already have and do something to keep it.

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Disclosure: Laura A. Stokowski, RN, MS, has disclosed that she has served as a consultant for Draeger Medical.

## STRATEGIES FOR QUALITY AND SAFETY IMPROVEMENT

### Falls after Age 90: Inability to Get Up and Prolonged Time on Floor Portend Poor Outcomes

*Authored by Paul S. Mueller, MD, MPH, FACP from Journal Watch General Medicine*

Fall risk increases with age. In a prospective study, U.K. investigators followed 110 elders (age, greater than or = to 90; 18% men) to determine the incidence and immediate aftermath of falls.

During 1 year of follow-up, 66 elders (60%) experienced 265 falls. In most falling incidents, elders were alone, were found on the floor, and required help getting up. After 21% of falls, elders remained on the floor for at least 1 hour or unknown duration. Inability to climb stairs was associated with inability to get up without help after one or more falls (odds ratio, 17, after adjustment for age, sex, and mobility). Severe cognitive impairment (OR, 8) and serious injury (OR, 7) were associated with remaining on the floor for at least 1 hour after falling. Lying on the floor for at least 1 hour after falling also was associated with fall-related hospital admission during the follow-up year (OR, 4). Needing help to get up after falling also was associated with hospital admission (OR, about 20). In 99% of the fall episodes in which the elders were alone and could not get up, they had access to an alarm system; however, during 80% of these episodes, they did not use the systems to call for help.

Falls are common in people older than 90, and many cannot get up after falling. Prolonged time on the floor after a fall is associated with injury and hospitalization. Notably, most elders in this study had access to alarm systems; of these, nearly one half had personal call alarms (e.g., pendant), whereas the remainder had call bells in their rooms or apartments. However, most elders who had these alarm systems usually did not use them. **As the authors note, these results have practical implications (e.g., developing new strategies for preventing falls, teaching elders how to get up after falls, and encouraging elders to use alarm systems, if available, after falls).**

### Rethink the Way You Throw Away Gowns

A new infection control technique involving the disposal of paper hospital gowns is a simple, but effective procedure created by Jasper Palmer, a patient escort at Albert Einstein Healthcare Network in Philadelphia. Infection control experts spoke about the technique recently at the Society for Healthcare Epidemiologists of America conference in San Diego.

Palmer began folding his protective gown small enough to fit inside a rubber glove so that it was easy to throw away, and it provided a protective barrier to prevent the spread of MRSA and other infectious diseases, [according to a Reuters article](#).

(<http://www.reuters.com/article/healthNews/idUSTRE52K1O920090323>) Experts say the technique has reduced the rate of antibiotic-resistant infections by 26%-62%.

*Source: Infection Control Weekly Monitor*

## SYSTEM DESIGN AND ORGANIZATIONAL CHANGE

### 'Do Not Resuscitate' vs. 'Allow Natural Death'

Could three words change the way severely ill patients and their loved ones think about death? Spiritual leaders and some medical staff at hospitals across the USA believe so, and they are reconsidering how they pose one of life's toughest questions: Do you want to sign a "Do Not Resuscitate" form? When they ask, family members often balk. They believe they are giving up, condemning a loved one to death.

Some are now asking the question a different way: Do you want to allow natural death?

Do not resuscitate. Allow natural death. Both phrases are uttered at the same time — the moment when doctors believe they have exhausted treatment options and death is inevitable.

But Lee Memorial Health System specialists in Fort Myers, Fla., are finding semantics do matter. "More often than not, the body language of the family will soften" when the phrase "allow natural death" is used, says the Rev. Cynthia Brasher, spiritual services director. "It shifts the burden."

### **Specific meaning for 'do not resuscitate'**

A study published last year in the *Journal of Medical Ethics* measured how often nurses, student nurses and people with no health care backgrounds would endorse allowing death to progress when they were approached with the phrase "do not resuscitate" vs. "allow natural death." The nurses were likely to support the dying process regardless, but all three groups reported a greater likeliness to forgo resuscitation if "allow natural death" was used.

Some intensive care doctors say the words "do not resuscitate" can't yet disappear. That phrase carries a specific command to the attending medical team. Razak Dosani, head of Lee Memorial Hospital's intensive care unit, says "do not resuscitate" means doctors will not perform cardiac resuscitation. But they will do everything up to that point. That might not be what the family or patient really wants. "Allow natural death" suggests doctors will offer only comfort measures, because any other aggressive treatment, such as intubation, may only prolong death. Intensive-care doctors believe adding new terminology will help families with their decision.

Only about 20% of Americans have advanced directives leaving their loved ones to make the call if they are too sick to do so. Brasher says she knows of only one other hospital in Florida — the Miami Children's Hospital — that uses similar terminology. It is not clear, she says, how many other health organizations across the country use it, but enough are doing so to pique the interest of scholars who are studying how words affect end-of-life decisions. "Our argument is it's more humane and more compassionate," Brasher says.

### **Debate drives discussions about death**

The semantic shift is a sliver of a broader question: how to talk about death, disease and the limitations of medicine. The conversations are more crucial than ever as doctors amass an arsenal of technologies to keep people alive — and a growing list of ethical dilemmas about the nature of life artificially supported. "Allow natural death" isn't a new concept.

Samira Beckwith, CEO of Hope Hospice in Fort Myers, says a statewide task force a decade ago looked at adopting the language on its Do Not Resuscitate forms. That didn't happen, Beckwith says, but it got health care providers talking. Hope Hospice providers use "allow natural death," along with other terminology, to make sure patients and family understand their options. "Our greatest responsibility is to listen to the person and find the language that is best understood by them," Beckwith says.

St. David's Health Care in Texas adopted the "allow natural death" terminology eight years ago, championed by the manager of spiritual care, the late Rev. Chuck Meyer, and his successor, the Rev. Amy Donohue-Adams. "I think people are much more comfortable with that," says Donohue-Adams, who first introduced the switch at the system's Round Rock Medical Center in Texas. "They hear 'allow natural death' and say, 'Well, that's exactly what we want. We want a death that is as natural as possible.' "

Frank Chessa, director of clinical ethics at Maine Medical Center, understands the rationale but questions its usefulness. He argues the phrase isn't specific enough. "'Allow natural death' to my ears is ambiguous between 'do not resuscitate' and 'comfort measures only,'" Chessa says. He suggests using no such terminology but rather explaining patients' options with specific examples of potential life-prolonging therapies. Many hospitals, Chessa says, are using lengthy, specific end-of-life order sets to decide on everything from CPR to dialysis to intubation to blood transfusions.

Dosani and Marilyn Kole, the Lee Memorial medical director for intensive care, say explaining terminology, options and implications of their choices will allow family members to make the best decisions for their loved ones. "That's one of the things lacking in our medical community," Dosani says. "We need to take time and educate."

*Source: USA Today*

## **Encourage Teamwork to Drive Change**

Exemplary professional practice requires teamwork among nurses, collaboration with patients and their families, and interdisciplinary partnerships. Follow these strategies to improve teamwork in your unit:

Exemplary professional practice requires teamwork among nurses, collaboration with patients and their families, and interdisciplinary partnerships. Follow these strategies to improve teamwork in your unit:

- Establish clear unit goals with staff members. Post a visible action plan in the unit identifying the various steps, responsible persons, and a timeline. Focus your efforts!
- Choose a theme for the month (e.g., resilience, change, patient satisfaction, fall prevention) and identify team actions that contribute to success.
- Have team members interview each other. As a result, they will discover unique characteristics and strengths in one another and spread the word.
- Post group photos of staff around the unit—not just photos of individual staff members. Include nurses, physicians, and ancillary staff.
- Invite all shifts to present their contributions to creating a healthy workplace. Encourage creativity, such as photos, poetry, and stories.
- Boost collaboration between staff members from different shifts through walking rounds, collaborative educational presentations, and journal article reviews.

Use visual aids and education to support change when it occurs. For example, post a map displaying the stages of change and ask staff to mark their current position and move their name along as they progress. Acknowledge staffs' feelings, list strategies that facilitate progress, model flexibility, and hold staff accountable to take actions to move forward. Identify change agents and mentor leadership skill development. Celebrate step achievements!

*Source: Nurse Manager Weekly*

## **CLINICAL CORNER**

### **Researcher Says Injections May Be Answer to Incontinence Problems**

Women who suffer from stress urinary incontinence can be helped by collagen injections, even after surgery has failed, a medical researcher says. A majority of nursing home residents suffer from one or more types of incontinence.

The collagen can be effective even after urethral or periurethral surgery hasn't been, says lead researcher Dr. Philippe Zimmern, a professor of urology at the University of Texas Southwestern Medical Center. When injected into tissue surrounding the urethra, collagen can tighten the urethral sphincter, staunching urine leakage, experts say.

"Patients with persistent or recurrent incontinence often do not wish to undergo another surgery," Zimmern explained. "The collagen injection is also a good alternative for those who cannot afford recovery time from surgery or are too medically unfit or frail to undergo a second surgical intervention."

*Source: Journal of Urology*

### **Tip of the week: Apply Restorative Nursing to All Residents**

The principles of restorative nursing care, designed to assist residents to attain and maintain the highest level of physical, mental, and psychosocial function possible, apply to all residents. They are as follows:

- *Begin treatment early.* Starting restorative care soon after admission or early in the disease will improve the outcome.
- *Activity strengthens and inactivity weakens.* Keep residents as active as possible. Encourage independence, even if the resident is cognitively impaired.

- **Prevent further disability.** For example, nursing personnel develop a preventive care plan for high-risk conditions, such as falls, pressure ulcers, contractures, and deformities.
- **Stress the resident's ability and not the disability.** Emphasize what the resident can do. Avoid expressions such as "You can't use your right arm." Instead, say "You can use your left arm." Do not assume the resident cannot complete a task until you've tried, particularly with residents who are cognitively impaired.
- **Treat the whole person.** You cannot isolate a medical problem from the rest of the person. Consider all of the resident's strengths and needs. Use and build on the strengths to overcome the needs.

Source: *HCP's Book – The Long-Term Care Nursing Desk Reference*, Author – Barbara Acello, MS, RN.

## **A Revolutionary "Non-Toxic" Model for Alzheimer's**

A study from the Buck Institute for Age Research offers a revolutionary new model for Alzheimer's disease (AD), a devastating neurodegenerative disorder which afflicts 24 million people worldwide. In an effort to unravel the normal function of a protein implicated in AD, scientists in California and France have discovered a naturally occurring protein that provides a new therapeutic target for the disease. The finding upsets the current theory that AD is a disease of toxicity stemming from damage caused by sticky plaques that collect in the brain this research points to the condition as a disorder involving an imbalance in signaling between neurons. The study appears online in the Nature publication *Cell Death and Differentiation*.

One of the mysteries of AD has been the normal function of the amyloid precursor protein (APP) which are concentrated at the points where neurons connect. Even though the sticky amyloid plaques which have been viewed as a hallmark sign of AD result from APP, it seems unlikely that APP exists simply to cause Alzheimer's disease. In their study, scientists from the Buck Institute and the CNRS (Centre Nationale de la Recherche Scientifique) show that APP binds to netrin-1, a protein that helps to guide nerves and their connections in the brain, as well as helping nerve cells to survive. When netrin-1 was given to mice that have a gene for Alzheimer's disease their symptoms were reversed, and the sticky amyloid was reduced. These results suggest that the long-held belief that AD is caused by brain cell damage inflicted by the amyloid plaques may be wrong; instead, it is beginning to appear that the disease stems from an imbalance between the normal making and breaking of connections in the brain, with netrin-1 supporting the connections and the amyloid breaking the connections -- both by binding to APP and activating normal cell programs. Not only did the netrin-1 binding to APP keep the nerve cells alive and connected, but it also shut down the production of the amyloid, all of which makes it an interesting potential therapeutic.

"I think we're going to see an explosion in the next five years involving the dissection of these signaling pathways whose imbalance leads to Alzheimer's disease," said Buck Institute Faculty Member Dale Bredesen, MD, who led the California half of the French-Californian collaborative research. "We now believe that APP is part of a 'plasticity module' that functions in normal memory and forgetting, and that netrin-1 gives us an important starting point to restore the normal balance."

"We believe that Alzheimer's disease is somewhat analogous to cancer, which results from an imbalance between the normal processes that support cell survival and those that cause cell turnover," said Patrick Mehlen, PhD, Director of the Apoptosis, Cancer and Development CNRS Laboratory at the University of Lyon and co-senior author of the study. "Our hope is that this research will lead to therapeutics that will be used to address this imbalance much earlier in the disease process."

Research is underway to develop a drug based on the findings. The Buck Institute and the CNRS in Lyon are partnering with Neurobiological Technologies Inc., (NASDAQ: NTII) to bring the discovery from the laboratory to clinical trials.

Other researchers involved in the study include first author Filipe Calheiros Lourenço, of the University of Lyon, along with co-workers Joanna Fombonne, Véronique Corset and Fabien Llambi; Verónica Galvan of the Buck Institute, and Ulrike Müller of the University of Heidelberg. The work was supported by the Agence Nationale de la Recherche, the CNRS (Centre Nationale de la Recherche Scientifique), the National Institutes of Health, the Joseph Drown Foundation, the John Douglas French Foundation, and the Alzheimer's Association.

**About the Buck Institute:** The Buck Institute is the only freestanding institute in the United States that is devoted solely to basic research on aging and age-associated disease. The Institute is an independent nonprofit organization dedicated to extending the healthspan, the healthy years of each individual's life. The National Institute on Aging designated the Buck a "Nathan Shock Center of Excellence in the Biology of Aging," one of just five centers in the country. Buck Institute scientists work in an innovative, interdisciplinary setting to understand the mechanisms of aging and to discover new ways of detecting, preventing and treating conditions such as Alzheimer's and Parkinson's disease, cancer, diabetes and stroke. Collaborative research at the Institute is supported by new developments in genomics, proteomics and bioinformatics technology. For more information: <http://www.buckinstitute.org>.

*Source: Medical News Today*

### **The NPUAP/EPUAP Unveils the NEW International Guidelines for Pressure Ulcer Prevention and Treatment**

By Jeri Ann Lundgren RN, CWS, CWCN, *Director of Wound and Continence Pathway Health Services, Inc*

I attended the National Pressure Ulcer Advisory Panel's (NPUAP) 11th National biennial conference that was held on February 27-28, 2009. The objective of the conference was to introduce the newly revised evidence-based International Guidelines for the Prevention and Treatment of Pressure Ulcers: Public Policy and Clinical Practice. The guidelines were developed by the NPUAP in conjunction with the European Pressure Ulcer Advisory Panel (EPUAP).

At the conference, the NPUAP and EPUAP unveiled the draft version of the Prevention Clinical Practice Guideline and the final version of the Treatment Clinical Practice Guideline. The NPUAP/EPUAP's plan is to roll out both final versions in May 2009. Currently, in the Prevention Clinical Practice Guideline the etiology of pressure ulcers, nutrition, support surfaces and repositioning sections are complete. The skin care section, risk assessment and the operating room statements are in the process of being finalized.

The NPUAP/EPUAP emphasized that these guidelines were developed after extensive research of the literature to ensure they promote evidenced-based practices. Overall, many of the current standard practices for the prevention and treatment of pressure ulcers remain the same, however, there were several new areas of interest worth noting. The follow is a brief overview of those areas.

Overall highlights or areas of interest of the DRAFT version of the Prevention Clinical Guidelines (EPAUP-NPUAP, 2009) are:

- Repositioning frequency is influenced by the individual and the support surface in use. It cites two randomized controlled trials in nursing homes (Defloor et al., 2005; Venderwee et al., 2007) showing that patients on a visco-elastic foam mattresses could be turned every four hours and did not result in an increase in pressure ulcer formation. There was no difference between turning a patient every two hours as opposed to four. Please note that they stress the importance of an appropriate support surface. Overall, you should assess the individual's skin and general level of comfort. If the individual is not responding to the repositioning regime, reconsider the frequency and method of repositioning.
- Having a pressure redistribution support surface, however studies are still deficient on what type of surface to use when. They note that there is no evidence that one high specification foam mattress is superior over an alternative high specification foam mattress. In addition, overlay or mattress-replacement alternating pressure active support surfaces have a similar efficacy in terms of pressure ulcer incidence.
- Active support surfaces are encouraged in the care of individuals who are unable to be repositioned due to their underlying medical or physical condition.

- Use a pressure-redistribution seat cushion for individuals sitting in a chair whose mobility is reduced. Defloor & Grypdonck (2000) found that air cushions produced the lowest interface pressure after one hour of immobilization. Reposition seated individuals more frequently than in a lying position.
- Use of small-cell alternating pressure air mattress or overlays are not recommended.

The following are some overall highlights or areas of interest of the Treatment Clinical Practice Guideline (EPUAP-NPUAP, 2009):

- Endorses the new NPUAP staging system that includes suspected deep tissue injury and unstageable for the use in the US. Reinforces to use the staging system for pressure ulcers only.
- Do not stage/classify pressure ulcers on mucous membranes.
- Observe the pressure ulcer for changes with each dressing change that may indicate the need for a modification in treatment.
- Assess the pressure ulcer initially and at least weekly, documenting findings. Reevaluate the pressure ulcer care and the individual if the pressure ulcer does not show progress toward healing within 2 weeks, when the goal is healing.
- To measure length and width it's recommended that the longest length head-to-toe, and longest width side-to-side, perpendicular (at 90 degrees) to the length.
- Reinforces that care should be taken to avoid causing injury when probing the depth of a wound bed or the extent of undermining or tunneling.
- Emphasizes to evaluate the progress of the wound and recommends utilizing a validated tool such as the Pressure Ulcer Scale for Healing Tool (PUSH) or the Bates-Jensen Wound Assessment Tool (BWAT).
- The Pain Assessment and Management section is new to the guidelines and recommends utilizing a validated pain scale to assess for pain.
- Recommends to replace the existing mattress with an "upgrade" support surface if the individual:
  - Cannot be turned off of the ulcer
  - Has pressure ulcers on two or more turning surfaces, limiting turning options
  - Fails to heal or demonstrates ulcer deterioration despite appropriate comprehensive care
  - Is at high-risk for additional ulcers;
  - "Bottoms out" on the existing support surface.
- Continue to turn/reposition the individual regardless of the support surface. Turning and repositioning should be based on the characteristics of the support surface and the individual's response.
- Do not turn the individual onto a body surface that is damaged or still reddened from a previous episode of pressure loading.
- Continues to recommend that heels be floated regardless of the support surface.
- The guideline gives guidance on the use of support surfaces by the stage of the pressure ulcer.
- The guidelines also addresses spinal cord injured individuals and bariatric individuals.
- The guideline has a section on wound bed preparation and biofilms in pressure ulcers.
- It details different types of dressings and when to utilize them. Areas of interest include the recommendation of medical-prepared honey dressings, cadexomer iodine dressings and silicone dressings (see guidelines for specifics). It also concluded that there is no evidence to support or refute the use of collagen dressings.
- The guideline supports the use of adjunctive modalities such as negative pressure wound therapy, electromagnetic agents (i.e., electrical stimulation or electromagnetic fields), ultraviolet-based phototherapy, acoustic ultrasound, low frequency ultrasound and hydrotherapy. Please refer to the guideline for indications of use.
- The panel found insufficient peer reviewed published evidence to recommend the use of hyperbaric oxygen therapy, topical oxygen therapy, biological dressings and growth factors at this time.
- Consider systemic antibiotics for individuals with clinical evidence of infection verses topically applied agents.
- Consider the use of silver or manuka honey for ulcers infected with multiple organisms (see guidelines for indications of use).

- The guidelines have a section on nutrition. It notes no research has demonstrated an effect of zinc supplementation on pressure ulcer healing. If there are clinical signs of a zinc deficiency, then zinc should be supplemented at no more than 40mg per day and for only 2-3 weeks. High doses of zinc can affect copper production and lead to anemia.
- The guidelines continue to provide guidance for debridement options. It continues to support the practice to not debride stable, dry, hard uninfected eschar on heels.
- The guidelines state that wounds debrided with papain-urea versus collagenase showed a reduction of the devitalized tissue and the amount of granulation was greater for those receiving papain-urea, however the healing rates were the same. I found this interesting as the papain-urea based products are no longer available in the United States.

The guidelines are scheduled to be finalized and officially rolled out, hopefully in May. We will revisit this issue at that time. You can also receive more information at [www.npuap.org](http://www.npuap.org).

*Pathway Perspectives*

References: NPUAP-EDUAP Prevention Clinical Practice Guideline – Draft (2009). NPUAP, Washington, DC. NPUAP-EDUAP Treatment Clinical Practice Guidelines, (2009). NPUAP, Washington DC

## **Rhode Island QIO Develops Workforce Stability Toolkit**

Workplace Practice (Workforce) refers to all of the activity, procedures and individuals whose labor and efforts impact on residents. This domain is critical because of the correlation between good jobs and good care.

The domain of **Workplace Practice** offered these possible changes: establishing relationships as the number one organizational priority, supporting necessary changes and adjustments that will allow relationships to flourish personally, organizationally and environmentally; the inclusion of elders, caregivers, and families in developing avenues for relationship building; the use and promotion of learning circles; welcome and hospitality committees; Red carpet orientation programs; ways of welcoming new families, staff, and residents.

### **Staff Stability Toolkit**

This toolkit developed by the Rhode Island QIO, incorporates experiences and lessons learned in over 400 nursing homes. It is designed to serve as a resource for homes just getting started with efforts to reverse turnover as well as employers who have already started to address recruitment and retention and need further assistance in a specific area. The toolkit includes references to the worksheets below.

[Click here \(http://www.lsnri.org/portals/0/pdf/Staff\\_Stability\\_Toolkit1.2\\_122308\\_smm.pdf\)](http://www.lsnri.org/portals/0/pdf/Staff_Stability_Toolkit1.2_122308_smm.pdf) to get the Staff Stability Toolkit, Version 1.2 Depending upon the type of Internet connection you have, the toolkit may take a few minutes to download. It includes worksheets, a section on Peer Mentoring, and a methodology to calculate CNA turnover.

## **OTHER ITEMS OF INTEREST**

### **Acute Geriatric Units Prevent Functional Decline during Hospitalization**

Compared with conventional hospitalization, care of elderly patients with acute medical disorders in acute geriatric units run by specialized multidisciplinary teams reduces the risk of functional decline at discharge and increases the probability of returning home. That's the conclusion reached by a Spanish research team, whose systematic literature review and meta-analysis appears in the January 23 issue of BMJ Online First.

According to lead author Dr. Juan J. Baztan at Hospital Central Cruz Roja in Madrid and co-investigators, acute geriatric units "provide increased attention to a patient's level of functioning, specific treatment of diagnoses common to older people, and integrated planning of discharge to maximize clinical outcomes." Such units are staffed by geriatricians, nurses trained in geriatrics, therapists, and social workers. Patients are treated for such problems as pneumonia and other infections, heart failure, and COPD that do not require treatment in an intensive care unit.

Their review and meta-analysis involved 11 studies published between 1985 and 2007 that compared outcomes of care in acute geriatric units and conventional hospital units for patients aged 65 years and older; 5 of the studies were randomized trials, 4 were non-randomized trials, and 2 were case-control studies. Three studies analyzed functional decline, defined as loss of independence in at least one activity of daily living. These results showed that care in a geriatric unit was associated with a lower risk of functional decline at discharge (combined odds ratio 0.78).

The likelihood of living at home after discharge was also greater for patients treated in acute geriatric units (OR 1.28), which was maintained at 3 months. The studies also indicated trends toward reduced length of hospital stay and a slight but significant lower cost of hospital care. There were no differences in rates of hospital re-admission or in case fatalities.

Dr. Baztan's team recommends that future research should "focus on the impact of acute geriatric units on functional decline in the medium term and should try to identify the specific activities associated with this effect," with priority given to randomized studies and with efficiency confirmed by calculation of cost effectiveness.

*Source: Reuters Health Information*

### **Physician Says Nursing Home Specialists could Improve Quality of Care**

Taking a cue from the hospitalist model, which created a physician specialty around a site of care, physician nursing home specialists may improve the quality of care in nursing homes, says **Paul R. Katz, MD**, professor of medicine and chief of the Division of Geriatrics and Aging at the University of Rochester School of Medicine and Dentistry.

Katz is the lead author of a recent *Annals of Internal Medicine* (<http://www.annals.org/cgi/content/full/150/6/411>) article proposing the concept of nursing home specialists to promote physician involvement in long-term care. Under the proposed model, nursing home specialists would be asked to commit 20% of their practice to nursing home care and demonstrate competency in nursing home medicine.

The article also recommends instituting a "closed" medical staff model in nursing homes, which Katz says could lead to improved efficiency, quality care, and resident satisfaction by limiting facility privileges to a small number of physicians. Katz says he hopes as physicians participate in closed staff models, evidence will show improvements in the quality of care and nursing home administrators will recognize the value of physicians working closely with nursing facilities and seek out this kind of care.

*Source: CLTC Weekly*

### **The Grim Truth about the Faculty Shortage in Nursing**

*Authored by: Marilyn W. Edmunds, PhD, NP; Laurie Scudder, MS, NP; from Medscape Journal Nurses Scan;*

The concern about nursing staff shortages is not new, but the shortfall predicted in 1998 has become an enduring crisis with no end in sight. In 2000, the gap between supply and demand for RNs was estimated at 110,800 full-time employees. This shortage was predicted to increase, by 2020, to a deficit of 1 million nurses, with 36% of RN positions vacant. By more conservative estimates, the shortage may grow to 285,000 full-time nurses by 2020, and to 500,000 by 2025, unless steps are taken to boost the supply of nurses. Whether one assumes a worst or best case scenario, however, the future looks bleak, largely because shortsighted policies have rendered the nurse workforce excessively vulnerable to demographic influences.

The combination of few jobs and few job-seekers that occurred in nursing during the mid-1990s also influenced the academic environment. In response to a 31% drop in nursing enrollment from 1995 to 1999, nursing faculty positions were slashed. A rough economy attracted some RNs back into nursing, temporarily boosting staffing levels, but as these older nurses left the workforce, there were insufficient

replacement nurses in the education pipeline. The increase in aging baby-boomer patients has exacerbated the supply-and-demand situation. At the same time, nursing as a profession has become increasingly sophisticated, specialized, and expansive in response to advances in medical technology. Today's patient demands a nurse with specialized skills. The absence of necessary knowledge and skill has resulted in poor nurse-patient ratios, further intensifying the shortage.

The overall situation has led to some positive changes in the nursing profession. Clinical nursing salaries and improved working conditions have made nursing one of the fastest growing areas of employment. Nursing jobs are expected to grow an average 23% by 2016, representing 587,000 new positions.

Right now, thousands more qualified people apply to US nursing programs annually than can be accepted. In 2007, schools rejected an estimated 30,709 qualified students who applied for entry-level degree programs. In 2005-2006, nearly one third of qualified candidates were denied admission to associate and baccalaureate programs. If these students could be accepted, they would satisfy the nation's demand for nurses. But nursing academic institutions are bulging with students and, stretched to the limit, cannot absorb more students. There is simply a lack of educational resources -- most importantly, a lack of educators. In 1980, 48,000 RNs were employed as nursing faculty; by 1988 there were just 30,000. Although it fluctuated during the intervening years, the faculty vacancy rate was estimated to be 7.9% in 2006-2007 and 8.8% in 2007-2008. These figures understate the educator shortage because they include only budgeted positions, not the additional faculty positions needed to increase enrollment.

In 2006, nearly 63% of full-time nursing faculty members were between 45 and 60 years of age, and another 9% were older. The average age of doctoral-prepared faculty ranged from 51.7 to 59.1 years of age, and those with master's degrees ranged from 50.1 to 58.9 years. At age 62.5 years, many of these individuals, a sizable portion of current faculty, will retire. The grim truth is that the pipeline cannot replenish these losses, much less fill additional positions. Academic salaries are not competitive with those in clinical practice: in 2007, the average salary for master's-prepared faculty was \$66,588, while it was \$81,517 for the average nurse practitioner. Most university faculty positions demand a doctorate, which means additional education, debt, and delayed entry into full-time employment. It is difficult to attract faculty to university positions because of the inordinately heavy workloads they will face. Nursing programs lack the funds to add any new teaching positions.

The goal has become clear. To reverse the projected shortage, we need to graduate 30% more nurses each year -- an additional 30,000. This would mean adding nursing faculty, not just filling existing openings. Gradually, public and private entities, other than those in nursing, have focused attention on this problem. While there is no comprehensive published analysis of actions to solve the nursing faculty shortage, greater attention has turned to reversing existing trends. This article examines the literature regarding strategies to alleviate the faculty shortage, to answer the questions: (1) what types of strategies are being implemented, (2) what are the outcomes, and (3) where do we go from here?

Investigators conducted a paper and electronic literature search for strategies responsive to the nursing faculty shortage published from 2000 to 2008. Articles were selected according to specific and rigid criteria. After conducting a systematic review of the literature from 2000 onward, the investigators analyzed and coded faculty shortage initiatives using techniques of content analysis and constant comparison.

Strategies for solving the nursing faculty shortage were categorized under 4 headings:

1. Advocacy, which uses mass media to promote a positive image of nursing. This domain also includes workforce data and policies that establish centers to aggregate statistical data, propose strategies, pilot solutions, promote information exchange and encourage stakeholder collaboration across sectors or geographic boundaries.
2. Educational partnerships, wherein academic institutions collaborate with at least one other entity to articulate clear goals, define mutual expectations, develop mutual plans.

3. Academic innovation to optimize faculty resources. The dimensions in this domain are: (1) nontraditional faculty, (2) technology, and (3) new curricula.
4. Funding, defined as straightforward funding of schools with the goal of increasing faculty. Within this domain are the public sector, philanthropy, and the healthcare industry.

These domains illustrate the scope of efforts to find lasting solutions of every type. Given the continued growth of the nurse and faculty shortages, any solution must ultimately be measured by its ability to bring change. Quick fixes that cannot produce sustained results are inadequate, however attractive they might appear in the short-term. Sustainable solutions that result in a healthier nursing education infrastructure are the only answer. "Collaboration among those with shared interests in defining goals, developing tactical plans, and ensuring an adequate funding stream -- and the importance of capital investment, especially at the outset -- is crucial to sustainability."

The authors make the following recommendations for moving forward:

- Build upon and expand models that offer substantial, sustainable, and replicable approaches to the nurse and nursing faculty shortages. These models invariably involve multiple stakeholders; solutions created in silos are not viable. Bringing traditional and nontraditional parties to the table to develop common goals and plans of action is critical;
- Articulate outcomes and define standardized baseline and evaluation indicators. Replicability -- and, ultimately, sustainability -- depend on a critical analysis of results. Consideration should be given to establishing a "sustainability quotient" that will indicate the relative usefulness of one strategy over another, or the level of investment that a given strategy warrants;
- Establish a national nursing workforce center to collect and disseminate data, effectively serving as a clearinghouse for best practices and solutions tailored to particular circumstances. A national entity such as the Center to Champion Nursing in America can act both as a repository for state experiences and develop the standardized outcome measurements needed for comparative analysis and replication; and
- Nurse leaders and their collaborating partners should publish their experiences in peer-reviewed journals. Developing a body of literature on strategies to resolve the nursing faculty shortage and ensure sufficient numbers of nurses in the healthcare system would advance the promulgation of robust, evidence-based approaches.

### **Viewpoint**

The authors suggest that every crisis presents an opportunity for positive change. The nurse faculty shortage creates both an incentive and a moral imperative for the nursing profession and key stakeholders to act.

Click here ([http://www.nursingoutlook.org/article/S0029-6554\(08\)00266-2/abstract](http://www.nursingoutlook.org/article/S0029-6554(08)00266-2/abstract)) to read Abstract of the article: ***A Systematic Assessment of Strategies to Address the Nursing Faculty Shortage, US***; Allen JD, Aldebron J; *Nurs Outlook*. 2008;56:286-297