Nursing Notes

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

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Tess Kwiatkowski MS, RN, Editor

HOT TOPICS

LSN MDS 3.0 Training

LSN is working on many different fronts to provide you all the training your staff will need for the upcoming MDS 3.0. From day long seminars this summer to distance learning opportunities, to co-sponsored events with IDPH, other state associations and AANAC and e-mail alerts, we are making every effort to ensure you will have all the information, training, tools, and peer support your entire organization will need with the time you will need for implementation. Be watching your e-mail and *Weeks News* announcing our dates for LSN sponsored MDS 3.0 trainings.

LSN Submits Comments to IDFPR on Draft NPA Regulation

LSN submitted comments (http://lsni.informz.net/lsni/data/images/nursing_notes/lsn_comments_on_npa_rules.pdf) to the Illinois Department of Financial and Professional Regulation prior to the November 16, 2009 deadline. Drafted by Tess Kwiatkowski, LSN Executive Vice President, in collaboration with the LSN Nurse Leadership Committee, the comments particularly stressed issues LSN membership would have with the with language on delegation and the LPN Scope of Practice. Click here (http://lsni.informz.net/lsni/data/images/nursing_notes/lsn_comments_on_npa_rules.pdf) to read the comments submitted by LSN.

Your Input Needed: When Are Pressure Ulcers Avoidable?

Jennifer Pettis, senior policy analyst for the New York Association of Homes and Services for the Aging, will serve as a voting participant on the upcoming National Pressure Ulcer Advisory Panel (NPUAP) International Multidisciplinary Consensus Panel on the Issues of Avoidable and Unavoidable Pressure Ulcers in All Care Settings. The conference, which takes place Feb. 25 at Johns Hopkins University in Baltimore, MD, will examine the clinical conditions in different care settings that create situations of unavoidable pressure ulcers; the documentation needed to substantiate these claims, and interventions and/or technology that can be developed to combat the problem. Pettis would like your input on defining avoidable/unavoidable in your particular care setting. Please send comments to Jennifer Pettis by Feb. 10, 2010. Fax comments to (518) 449-8210. Contact: Jennifer Pettis, (518) 449-2707 ext. 146. For more information on NPUAP. (http://www.npuap.org/conferences.htm)

AHRQ Studies HIT in Long-Term Care Settings

Since 2004, the Agency for Healthcare Research and Quality (AHRQ) has invested over $260 million in contracts and grants to encourage the adoption of health information technology (HIT). The agency just released a report that shares some of the lessons learned by grantees that implemented HIT in long-term care settings. Those lessons cover a variety of topics, including

staff engagement and preparedness, working with partners and vendors, adapting software to the long-term care environment and managing implementation. Click here (http://lsni.informz.net/lsni/data/images/nursing_notes/ahrq_studies_hit.pdf) to download the full report.

CLINICAL CORNER

Norway's Solution to Infections Includes Fewer Drugs

Health experts worldwide have urged doctors to rely less on antibiotics in order to reduce the growth of antibiotic resistant superbugs, such as MRSA. By now some organisms have become so resistant experts are concerned that there will be nothing left to fight them. But Norway is one of the only countries that adopted an aggressive program that severely cuts back on the use of antibiotics, which has made it the most infection-free country in the world.

Now a number of studies have said Norway's model can be replicated in other countries, potentially eliminating 19,000 unnecessary infection-related deaths in the United States, according to *CBS News*. (http://www.cbsnews.com/stories/2009/12/23/tech/main6014559.shtml)

The shelves of hospital pharmacies in Norway are lined not with the latest and greatest antibiotics, but with medicines considered obsolete in many other countries. These medicines are effective in Norway because drug-resistance is much lower.

"We don't throw antibiotics at every person with a fever," says Dr. John Birger Haug, the infectious disease specialists at Aker University Hospital. "We tell them to hang on, wait and see, and we give them a Tylenol to feel better."
Source: Infection Control Monitor

Study Finds MRSA Strain Resistant to Treatment

One strain of Methicillin-resistant *Staphylococcus aureus* (MRSA), USA600, has been found to be partially immune to an antibiotic that is used to treat the condition, according to *HealthDay.com*. (http://www.healthday.com) MRSA causes infections in the skin and bloodstream, and can infect surgical wounds and pneumonia.

Half of the patients who developed this strain died within a month, which is five times faster than other people infected with MRSA are. These statistics were presented at the Infectious Diseases Society of American, held October 29 through November 1, in Philadelphia, PA.

Researchers believe that the USA600 strain is unique and that the age of the patient could play a part in whether antibiotics can treat the infections or not. Patients who developed the USA600 strain averaged around 64 years of age, as compared to 52 years of age.
Source: Accreditation Connection

Studies Show Dementia Care Fails People with Sight Loss

A fresh approach to dementia care with attention paid to sight loss should be considered in healthcare, according to sight loss charity Thomas Pocklington Trust. A sensory model of care practice should be developed, the charity said, after two new studies revealed a widespread failing to acknowledge the importance of sight loss.

The first study, "People with dementia and sight loss: a scoping study of models of care," exposes pressing and persistent problems in the care of those with dementia and sight loss. The study finds that both the most widely used model of care and the leading best-practice literature display "a fundamental lack of sensitivity about sight loss."

The second study, "Visual Hallucinations in Sight Loss and Dementia," describes people with joint dementia and sight loss as a forgotten group, and finds that many cases are missed or misdiagnosed because of failures to assess for both conditions.

"Sight loss plays a major role in people's experience of dementia, yet it is almost entirely excluded from current models of care," researchers said. "A change in policy and practice is needed, where sight loss is made visible in dementia care."
The first study looked at major texts, interviewed practitioners and audited care homes. It found that while front-line care workers try to respond to the problems of dementia and sight loss, neither official policy nor guidance provides the means to fully address the issue.

Eight leading models of practice were assessed. One specifically gives importance to visual cues. Of the rest, only two explicitly mention visual impairment. The most common model used in the UK, which is embedded in dementia policy, fails to take sight loss into account.

Dementia policy, says the study:

- pays too little attention to the physical environment to be sensitive to joint dementia and sight loss;
- overlooks sensory solutions that help groups of people such as good lighting, contrasting and tactile signage, and positive sounds;

Researchers found that in dementia care practice: sensitivity to and awareness of sight loss issues varies amongst practitioners; care home inspectors often rely on notice boards to provide information; and the importance of wearing spectacles, having eye examinations, and taking up free NHS tests can be overlooked.
Source: Long-Term Living

WORKFORCE WISDOM

Re-Recruiting for Retention!

A national survey done by Kepner-Tregow (a Princeton-based management consulting firm) found only 40% of workers feel adequately recognized at work, yet it's been estimated that U. S. companies spend ~ $18 billion annually for recognition incentives (Ventrice, 2003). Apparently employees desire something different from what their organization offers.

An excellent form of recognition is "re-recruitment", an easy activity for any leader to accomplish. Here are some tips on how to accomplish it:
1. Think about your best staff member. Now imagine he or she is coming to see you today. What would you do or say if he said he was leaving? Do those things anyway.

2. When you're in the unit chatting with your staff, periodically ask questions such as, "If you could make any changes about your job, what would they be?", or "What things about your job do you hope never change?" Another excellent question to ask is, "What makes for a great day?"

3. Use 30 / 60 / 90 day retention interviews. These face-to-face meetings help solidify retention of your newest staff members. Ask if the job is what they expected from the interview. Also ask if they've noted anything that could be done better – new eyes always have keen perspective, plus you may gain an improved way to accomplish something you've been struggling with! Finally, ask what has been the greatest and most frustrating thing they've discovered. Use their positive comments to give KUDOs to staff who are doing a great job and their frustrating situations to make changes.

Remember, in the current competitive employment environment, other employers are interested in recruiting your best people! The best retention strategy is to re-recruit them yourself and beat the competition to the punch!
Source: Nurse Manager Weekly; and *Ventrice, C. (2003) Make Their Day! Employee Recognition That Works. Berrett-Koehler: San Francisco*

Creating a Culture that Drives Great Nurse Performance

Organizations do not achieve outstanding results by accident— they take a powerful, common-sense approach that motivates all employees to consistently do their best. Exceptional organizations apply an approach that promotes outstanding individual performance, called the performance pyramid. At its core, "the power of the pyramid" is a human resource management tool and is a common-sense approach to creating a nursing performance improvement culture.

Here are the steps to achieve great nurse performances: visualize these steps starting from the bottom of the pyramid (the largest part of the pyramid that supports the whole structure) and moving up through the various layers that make up the whole:
Appoint excellent nurses: If you start by bringing nursing staff into the organization who are well qualified and competent, you improve your ability to reach the level of excellence you desire. Carefully selecting nurses requires solid screening systems, so it is important to create and maintain the highest possible standard for nursing.
Set and communicate expectations: The nursing department should tell every nurse, in writing, what is expected of him or her to achieve excellence. This is your opportunity to establish expectations for the type of nursing culture you want.
Measure performance against expectations: Once an organization has established expectations and communicated them to the nursing staff, it must measure each nurse's performance against those expectations. The foundation of any successful quality program is the basic premise that measuring something drives improvement.
Provide periodic feedback: Feedback should be frequent and targeted. Ongoing feedback to nurses on their performances is essential and reinforces the expectations established by the organization. When nurses receive feedback in a timely and easy-to-follow manner, they will use it for self-improvement.
Manage poor performance: Nursing managers should not wait until the annual review process to address performance issues. Discuss such issues with the appropriate nurse as soon as concerns arise. Use appropriate leaders and mentors to help motivate the nurse to change or eliminate unacceptable performance.
Take corrective action: Nursing leadership must act when all of the steps outlined have been taken but a nurse fails to self-improve and her or his poor performance threatens quality of patient care. Nursing leaders must consult human resources or the appropriate authority before corrective action is taken.
Source: Nurse Manager Weekly; Author: Laura Cook Harrington, RN, MHA, CPHQ, CHCQM

How Can I Get Other Nurse Managers and Supervisors to be Accountable?

Remember, accountability is about commitments. It is doing what you say you are going to do. To get other managers or your supervisor to be accountable, you use the same accountability tools you use in other situations: your personal accountability and holding your staff and peers accountable.

Here are a few things to remember on how to get other managers accountable:
Start with the language: Remember, it's the "yes" or "no." Ask for a commitment and hear the "no," which may be phrased as a "yes, but."
Reset the conversation: When trying to reset a conversation, effective questions are helpful. One effective question is "What worries you?" Asking your supervisor what is preventing him or her from making a commitment, and most especially, from keeping that commitment, is critical.

Set the scene: When you deal with other managers or your supervisor, you should try to understand the work at hand and how your manager/supervisor views the work. Once you determine his or her views, you can make requests and offers, or ask effective questions to help them 'be' in the right kind of work.
Flip negative energy: Negative energy can show up in many ways. When your manager or supervisor tells you something will not work, it is important to ask questions. You are making an offer to elicit a commitment, to elicit accountability. Fashion the offer so that your manager/supervisor can make a commitment.
Pacing event: A pacing event is a forum for public displays of accountability and public commitments. It is much easier to have people keep a commitment when they have publicly declared it. This can be effective to use with other managers or a supervisor when you are not sure that you really have a commitment.
Source: Nurse Manager Weekly-- Eileen Lavin Dohmann, RN, MBA, NEA-BC

STRATEGIES FOR QUALITY & SAFETY IMPROVEMENT

Advancing Excellence in Nursing Homes Campaign Kicks Off New Phase

Advancing Excellence in America's Nursing Homes has launched the second phase of its campaign to help nursing homes achieve excellence in quality care and quality of life for people who live and work in the nation's nursing homes.

With workforce goals of reducing CNA, LPN, and RN turnover, increasing use of consistent assignment, and measuring overall staff satisfaction, the three-year-old campaign has reordered its objectives to "better reflect that staffing issues are clearly drivers of overall quality improvement at a nursing home." The coalition considers all eight clinical and operational goals to be equally important to improve the quality of care and life for residents and to provide a good working environment.

The campaign website (http://www.nhqualitycampaign.org) has undergone a makeover, and now offers new resources and materials, including CNA Fact Sheets to help nursing homes engage certified nursing assistants in all eight campaign goals. Nearly half of the nation's nursing homes joined Phase 1 of the Advancing Excellence in America's Nursing Homes Campaign, which reports very promising results. Nursing homes that focused on specific clinical goals improved at a significantly faster rate than other nursing homes, for example.

"There are tangible benefits for homes as well: improving staff retention and maintaining staff stability saves money, improves efficiency as well as outcomes, and contributes to better relationships between residents and their caregivers," said **Mary Jane Koren**, MD, MPH, Chair of the Advancing Excellence Campaign.

The three clinical and five operational campaign goals (http://www.nhqualitycampaign.org/star_index.aspx?controls=eightgoals)are:

- Staff Turnover
- Consistent Assignment
- Restraints
- Pressure Ulcers
- Pain
- Advance Care Planning
- Resident/Family Satisfaction
- Staff Satisfaction

The coalition stimulates quality improvements by providing nursing homes with free, current, and practical evidence-based resources; (http://www.nhqualitycampaign.org/star_index.aspx?controls=resByGoal)empowering residents and their families with education; and helping participants reach their targets. Homes can also compare their progress with state and national averages.

Nursing homes that have been participating in the campaign are required to re-enroll to update profiles, select new goals, and set new targets for improvement. Nursing homes that re-enroll by January 31, 2010 will be designated as an Advancing Excellence Charter Member. Homes that have yet to participate in the coalition's quality improvement effort — the first to measure quality by setting clinical and organizational goals for nursing homes — are encouraged to sign up

Nurses Use Repetitive Processes to Catch Medication Errors

Author: Heather Comak, for HealthLeaders Media, October 30, 2009

Each year, medication errors are responsible for 7,000 patient deaths and cost the healthcare system $2 billion. Even more shocking, perhaps, is the knowledge that nearly 50% of potential medication errors are caught before making it to the patient. Of those potential errors, 87% are intercepted by nurses.

Linda Flynn, RN, PhD, associate professor at the University of Maryland School of Nursing, recently led a study concerning medication errors and how the practice environment and the level of nurse staffing affect medication error rates. Flynn, also the project director and principal investigator of this Interdisciplinary Nursing Quality Research Initiative (INQRI)-funded study, presented on the topic during an INQRI Webcast on October 7. INQRI, a project of the Robert Woods Johnson Foundation, was created to examine nurses' impact on patient safety.

"Nurses are the safety net that keeps patients safe from experiencing a medication error," said Flynn. "Our question was, what are the factors that impact this nursing safety net—what are the factors that help nurses in doing their job to intercept medication errors before they reach the patient, and what are the factors that serve as barriers to this safety net?"

Flynn's study focused on identifying the costs and implications of medication errors. Her team from the New Jersey Collaborating Center for Nursing at Rutgers University's College of Nursing did so by examining both work environments and nurse staffing situations. Broken down into three separate parts, the study received participants from 14 hospitals in New Jersey.

Ultimately, the study revealed that medication errors are expensive, averaging more than $6,000 extra spent on patients who experience a medication error (not necessarily an adverse drug event). Additionally, nurses employ four distinct medication safety processes to help themselves find medication errors before they reach the patient. These processes were enhanced when the nurses felt that their work environment was supportive, giving them time to effectively use these processes.

What processes do nurses use to catch medication errors?

The first part of the study examined what it is that nurses do specifically during their everyday jobs to prevent medication errors from reaching the patient. Flynn and her team interviewed 50 staff nurses from 10 hospitals, transcribed the interviews, and analyzed the lines of text for patterns and commonalities. They found that nurses take seven routine steps in the name of medication safety:

1. Conduct independent review of the medication administration record (MAR) in comparison with the medication order
2. Perform a focused assessment of the patient prior to administering medication
3. Question rationale
4. Prioritize face time with physicians
5. Encourage patients and families to be the last line of defense for a medication error
6. Advocate with pharmacy to ensure timeliness of medication delivery.
7. Clarify orders/handwriting with physicians

Of these processes, Flynn and her team found that numbers 1, 3, 5, and 7 were significantly associated with fewer medication errors. Additionally, there was overwhelming evidence that these practices were enhanced when the nurses worked in a supportive staffing environment.
Heather Comak is a Managing Editor at HCPro, Inc., *where she is the editor of the monthly publication* Briefings on Patient Safety, *as well as patient safety-related books and audio conferences . She is also is the Assistant Director of the Association for Healthcare Accreditation Professionals.*

Prevention of Falls Related to Unassisted Transfers

By Betsy Willy PT, MA, FCCWS, Pathways Health Services

Reduction of falls in our nursing homes is a multifaceted challenge. A large majority of these falls result from attempts to rise from a wheelchair unassisted and unsupervised. This is often blamed on the resident for not waiting and/or having poor safety judgment. As we attempt to provide interventions to prevent injuries due to falls, it is imperative that we step back from the blame game and attempt to determine what initiated the need to stand up and go someplace.

The need to change positions, for example, rise from a chair, or just go *somewhere* stems from a restlessness that may be linked to many to pain and discomfort, boredom, or the inability to tolerate over stimulation in the form of noise, clutter, and confusion in the environment.

Often overlooked in our attempt to get to the root cause of this discomfort is actually caused by an inappropriately-fit wheelchair. Wheelchairs commonly used in nursing homes were never meant to provide all day seating for an elderly individual. Instead, they were designed as a temporary means of transportation. Just as we expect toddlers to sit quietly in a car seat on a long trip, we expect our elders to sit happily in a wheelchair all day with infrequent position changes.

When someone with poor balance attempts to rise from his chair, he is often told to sit down. If this was our toddler in the car seat who was fussy, uncomfortable, wet, hungry or bored, we would pull into a rest stop and check their pants, give them a snack, and run their little legs off to reduce their excess energy so they can tolerate sitting for another 50 miles or so. Are we as vigilant in recognizing and meeting the needs of our elders?

If telling folks to sit down doesn't work, we attach an alarm to them. The auditory alarm adds to the unfamiliar cacophony of sounds increasing the agitation level of everyone in the area. If that doesn't work, we add a seat belt or lap buddy to prevent rising from the chair. And still, we have not recognized why this person is rising from his chair, nor met the need of that individual.

Maintaining the highest level of physical fitness has become a priority in our community culture. However, once an individual is admitted to a nursing home, they are often automatically issued a wheelchair making it convenient for the staff to push them quickly from place to place, or to avoid the need to supervise them closely as they attempt to walk from place to place. Removing this opportunity to exercise further contributes to balance, strength and endurance deficits. Promoting physical activity by limiting the use of the wheelchair, selectively leaving it outside the room, or encouraging walking to the bathroom, dining room and activities will help reduce the loss of fitness.

When we go home, we don't look for the most uncomfortable chair to relax. We head for our favorite chair or recliner. Provision of alternative seating in the form of recliners in common areas, or in resident's rooms, along with time to rest in bed instead of being allowed to sleep in a wheelchair, would reduce the aches and pains that only movement or rising from the chair can allay.

The wheelchair itself must fit the resident. One size does not fit all. When the knees are lower then the hips and the resident seeks the most comfortable position by sliding into sacral sitting, he is on a slow ride to the floor. Provision of a chair that is low enough to get the feet flat on the

floor for self propelling prevents the resident from oozing onto the floor while propelling the chair forward. Nursing home wheelchairs weigh approximately 50 pounds. Providing a light weight or 15 pound wheelchair greatly reduces fatigue and the judgment errors that occur with exhaustion.

Our very tall men need extra deep seats with taller backs and seats that are higher from the ground or they look like a basketball player sitting in the economy section of an airliner who can't wait to stand up at the end of the flight.

Many of our older women and some of our older men have severely curved upper backs. When seated in a wheelchair, it is impossible for them to scoot their bottom back into the chair. If they do accomplish this, their face is looking directly at their knees. In order to interact with others or feed themselves, they must hyperextend their necks to hold their face vertical. Try it – it hurts! By replacing the wheelchair sling back with a deep surround back, recessed into the frame of the chair and utilizing the dual axel component of the chair to lower the back of the seat, gravity helps to keep their pelvis back into the chair and their back is fully and comfortably supported.

Understanding how discomfort, agitation and boredom are related to increased falls will drive a different set of interventions then blaming the attempts to rise from a chair without supervision on bad behavior or poor safety judgment. The resident will still have poor safety judgment, but if we can address the cause for rising unassisted, we may be able to prevent falls without use of restraints and their detrimental side effects.
Source: Pathway Perspectives Newsletter, Vo. 41

SYSTEM DESIGN & ORGANIZATIONAL CHANGE

Commonwealth Fund Publishes Issue Brief on State Culture Change

In order to move toward a new model of nursing home regulation, the states and federal government must strike a balance between the traditional regulatory approach of weeding out substandard facilities and a partnership model aimed at promoting high performance. That's the conclusion of an Institute for the Future of Aging Services (IFAS) issue brief published online by the Commonwealth Fund. *Supporting Culture Change: Working Toward Smarter State Nursing Home Regulation* emphasizes the importance of structuring new regulatory models so that agency staff, providers, consumers groups, residents and their families are educated about and committed to the principles of culture change and person-centered care. Click here (http://lsni.informz.net/lsni/data/images/nursing_notes/1328_stone_supporting_culture_change_smarter_state_nursing_home_reg.pdf) to read the 10-page Issue Brief.

OTHER ITEMS OF INTEREST

Study Examines End-of-Life Care in Assisted Living

When an assisted living resident wishes to die in place, a community that supports that wish will benefit by developing systems of care that promote resident-staff relationships and optimize communication and collaboration among care providers and with hospice staff, according to a recent study in *The Gerontologist*. Click here (http://www.ahcancal.org/News/publication/Provider/ENOOct2009EndofLife.pdf) to read a summary of the study, *Resident, Staff Relationships Factor in Good Care,* published in *Provider* in October, 2009 and authored by Meg LaPorte.

Recognizing Patient Spirituality Could Improve Quality of Care

Janice Simmons, for HealthLeaders Media, December 17, 2009

When it comes to quality and medicine, we're often comfortable discussing many subjects, such as the latest technologies, the newest journal findings, recent legislation, or even revised payment strategies. However, if we move the subject to the human aspect—examining patient spiritual needs—the comfort zone seems to shrink.

We may have our own set of personal beliefs, but sometimes addressing a patient's spiritual needs as part of his or her care may appear out of place or inappropriate. However, two new studies find that recognizing that spirituality may be an important part of providing quality care.

In the first study, researchers at Dana Farber Cancer Institute in Boston found support of terminally ill cancer patients' spiritual needs by medical teams was associated with greater quality of life (http://jco.ascopubs.org/cgi/content/abstract/JCO.2009.24.8005v1) — even during the last remaining days.

Recent research has shown that religion and spirituality many times are prime sources of comfort and support for patients confronting advanced disease, according to the study's senior author, Tracy Balboni, MD, MPH, a radiation oncologist at Dana Farber. "Our findings indicate that patients whose spiritual needs are supported by their medical team—including doctors, nurses and chaplains—have better quality of life near death and receive less aggressive medical care at the end of life," she said.

The study, which appears on the current online version of the *Journal of Clinical Oncology*, involved 343 incurable cancer patients at hospital and cancer centers nationwide. Participants were interviewed about how they coped with their illnesses, the degree to which their spiritual needs were met by medical teams, and their preferences regarding end of life treatment. Each patient's course of care was tracked during the remainder of his or her life.

Patients whose spiritual needs were supported by the medical team were likely to move to hospice care at the end of life, the researchers noted. Also, spiritual support among those patients who relied on their religious beliefs to cope with their illnesses reduced their risks of receiving aggressive medical treatments at the end of their lives.

Support of patients' spiritual needs by the medical team also was associated with better patient well being toward the end of life: scores averaged 28% higher among those receiving spiritual support.

In a separate study (http://journals.lww.com/smajournalonline/Abstract/2009/12000/Prayers_in_the_Clinic__How_Pediatric_Physicians.11.aspx) from Rice University, Houston, and Brandeis University, Waltham, MA, it was found that while more physicians say religion and spirituality help some patients and their families cope with serious illness, it was often the families and patients—not the physicians—who raised the issue of prayer. This study, which appears in the current issue of *Southern Medical Journal*, suggests that medical education could be enhanced by courses that address the topic of prayer—but which go beyond just praying.

"We know that prayer in physician patient interactions is attracting more attention," said coauthor Wendy Cadge, a sociologist at Brandeis University. "Most research in this area focuses on whether physicians and patients think prayer is relevant. But, in this study, we wanted to find out when and how prayer comes up in the clinic, and how physicians respond."

The study found that pediatricians usually respond to requests for prayer in one of four ways:

- They participate in the prayers.
- They accommodate the prayers, but don't participate.
- They reframe the prayers.
- They direct the families and patients to religious and spiritual resources, such as hospital chaplains.

A few physicians did join in prayers with families and/or participated in religious rituals, such as baptism or being at the bedside. Others said they accommodated prayers, but didn't actively participate in them. Another group of pediatricians reframed the prayer requests in ways they

thought were more realistic and appropriate, Cadge said. The fourth group of physicians responded to requests for prayer by referring patients and families to other resources, such as the family's religious leaders or hospital chaplains.

Overall, the study showed that the situations that lead to requests and physicians' behaviors in response are far more complex "than simply praying or not praying," said Cadge. In the long run, both these studies seem to show that while responding to spirituality seems to be a personal issue, there may be more there in adding it to the arsenal of providing quality care—and maybe we shouldn't be so shy to talk about it.

Almost 40,000 Qualified Nursing School Applications Turned Away

John Commins, for HealthLeaders Media, December 3, 2009

Enrollment in entry-level baccalaureate nursing programs increased 3.5% in 2009, but nearly 40,000 qualified applicants were turned away, according to preliminary data released recently by the American Association of Colleges of Nursing (AACN).

Even with a decade of enrollment increases, and the continued heavy demand for nurses, AACN's *29th Annual Survey of Institutions with Baccalaureate and Higher Degree Nursing Programs* found that nursing schools are still hindered by a shortage of faculty, insufficient clinical education sites, and budget cuts. "Despite considerable financial challenges and capacity constraints, nursing schools nationwide were successful in their efforts to maintain a robust pipeline of future nurses this year," said AACN President Fay Raines.

This year's 3.5% enrollment increase for entry-level baccalaureate programs is based on data supplied by the same 511 schools that reported in both 2008 and 2009. This is the ninth consecutive year of enrollment gains.

Though interest in nursing careers remains strong, the survey found that faculty and resource constraints meant that 39,423 qualified applicants were turned away from 550 entry-level baccalaureate nursing programs in 2009, a number comparable with data from the last five years, which ranged from 36,400 to 41,385 rejected applications. AACN expects this number to increase when final data on qualified applications turned away in 2009 is available in March 2010.

Based on data received from 318 schools of nursing, the primary barriers to accepting all qualified students at nursing colleges and universities continue to be a shortage of faculty (60.7%) and an insufficient number of clinical placement sites (61%). With cuts in state funding to schools of nursing last year, the number of schools reporting budget cuts/insufficient budget as a primary reason for turning students away more than doubled from 14.8% in 2008 to 31.1% in 2009.

It's not all bad news. Survey data also show a surge in enrollments in graduate nursing programs, which Raines said is a promising trend.

"Moving more nursing students into graduate programs is a top priority for the profession given the growing demand for more nurses to serve as teachers and researchers as well as specialty and primary care providers," Raines said. "As we move closer to healthcare reform, many more nurses with master's and doctoral degrees will be needed to provide essential healthcare services, including nurses to serve in the four Advanced Practice Registered Nurses roles," such as clinical nurse specialist, nurse anesthetist, nurse practitioner, and nurse midwife.

Preliminary data from AACN show that enrollment in master's and doctoral degree nursing programs increased significantly this year. Nursing schools with master's programs reported a 9.6% increase in enrollment (409 schools reporting) and a 10.5% increase in graduations (380 schools reporting).

In doctoral nursing programs, overall enrollment is up by 20.5% (154 schools reporting), and graduations increased by 1.9% (92 schools reporting) from 2008 to 2009. Doctor of Nursing Practice programs account for the largest share of growth in this student population with a 40.9% increase in enrollments reported this year (85 schools reporting). In 2009, the number of students enrolled in research-focused doctoral programs increased by 4.1%, according to preliminary estimates.