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Florida Association Directors of Nursing Administration/LTC

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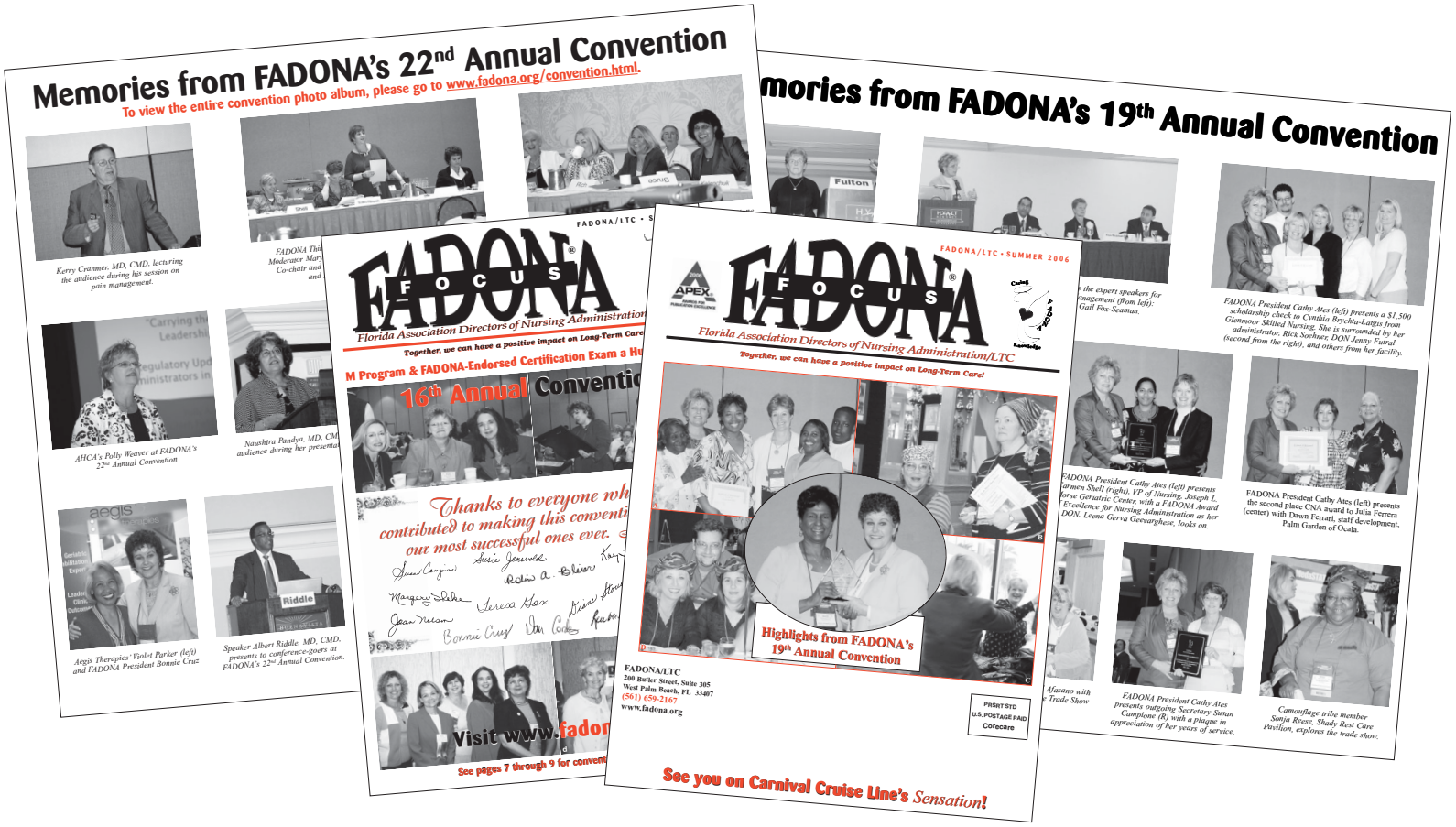

See pages 11-13 and the 2010 convention brochure at www.fadona.org.

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Message from the President

The FADONA board has been working feverishly this past year to bring you, the members, another outstanding FADONA convention for 2010. "Carrying the Torch of Leadership," which starts on April 28, will provide you with a wide variety of topics to utilize in your work environment.

Bonnie Cruz

Want to become a NADONA-certified DON? Then register to attend the prep course offered by NADONA's new Executive Director Regina Kaurich and our very own Gilda Osborn.

If learning about MDS 3.0 is your focus, then there will be a session on this topic, also. So many exciting sessions for you to choose. Learning and networking with your colleagues to obtain best practices while relaxing at the Buena Vista Palace Hotel. . . not a bad combination.

Our health care system is about to experience an overhaul, and nurse administrators will face increased challenges. FADONA is your organization for nurse leaders to have ONE voice. Many times, we are called on to offer opinions regarding the state of the union activity.

This past year, Florida's Agency for Health Care Administration asked FADONA to lead the PACT Initiative, and today, FADONA has made progress with the hospital association and medical directors in Florida. For the first time, these three organizations are meeting face-to-face to collaborate and improve communications regarding continuity of residents' care. One goal is to reduce pressure sores in Florida. The dialogue is open, and the hospital association is learning about long-term care and the challenges we face.

As nurse leaders, you can make a difference by being involved with FADONA at a local or state level. Our goal is to provide you with the education and resources to operate effectively in your facilities while offering collaborative professional networking to assist you along the way.

FADONA understands the challenges you face because many of us are or have been directors of nursing. We are here for you. Together, we nurse administrators may rally and be one voice and stand strong for our beliefs and convictions as we move forward in our world of long-term care.

I look forward to seeing you at FADONA's 23rd Annual Convention & Trade Show, April 28-May 1, 2010. Please come energized to learn, relax and have fun.

Also, please let your administrators know that FADONA is offering CEUs for administrators as well.

As always, please feel free to contact FADONA if you have any input to make our organization stronger. Ideas and feedback are always welcome.

Respectfully,

Bonnie Cruz

Bonnie Cruz, RN, BSN, MEd
President

Regional Reports


Sharyn Figgins

REGION I

Region I—Northwest

1A—Bay, Escambia, Holmes, Okaloosa, Santa Rosa, Walton, Washington; 1B—Jefferson, Madison, Calhoun, Leon, Taylor, Franklin, Gadsden, Gulf, Jackson, Liberty, Wakulla

Our Fort Walton Beach Chapter is thriving. Participation continues to grow as we had 20 people at our last meeting. The Chapter members actively discussed current legislative issues, culture change, and ways to obtain narcotic scripts in a timely manner from doctors. This last issue plagues us all! The chapter meetings are held monthly, the second Friday of the month at 12:30. The sites are rotated. Contact **Bonnie Cruz** at The Manor at Blue Water Bay in Niceville at **(850) 897-5592**, for more information.

The Pensacola Chapter has not met in several months; we took a long holiday-season vacation. Our next meeting is Wednesday, April 21, at Rosewood Manor and is sponsored by Sanofi-Aventis (thank you, **Cynthia Fulford**). The Chapter meets the third Wednesday of the month at noon. Sites vary between facilities and restaurants, depending on sponsorship. We are arranging a meeting with the hospital discharge planners to discuss obtaining narcotic prescriptions on admission to our facilities.

For more information, contact **Sharyn Figgins**, the director of nursing at Rosewood Manor at **(850) 430-0500** or **sfiggins@gulfcoasthealthcare.com**.

Sharyn Figgins, RN, MSN
Region I Coordinator

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FADONA's 23rd Annual Convention:
Carrying the Torch of Leadership 2010
April 28-May 1, 2010
Buena Vista Palace Hotel, Lake Buena Vista


Tina Vanaman

REGION II

Region II—Northeast

2A—Hamilton, Lafayette, Alachua, Marion, Clay, Nassau, Suwannee; 2B—Dixie, Union, Putnam, Baker, St. Johns, Columbia, Gilchrist; 2C—Levy, Bradford, Duval, Flagler

At press time, Region II was working hard to hold a chapter meeting geared toward end-of-life care and recruitment. Odyssey Hospice had agreed to sponsor our meeting. It is scheduled for March 25, 2010, at 11:30 a.m. at Palm Garden of Ocala.

This region has been slow to grow. Back in February, I began to flood local DONs and members with various invitations: faxes, e-mails, and even the old form of communication, telephone calls. I hope my efforts paid off.

I am very pleased to announce that the Jacksonville area has revived its chapter and has started meeting again. Stayed tuned for more information in the next issue of *FADONA Focus*.

If any of you live in one of the many Region II counties, and you would like to help organize meetings in your area, please call me.

I know that together we can make Region II a strong, more active supporter of FADONA/NADONA.

You can reach me at Palm Garden of Ocala at **(352) 854-6262** or my cell number, is **(352) 553-7475**, or my e-mail address is **Tvanaman@Gramercyhealth.com**.

Thanks in advance for your support and assistance.

Tina Vanaman, RN, CDON/LTC, CCNC-C
Region II Coordinator


Norma Collins

REGION III

Region III—Centraleast

3A—Lake, Osceola, Orange, Seminole
3B—Volusia, Hardee

I would like to thank Florida Clinical Laboratory for sponsoring our last meeting in Lake Mary at FishBones Steak & Seafood. Thanks to all who braved the weather and showed up to support our sponsor.

The president of GOFADONA, James Metcalf, will be visiting the DONs at local skilled nursing facilities to encourage participation in our local and state chapter. We look forward to seeing our local members at convention.

There continue to be lively discussions and exchanges of ideas at our meetings that are beneficial to all. Please let us know the things that

concern you, and we will try to plan our speakers around them. We would love to see you become a part of our group.

I can be reached via the FADONA office and/or my e-mail at **normac1212 @aol.com**.

Norma D. Collins, RN, BS, LHRM
Region III Coordinator

REGION IV

Region IV—Centralwest
4A—Hillsborough, Pinellas, Highlands, Polk
4B—Hernando, Sumter, Citrus, Pasco

FADONA in Hillsborough County continues to grow. Any questions about Hillsborough County may be directed to **Mariann Calta** at **(813) 329-6061**.

Pinellas County FADONA has its regular meetings the second Tuesday, 5:30 p.m. at Banquet Masters. Any questions about Pinellas County may be directed to **Liz Raymond** at **nurse_raymond @yahoo.com**.

Polk, Hardee, and Highlands counties are having meetings quarterly. Please contact **Sandy Kenyon** at **(863) 422-8656** or **(863) 632-6367**, if you have questions or want to volunteer to help.

If you have any questions, suggestions, or just want to chat, feel free to call me at **(813) 960-1969**. My cell is **(813) 503-2810**, and my fax is **(813) 960-8510**. My e-mail addresses are **crusso@filtc.com** or **tyler48m@aol.com**.

Carla Russo, RN, CDON/LTC
Region IV Coordinator

SAVE THE DATE

"Carrying the Torch of Leadership 2010"

April 28-May 1, 2010
Buena Vista Palace Hotel & Spa

REGION V

Region V—Southwest
5A—Manatee, Charlotte, Collier
5B—Desoto, Lee, Sarasota

Region V needs your help. We are currently developing a new chapter in the Southwest tip of our state. If you wish to become involved in this area or any other in our region, or are interested in serving on any committees, please contact Cherryl at **cchmielewski@ greystonehcm.com**, or **(813) 635-9500**.

Cherrl A. Chmielewski, RN
Region V Coordinator

Region VI—Southeast
6A—Dade, Monroe, Broward, Palm Beach; 6B—Brevard, Indian River, St. Lucie, Martin, Okeechobee; 6C—Hendry, Glades

Regional REPORTS

Nursing administrative staff in long-term care must continue to promote the environment in which we work and address the challenges that face us daily.

Every area of Region VI needs dynamic people to champion a group of DONs in their area. Though time, effort, and energy are involved, the results are support for all. Who better to understand our day-to-day challenges than those of us who experience it daily?

We are all in this environment of health care because it is a calling — it's not for the financial reward. Please, consider coordinating a local group meeting. There are a lot of resources available to sponsor the food, help with notifications, etc.

Continued on page 6

Regional Reports

Continued from page 5

Please call if support, help, questions, or information are needed to urge you toward this valiant goal.

Here is the following local chapter contact information:

1. ***Indian River County*** — We invite you to attend our next meeting by calling **Nancy Henderson** for details. She is the local contact, and she can be reached at **(772) 288-0060**.
2. ***Palm Beach County*** — **Deborah Grotke** at **(561) 588-4333**. The Palm Beach County DON Association continues to meet monthly on the third Wednesday.

We have an active, growing group of members and associate members. Lunch and CEs are usually provided with support from our vendors. These meetings allow us to network and share valuable information with our fellow nursing administrators and associates. This in turn helps increase the quality of care that our facilities can provide to our residents and supports our efforts to be survey-ready.

3. ***Miami-Dade County***

The chapter officers are as follows:

~ President: **Hank Drummond**, RN, PhD; DON, Gramercy Park
~ 1st Vice-President: **Regina Caines**, DON, Miami Gardens Nursing Center
~ 2nd Vice-President: **Delia Rudio**, DON, Perdue Nursing Center
~ Secretary: **Anne Museau**, DON, Pines Nursing Home
~ Treasury: **Carol Stuchins**, DON, North Beach Rehab. Center

For more information about the Miami-Dade chapter, contact **Hank Drummond** at **hankmiami@yahoo.com**; cell: **(786) 566-0598**, or fax: **(305) 255-4530**.

The FADONA board of directors recently voted to ask the membership to consider an amendment to its bylaws that would allow FADONA to create a new region by taking three counties from Region VI, which runs from Vero Beach all the way to Key West.

The results will be formally announced at the 2010 annual convention.

We need your help to re-energize other areas of Region VI. If you are interested in helping out, or know someone you think would be a great asset, please contact **Ian Cordes** at **(561) 659-2167**, or e-mail **icordes@bellsouth.net**.

FADONA Focus

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Lobby Wednesday with FHCA

By Tina Vanaman, RN, CDON/LTC, CCNC-C; Director of Nursing, Palm Garden of Ocala; Region II Coordinator, FADONA

Back in March, many legislators heard the strong force of LTC leaders across the state. At the time of this article submission, none of us knew the outcome of our lobbying efforts. We hope that the legislators continue to realize that we serve a population that has paid their dues. Many served our country in the armed forces and deserve to live out their lives with dignity and respect from us all.

Palm Garden of Ocala represented the long-term care industry at the Florida Capitol. Pictured left to right are Carrie Hinson, Jennifer Mikula, Speaker of the House Larry Cretul, Tina Vanaman and Rhonda Dozier

On March 16, along with many others from Cypress Healthcare Management, I headed to the Capitol in Tallahassee. Upon arrival, FHCA welcomed us and did a wonderful job briefing us on the top issues that faced our legislators in this very difficult budget year. Early on March 17, we headed out to begin our day of walking the halls of the Senate building and the House. We met with about 12 legislators or their aides on the burning topics effecting LTC, and here is what we found out.

HB 1143, sponsored by Rep. Matt Hudson, and SB 2434, sponsored by Sen. Andy Gardiner, are likely to pass. These items contain several components that include exchanging paper reporting to the Agency for Health Care Administration (AHCA) for forms that are now incorporated into other electronic reporting functions; placing a $25-million cap on the lease bond requirement; eliminating current state administrative rule references for maintaining residents' medical records and adopting federal law and regulation (it is my opinion that this would eliminate the requirement for a medical records consultant); allowing AHCA to initiate more desk reviews in response to identified deficiencies that do not involve quality of care; and lastly — the largest part of the bill — is the elimination of duplicative requirements and regulations. This portion of the bill would save the state substantial amounts of money by eliminating annual inspections by all agencies outside of AHCA.

Other proposed legislation that would have a substantial impact on long-term care was HB 7069, sponsored by William Snyder, and SB1520, sponsored by Ronda Storms. This bill would require a level-2 nationwide FBI check for all employees providing care or services directly to residents or for anyone who has access to resident living areas, resident funds or property (in other words, all employees).

The process would require electronic fingerprinting. Currently, there are only about 25 vendors registered in the state of Florida to perform this service. This will lead to expensive start-up costs for many. While visiting with various legislators, I did learn that none of them are sure what the cost per employee will be. Estimates varied tremendously from $30 to as much as $70 per employee. The one thing that seemed consistent was that it would not be a government-funded program and that the cost should be passed on to the potential employee.

I have my own views on this and cannot help but wonder, in a time when many cannot find jobs and can barely pay for essentials, how are they going to pay to get a job? The answer to this question also seems to be pretty consistent: payroll deduction after hire. I recommend we all begin to plan on how we will handle yet another expense as I suspect this legislation will also pass both the Senate and the House.

While discussing these two issues, we heard a lot of talk about proposed Medicaid cuts to nursing homes and combining of nursing home staffing. This would mean you would have a CNA and nursing requirement daily of 3.9, and CNA staffing could never be below 2.7.

The certificate of need (CON) requirements were also discussed in regards to enforcing fines and penalties on facilities that do not meet the Medicaid CON requirement. Stricter enforcement and higher fines would generate more income. It does not appear that this thought will go anywhere this year, but the seed has definitely been planted.

Well, this was my second year to lobby in Tallahassee, and I loved every minute of it. I find it educational and cannot think of a better way to lead our industry and represent my profession than to have the undivided attention of those who pass the laws that affect us all every day.

Next year, I would like to plan a FADONA event, have our board of directors meet in Tallahassee, and let our voices be heard. Hope to see you on the hill next year!

FADONA to Offer Certification Preparedness Course for CDON/LTC – Certified Directors of Nursing

Since 1989, the National Association Directors of Nursing Administration in Long Term Care (NADONA/LTC) has been certifying directors of nursing and assistant directors of nursing in long-term care facilities. More than 1,800 DONs have been certified through this program.

On April 28, 2010, FADONA will offer an exam preparation course during its 23rd Annual Convention, "Carrying the Torch of Leadership 2010," in Orlando. FADONA Past-President Gilda Osborn, who is a NADONA-approved instructor, will join NADONA Executive Director Gina Kaurich to lead the course. For more information, contact the FADONA business office at **(561) 659-2167**, or NADONA at **(800) 222-0539**.

What Does Certification Mean?

Certification indicates that the DON and ADON in long-term care possess a specific core of knowledge in their profession. The profession is unique in the nursing field, and becoming certified validates the uniqueness.

Your field is a specialty and NADONA/LTC is a specialty association specifically for DONs, ADONs, and other nurse administrators. You must be certified to use "CDON/LTC" along with other credentials you may have already achieved.

Why Should I Become Certified Through NADONA/LTC?

Since NADONA/LTC is the specialty association for nurse administrators in long-term care, it makes sense to become certified through that organization. In addition, the certification program, the rules and regulations, and the test itself, have all been developed by DONs in long-term care. Only a DON or ADON can realize the many facets of the profession.

If I Fail The Exam, Can I Take It Over Again?

Yes. Included in NADONA's fees are two attempts to take the NADONA DON certification exam. If you fail the exam, you may retake it one additional time. If you pass the exam on the first try, retaking it is not recommended.

NADONA recognizes that many individuals have great difficulty with testing; therefore, NADONA/LTC encourages candidates to retake the examination until they achieve success.

DON Qualifications

In order to qualify to become certified, each candidate must have completed a minimum of 1,000 hours as a DON or consultant in the long-term care specialty within the last 3 years, have at least 2 years of full-time experience as a DON or ADON, and be able to provide evidence of at least 50 hours of continuing education; or retake the examination.

For more information about the NADONA certification program, contact NADONA at **1-800-222-0539**.

FADONA/NADONA Membership Application

Please be advised: Applications without fees cannot be processed.

Name: _____ *Title:* _____

LTC facility name: _____

Other company name: _____

Address: _____
Street *City* *State* *ZIP*

County: _____ *Phone: (* _____*)* _____ *E-mail:* _____

I am enclosing my FADONA and/or FADONA/NADONA membership dues.

[ ] **Full Member:** *$120/yr. or $220 for 2 years.* **Eligibility:** *Any registered nurse who is currently or has previously within the past five (5) years (upon initial application) served as director of nursing, assistant director of nursing or administrative RN in a long-term care facility, assisted living facility, or a home health agency that is long-term care, facility-based.* ***"Full" members from Florida automatically join FADONA when joining NADONA. Make all "Full" member dues payable to NADONA and mail directly to:*** **Reed Hartman Tower, 11353 Reed Hartman Highway, Suite 210, Cincinnati OH 45241**

[ ] **Associate Member:** *$240/yr.* **Eligibility:** *Open to any RN, LPN, physician, or other professional who is involved in the health care field and who is interested in supporting the goals and objectives of FADONA. Associate members are non-voting FADONA members and are not eligible for vendor discounts for advertising, exhibiting, etc. You must join FADONA as a Patron or Alliance Council member in order to receive vendor discounts and other benefits.* ***Make "Associate" member dues payable to FADONA/LTC and mail to:*** **200 Butler St., Suite 305, West Palm Beach, FL 33407.**

To Receive FADONA Convention Membership Rate: *Make a "copy" of this completed membership form with its accompanying payment and attach copy to the completed Convention registration form.*

Amount Enclosed $ _____

Mentorship: Musings on Who Mentors the Mentor

By Reuben Bowie, RN, MS, CDON/LTC; Treasurer, FADONA

FADONA has a goal to establish a mentoring program. Where do we begin? Why is this important? Nursing is an ever-changing and challenging profession.

Reuben Bowie

In addition, long-term care nursing is constantly critiqued and must compete for survival. While litigation is not as bad as it once was, it is still an issue.

Economic crises are affecting our budgets, and there is even a move in the works to transfer some residents from skilled nursing facilities to assisted living or home-based care. Such a plan poses many concerns for residents, and if it comes to fruition, it would increase the intensity of care needed in skilled nursing facilities. It is no surprise that staff turnover is a major problem in such an environment.

Most of our nurses can relate to phrases like "When it rains, it pours, and it is always raining" or "Nurses eat their young." Such phrases highlight the overwhelming stress and lack of support that so many nurses feel.

Mentorship could be the answer. Mentorship can be a solution to the worsening decline in nursing staff morale and support.

Mentorship refers to a developmental relationship between an experienced and knowledgeable person and one less experienced and knowledgeable where knowledge, skill, perspective, information and guidance can be shared. The mentor is a wise and trusted coach, tutor, or counselor. The goals of mentorship can be diverse, but it would seem that the main goal of mentorship would be to encourage a depth of knowledge not achievable in school. Practical or tacit knowledge comes from that mentoring relationship.

Organizations that support a mentorship program may have goals of staff retention or staff competence. With the budgetary constraints that we all face, is it realistic to try to put a mentoring program in place? We can't really afford not to do so.

There is hardly a facility anywhere that does not need to hire at least one new nurse or CNA right now. That is where we begin. Hire staff members who have an open mind and a willingness to learn new and different things. If they feel there is nobody better at their job or they can't identify something new that they learned at the last class they attended or from someone they worked with, a mentor won't help them. The new hire must have a desire to learn a better way or something new. Mentoring is a brain to pick, an ear to listen, and a push in the right direction.

Who will be your mentors? Who are the staff members who "do it right" and are willing to share and help? Mother Teresa said, "Do not wait for leaders; do it alone, person to person. These are your mentors. Be the change you want to see in the world." The person making a difference is a mentor to those willing to look, listen and learn.

Maya Angelou said, "People will forget what you said, people will forget what you did, but people will not forget how you made them feel." Who on the staff makes new people feel welcome?

Directors of nursing are often the mentors, but who mentors them? Some become DONs because they are the last RN standing. When that position has been gained because the previous DON was ushered out after a bad survey, the DON may be overwhelmed by having to "fix" whatever caused the bad survey and having no orientation to the position.

Mentoring involves a voluntary, mutually-beneficial and usually long-term professional relationship. Where does a DON find that? Try FADONA. Your FADONA board is comprised of experienced and knowledgeable leaders willing to support the maturation of less-experienced DONs. There is a tendency to think you don't have time to join another organization because you are already so overwhelmed, but help is there for the asking. An hour or so each month will introduce you to a network of people who have overcome similar experiences that you are encountering. Within this group, you can find your mentor.

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To learn more about Aegis Therapies and our progressive therapy programs, call us at **866.338.8789** *or visit* **www.aegistherapies.com**.

aegis therapies™

I Love Convention Time!

By Robin A. Bleier, RN, HCRM, FACDONA; 1st Vice-President and Convention Chair, FADONA

Come one, come all to the 23rd Annual Convention!

I am very excited to work with my colleagues on your state FADONA board and with our staff to present to you "Carrying the Torch of Leadership 2010."

Please mark your calendar now for the annual FADONA conference, which will be held April 28-May 1, 2010, at the comfortable and beautiful Buena Vista Palace Hotel & Spa.

We have optional staff education and mandatory CEU education during a pre-conference day; national, state, and locally-recognized speakers to include AHCA regulatory experts, clinical and risk professionals based on the 2009 FADONA "Principles of Excellence" (to see the "Principles," please go to **www.fadona.org**) created by our Think Tank, a statewide group of vice presidents of clinical services and similar positions, along with FADONA board members.

The Principles were created to shape the domains and specific details of what successful nursing leaders demonstrate by looking at key domains or categories.

There are many benefits to the professional nursing leader by attending the FADONA conference. Examples are: meeting and networking with peers; sharing of clinical, regulatory, human resources, and other common problems to share problem solving methods; focused educational opportunities that eliminate the day-to-day personal and professional distractions; confidence and experiences to share back at their facilities, and much more!

So please do take the time to make the dates of YOUR conference a priority for YOU and your professional development, to recharge your batteries while immersing yourself in education, training, and leadership growth.

For questions about the conference, please call us today!

Sincerely,

Robin A. Bleier

Robin A. Bleier

FADONA's 23rd Annual Convention: Carrying the Torch of Leadership 2010

Wednesday, April 28, to Saturday, May 1, 2010
Buena Vista Palace Hotel, Lake Buena Vista, Fla.

Attention: DONs, ADONs, all LTC Nurses, and Administrators...

Sign up today for the most innovative lineup of clinical, administrative, and motivational offerings — not to mention — the best LTC educational value in Florida.

- ✔ **Optional: 1-day NADONA DON Certification Prep Course**
- ✔ **Optional: Mandatory licensure-renewal courses** for Florida nurses and nursing home administrators.
- ✔ **Optional: *"NEW"* "Staff Training Day: Advanced Training for Long-Term Care Nurses"** (both RNs and LPNs) — This series is committed to promoting the highest standards of professional practice. It will include: 2 hours of "Risk Management as it Pertains to Medical Errors;" 1 hour of "Be a Pioneer;" 1 hour of "Nurse Practice Act" (and what F-tag 281 is all about); and 1 hour of "Survey Preparedness." **All ONLY $75!**
- ✔ Exciting leadership sessions
- ✔ State-of-the-science clinical presentations by renowned clinicians
- ✔ Regulatory update from the Agency for Health Care Administration
- ✔ Annual Awards Luncheon with presentation of ***"NEW"*** LPN awards and enhanced CNA awards.

SAVE MONEY with Flexible Options & Affordable Fees:

- ✔ Half price for 1st-time attendees
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Observing Legal Trends in LTC Case Law

By Karen Goldsmith, JD; Goldsmith Grout & Lewis, PA

As many of you know, our firm is embarking on an adventure with Hugh Heaton. We are launching a website that will supply quick access to health care providers as to rulings on federal and state survey and certification cases, tutorials to help you with staff in-services, and an understanding of the nuances of the requirements (such as RIC and MAC audit information, advance directives, etc.) and information to keep you current on legal trends.

Karen Goldsmith

In preparing the site, Jon Grout and I have read virtually every federal administrative law judge (ALJ) and Departmental Appeals Board (DAB) case that might impact your practice. In doing so, we have learned a lot that we want to share with our clients and friends. From time to time, I will use this forum to bring you critical information.

The most-often-challenged tag is F 323, assistive devices and resident supervision. While F 323 does not hold a provider to strict liability in preventing accidents, it does set a high bar for your staff. It requires that the facility take whatever measures it must to prevent accidents and incidents, taking into account the resident involved, his or her history and condition, and the environment in which the resident resides. You may choose the methods, but they better work.

In addition, the incident must be reasonably foreseeable, although the exact nature of the incident need not be. For example, a resident may be prone to falls that the facility attributes to sundown syndrome. The resident may fall only at certain times of the day. Each time the resident does fall, the facility must still analyze the fall and determine whether there is a way to prevent further falls. This is true even though the resident seems to be falling for the same reason and the facility has tried many interventions to break the cycle.

That same resident may fall at a different time, and that incident may be more fully explored. Upon investigation, the facility may learn that the resident fell because his slippers were too big.

Upon further examination, the surveyors may determine that the earlier falls were not attributable to sundown syndrome at all, but rather ill-fitting slippers. The facility will not only be cited for the sundown falls, but the new one as well. The facility, had it thoroughly investigated the earlier falls, would have learned that the resident got ready for bed just before sunset, removing his shoes and putting on his slippers. Because it seemed so obvious that he was suffering from a common effect of dementia, a superficial investigation was performed.

You would likely be cited at an immediate-jeopardy level. Do you know that of the 800+ cases appealed to the federal DAB since 2000, the vast majority involved immediate jeopardy? It is a lot more common than you think, and only a small handful of the cases go in the provider's favor.

Another tag often cited is F 157, notice to the physician of a significant change in condition. The cases are all over the map on this one. For example, I recently read a case in which residents were suffering from relatively high fevers. The ALJ held that, based on the residents' condition and transient illness and that the fevers were being reduced temporarily with treatment, there was no requirement for the nursing home to call the physician.

On the other hand, there are a number of cases that, applying 20/20 hindsight (usually where there has been a negative outcome), the facility was cited at the immediate-jeopardy level for failure to notify the physician.

Documentation is always a problem in these citations, but most especially in F 157. Nurses are busy and do not document. That old adage "If it is not documented, it is not done" is alive and well with the federal appeal system. I have seen cases with great testimony to support the record just going sour on the facility.

To avoid F 157, there are a few simple steps. Know what is considered a significant change. Of course, each case will depend on its facts; but generally, a change in condition includes clinical complications or a need to alter treatment. In some cases, nurses have taken it upon themselves to change treatment, such as applying a different topical to a decubitus ulcer. The judges have blasted them, reminding them that they cannot practice medicine and that they also have an obligation to get the doctor involved.

Continued on the next page

Observing Legal Trends in LTC Case Law

Continued from previous page

F 157 requires that the doctor be consulted immediately. This relates to all significant changes, not just those that are life-threatening. In the original proposed rule, way back when, there was a requirement for consultation within 24 hours. That was eliminated early in the drafting, and a requirement that notification be immediate was added. Just calling the doctor and waiting for a callback will not be enough if the resident suffers negative consequences. Nurses must be persistent in getting the doctor's attention. Talking to the nurse in the office may not be enough, depending on the resident's condition. In fact, I would be reluctant to advise a client to ever rely on what she is told by a doctor's office. You should speak to a doctor, preferably the resident's attending.

Much law has been created around the idea of a "consultation." The cases have held that a consultation requires an exchange of information between the nurse and the doctor. It is not up to the nurse to determine what information she believes the physician needs. She must give the physician all the information she has and let the physician sort through it. Even if the response from the physician is merely direction to monitor the resident, that must be recorded in the chart, though that is pretty obviously something the nurse intends to do. Remember, a consultation is an exchange of information, not mere notification. A dialogue is required by F157.

As we observe trends in these cases, we will share that information with you. We certainly have learned that, in many areas, to be in compliance, much more is expected of our nurses than previously believed.

This column is a regular feature of ***FADONA Focus***. If you want a subject discussed, please e-mail **Karen Goldsmith** at **klgoldsmith@cfl. rr.com**.

Indications and usage

Levemir® is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

Important safety information

Levemir® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir®. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Levemir® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetes treatment may require adjustment.

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. **Levemir® should not be diluted or mixed with any other insulin preparations.** Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir® from other intermediate or long-acting insulin preparations. The dose of Levemir® may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation.

*Whether these observed differences represent true differences in the effects of Levemir®, NPH insulin, and insulin glargine is not known, since these trials were not blinded and the protocols (eg, diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences in weight has not been established.

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References: 1. Data on file. Novo Nordisk Inc, Princeton, NJ. **2.** Meneghini LF, Rosenberg KH, Koenen C, Meriläinen MJ, Lüddeke H-J. Insulin detemir improves glycaemic control with less hypoglycaemia and no weight gain in patients with type 2 diabetes who were insulin naive or treated with NPH or insulin glargine: clinical practice experience from a German subgroup of the PREDICTIVE study. *Diabetes Obes Metab.* 2007;9(3):418-427. **3.** Hermansen K, Davies M, Derezinski T, Ravn GM, Clauson P, Home P, for the Levemir Treat-to-Target Study Group. A 26-week, randomized, parallel, treat-to-target trial comparing insulin detemir with NPH insulin as add-on therapy to oral glucose-lowering drugs in insulin-naive people with type 2 diabetes. *Diabetes Care.* 2006;29(6):1269-1274. **4.** Klein O, Lynge J, Endahl L, Damholt B, Nosek L, Heise T. Albumin-bound basal insulin analogues (insulin detemir and NN344): comparable time-action profiles but less variability than insulin glargine in type 2 diabetes. *Diabetes Obes Metab.* 2007;9(3):290-299. **5.** Philis-Tsimikas A, Charpentier G, Clauson P, Ravn GM, Roberts VL, Thorsteinsson B. Comparison of once-daily insulin detemir with NPH insulin added to a regimen of oral antidiabetic drugs in poorly controlled type 2 diabetes. *Clin Ther.* 2006;28(10):1569-1581. **6.** Danne T, Endahl L, Haahr H, et al. Lower within-subject variability in pharmacokinetic profiles of insulin detemir in comparison to insulin glargine in children and adolescents with type 1 diabetes. Presented at: 43rd Annual Meeting of the European Association for the Study of Diabetes; September 17-21, 2007; Amsterdam, Netherlands. Abstract 0189. **7.** Heise T, Nosek L, Rønn BB, et al. Lower within-subject variability of insulin detemir in comparison to NPH insulin and insulin glargine in people with type 1 diabetes. *Diabetes.* 2004;53(6):1614-1620. **8.** Data on file. NDA21-536. Novo Nordisk Inc, Princeton, NJ.

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133236-R2 November 2008

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INDICATIONS AND USAGE
LEVEMIR is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long acting) insulin for the control of hyperglycemia.

CONTRAINDICATIONS
LEVEMIR is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

WARNINGS
Hypoglycemia is the most common adverse effect of insulin therapy, including LEVEMIR. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations.

Glucose monitoring is recommended for all patients with diabetes.

LEVEMIR is not to be used in insulin infusion pumps.

Any change of insulin dose should be made cautiously and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Concomitant oral antidiabetic treatment may need to be adjusted.

PRECAUTIONS
General
Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal.

LEVEMIR is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration.

LEVEMIR should not be diluted or mixed with any other insulin preparations (see PRECAUTIONS, Mixing of Insulins).

Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins.

As with all insulin preparations, the time course of LEVEMIR action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity.

Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

Hypoglycemia
As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR. Hypoglycemia is the most common adverse effect of insulins. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions). Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients' awareness of hypoglycemia.

The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from other intermediate or long-acting insulin preparations to once- or twice-daily LEVEMIR, dosages can be prescribed on a unit-to-unit basis; however, as with all insulin preparations, dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia.

Renal Impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with renal impairment.

Hepatic Impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with hepatic impairment.

Injection Site and Allergic Reactions
As with any insulin therapy, lipodystrophy may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR.

In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique.

Systemic allergy: Generalized allergy to insulin, which is less common but potentially more serious, may cause rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

Intercurrent Conditions
Insulin requirements may be altered during intercurrent conditions such as illness, emotional disturbances, or other stresses.

Information for Patients
LEVEMIR must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, life-style management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, timing of dosage, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as intercurrent conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the LEVEMIR "Patient Information" circular for additional information.

As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hypoglycemia or hyperglycemia.

Patients with diabetes should be advised to inform their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy).

Laboratory Tests
As with all insulin therapy, the therapeutic response to LEVEMIR should be monitored by periodic blood glucose tests. Periodic measurement of HbA_{1c} is recommended for the monitoring of long-term glycemic control.

Drug Interactions
A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring.

The following are examples of substances that may reduce the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol, terbutaline), isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogens, progestogens (e.g., in oral contraceptives).

The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, fibrates, fluoxetine, MAO inhibitors, propoxyphene, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics.

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent.

The results of *in-vitro* and *in-vivo* protein binding studies demonstrate that there is no clinically relevant interaction between insulin detemir and fatty acids or other protein bound drugs.

Mixing of Insulins
If LEVEMIR is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR with insulin aspart, a rapid acting insulin analog, resulted in about 40% reduction in $AUC_{(0\text{-}2h)}$ and C_{max} for insulin aspart compared to separate injections when the ratio of insulin aspart to LEVEMIR was less than 50%.

LEVEMIR should NOT be mixed or diluted with any other insulin preparations.

Carcinogenicity, Mutagenicity, Impairment of Fertility
Standard 2-year carcinogenicity studies in animals have not been performed. Insulin detemir tested negative for genotoxic potential in the *in-vitro* reverse mutation study in bacteria, human peripheral blood lymphocyte chromosome aberration test, and the *in-vivo* mouse micronucleus test.

Pregnancy: Teratogenic Effects: Pregnancy Category C
In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 nmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 nmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 nmol/kg/day (approximately 135 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. Drug-dose related increases in the incidence of fetuses with gall bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 nmol/kg/day. The rat and rabbit embryofetal development studies that included concurrent human insulin control groups indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity.

Nursing mothers
It is unknown whether LEVEMIR is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both.

Pediatric use
In a controlled clinical study, HbA_{1c} concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR and patients treated with NPH human insulin.

Geriatric use
Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

ADVERSE REACTIONS
Adverse events commonly associated with human insulin therapy include the following:

Body as Whole: allergic reactions (see PRECAUTIONS, Allergy).

Skin and Appendages: lipodystrophy, pruritus, rash. Mild injection site reactions occurred more frequently with LEVEMIR than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy).

Other:

Hypoglycemia: (see WARNINGS and PRECAUTIONS).

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4).

Weight gain:
In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in the effects of LEVEMIR and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

Table 4: Safety Information on Clinical Studies

			Weight (kg)		Hypoglycemia (events/subject/month)	
	Treatment	# of subjects	Baseline	End of treatment	Major*	Minor**
Type 1						
Study A	LEVEMIR	N=276	75.0	75.1	0.045	2.184
	NPH	N=133	75.7	76.4	0.035	3.063
Study C	LEVEMIR	N=492	76.5	76.3	0.029	2.397
	NPH	N=257	76.1	76.5	0.027	2.564
Study D	LEVEMIR	N=232	N/A	N/A	0.076	2.677
Pediatric	NPH	N=115	N/A	N/A	0.083	3.203
Type 2						
Study E	LEVEMIR	N=237	82.7	83.7	0.001	0.306
	NPH	N=239	82.4	85.2	0.006	0.595
Study F	LEVEMIR	N=195	81.8	82.3	0.003	0.193
	NPH	N=200	79.6	80.9	0.006	0.235

* Major = requires assistance of another individual because of neurologic impairment
** Minor = plasma glucose <56 mg/dl, subject able to deal with the episode him/herself

OVERDOSAGE
Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid reoccurrence of hypoglycemia.

More detailed information is available on request.

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Industry Buzz Words… "Culture Change" Part II

By Tina Vanaman, RN, CDON/LTC, CCNC-C; Director of Nursing, Palm Garden of Ocala; Region II Coordinator, FADONA

The top concern for our industry this year is budgets. Everywhere you go, it is the one thing we all have in common. The need for money outweighs the money available.

We work in an industry where we are always expected to do more for less. Providing quality care and giving those that depend on us the best quality of life possible seems to get harder and harder. Many of us hold our heads at the end of the day and say, "How am I going to do this?" as we just received the news of further budget cuts.

While writing this article this quarter, I tried to keep in mind that culture change was never intended to further stress any of us. It is expected, and it truly is simply living life to its fullest, instead of just having a life.

Restaurant-style dining

In the first article we discussed the definition of culture change. I used the Princeton University definition: "Culture Change is the attitudes, behaviors, knowledge and values shared by a group." At this point, I hope many of you have begun to change those characteristics in your communities (facilities). I am sure that many of you have formed your Culture Change Committee and have worked together to develop your vision

Jennifer Mikula, NHA, and Tina Vanaman, DON, spoke at FADONA's 22nd Annual Convention.

I simply cannot think of anything that makes me smile more as a nurse than to see someone happy and enjoying life.

statement. After these two tasks were completed, I hope your team was able to identify two or three areas that were the most important to you to use to begin your journey and establish your subcommittees.

Now, as I promised earlier, I will keep budgets in mind and focus on projects you can complete with absolutely no monetary investment. These two projects take only time and patience.

The first one is to develop neighborhoods within your community. Many of us work in communities that were constructed in a hospital format with long halls and semi-private rooms. We cannot change the foundation of the community, but we can improve it.

Take those long halls and form "neighborhoods." Give everyone on the neighborhood (sometimes as many as 30 people) the opportunity to meet each other, to socialize together, and to plan their own calendar of hobbies and interests unique to them.

Pool party with neighborhood leaders

Encourage them to meet and to initiate their own events. Ensure that each neighborhood has the supplies they need to successfully work independently or as a team. This will allow you to smile as you watch relationships grow. I simply cannot think of anything that makes me smile more as a nurse than to see someone happy and enjoying life.

Independently functioning neighborhoods sound great. But, like you, I am a real DON working in reality and we all know that people need guidance

and strong leadership to be successful with any change.

Out of this knowledge comes project number two. You must select a team of "Neighborhood Leaders." These are CNAs that possess the skills and ability to lead others into change. Develop a process for selection, and stick to it. It should, at minimum, include an application, an interview, and a very structured educational program.

Neighborhood leaders prepare for the Community Picnic.

You want to empower these individuals to be independent, to understand the basics of the regulations under which we must function, and most importantly to have and encourage everyone to have FUN! These select few will become the core of your culture-change journey. They will lead other staff into the new way of thinking. Your residents will learn to turn to them to resolve concerns or conflicts.

You have now established a very strong culture-change foundation. You have a committee, subcommittees, neighborhoods, and neighborhood leaders who possess the skills to carry you through a journey of a lifetime.

I wish you all the best with the new phases of your journey, and I look forward to the next issue, where we will discuss learning circles and staff challenges. Until then, "Good luck" and may your journey carry very few bumps and bruises.

Clinical Proficiency, Good Risk Management

By Norma Collins, RN, BS, LHRM; Region III Coordinator, FADONA

The purpose of risk management is to protect the organization's assets. It should have three components: Proactive, Reactive, and Continuous Quality Improvement.

As a clinical specialist, I always consider the skills check and confirmation process as one of the key proactive steps that I as a consultant and a former nursing administrator could and should take.

Today's skilled nursing facility (SNF) resident typically comes to us from an acute care facility or skilled care stay. In the years I have worked in long-term care (LTC), our acuity levels have risen and continue to do so. Therefore, one of the most key elements to sound clinical services is to ensure that staff have or gain the skills to evaluate and assess the residents and their conditions. This allows for appropriate and timely services.

So my challenge to you as a fellow FADONA professional is three-fold:

1. What do you do to ensure that the nurses you hire possess the skills necessary to meet the clinical needs and expectations of your residents and other health care professionals?
2. What kind of education do you provide to help the nurses gain and/or maintain their skills to function in the ever-increasing skilled service environment we practice in?
3. What remediation programs do you have in place to support the less-skilled nurse in order to bridge the gap and enhance the nurse's skill set?

While some facilities have a specific nurse assigned to staff development, this is still the job of all administrative nurses. Education should be geared to multiple levels of learning, as each of us has individual learning needs. Return demonstration is key and should happen at all levels on all shifts to ensure that the nurses are comfortable to complete their jobs while working with and/or supervising the nursing assistants functioning as a key member of the interdisciplinary team. Increased education can enhance job satisfaction, reduce turnover, and decrease risk to our facilities.

For more information on clinical-services educational programs, contact **Norma Collins**, senior clinical specialist with RB Health Partners, Inc., at **Norma@RBHealthPartners.com**.

Pneumococcal Pneumonia in the LTC Setting

By Steven J. Schweon, RN, MPH, MSN, CIC, HEM; Infection Preventionist

P.D. is a 78 y.o. alert female resident in an LTC facility. She sud-denly develops a 102.2 fever. She appears ill and has an apical pulse rate of 118 bpm, with a respiratory rate of 28/min. Her pulse oximetry is 84% on room air. She complains of pleuritic chest pain (i.e., pain with breathing/coughing) and shortness of breath. She is expectorating mucopurulent, rusty sputum. She is transferred and admitted to the local hospital. Her chest X-ray is interpreted as pneumonia. Her sputum culture is positive for Streptococcus pneumoniae while her blood cultures are negative. Based on the sputum antibiotic sensitivity report, she is treated with penicillin and makes a full recovery. Of note, P.D. received the pneumococcal polysaccharide vaccine (PPSV23), the "pneumonia shot," at the time of admission, four years ago.

Steven Schweon

Streptococcus pneumoniae, also known as the pneumococcus, is a gram-positive organism commonly found in the respiratory tract. Transmission occurs by respiratory droplets that are spread person-to-person. The process of how a colonized individual, a carrier, develops disease is not clearly understood.

Test your knowledge:

Q1: Does the pneumococcal polysaccharide vaccine (PPSV23), routinely given to LTC residents, protect against pneumococcal pneumonia?

a. Yes, the vaccine does protect against pneumococcal pneumonia.

b. No, the vaccine does not protect against pneumococcal pneumonia.

A: The pneumococcal vaccine is effective with preventing invasive disease, e.g., bacteremia, meningitis. However, the vaccine does not provide protection against pneumococcal pneumonia and should not be referred to as the "pneumonia vaccine."[1]

Q2: According to the National Childhood Vaccine Injury Act, LTC facilities must offer the resident/POA the pneumococcal vaccine VIS (Vaccine Information Statement) prior to receiving the vaccine.

a. Yes, this legislation applies to all pneumococcal vaccine recipients, regardless of their age.

b. No, this legislation applies to children who are receiving the pneumococcal conjugate vaccine only.

A: Though not mandated by the National Childhood Vaccine Injury Act2, the pneumococcal polysaccharide vaccine (PPSV23) Vaccine Information Statement is a CDC-produced information sheet that describes the vaccine's benefits and risks. For health teaching purposes, the VIS can be presented to the resident/POA prior to the vaccine's administration. (This VIS is available from: **www.cdc.gov/vaccines/pubs/vis/downloads/vis-ppv.pdf**.)

Q3: Per the CDC, all health-care workers (HCWs) should routinely receive the pneumococcal vaccine in addition to the influenza vaccine to protect them against pneumococcal disease.

a. Yes, all HCWs should be routinely vaccinated.

b. No, all HCWs should not be routinely vaccinated.

A: HCWs should receive the pneumococcal vaccine only if they have pneumococcal disease risk factors:

- 65 years of age and older
- Heart disease
- Lung disease
- Sickle cell disease
- Diabetes

Per the CDC, all health-care workers should routinely receive the pneumococcal vaccine only if they have pneumococcal disease risk factors.

- Alcoholism
- Cirrhosis
- Cochlear implant
- Cerebrospinal fluid leak
- Hodgkin's disease
- Lymphoma or leukemia
- Kidney failure
- Multiple myeloma
- Nephrotic syndrome
- HIV infection
- Damaged or absent spleen
- Organ transplant
- Receiving long-term steroids or certain cancer drugs
- Smoking
- Asthma

Otherwise, the vaccine is not recommended routinely to HCWs, because their disease risk is not greater than the general population.[3]

Q4. Due to their age and declining immune system, all elderly residents should be offered a pneumococcal vaccine booster at five years after their

initial vaccination.

a. Yes, the vaccine works best when supplemented with a booster dose.

b. No, only individuals with certain risk factors should be offered a booster dose.

A: Routine revaccination of immunocompetent individuals is not recommended.[1] Revaccination is recommended for persons with:

- Immunosuppression
- Transplant
- Chronic renal failure
- Nephrotic syndrome
- Functional or anatomic asplenia
- Or, those who were vaccinated at less than 65 years of age.

References:

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2. Immunization Action Coalition. Ask The Experts. General Vaccine Questions. **http://www.immunize.org/askexperts/experts_general.asp#safety**. Accessed March 1, 2010.
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Medication Administration Errors

By Robin A. Bleier, RN, HCRM, FACDONA; 1st Vice-President, FADONA

Recently, I received multiple calls about the increased incidence of medication administration errors identified during surveys. Furthermore, I am being told by directors of nursing and regional/management/corporate staff that they too feel that these errors are on the rise since the initiation of the Quality Indicator Survey (QIS) process.

Robin Bleier

Therefore, the purpose of this article is to discuss important aspects of the medication administration process. Feel free to use any of this information with your staff as you are so inclined.

Medication Cart Preparation – It all starts with our getting prepared. Taking a few moments before the start of the medication pass will save some time during the actual medication administration, and hopefully there will be an error reduction by eliminating or reducing distractions.

To prepare, see that :

a) The cart is stocked with cups, straws, spoons, beverages, etc.;

b) Over-the-counter (OTC) meds, sprays, drops, etc. are in the cart and ready to go, to avoid interrupting your medication pass getting something you should already have had;

c) The cart is re-stocked after each medication pass.

You are polite to the next nurse by ensuring that a, b, and c are done. Occasionally, someone might have a hard shift and not get to it, but if that happens often, notify your nurse manager to see whether there is a major problem or just temporary difficulties.

Medication Administration – Once you and your cart are ready to go, it is time to pass medications and recall the five (5) Rs + two (2) more which I like to add:

1. Right Resident,
2. Right Medication,
3. Right Dose,
4. Right Route,
5. Right Time,
6. Right Documentation *
7. Right Infection Control **

* **Right Documentation** means that we "document per reasonable practice." For example, the nurse documents in the narcotic book when removing the narcotic from the narcotic drawer, indicating that the medication was removed but not yet given to the resident. The nurse then documents on the medication administration record (MAR) immediately following the acceptance or administration of the medication, rather than at a later time in the shift.

* **Right Infection Control** means that you wash your hands before medication administration; between residents; between drops, sprays, etc.; and at the conclusion of the medication pass.

So remember, good clinical risk management is proactive to reduce opportunity for errors and improve resident care and outcomes!

Robin A. Bleier, owns and operates RB Health Partners, Inc., a clinical risk regulatory consulting firm based in Tarpon Springs, Florida. She can be reached at (727) 744-2021, or robinbleier@yahoo.com.

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If you prefer, for an extra charge of $25, you may order a set of handouts no later than April 16, and it will be ready for you at the registration counter when you arrive. However, please be aware that we cannot ensure the availability of every PowerPoint presentation or handout for every session.

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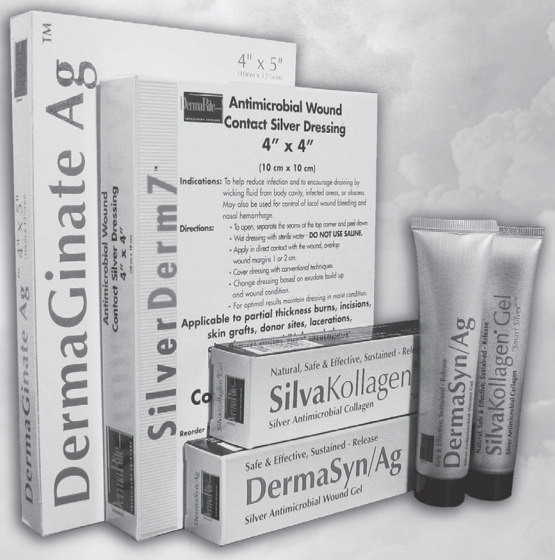

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Medicare Therapy Cap Update

In a very short-term, but hard-fought victory, Congress has extended the Medicare Therapy Cap outpatient Part B exceptions process through March 31, 2010, and retroactively from Jan. 1, 2010. The Centers for Medicare and Medicaid Services (CMS) will pay all claims through March 31.

Additional congressional action is needed to ensure that the Cap does not go back into place on April 1, when the current extension expires. The short-term extension is a good sign that Congress understands the problem of the therapy cap for providers and beneficiaries alike.

The U.S. Senate passed legislation that would provide longer-term extensions of the Medicare Part B therapy cap exceptions process, the freeze of the physician fee schedule, and the enhanced Federal Medical Assistance Percentage (FMAP) Medicaid funds.

Prior to the fee schedule relief's expiration on Sept. 30, Congress is expected to adopt legislation addressing the issue further.

The therapy exceptions process will be extended through Dec. 31, 2010, and the scheduled reduction in the Medicare physician fee schedule will be postponed until Sept. 30 of this year. The enhanced FMAP funds will be extended for six months through June 30, 2011. These provisions were in a larger bill with a series of "extenders" of government programs or provisions that were expiring or had expired.

As most of you know, our friends at Florida Health Care Association have been actively engaged with the American Health Care Association's lobbying, grassroots, and media-outreach efforts for Congress to pass a longer-term therapy cap exceptions process as well as for the six-month extension of the enhanced FMAP funding.

The bill, which passed the Senate by a vote of 62-36, must now go to the House of Representatives for a vote, or the House and Senate must proceed to a conference committee to work out the differences in the two versions of the bill. There is a great deal of pressure on Congress to complete work on the bill before returning home for Easter/Passover Recess at the end of March. We will continue to monitor the progress of this important legislation on Capitol Hill.

As previously announced in the media, Congress passed legislation providing relieve on the cap and the Medicare fee until the end of March. This longer-term legislation will give additional stability to the situation.

Prior to the fee schedule relief's expiration on Sept. 30, Congress is expected to adopt legislation addressing the issue further; physician groups are advocating for a permanent solution.

– Source: Florida Health Care Association

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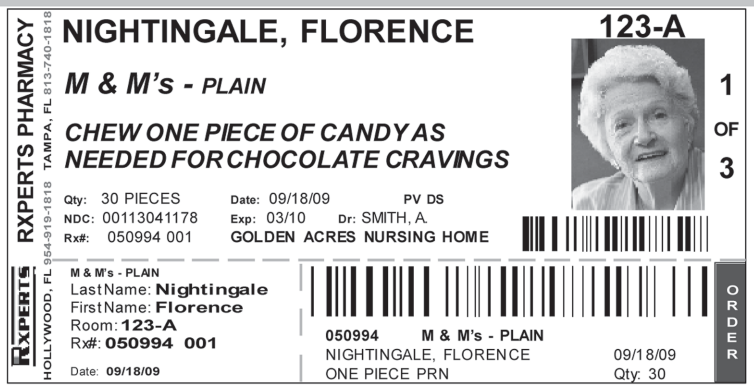

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