Volume 35 • Issue 3

August, September, October 2010




DNA Reporter

The Official Publication of the Delaware Nurses Association

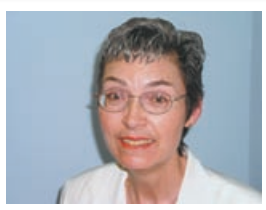
Constituent member of ANA

The mission of the Delaware Nurses Association is to advocate for the interest of professional nurses in the state of Delaware. The Delaware Nurses Association is dedicated to serving its membership by defining, developing, promoting and advancing the profession of nursing as an art and science. Quarterly circulation approximately 12,000 to all RNs, LPNs, and Student Nurses in Delaware.

Inside DNA REPORTER

DNA received a Senate Tribute

Page 3



Data Bits

Page 9

President's Message

A Long Term Care… How Do We Prepare?

Norine Watson, MSN, RN, NEA-BC

Norine Watson

The US population is aging…and this aging has huge implications for the nursing profession. Our *DNA Reporter* co-managing editors, Heidi LeGates, MSN, RN and Donna Shanosk, MSN, RN had the good insight to devote this entire issue to this important topic that impacts us all, regardless of where we practice.

Here are a few facts about the Long term care demands from the U.S. Department of Health and Human Services:

- Today about 9 million people over the age of 65 require long-term care and by 2020 that number is predicted to grow to 12 million.
- People who reach age 65 will likely have a 40 percent chance of entering a nursing home.
- 10 percent of the people who enter a nursing home will stay there five years or more.

The aging of the population will affect the nature of the skills and services nurses must be equipped to provide, and it will also change the settings in which this care is provided. The so-called "baby boom" generation (people born between 1946 and 1964) is already having an effect on the health care system and it is expected to grow as the century progresses. The first of the U.S. baby boomers began turning 60 in 2006 and within the next 2 years, 40 million people will be 65 or older. Looking a little further out, the U.S. Census Bureau forecasts show 20 percent of the country's population will be seniors by 2030.

Nurses should be aware of these other changes of this generation:

- Older adults will be increasingly racially and ethnically diverse, particularly more will identify themselves as Asians and Hispanics
- Older adults will be better educated, have greater access to information, and more socioeconomic resources

These demographics will lead to changing patterns of utilization and different demands for health services than those seen in past generations of older adults.

The projected demand for health services from this population is most likely an underestimation of their true need for services, which is influenced by their ability to find or pay for health care services.

Nursing implications are many:

- Education regarding care for older adults will need to increase to ensure the availability of competent care for this population.
- Drug, devise and other types of research studies will need to increasingly focus on or include participants over 80.
- To prepare for the future demands nurses will need to stay abreast of:
  - Health insurance reimbursement policies
  - Emerging technologies
  - New models of care
  - Changes in profession-specific scope of practice

I hope that you enjoy this issue of the *DNA Reporter* and while you are reading through it think about the expectations that you would have for long term care for yourself or members of your family. What competencies would you want those providing this care to have?

Executive Director's Column

Sarah J. Carmody
Executive Director

Sarah Carmody

Hello Everyone!

Throughout the summer, DNA is working hard to prepare for events in the fall and winter. The DNA Fall Conference is scheduled for October 29, 2010 at Delaware State University in Dover. The Professional Development Committee, as always, has arranged a fantastic program on Mental Health. The DNA General Membership meeting will be held during the lunch hour. I hope that you will consider joining us at this event.

The Continuing Education Committee continues to be busy peer-reviewing program applications for nursing contact hours. This group welcomes any DNA member that meets the qualification of having a baccalaureate or higher degree in nursing, and educational and clinical expertise. This is a great way of volunteering a little of your time to support the educational needs of nursing while obtaining nursing practice hours.

Our Legislative Committee has done a great job monitoring and initiating bills this past Legislative season. We had success in passing the Nurse Title Protection bill and the BPA Resolution as well as receive a Senate Tribute to Nurses. While the days of summer may be lazy, this group will be actively working on DNA's legislative agenda throughout the summer.

Executive Director continued on page 2

current resident or

Presort Standard
US Postage
PAID
Permit #14
Princeton, MN
55371

Index

Executive Director continued from page 1

We will continue our legislative work at our nation's Capital as the DNA Delegation will be participating in the ANA Lobby Day on Capital Hill on June 16th. We will take this opportunity to meet with Delaware's legislators and talk with them about issues that affect the nursing profession and environment in our state.

In addition to participating in the Lobby Day activities, the DNA Delegation will take part in the ANA House of Delegates from June 16-19th. The House of Delegates is great for meeting other nurses from around the country, learn about issues that affect them as well as vote on the direction of ANA activities. Results and information from these two events will be shared at a later date.

I hope you are enjoying your summer. If you are interested in participating on any of the many DNA committees or have ideas/suggestions that you would like to share, please contact me at sarah@denurses.org.

I look forward to seeing everyone at the DNA Fall Conference October 29, 2010!

Vision: The Delaware Nurses Association is dedicated to serving its membership by defining, developing, promoting and advancing the profession of nursing as an art and science.

Mission: The Delaware Nurses Association advocates for the interest of professional nurses in the state of Delaware.

Goals: The Delaware Nurses Association will work to:

1. Promote high standards of nursing practice, nursing education, and nursing research.
2. Strengthen the voice of nursing through membership and affiliate organizations.
3. Promote educational opportunities for nurses.
4. Establish collaborative relationships with consumers, health professionals and other advocacy organizations.
5. Safeguard the interests of health care consumers and nurses in the legislative, regulatory, and political arena.
6. Increase consumer understanding of the nursing profession.
7. Serves as an ambassador for the nursing profession.
8. Represent the voice of Delaware nurses in the national arena.

DNA Reporter

OFFICIAL PUBLICATION
of the
Delaware Nurses Association
5586 Kirkwood Highway
Wilmington, DE 19808
Phone: 302-998-3141 or 302-998-3142 FAX 302-998-3143
Web: http://www.denurses.org

The *DNA Reporter*, (ISSN-0418-5412) is published 4 times annually, by the Arthur L. Davis Publishing Agency, Inc., for the Delaware Nurses Association, a constituent member association of the American Nurses Association.

Subscription to the *DNA Reporter* may be purchased for $20 per year, $30 per year for foreign addresses.

For advertising rates and information, please contact Arthur L. Davis Publishing Agency, Inc., 517 Washington Street, PO Box 216, Cedar Falls, Iowa 50613, (800) 626-4081, sales@aldpub.com. DNA and the Arthur L. Davis Publishing Agency, Inc. reserve the right to reject any advertisement. Responsibility for errors in advertising is limited to corrections in the next issue or refund of price of advertisement.

Managing Editors
Heidi LeGates, MSN, RN, NEA-BC
Donna W. Shanosk, RN, MSN, NE-BC

The *DNA Reporter* welcomes unsolicited manuscripts by DNA members. Articles are submitted for the exclusive use of T*he DNA Reporter*. All submitted articles must be original, not having been published before, and not under consideration for publication elsewhere. Submissions will be acknowledged by e-mail or a self-addressed stamped envelope provided by the author. All articles require a cover letter requesting consideration for publication. Articles can be submitted electronically by e-mail to Heidi LeGates, MSN, RN, NEA-BC @ Heidi_Legates@Bayhealth.org or Donna Shanosk, RN, MSN, NE-BC @ dshanosk@christianacare.org.

Each article should be prefaced with the title, author(s) names, educational degrees, certification or other licenses, current position, and how the position or personal experiences relate to the topic of the article. Include affiliations. Manuscripts should not exceed five (5) typewritten pages and include APA format. Also include the author's mailing address, telephone number where messages may be left, and fax number. Authors are responsible for obtaining permission to use any copyrighted material; in the case of an institution, permission must be obtained from the administrator in writing before publication. All articles will be peer-reviewed and edited as necessary for content, style, clarity, grammar and spelling. While student submissions are greatly sought and appreciated, no articles will be accepted for the sole purpose of fulfilling any course requirements. It is the policy of DNA Reporter not to provide monetary compensation for articles.

Practical Approach to Pain Management in Skilled Nursing Facilities

Debra Baich Pietlock, MBA, BSN, RN
HCR Manor Care
Regional Clinical Service Consultant

Debra Baich Pietlock

Debra Baich-Pietlock graduated from the Nursing School of Wilmington in 1976 followed by an undergraduate degree in Nursing as well as a graduate degree in Business Administration from Wilmington University.

Experience: 34 years of nursing experience; Currently she is serving as a Clinical Service Consultant Mid-Atlantic Region for HCR-Manor Care. Prior to long term care, she worked in acute care settings with effective and various leadership roles including Director of Nursing in Critical Care.

Member of the Delaware Nurses Association, this is her first publication in the *DNA Reporter*. Debra spends her free time at the beach and is committed to maintaining a work life balance.

She may be reached by e-mail at dbaichpietlock@hcr-manorcare.com or (302)562-3842.

Abstract

The purpose of this article is to provide a practical approach to pain management in skilled nursing facilities. Although pain can be managed by multiple modalities, we will cover the main interventions useful in skilled facilities.

Pain arrives as an "Uninvited Guest" and can cripple anyone, at any age and in any severity. Pain is defined as "an unpleasant sensory and emotional experience that can be acute, recurrent or persistent." Pain can cause function to decrease and therefore can lead to a diminished lifestyle.

Recent challenges in healthcare include a population of patients that are faced with the need for skilled nursing services-this usually follows an acute hospitalization with limited days to address the entire complexity of the patient. The need for a continuum nursing and multi-disciplinary service often includes rehabilitation. The ultimate goal is to increase independence and to maximize self care.

Complexity of care often includes pain management. Whether the patient is post hip fracture or suffering from Diabetic neuropathy, pain management is the number one intervention-decrease pain and increase functionality to achieve the ultimate goal of discharge.

Three Main Pain Descriptions

Pain is divided into the following types: Visceral, Somatic and Neuropathic.

- Visceral pain mainly encompasses *organs*, such as abdominal organs (i.e. liver, pancreas, kidneys, and bladder). This type of pain is often described as "tight" "cramping" or "dull or deep." With Visceral pain, appropriate diagnostic tests may need to be ordered by the Physician to ascertain the underlying cause.
- Somatic pain is usually associated with bones, soft tissues, muscles, or joints. This pain is described as "deep, aching and throbbing" and may occur at rest or exacerbate with movement. Depending on severity, somatic pain management may include non-pharmacological interventions, non-steroidal anti-inflammatory medications, corticosteroids, or higher potency narcotics.
- Neuropathic pain is derived from nerve inflammation, damages or impairment of nerve endings. This type of pain is described as burning, shooting, radiating or skin sensitivity such as throbbing, often verbalized as constant deep aching. Recent guidelines emphasize the role of narcotics as the primary intervention for Neuropathic pain along with adjuvant medications.

Key Measures:

The key to identifying any complaint of pain is by obtaining a thorough history. Ask the patient questions related to changes in their physical status, what activity can increase pain and what may alleviate their pain. It is imperative to ask direct questions and listen to the answers so the patient can guide the nursing professional in making an accurate assessment. Physical observation is also vital. Is the patient displaying nonspecific signs of pain i.e. restlessness, rubbing, grimacing, grinding of teeth? Observe their social immersion including cultural sensitivities as well as previous complaints of pain. Diagnostic tests may also be essential in providing accurate assessments enhancing the ability to treat effectively.

The Use of Pain Scales

There are three pain scales traditionally used – Numeric, Wong-Baker and the Behavioral Observation Scale. All three of these scales use the same 0-10 rating however; they require individual usage depending on the patient's cognitive status and ability to communicate.

All scales also require individualized assessment of the rating to determine the level of pain. Evaluation of pain scores is crucial in guiding appropriate interventions. Pain scores from 1-3 generally indicate mild pain that should not interfere with activities of daily living. Pain scores 4-7 indicate moderate pain that can interfere with activities of daily living. Moderate pain requires treatment of varying degrees for the patient to perform their activities of daily living, and can also interfere with treatment- i.e. attending physical therapy Pain scores from 8-10 are indicative of severe pain causing the patient to be confined to their room or bed bound. This degree of pain requires the immediate input of a physician. More specifically a pain score of 10 observationally should describe a patient in severe distress unable to interact with the environment. A score of 9 will reflect severe distress, minimally able to interact with others, perhaps watch TV but not be able to concentrate to read a book. A pain score of 8 reflects resting pain but the patient is able co converse, watch TV or read a book.

Throughout training, healthcare professionals are appropriately advised to believe the patients-however, some patients will over estimate or under estimate their pain. It is crucial for the healthcare professional to observe patient behavior, and to educate the patient regarding pain scores.

(Joseph Higgins, MD, 2010).

Management of Pain and the Rule of Three

Management of pain in the SNF patient requires appropriate medicine titration. The pattern of pain is important in that a scheduled dose of pain medication should be administered prior to the anticipated onset of pain. Continuous pain requires medications scheduled as continuous dosing. Also the "rule of three" is important. Patients that require as needed pain medicines either three times in one day or on three consecutive days often require scheduled medication or upward titration of existing scheduled medication.

Nursing Defense in Pain Management

Basic Nursing defense related to pain and pain treatment modality includes nurse physician communication and knowledge of medication administration related to primary guidelines. Every nurse needs to be aware of frequently caused side effects associated with narcotic administration, such as constipation, GI upset, nausea and insomnia. With the use of any narcotic, a pro-active bowel regiment is also recommended such as a combination of laxatives and stool softener. Physician's orders may also include interventions to increase fluids, increase activity and increase fiber.

Pain can also cause depression especially when it is chronic. Assess the patient's mental status for signs and symptoms of depression. Are they refusing care, refusing therapy?

Promotion of safety awareness associated with narcotic administration should include interventions associated with fall risks. Keeping the patient's bed in low position, fall mats for those bed bound, assistance in transferring, and educating the patient to ask for assistance when applicable are a few proactive interventions that can reduce falls.

As a corporate Clinical Service Consultant, recommendations would include daily pain scores and pre and post analgesic pain scores with the use of the appropriate pain scales. Use of the SBAR Communication Model to discuss pain with the patient's physician can also promote effective treatment.

Reference

Higgins, Joseph, M.D. Regional Medical Direction, Mid-Atlantic Division, HCR-Manor Care

June 1, 2010-The Delaware Nurses Association received a Senate Tribute from the Senate of the 145th General Assembly paying tribute to all Delaware Nurses observing 2010 as the International Year of the Nurse. Pictured from left to right are: Sarah Carmody, DNA Executive Director, Alana King, DNA Legislative Chair, Senator Bethany Hall-Long and Kim Scott, Legislative Committee member Special thank you to Senator Bethany Hall-Long for supporting the Nurses Tribute.

Cultural Competence???

Janice Warrington, MSN, Ed, RN, SD-CLTC

Janice Warrington

Janice has received both her BSN and her MSNEd, from University of Phoenix. She is certified in Staff Development in Long Term Care.

Janice has been a nurse educator in long term care, working for Genesis Healthcare Corporation at Seaford Center in Seaford Delaware since 2002. Recently she joined the faculty at Delaware Tech as well. She has been there since 2008.

Her interests include creative/alternative teaching strategies, simulation education, and generational issues impacting learning as well as cultural competence. Research interests include impact of cultural diversity on learning and educational technology.

Janice is currently the Nurse Practice Educator at Seaford Center. Her responsibilities include staff education, infection control and employee health.

Janice is also a faculty member at Delaware Tech where her responsibility is education of nursing students at all levels. Janice can be reached at jwarrin7@dtcc.edu.

This country is constantly changing and growing demographically. In the United States, cultural diversity is generally thought of in terms of race and ethnicity, but in recent years has taken on a much broader definition which includes gender differences, social class, religion, spiritual beliefs, sexual preferences and generational differences. According to Dr. Larry Purnell, Professor College of Health Sciences at the University of Delaware and author of the Purnell Model for Cultural Competence, the definition of culture is "The totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, life-ways and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making."

Because our society has become so culturally diverse, it is imperative for healthcare providers to not only understand cultural diversity but to respect the personal beliefs, values and health practices of the people who come to them for care. Cultural competence is one of the biggest factors in increasing client satisfaction and for reducing disparities and overall complications.

According to the United States Census Bureau, in 2007 19.8% of the population was aged 65 or older (U.S Census Bureau, 2009). In general, 83.7% of the population is listed as white, 13.8% is black and 6.5% is Hispanic (U.S Census Bureau, 2009). 7.1% of the population speak a language other than English in their homes (U.S Census Bureau, 2009).

Racial and ethnic minorities have a tendency to have a much higher morbidity and mortality related to chronic disease. African Americans and Latinos are more likely to have asthma, heart disease, diabetes and high blood pressure. These conditions often go untreated due to lack of access to health care services. Many do not have adequate health care insurance coverage.

Language barriers can be problematic to individuals seeking health care services. According to the Center on an Aging Society, non-English speaking individuals are less likely to seek medical attention for illnesses or preventative care but are more likely when they do, to express dissatisfaction with the care they do receive (ACAS, 2004). People who have chronic conditions require more interaction with healthcare providers.

With all that said, cultural diversity gains an even greater importance when the individual has to be admitted to a long term care center (even if only for short term rehabilitation). The elderly are very protective of the very thing that makes them unique-their cultural values and heritage. "Elderly people of all cultures really want to maintain their life ways-whatever routines or traditions they had in place before they went into the nursing home" according to Marilyn McFarland, RN, Ph.D (co-author of Culture Care Diversity and Universality: A Worldwide Nursing Theory). It is important for the nursing staff to become intimately involved with the family to learn how a resident's cultural beliefs affect their health care needs.

Historically, care provided in long term care centers has been influenced by the worldview of Americans in regards to things like social activities, food, religious activities, even beauty/barber services. Long term care centers have thought that they were being culturally diverse if they had racial diversity in staff and differences in cultural preferences for the resident's everyday living have not been generally incorporated in care.

When a resident is admitted to a facility and does not speak English, there is generally a scramble to find someone (anyone) who can help with interpretation-usually a family member or (if the staff is really lucky) some staff member who has any knowledge of the language. How often is the facility able to accommodate language with authenticated language services of an interpreter? Is signage in the facility written in languages other than English (and Braille)? What about the mountains of paperwork a resident (or their family) is asked to complete on admission to a facility?

Language is only one aspect of care that needs to be considered when dealing with residents of other cultures. Every aspect of an individual's life is impacted by the culture they were raised with. With the ever growing and changing diversity of our elder populations, nurses in long term care need to start exploring cultural education and incorporating cultural values into the care of the residents. Train staff to recognize that differences are important and to recognize the need to acknowledge differences. It is only in being comfortable in recognizing that we are all different that we can provide the type of care our residents deserve.

Standards have been published by the Office of Minority Health in the United States Department of Health and Human Services. They are titled the National Standards on Culturally and Linguistically Appropriate Services (CLAS). These standards are organized by themes. Standards one to three deal specifically with culturally competent care. Standards four to seven are related to language access services and standards eight to fourteen deal with supports for cultural competence. It is important to note that most of the standards are guidelines and recommendations with the exception of Standards four, five, six and seven which are mandated for any recipient of Federal funds. A complete guide for implementation of this set of standards has been created and is available as a reference online. It provides the health care provider with tools that can be used to evaluate compliance with each standard, checklists for implementation, as well as recommendations for training of staff.

Standards of practice are important to provide a framework for the provision of quality care. Cultural competence is imperative in light of the growing diversity of today's society and organizations must be responsible for providing staff with guidelines and training necessary to meet the needs of the patients they serve.

References

Center on an Aging Society. (2004). Cultural competence in health care: is it important for people with chronic conditions? Retrieved April 18, 2010 from Edu Web Site: http://ihcrp.georgetown.edu/agingsociety/pdfs/cultural.pdf

CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care http://www.omhrc.gov/assets/pdf/checked/CLAS_a2z.pdf

Orlovsky, C. (2004). Transcultural nursing: providing cultural care for the elderly. Retrieved April 18, 2010 from com Web Site: http://www.nursezone.com/Nursing-News-Events/more-features/Transcultural-Nursing-Providing-Cultural-Care-for-the-Elderly_21956.aspx

Purnell, L. (2005). The Purnell Model for cultural competence. Journal of Transcultural Nursing and Health, 11(2), 7-15.

United States Census Bureau. (2009). Sussex County Delaware quick facts. Retrieved April 18, 2010 from gov Web Site: http://quickfacts.census.gov/qfd/states/10/10005.html

Higher Education in Long-term Care Nurses

Melissa Banks-Sockriter, RN MSN

Melissa Banks-Sockriter

Melissa has received her BSN from Wilmington University and her MSN from Wesley College.

Melissa has been one of the nursing faculty at Delaware Technical and Community College in Georgetown, DE since August 2009. She was the Education Coordinator at LifeCare at Lofland Park from 1998- 2009. In 2008, she won the Delaware Healthcare Facilties Association Registered Nurse of the Year award. Her interests include creative teaching strategies and projects to enhance the student's learning, teaching in the clinical settings, and always maintaining a gerontological focus.

Melissa is currently a Nursing Faculty in the Evening Program for Licensed Practical Nurses at Delaware Tech in Georgetown. Melissa can be reached at msockri3@dtcc.edu.

Today's geriatric population is increasing every day. According to the Administration of Aging, there are 38.9 million people over the age of 65 as of 2008 (the latest year for which data is available) representing 12.8% of the U.S. population. The estimated number of older persons is expected to be about 72.1 million by year 2030. Due to this, there is a need for more long term care services and facilities to care for these elderly men and women as well as the need for more educated healthcare professionals to work in the homes, centers, and facilities. Is there a need for these healthcare professionals to be specially trained in geriatrics? What about the aging disease processes such as dementia? Here lies the dilemma. As a nursing educator, I strongly feel the need for there to be the additional education for those individuals working in long term care to be knowledgeable of the specifics associated with the aging person. This education shouldn't just be given initially, but on-going to provide the competence that long term care nursing needs to improve our capacity and effectiveness in dealing with the health needs of our growing senior population.

In the past, nurses who worked in long term care settings were viewed as less competent nurses, seen as less intelligent, less skilled, slow, and unable to manage working in an acute care setting. What people don't realize is that these nurses have the unfortunate tasks of balancing multiple skills including administering medications, treatments, documenting, tackling family dynamics, being a physician liaison, etc. The reality is that long term care nurses work under less supervision, with less support, and more responsibility for the resident's well being. This requires a higher level of critical thinking and time management without the benefit of higher education. Typically, in long term care, there has not been a focus to further your education or increase your knowledge based on your specialty. Fortunately, a recent trend in long term care has been the increased awareness and encouragement of nurse professionals to become becoming certified.

There was a study conducted that examined the strengths and learning needs of four categories of nursing staff practicing in New Brunswick nursing homes in which The American National Gerontological Nursing Association (NGNA) recognized that nurses working in a variety of settings required specialized educational resources to care for older adults (Ebersole & Hess, 1998), and the NGNA Core Curriculum was developed to encompass the knowledge required by nurses to provide basic care (Luggen & Meiner, 2001). Gerontological nursing care is holistic, and means assessing and interpreting individual residents' behaviors within their environment on the basis of knowledge about psychosocial functioning (Miller, 2004). In addition, physical illness presents differently in older adults than in younger persons (Ebersole & Hess, 1998), so enhancing nurses' ability to do a needs assessment in LTC requires continuing education to support learning based on research (Daley & Wilson, 2001).

There are several ways to overcome these difficulties that long term care facilities and healthcare professionals are facing. One way is to adopt the concept of a teaching nursing home, to be created through a collaborative partnership among staff, residents, families, and the college faculty. The aim is to create within the nursing home an environment for living, working, and learning (Davies, Powell, & Aveyard, 2002). This is a concept that we utilize for our students during their first clinical rotations through collaborative agreements with our local long term care facilities. It allows the first-level student to experience the long term care population while being introduced to basic nursing.

Another way to overcome the difficulties faced in caring for the elderly is providing the necessary education and competency required for all employees. In Delaware, we are fortunate to be required to provide our certified nursing assistants with twelve-hours of education each year. Some might say that this is unnecessary and meaningless. But, as an educator and one that has seen the positive results when you have competent, caring nursing assistants in your facility, I see that this is a necessary evil. Also, as nurses, we know that there are mandated continuing education hours that one must have to maintain licensure. One would hope that the nurse would become updated and more educated in areas of his/her specialty.

A statewide dementia-specific training collaborative was created in Virginia through the co-occurrence of three different convergent initiatives. The study compares changes in job satisfaction and career commitment among Alzheimer's care staff participating in a two-phase, state-level training collaborative to improve dementia care. Results reveal an increase in extrinsic job satisfaction and a decrease in career commitment. Because at least half of all older adults in need of long term care have dementia, and because these individuals require such a great level of attention from direct-care workers, high turnover and staff shortages are particularly troublesome trends for this population (Riggs, 2002). There is evidence, however, that various management practices can be implemented to help address this long-term careworkforce crisis, which has been the focus of both international and national Alzheimer's conferences this decade. Our local long term care facilities should consider the importance of offering continuing education to their staff on dementia and dementia-like diseases. This would not only provide the education needed for the staff but also provide more of a comfort level for staff, families, and administration when the outcome is overall better care for the patients.

Lastly, the NLN has recently introduced a new initiative called ACES, Advancing Care Excellence for Seniors. This is a grant funded initiative to foster gerontological nursing education for pre-licensure nursing programs with a website that includes gerontological resources for faculty and students. There are four objectives that include developing a set of minimum standards of the knowledge, skills and attitudes required to care for older adults for pre-licensure nursing students, disseminate and publicize minimum standards and existing resources, provide NLN-based faculty development workshops about use of the minimum standards and other products and tools developed with The John A. Hartford Foundation funding, enhance student expertise in geriatric care by incorporating appropriate content into clinical nursing education through the innovative use of simulations and unfolding case studies (http://www.nln.org/facultydevelopment/facultyresources/aces/index.htm).

In conclusion, increasing standards for long term care nurses' training and opportunities for advancement and professional development are two of the major requirements in ensuring a quality workforce to assist in caring for older adults. By encouraging and fostering an environment of continuing education, as educators we can ensure that we will have quality nurses to care for our aging population.

References

Coogle, C., Head, C., & Parham, I. (2006). The Long-Term Care Workforce Crisis: Dementia-Care Training Influences on Job Satisfaction and Career Commitment. *Educational Gerontology*, 32(8), 611-631. Retrieved from ERIC database.

Cruttenden, K. (2006). Long-Term Care Planning Study: Strengths and Learning Needs of Nursing Staff. *Canadian Journal on Aging*, 25(4), 347-361. Retrieved from ERIC database.

Daley, B., & Wilson, S. (2001). Needs assessment in longterm care facilities: Linking research and continuing education. Journal of Continuing Education in the Health Professions, 19, 111–121.

Dawson, S. L. & Surpin, R. (2001). Direct-care health workers: The unnecessary crisis in long-term care. New York: Paraprofessional Healthcare Institute. Retrieved November 3, 2004, from http://www.paraprofessional.org/publications/Aspen.pdf

Ebersole, P., & Hess, P. (1998). Toward healthy aging: Human needs and nursing response (5th ed.). St. Louis, MO: Mosby.

Luggen, A.S., & Meiner, S.E. (2001). NGNA core curriculum for gerontological nursing. St. Louis, MO: Mosby

Riggs, J. A. (2002). Exploring pathways to long term care staffing solutions. Retrieved

November 3, 2004, from http://www.alz.org/advocacy/downloads/WorkforcepaperJRiggs02.pdf

A Personal Journey of Culture Change

Linda Darling

Linda Darling

Linda Darling serves as Director of Nursing for the Milford Center, Genesis Healthcare. In her current position, Linda is responsible for directing the care of 136 residents in a variety of care models including a dementia unit, a short term skilled nursing and rehab program and intermediate care services. Linda has been with Genesis for over 7 years. She also spent 11 years at Easton Memorial Hospital as a neuroscience nurse, public speaker, coordinator of stroke programs and support groups, clinical care coordinator, president of Partnership 2000 (a nursing shared governance model) and co-authored "Partnership 2000: A Journey to the 21st Century" in *Nursing Administration Quarterly*. Linda received her Diploma in Nursing from McQueen Gibbs Willis School of Nursing and her Bachelor of Science in Nursing from the University of Maryland.

The first time I ever heard the term "culture change", it was the late 90's and I was a nurse working in a hospital. At the time, my hospital was preparing to affiliate with a rival community hospital and the challenge for nursing was how to develop a new nursing culture reflecting both hospitals, and build a foundation for nursing growth in a new millennium. Along the way, we not only built a shared governance model, we also strengthened the leadership abilities of many of our nurses. New relationships developed between nurses and management staff. Renewed enthusiasm led nurses to create programs which benefited our patients. We were truly on a journey of culture change. What I didn't realize at the time was that another "culture change" movement was also gaining strength in the long term care industry and would become a significant part of my future nursing career. This culture change was focused on transforming the traditional medical model of nursing homes into a more life-affirming, person-centered model of care.[1] Within the decade, person-centered care would become a major focus in the long term care industry.

If I had a nickel for every time someone who had just learned I worked in a nursing home made the comment "those places are so depressing", I could be rich. A common perception is that people come to nursing homes to die, but the fact is that nursing homes can be places that are full of life. The movement toward person-centered, high quality care has helped to bring about that change. However, if I am totally honest, I didn't really understand much about nursing home life when I first made the transition from hospital nursing to long term care nursing in late 2002. I was more knowledgeable about building professional nursing practice and, in a hospital setting, I had been accustomed to my patients going home within days. Throughout the first couple of years in my new job, I was focused on learning a new nursing role including all the regulations and practices of long term care. I will admit that my focus was not always on what the resident wanted in terms of a day to day life experience. However, within the first year, my father came to live at my nursing home and suddenly, I was now both a nurse and a daughter of a resident. My father's day to day life experience as a resident in a nursing home was now personal.

Soon after my father's arrival, my center began its own journey toward culture change. Some of us were fortunate to attend a national seminar on person-centered care. We came back excited and nervous about how we would begin to implement such significant change. Some days there seemed to be so many barriers to the place we wanted to be and the care we wanted to give. Could we really make this happen? What did our staff want to do differently in the way they cared for their residents? How did our residents want to experience the ordinary activities of life such as bathing and sleeping and dining? It seemed so simple and yet so complex.

The first step was to begin exposing our staff to the idea of culture change. We offered videos and opportunities to talk about what person-centered care meant. During those times of dialogue about our residents and ideas for change, I learned an important lesson: never underestimate the knowledge, feelings and creativity that your staff can bring to the table. Many of our staff knew what their residents wanted but they felt caught up in old practices and ways of doing things themselves. Some of them expressed that their frustration was in not knowing how to change the way things had always been done. A few staff voiced all the reasons they thought we couldn't make the change. Some came to realize that the first change had to be within themselves and they began to make little changes in the way they interacted with residents. One nurse on a dementia unit decided that he would make the early evening hours on his unit more like home. He turned the overhead florescent lights off and turned on softer lamps in his residents' lounge. He played soft music or a family centered TV program. He gave his residents hugs and encouragement. Many of them began to think of him as a grandson. He built caring relationships. The residents began to be more relaxed and experienced fewer behaviors in the evenings.

Once the idea of person-centered care caught on, our staff decided to change the way we dealt with death and dying. In the old practice, the death of a resident tended to be hidden from other residents. The process of dying was very impersonal. Before the deceased was taken to the funeral home, the hallways were cleared of residents and doors closed. There were few opportunities to say goodbye to a friend. In the new practice, with a more person-centered focus, residents and staff alike are encouraged to visit ailing friends, they interact with families, and doors are no longer closed. In fact, the creativity of two nurses produced a beautiful quilt of many brilliant colors which is placed over the deceased as they are escorted out of the facility. The resident's room and bed are tidied up and a rose is placed on the bed. The resident's belongings are neatly packed and ready for pick-up by a family member. A CNA began organizing quarterly memorial services so that families, residents and staff can have a time to remember and honor those who have passed on. Many of our families have expressed great appreciation for the respect shown to them and their loved one through this experience. The staff also experiences grief at the death of someone they have cared for. They expressed hurt that they often walked into an empty room looking for their resident only to be told the resident had died. Now, we post a notice with the names of anyone who has died by the employee entrance. Staff can find out about the death before they walk into that empty room and they feel more prepared and able to deal with their grief.

One day a CNA came to see me. The CNA had worked for us previously and just been rehired, but had not been in the center since we had begun our culture change. She was frustrated with other staff who had advised her to allow a resident to stay up until she was ready for bed. The resident had become agitated and combative with the CNA when she attempted to provide her evening care and get her into bed by 7:30 pm. I asked the CNA why she thought the resident needed to be in bed so early. The CNA responded that she had a schedule to keep if she was to get all her work done and it was that resident's turn to get ready for bed. She also stated night shift would be angry if someone was still up when they came on. I also asked her, what did she think made the resident so agitated. The CNA told me the resident was confused and thought she was on a cruise with her husband and getting ready to go to dinner. I then began to explain to the CNA that a lot had changed since she had last worked here and we discussed person centered care and how she could have handled this situation differently. We talked about everyone providing care regardless of the shift time, if that was what the resident wanted or needed. We also talked about how she could have used the moment the resident was experiencing to provide the needed care by offering to help her get freshened up and ready for dinner with her husband. After our conversation, I realized that the staff had encouraged her to let the resident choose her own bedtime because the person-centered care approach had become such an engrained part of the way they provided care. That was when I knew how far we had come in the journey.

Five years later, we are still on the journey of culture change. Residents have more choices in bathing, sleeping and dining experiences. We have learned you don't have to have a fancy new building to implement culture change. We learned that our relationships with the residents are at the very center of everything we do. We learned that the journey doesn't end as every day there are new ways to explore creating a person-centered care living environment. Hardly a day goes by that I don't hear someone say, "But what does the resident want?"

So how has life changed for my father since he came to live here with us? In his previous living situation, he was made to get up at 6:30 am every morning because the staff told him he was too slow to make it to breakfast by 8:00 am. Now my father sleeps late when he wants to and eats breakfast when he awakens. His fear of living in a nursing home has been replaced by warm and caring relationships with the staff. They know him as a person. They know he likes to drink milk and has multi-grain bread with his meals. They know he was once a commercial artist and enjoyed drawing cartoons which he has shared with his staff friends, along with photos of his art work and poems he wrote over the years. Their interest and the time they took to talk with him meant so much. His relationships with those special staff became very important to him and they are part of his extended family.

In the last few months, my father's health has declined considerably and he has made the decision for comfort care. He sleeps much of the time and interacts less. This has not, however, changed the beautiful way his caregivers attend to his needs. They gently turn him from side to side. They bathe him and put lotion on his skin. If he has the strength to feed himself, he does. If not, loving hands feed him and kind hearts spend time talking to him. They ask him how he is feeling. They even care for me, sharing hopeful and uplifting comments about my father's day. Recently, his daytime CNA told me, "Miss Linda, I take care of him like he was my own pop pop." Every day when I go home, I know he is safe and cared for. I am both my father's daughter and the nurse who made this journey toward person-centered care with those who now care for him. As the daughter, I am forever grateful to those very special people who take the time to really know him and work so hard to give him the best possible day, every day. As a nurse and a leader, I am a witness to the power we have to improve the quality of life our residents and patients experience.

References

[1] Pioneeringnetwork.net

A Nurse's Role in Promoting Health in an Assisted Living Environment

Bridget Adams, RN

Bridget Adams, RN, is the Customer Care Director at Heritage at Milford Assisted Living Community in Milford, Delaware. Prior to joining Heritage at Milford, Adams worked for Bay Health, Milford Memorial Hospital.

She can be reached at 302-422-8700, bridget.adams@genesishcc.com.

Bridget Adams

Have you ever thought about working in an assisted living environment? Many nurses choose alternative settings because they feel it will not be clinically challenging. They do not realize the dramatic impact they can have on the health of seniors living in these communities.

How challenging can it be to care for residents with that level of independence in an assisted living environment? Actually, this is a great opportunity for nurses who have an interest in health promotion. Seniors who reside in an assisted living community do not have to worry about issues like managing a home, working, and food shopping or cooking. They can focus on their health and benefit from the clinical support of nurses who oversee medical and medication management, and educate them on the steps they can take to better manage their own diseases.

Most individuals have received education about their diseases at a time when many other daily stressors took priority in their lives. Now with time to focus on self, seniors are motivated to focus on improving and maintaining their good health.

The typical assisted living resident is an 87-year old individual with 2 or more chronic illnesses. At this time in their lives, when the margin between feeling well and hospitalization can be very slim, it is critical to recognize even the slightest change in health in order to quickly intervene and avoid unnecessary exacerbations of chronic conditions and hospitalization.

I have seen firsthand the impact that nurses can have as the Customer Care Director (or Director of Nursing) at Heritage at Milford, an 80-bed assisted living community owned and operated by Genesis HealthCare. While I have directed nursing at this community for two and half years, I previously worked in an acute care setting. I never realized that I would use my clinical skills even more in this environment.

Our residents are very independent. They want to carry on routines similar to individuals half their age, but unfortunately most have chronic conditions that can affect their independence. In this environment, they can make the social part of their life the priority, knowing that they are supported by qualified clinical staff.

I, and the other RN's and LPN's at Heritage at Milford, have to thoroughly know all the residents in the community. When there is an exacerbation of disease processes, you have to notice even the slightest change. Quick identification of declining health can potentially prevent hospitalization, and enable them to maintain independence.

The critical role a nurse can play in this setting is clear when examining the case of a resident with diabetes. He or she may have dealt with diabetes for more than 20 years before moving to assisted living and often arrive with erratic blood sugar levels. At home, his or her disease management likely focused on calling the doctor and quickly having medication increased in an effort to control the blood sugar. In an assisted living environment, disease management can focus on proper education to empower the resident to better control his or her own health. The nurse, physician and dietitian work hand-in-hand with the resident on education for successful disease management and recognition of the precursors that can lead to a decline in health. A nurse can help manage the medications and administer the finger sticks/lab work for the patient. Overall, residents have reported a marked improvement in overall wellbeing once their chronic conditions are appropriately managed.

The nurse in an assisted living community provides the safety net for independence. Often, symptoms of inadequate disease management are accepted by seniors as expected symptoms of aging. When residents take control and manage diseases such as diabetes, they realize that some symptoms are fully manageable and that their quality of life can improve. We not only coach them to make better decisions on their own, but we use our assessment skills every day to promote optimum health maintenance.

If we do our job well, we can promote healthy living and minimize hospitalizations. And that's our goal. This is the most rewarding thing I have done professionally.

For a nurse, working in an assisted living environment can be challenging and satisfying. In this environment, a nurse is both teacher and caregiver; nurses educate and guide residents to better manage their own illnesses in order to maintain optimal health. But they also utilize clinical assessment skills every day in an effort to avoid hospitalizations or rapid declines in health. The result is a rewarding career where nurses, like me, can see firsthand the positive impact they are having on the lives of those they care for every day.

Nurses Healing Our Planet, Update

Sandra Reddy RN, BSN
NHOP Chair

Nurses Healing Our Planet would like other Nurses to join us in making our Environment Healthier because without clean air, water and land, we can not have heathy people. We need a healthy Environment to do this. We need Nurses to take a stand for a Clean Environment for the future of our children and grandchildren. Don't trash the planet!

"Past and Future Activities for a cleaner Delaware and a cleaner Planet".
"Sick Environment = Sick Populations"
"Healthy Environment = Healthy Populations"

Nurses Healing Our Planet, along with the Delaware Nurses Association held the first Take Back Medication Events in the State of Delaware. NHOP has actively participated in speaking with Senators about BPA Free Legislation. Volunteering in the Christina River Clean-up and picking up trash, styrofoam, plastic and plastic bags, and cigarette butts that litter Delaware.

NHOP held a 2010 Lecture Series

Hazardous Chemicals in Health Care. How many chemicals were found in a study with doctors and nurses. How Safe is your Make-Up - Education on toxins in our personal care products and make up. Healthy Homes by Delaware Healthy Homes was given by the Delaware Public Health Department.

What we can do to make our homes healthy and learning the average home today contains more chemicals than a typical chemistry lab did 100 years ago. Things you use every day may contain harmful toxins that can hurt you and your family and learn how to reduce your exposure and limit your cancer risk was the topic. Call 1-800-464-HELP or www.delawarehealthyhomes.org for more information.

Contact hours were awarded and we collected plastic bags for recycling at the lectures and take back events.

Recently, the Public Health Department had a Take Back Medication Day on May 14, 2010 throughout the State of Delaware. Many NHOP Nurses and others volunteered and participated in this event and because of our efforts have prevented pharmaceuticals from entering our waterways.

Christiana Care Hospital has held 2 Take Back Events, along with Nurses Healing Our Planet and the Delaware Nurses Association.

NHOP Nurses volunteer at their hospitals and belong to Environmental Green Teams. Projects they are involved in consist of recycling, writing Web Education, writing articles, planning vegetable gardens and getting and managing champions to help with green efforts.

Recognitions

NHOP Nurses are on the Nurse Luminary and you can read their stories on www.theluminaryproject.org, go to stories, and then states. More NHOP Nurses are expected to be on the nurse luminary.

NHOP Nurse Michelle Lauer MSN, BC was nominated for the 2010 Spirit Award at Christiana Hospital.

Future Plans

NHOP Nurses have applied for grants to continue with future lectures and education and having more legislative input for a cleaner environment.

NHOP Nurses are attending conferences in Baltimore on June 7 and 8, 2010 Our Environment, Our Health: A Nurse's Call to Action

Take Back Medication Event and Mercury Thermometer Take back Event to be held in October at Christiana Care Hospital with NHOP Nurses participating.

Come join us at our monthly meetings and get involved. Delaware needs nurses to take the lead in helping make a cleaner environment and cleaner planet so we can have a Healthy Planet, which equals a Healthy population.

NHOP meets the first Tuesday of the month at Christiana Care Hospital room 1303, in the hospital cafeteria from 1900 till 2000.

You can contact me at sreddy@christianacare.org

Professional Development Committee

Chair - Karen A. Carmody, RN, MSN, FNP-BC

The role of the Professional Development Committee is to plan and develop continuing nursing education (CNE) activities to support nurses' immediate and future career goals in their lifelong professional development. Varied educational options are necessary to meet the diverse needs of the nursing population.

Many thanks to Michelle Lauer and the Nurses Healing Our Planet (NHOP) for coordinating three CNE seminars on health and the environment. These evening sessions held at the CCHS Ammon Center March 18th, April 22nd & May 20th covered such topics as Hazardous Chemicals in Health Care: A Snapshot of Chemicals in Doctors and Nurses, How Safe is Your Make-Up? (The Ugly Truth behind the Beauty Industry) and Healthy Spaces for Healthier Indoor Environments.

Every year the Professional Development Committee plans two major conferences with an associated DNA membership meeting. The 2010 Fall Conference MANAGING LIFE'S STRESSORS will be held in Dover in late October. At this meeting the DNA Board of Directors will pass the baton to the newly elected officers and directors. Be sure to participate. For detailed agenda information visit the DNA website at www.denurses.org.

We are always interested in new committee members with fresh ideas. Many hands make light work. Please consider volunteering to work with the planning committee to implement these and other Professional Development programs. Contact the DNA office at 302-998-3141.

When the Next Step is Necessary

Heidi A. LeGates, MSN, RN, NEA-BC

Heidi LeGates

Heidi received her BSN from Wilmington University and MSN from the University of Delaware.

Heidi has been a nurse for 29 years employed with Bayhealth Medical Center for the past 28 years. Her role has been Director of Patient Care Services for the past 10 years with Bayhealth. She has also had experience with Care Management and Nursing Education.

Heidi can be reached at heidi_legates@bayhealth.org. 302-430-5596.

It is not something we want to think about, but nearly half of all Americans will need long term care at some point in their lives. The American Health Care Association has published that one in five adults of age 50 is at risk of needing long term care within the next 12 months. With this daunting fact before us, we need to be better prepared and planning is crucial. Fortunately, there are choices for us to make either for ourselves or for out family and friends. I have had to assist in making this determination for family and it can be difficult and result in some feelings of guilt and dismay, but it does not need to be this way.

By planning ahead, you can relay a lot of anxiety for you and for your family. You can also find the quality of care and quality of life that meets your particular situation. When considering long term care, a key advantage to planning is that you will be prepared for the financial changes that this decision may bring to yourself or family. Financial concerns are one of the most critical in making this decision. There are options available such as long term care insurance, private funds, Medicare, and Medicaid services. Seeking assistance with a financial adviser early may make all the difference in the world.

Other ways to prepare yourself and family are through conversation. It is important to understand the wishes and desires of family members. Find out what your locality offers in terms of assisted living or skilled nursing care. Your education may lessen the fears of your family as you will be able to provide answers instead of speculation.

Ask permission of your family to discuss long term care needs. Some family members may need more time to discuss the future needs of their health more so than others. By discussing the topic openly you can assure your loved one that you will respect the wishes and desires that they have. Sometimes a life event may bring on the conversation such as planning a will or making the advanced health care directive that is vital for all of us in today's healthcare society.

We all have family members who can't face that their lives are changing and not for the better. What are some of the signs to help you determine when it is necessary to begin thinking of long term care?

- Isolation/Depression: Are they intentionally isolating themselves from social contacts? Do they seem exceptionally lonely
- Daily Activities: Are the usual grooming habits slipping? Is there difficulty with walking, dressing, and eating. Lack of environmental grooming?
- Cognitive Ability: Is your loved one's mental reasoning ability at a level where his/her personal safety and safety of others is at risk? Are they able to still run the household, such as bill paying and money management?
- Increasing medical needs: Does your loved one need medical care that they or you cannot provide daily? Are medications becoming very complex and more assistance is needed? Are medical treatments and therapies needed that require more supervision?

These are all signs that it is time to think about the next step in life's journey. By preparing in advance and having open communication decisions can be easier to make. By dealing with these issues upfront, there is less pressure on everyone to discuss this important topic. It is like discussing the facts of life for our children, not always pleasant but it makes a world of difference when decision must be made.

There are numerous resources that can be made available to discuss long term care needs. It is sad that all too often families don't make this choice until something tragic happens. Then it becomes a true burden, one that in some cases can tear a family apart. I was very fortunate, through conversation and pre-planning this life decision became another road to the journey of life. I encourage you to think about this with your own family. Facilities all over the state are very welcoming and will allow families to tour and discuss the options that are available to meet your family's needs. They can even serve as a resource for assisting with needed financial planning.

Nurses
CARING TODAY FOR A HEALTHIER TOMORROW

Data Bits

Dot Baker, RN, MS(N), CNS-BC, EdD
Professor, College of Health Professions – Nursing, Wilmington University

Dot Baker

A need for long-term care (LTC) can occur at any age. Long-term care is an umbrella for medical and non-medical care and services. These can be direct and/or support services. Long-term care settings can include: home, nursing home, assisted living, boarding home, group home, and community-based services. Community services can include: medical and specialty day cares, child---senior centers, case management, transportation, financial management, nutrition & meal services, referrals, security/well-being monitoring, ombudsman services, rehab, palliative care, holistic services, counseling services, etc. This table contains information about relevant organizations, programs, research, accreditation, journals, books, and evidence-based practice.

Visit the National Health Policy Forum's April 2010 report "National Spending for Long-Term Services and Supports (LTSS)" at http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_04-30-10.pdf

ORGANIZATIONS & PROGRAMS	WEB ADDRESS
Agency for Healthcare Research & Quality (AHRQ) (multiple publications)	http://www.ahrq.gov/
American Academy of Child & Adolescent Psychiatry (children with longterm illnesses)	http://www.aacap.org/cs/root/facts_for_families/the_child_with_a_longterm_illness
American Nurses Credentialing Center (2010). *Pathways to excellence in long term care program*™	http://www.nursecredentialing.org/Pathway/PTE-LTC.aspx
Center for Nursing Excellence in Longterm Care (Sigma Theta Tau)	http://www.geriatricpain.org/Content/AboutUs/Pages/Center_for_Nursing_Excellence.aspx
Center to Advance Palliative Care (longterm care)	http://www.capc.org/palliative-care-across-the-continuum/long-term/
Long-term Quality Alliance	http://www.ltqa.org/2010-01-24-long-term-quality-alliance-improves-care.html
Mayo Foundation for Medical Education and Research (Long term care: Early planning pays off)	http://www.mayoclinic.com/health/long-term-care/HA00054
Medicare – What is Long-term Care?	http://www.medicare.gov/longtermcare/static/home.asp
National Association of Long Term Hospitals	http://www.nalth.org/
National Care Planning Council Longterm Care Link (comprehensive resource for Eldercare, Senior Care, and Long Term Care Planning)	http://www.longtermcarelink.net/
National Clearinghouse for Long-term Care Information (understanding, planning, paying)	http://www.longtermcare.gov/LTC/Main_Site/index.aspx
National Consumer Voice for Quality Long-term Care	http://www.nccnhr.org/
National Hospice and Palliative Care Organization (2009 report about services for pediatric children who have chronic conditions)	http://www.nhpco.org/files/public/quality/Pediatric_Facts-Figures.pdf
National Long-Term Care Ombudsman Resource Center	http://www.ltcombudsman.org/
Robert Wood Johnson Foundation (multiple publications about long-term care)	http://www.rwjf.org/pr/topic.jsp?topicid=1198
RESEARCH	**WEB ADDRESS**
Long-term Care Project @ University of Maryland includes Geri-Ed programs	http://gerontology.umaryland.edu/longterm.html
Mobily, P. Barriers and facilitators for translational research in long-term care [Abstract]	http://www.nursinglibrary.org/Portal/main.4024&pid=24388
Hickman, S.E., Cartwright, J.C., & Young, H.M. (2008). Administrators' perspectives on ethical issues in long-term care research [Abstract]	http://caliber.ucpress.net/doi/abs/10.1525/jer.2008.3.1.69?journalCode=jer
Tak, S.H., Benefield, L.E., & Mahoney, D.F. (2010) *Technology for long-term care* [Abstract]	http://www.geronurseresearch.com/view.asp?rID=50887
Agency for Healthcare Research & Quality (AHRQ) - each monthly publication of "Research Activities" features long term care	http://www.ahrq.gov/research/
ACCREDITATION	**WEB ADDRESS**
Joint Commission. (2010). *Facts about long term care accreditation.*	http://www.jointcommission.org/AboutUs/Fact_Sheets/ltc_facts.htm
BOOKS	
Matthews, J.L. (2010). *Long-term care: How to plan & pay for it* (7th ed.). Berkeley, CA:Nolo.	
Pratt, J. R. (2009). *Long-term care: Managing across the continuum* (3rd ed.). Jones & Bartlett: Sudbury, MA.	
JOURNALS & PUBLICATIONS	
Check for relevant journals @ http://www.nursingcenter.com/library/index.asp#journals and @ http://www.thefreelibrary.com/Business+and+Industry-p1+Health+care+industry	
EVIDENCE-BASED PRACTICE	**WEB ADDRESS**
ConsultGeriRN.org (Hartford Institute's evidence-based practice website)	http://consultgerirn.org/
Academic practice partnerships to promote evidence-based practice in long-term care: oral hygiene care practices as an exemplar (2007)	http://www.ncbi.nlm.nih.gov/pubmed/17386313

Membership Benefits

Full DNA/ANA Membership

$229 per year/$19.59 monthly, electronically

- Employed-full time/part time
- Save up to 45% on conference registration
- Save on ANCC certification fees
- Save 10% on professional liability insurance with Marsh*
- Free and discounted online continuing education
- Save 10% on personal accounting fees
- Discounts to insurance programs such as life, disability, job loss
- Email alerts
- Online networking-DNA Facebook page and ANA Nurse Space
- Publishing opportunities and discounts
- National and State leadership opportunities
- Much more!

* *Must hold certification from ANCC; one-time savings.*

Delaware State-Only Membership

$149 per year

- Employed-full time/part time
- Save up to 45% on conference registration
- Free and discounted online continuing education
- Save 10% on personal accounting fees
- Discounts to personal insurance such as life, disability, job loss
- Email alerts
- Online networking-DNA Facebook page
- Publishing opportunities and discounts
- State leadership opportunities
- Much more!

American Nurses Association Only Membership

$179 per year

- ANA Smart Brief
- Federal lobbying
- Save on ANCC certification
- Much more!
- ANA Nurse Space
- Discount to national conferences
- Free and discounted publications

Coming soon!

Delaware license plates for registered nurses.
Only available to full and state-only members.

DNA has partnered with the following organizations for member discounts and programs.

Apply online at www.denurses.org

CEUlectures.org — Accredited Online Learning for Healthcare Professionals

InsureEZ.net

Hewlett and Company, Inc.
Tax Preparation, Bookkeeping & Payroll

e-leaRN — online continuing education for nurses

Get Liability Insurance
MARSH
Affinity Group Services
a service of Seabury & Smith

iStudySmart™

ANA Continuing Online Education

Bank of America — Higher Standards

ANCC Certification Recertification

Welcome New and Reinstated Members!

Walle Adams-Gerdts	Wilmington	Mary Hamilton	Wilmington
Norberto Aquino	New Castle	Tiffany Hill	Newark
Debra Baich-Pietlock	Hockessin	Michelle Jonkiert	Newark
Carol Boettler	Smyrna	Debra Kent	Downingtown, PA
Kenneth Bullwinkle	Morton, PA	Linda Kotalik	Wilmington
Rebecca Cecala	Springfield, PA	Linda Martz	Wilmington
Smyrna Cyrille	Bear	Odion Ologbauma	New Castle
Lyron Deputy	Lewes	Susan Petrillo	Wilmington
Elizabeth Di Clemente	Hockessin	Donna Ramage	Hockessin
Musu Doe	Bear	Marie Renzi	Milford
Peggy Duffy	Newark	Shannon Rule	Newark
Michelle Fisher	Dover	Donna Shanosk	Bear
Marianne Foard	Magnolia	Janelle Thomas	Middletown
Kent Gory	Dover	Rene Trent-Carter	Dover
Katherine Griffith	Newark	Susan Ventura	Newark
Shanda Hall	Middletown	Veronica Wilbur-Lincoln	University, PA