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Reflections on a 25th Birthday

In June 1980, *Geriatric Nursing* was born, and Cynthia Kelly brought it into the world. In reviewing her initial editorial, I am struck by the things that are the same and the things that have changed in the care and cultivation of older persons. “Cultivation” is rather a strange word to use, but it seemed right until I looked it up in my trusty thesaurus and saw farming, agriculture, horticulture, and husbandry. But cultivate is a wonderful word—and what I hope we are doing: edify, enrich, reclaim, enlighten, and humanize (thanks to Kirk Swearingen, my first Mosby editorial manager in 1991, I was taught to put words together in order of size unless there was a reason not to). And I called Cynthia at least weekly to learn what I should be doing with this journal. Commendations to the foresight of *American Journal of Nursing* (AJN) publishers who saw the need for the journal before geriatric nursing had become fashionable.

I offer my profound gratitude to one of our columnists, Peggy Yen, who has been with us the entire quarter century of *GN*’s existence, keeping us current on considerations regarding geriatric nutritional health. In the premier issue, Virginia Barckley wrote of her experience trying to eat on $1.18 per day to make the plight of many of the aged at that time more real to her. Now one major concern is how to eat and purchase medications on $4 daily.

That first issue included numerous messages of support and congratulation. Mary Opal Wolanin’s letter noted, “we do not use older persons as resources. We study them—as anthropologists study the last of the aborigines. And perhaps we are the new aborigines. But it is as strangers looking at some wonderful new thing that has just been discovered. We older folks have discovered also, the reality of aging.”

I was impressed by Ingeborg Mauksch’s enthusiastic welcome to the new arrival. A champion of geriatric care, I first met her in 1976 and was impressed by the clarity of her thoughts. She recently died, and her obituary appeared in the October 1994 issue of *AJN*. Her article in the premier issue of *GN*, “A Look at the Elderly at Home and Abroad,” compared medical and social security benefits in the United States, Denmark, and Israel. We fell far short.

Now, 25 years later, what have we done? In Cynthia’s editorial, she wrote of the scary world we entered—cutbacks in programs and services, tight economics for most people and especially for elders—these are the same now, maybe worse. I fear the world my 25-year-old grandson faces and the burgeoning number of single mothers struggling with little help to raise children. It has traditionally been thought that the young are our hope for the future. If that be true, we do precious little as a society to husband them, to cultivate their potential. And what of the old?

The situation in “health care” has gone from bad to worse. Now nearly 41 million people in the United States have none. Older persons are quickly discharged from acute care, most to their homes or those of relatives, where there may or may not be anyone with sufficient energy, incentive, or knowledge to care for them properly. In nursing homes, even though only about 5% of elders live in them at any one time, 45% are expected to spend some time in a nursing home before they die. The nursing home 5% figure has shifted somewhat with the growth of assisted living options. These are occasionally used and administered inappropriately.

But is this any way to celebrate a birthday? What have we done? We have learned that the aged give us far more than we give them. A great wave of interest in the stories, oral histories, memoirs and reminiscences of the aged has grown to tsunami dimensions. We have marvelous senior centers throughout
the United States, providing nutritious meals, activities, and opportunities for travel and meaningful contributions to their communities. Applied research and humane considerations have almost ended the use of restraints in institutional settings, and a growing interest in end-of-life-care is allowing numerous elders to end their days in dignity.

The offshoots of the Hartford Institute for Geriatric Nursing, directed by Mathy Mezey, are reaching throughout the United States. By numerous creative methods, nurturing, recognition, consultation, and financial support, the Institute has brought geriatric nursing to the attention of the nation’s nurses. Several endowed chairs of geriatric nursing exist in universities, the first being the Florence Cellar Gerontological Chair at Frances Payne Bolton School of Nursing, Case Western Reserve University, in Cleveland, Ohio. Florence, an obstetric nurse at University Hospital said, “When I saw the superb care and caring my parents were receiving in the nursing home, I knew that improving geriatric education was the proper place to invest my money” (Cellar, personal communication, 1988).

Irene Burnside wrote, “At this one [nursing home] there is a talkative cockatoo, a dog named Trudy, who fetches and carries tennis balls and seems to be adept at avoiding octogenarian legs.” And, “Remember that ‘he who laughs, lasts’” (Geriatr Nurs 1980;1:31). The geriatric nurse pioneers knew all these concepts decades ago and incorporated pets, gardens, children, and even happy hours into the homes. Eden Alternative—step aside.

I am now 76 years old, and Cynthia is 87. What have we discovered? Cynthia, the tenacity of the human spirit, and I that living the theories is an entirely unique and individual experience. Cynthia wrote, “Health at any time of life, but especially in our advanced years, is inseparable from decent housing and transportation, food, water and sunshine, relief from pain, solace in loss, affection, respect, and stimulation, independence of choice, and physical-emotional care when our reserves begin to flag.” There is nothing more I can add.

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Global Study on Nursing

Sigma Theta Tau International, the Honor Society of Nursing, recently concluded a global study of the role, future, and challenges facing the nursing profession. Arista3, the third in a series of conferences held around the world, brought nearly 200 medical experts on nursing and health care together during the last 3 years. Among its findings is the fact that the nursing shortage is global, although the causes of that shortage are different in different parts of the worlds. For example, in the United States and Canada, the most prevalent problem is the aging of the nursing work force. In African and the Near East, AIDS and related deaths among nurses are the most prevalent problems creating the nursing shortage. An executive summary of Arista3 is available at no cost, and the full report is available for purchase at www.nursingsociety.org.

Survey Finds Nursing at the Peak of the Top 10 Health Care Career Opportunities

A survey conducted by the Health Job Bank, an online resource designed to connect job seekers and employers, showed that Americans looking for a career in health care will find the highest number of opportunities in nursing. Although nursing itself is subdivided into four career paths—registered nurses, licensed vocational nurses, certified nurse assistants, and licensed practical nurses, the overall need for nurses is considerable. For more information, you can visit the Health Job Bank Web site at www.healthcarejobbank.com.

GSA and AJN Partner to Offer Geriatric Nursing Special Series

The Gerontological Society of American (GSA) and the American Journal of Nursing (AJN) are joining together to improve the care of older adults in a 3-year project: the Geriatric Nursing Special Series. Through this, AJN and GSA hope to show best practices and deliver cutting-edge research information on the care of older adults to nurses across all clinical practices. With more than 50% of hospital patients over age 65 and only 1% of nurses certified in gerontology, the series is designed to help nurses in hospitals and nursing homes to develop the age-specific competencies required by federal regulatory agencies and the Joint Commission for the Accreditation of Healthcare Organizations. AJN will produce a bimonthly series on nursing care of older adults, publishing 15 evidence-based articles and columns over a period of 30 months. Additionally broadcasts and other multimedia materials will be available such as videotapes, DVDs, and CD-ROMS to disseminate the series and related information to institutions and facilities that employ nurses and others involved in hands-on care of older adults. The Hartford Institute for Geriatric Nursing will also contribute to the project, identifying opportunities for distributing these materials to nurses interested in obtaining certification in geriatrics or simply enhancing their knowledge of caring for older adults. The aims of the program are threefold: 1) to increase the number of nurses sitting for certification in geriatrics, 2) to stimulate institutional changes in nursing care of older adults, and 3) to increase the number of certified and noncertified nurses in all specialties who are fulfilling their continuing education requirements through self-study in care of older adults.

Nurse Internship Program

Few nursing professionals have the opportunity to try a job before they commit to it, but through the Nurse Internship Program at the Ohio State University (OSU) Medical Center, newly licensed RNs can learn new technical skills and experience the cultures within various medical units before deciding whether to pursue a long-term career in a specific area. The paid 16-week program provides full salary and benefits and includes formal classroom instruction specific to each specialty track, as well as clinical rotations that allow individuals to explore related services and make important contacts in other areas through the hospital. For more information on this OSU nursing program or the Clinical Ladder Program for
Nursing Home Advocates Call on California's Governor to Protect Seniors

Nursing home advocates recently rallied in Sacramento and Los Angeles, California, to deliver thousands of postcards requesting the state's governor to sign the Nursing Home Quality Care Act (AB 1629). This legislation will change the way Medi-Cal funds nursing homes to improve quality and accountability by basing reimbursements on the actual cost of providing care. AB 1629 will bring in an estimated $900 million in federal Medicaid dollars for nursing home care over the next 4 years, according to a recent release from the California United for Nursing Home Care Coalition. It is hoped that other states may find this a useful model for ensuring quality nursing home care.

Duke-Carolina to Bring Visiting Geriatric Nursing Professor to Campus

The University of North Carolina at Chapel Hill and Duke University schools of nursing have established a Visiting Professorship in Geriatric Nursing to enhance the quality of geriatric patient care and nursing education. Dr. Sarah Kagan, recipient of the 2003 John D. and Catherine T. MacArthur Foundation's Genius Award, is the first recipient of the professorship. She recently gave a talk titled, “What's Wrong with This Picture?—Nurses' Influence on Being Old and Ill in America” at the Carolina campus. Faculty members from both universities will meet with the visiting professor to explore new ideas in geriatric care and education.

Life Care Centers of America Directors of Nursing (DONs) Join NADONA/LTC

The National Association of Directors of Nursing Administration in Long Term Care (NADONA/LTC) recently announced that Life Care Centers of America will sponsor 2-year memberships for its directors of nursing. Life Care Centers of America operates more than 260 skilled nursing, Alzheimer's, assisted living, and retirement centers in 28 states. Susie Hutchings, RN/CPHQ, senior vice president of clinical services for Life Care Centers of America said, “We believe in providing an environment in which our DONs are recognized and rewarded for their individual contribution and feel a sense of accomplishment and pride in their work. Providing NADONA/LTC membership and the many unique benefits that accompany that membership is a natural extension of that belief.” Life Care is the first corporation to sponsor its DONs fully in CDONA certifications through NADONA/LTC's online university. All DONs at Life Care Centers of America will become certified via www.nadonauniversity.org.

Drugs Prescribed for Elderly Americans are Often Risky

Many Americans over age 65 have prescriptions for drugs considered potentially risky for elderly patients, yet in a recent issue of the Archives of Internal Medicine (August 9, 2004), researchers found that over the course of a year, 1 in 5 elderly Americans filled a prescription for at least 1 drug classified as a “drug of concern” according to established criteria known as the Beers list. The findings suggest that some doctors may be uninformed about increasing risks presented by common medications as people age, thus underscoring the need to show more clinical evidence for the risks presented by particular drugs when taken by elderly patients. The elderly are rarely included in the clinical trials that generate information about drug side effects. The Beers list, a list of criteria for determining the appropriate use of medication in elderly living in nursing homes, was initially developed in 1991 from a panel of experts and then refined in 1997 for institutional use in any setting, named 28 medications or medication classes considered inappropriate for use in elderly patients. An update of the Beers list including 48 medications or classes of medications to avoid in adults aged 65 or older was published in the December 8, 2003, issue of the Archives of Internal Medicine.

Warn Patients to Practice Safeguards When Using Online Pharmacies

In light of high prescription prices, many consumers are looking to the Internet to provide cheap sources for their medications. Consumers should be careful to screen out unscrupulous online pharmacies. Look for the seal from the National Association of Boards of Pharmacy or call (847) 698-6227 to learn whether an online pharmacy is in good standing. Online pharmacies labeled VIPPS (Verified
Internet Pharmacy Practice Sites) have met the strict standards of the Boards of Pharmacy. Make sure your online pharmacy asks for prescription and doctor verification and provides the opportunity for consult with an online pharmacist in case of questions about the prescription or potential drug interaction. Also make sure a telephone number is provided in the event additional questions arise.

**National Private Duty Association Supports Pending Legislation in California**

The National Private Duty Association (NPDA) is a national voice for organizations that provide private home care services and an advocate for services that benefit the consumers for whom they care—seniors, children, persons with disabilities, those with chronic health conditions, and anyone whose quality of life can be improved by having a caregiver help in their home. The NPDA has worked to drum up support for proposed California legislation (AB 2704: Underground Economy in Home Care), a law that would begin to address the issues of protecting consumers of home care and close the trust-account loophole. The NPDA was founded in 2002 and is the nation's first association for providers of private home care services. NPDA chapters are being formed across the country, and to date the Association represents more than 500 home care agencies in 44 states and Puerto Rico. Its mission is to enhance the strength and professionalism for private home care providers through education and best practices. Further information can be found on their Web site at [www.privatedutyhomecare.org](http://www.privatedutyhomecare.org).

**Caregiving and Depression**

Researchers at Case Western Reserve University recently disclosed initial findings that showed grandmothers who were primary caregivers in their families experienced greater stress and depression than non-caregivers. With the aging population on the rise in the United States and an anticipated increase in the number of grandmothers taking on the caregiving role, the Case researchers are trying to understand how to help these women stay healthy and identify factors that may moderate the effects of stress. This 4-year National Institutes of Health–funded study, which concludes in 2005, includes comparison groups of grandmothers living in multigenerational homes and non-caregiver grandmothers and examines the links between the women and their families in terms of overall stress, health, and well-being.

**Clinical Study Seeks Patients**

The New York-Presbyterian/Weill Cornell Medical Center recently announced that it is seeking patients with relapsed or refractory mantle cell lymphoma to participate in a multicenter, single-arm, open-label Phase II trial of Velcade. Mantle cell lymphoma, an aggressive form of non-Hodgkin’s lymphoma, is not curable with existing therapies, and only one-fifth of patients survive more than 5 years following diagnosis. For information regarding study entry criteria or to find a local study site, call (866) 835-2233.

**RESOURCES**

**Careers in Aging**—Professionals seeking work in the field of geriatrics have a wide variety of occupations and areas that can utilize their services. The Association for Gerontology in Higher Education has a great Web site that outlines a host of information about careers in Gerontology and Geriatrics at [www.careersinaging.com/careersinaging/job_career.html](http://www.careersinaging.com/careersinaging/job_career.html).

**Web Sites to Investigate**—The Web sites that follow may be worth visiting. The first, [www.centerwatch.com](http://www.centerwatch.com), lists more than 41,000 industry and government sponsored clinical trials, as well as new drug therapies recently approved by the Food and Drug Administration. It also lists information on what government-funded research studies are currently underway at the National Institutes of Health. The second site, [www.searchpointe.com](http://www.searchpointe.com), provides background information on medical doctors and doctors of osteopathy with an active license to practice in the United States. The information, compiled from private, professional, and federal agencies and medical boards, includes doctor locations, degrees, training, licenses, and disciplinary actions. You can also learn where a doctor attended medical school and what specialized training the doctor has received, such as fellowships.

**Web Site Fills Gaps in Geriatric Nursing Knowledge**

[GeroNurseOnline.org](http://GeroNurseOnline.org), a new Web site of the Nurse Competence in Aging (NCA) initiative, is a
The site is a sophisticated resource for nurses who wish to learn more about geriatric syndromes and their possible causes and treatments and to translate that knowledge for the immediate benefit of their patients. It is a resource for nurses nationwide and will help enhance nursing practice and improve patient outcomes for older adults. The site can be searched in 3 ways: by patient clinical signs and symptoms, specific geriatric topics, or specialty nursing practice areas. The content is organized into 3 levels of depth and complexity: Need Help Stat, Want to Know More, and Topic Resources. The goal of the NCA initiative is for 60 specialty nursing associations to be designated “Web Fellows” who will be responsible for providing content to the site in relation to that specialty area.

Internet-Based CEU Program for Nurses

A new knowledge resource from Sigma Theta Tau International, the Honor Society of Nursing, is now available. CareeRxel™ is a new, Internet-based continuing education program for nurses and nursing students that provides self-paced activities to aid in identifying the deep motivators that stimulate high performance and high fulfillment in the workplace. To learn more about CareeRxel and to download a demo of the program, visit the society’s Web site, www.nursingsociety.org/publications.

Online Geriatric Care Management Certificate

Kaplan University’s School of Continuing and Professional Studies has introduced a new online program that provides comprehensive geriatric care management training for health care professionals. The Geriatric Care Management Certificate will be offered online as a 12-month, noncredit program beginning in December 2004. Geriatric care managers are increasingly in demand, and the online, self-paced program delivery affords busy health and human services professionals the opportunity to break into this dynamic field. For more information on this program or to enroll, contact the Web site at www.Kaplan.edu/hcp.
Outcomes of care improve when older patients are cared for by nurses with demonstrated competence in geriatrics and in environments that structure nursing care around the needs of older adults. The past twenty years has seen the development of a number of exciting new nursing models in the delivery of care for older adults. This article highlights some of these evolving models of nursing practice in assisted living, home care, hospitals, and nursing homes. (Geriatr Nurs 2005;26:11-5)

Today, the day-to-day practice of most nurses involves caring for older patients. Yet few nurses have been exposed to specialized knowledge about care of older adults, either in their educational programs or in the work setting. This is of particular concern given that it has been shown that outcomes of care improve when older patients are cared for by nurses with demonstrated competence in geriatric knowledge and skills.

Despite nurses generalized lack of knowledge about geriatric care, the past 20 years have seen the development of some exciting new roles for nurses in the delivery of care for older adults. Of particular importance have been the programs funded by the John A. Hartford Foundation (JAHF; www.gni.org). With an investment of more than $35 million, the nursing programs funded by JAHF have substantially strengthened nursing education, practice, and research and have positioned nursing to take a leadership position in assuring quality care to older adults. The JAHF funding, coupled with other practice initiatives, have been instrumental in creating new roles for nurses in various health care settings serving older adults. The purpose of this article is to describe some of these new roles that are evolving in assisted living, home care, hospitals, and nursing homes.

Assisted Living

Assisted living (AL), which provides a varying mix of personal, supportive, and health-related services in a noninstitutional, “homelike” environment, is beginning to offer new opportunities for nurses to work with independently living older adults. At least one-third of states permit, and indeed encourage, AL residences to admit or retain residents who meet a nursing home level of care.

Estimates vary widely about the number of AL facilities and residents. One study reports almost 12,000 facilities with slightly more than 500,000 residents, most of whom are Caucasian women, widowed, and in their early 80s. One study found that 17% of residents were in good physical health but with significant cognitive impairment; 9% were functionally impaired due to chronic illness; 14% were dually impaired; and 45% had no impairment. Another study reported that approximately 60% to 81% of AL residents evidenced dementia, depression, some other psychiatric illness, or were on a psychotropic medication.

Currently, about 25% of AL facilities have a dedicated Alzheimer’s or dementia unit. Only 14 states require a licensed nurse presence in AL facilities for some portion of the day or week (8 states do not specify RN or LPN). Varying with state regulation, an RN would do admission and periodic physical and mental status assessments; review medications; see any resident experiencing physical, mental, functional, weight, or decision-making capacity change; write and review the plan of care; observe staff performance; and provide or recommend inservice education. The most commonly prescribed medications for AL residents are cardiovascular, central nervous system, psychotropic, and nutritional. Fifty percent of residents are on antihypertensive therapy. Approximately 50% to 75% of AL residents are thought to require assistance of some kind with their medication. Twenty-two states permit variously trained unlicensed personnel to administer medications—in some states, as a delegated authority, in others, by virtue of a state regulation.
Most states do not permit intravenous administration, feeding tubes, or grade 3-4 pressure ulcer care but do permit oxygen administration, in-dwelling catheters, ostomy, and blood sugar testing. Nursing services, generally in the form of assistance with activities of daily living and medication management, are offered by 90% of AL facilities, and skilled nursing is available in 60% of facilities, most of which is contracted from a licensed home care agency. All states permit hospice services in AL, but the relationship, extent of communication, and burden of care vary widely.

Home Care

Today, 80% of home care is delivered to people 65 and over. Several models, including the emerging use of advanced practice nurses to deliver primary care at home, are beginning to change the horizon for new models of nursing practice with older adults in home care.

One exciting new home care model is the Visiting Nurse Service (VNS) CHOICE program, a managed long-term care program that has been serving the frail elderly of New York City for more than 5 years. CHOICE offers an array of health and long-term care services provided primarily in the home and community. Covered services include comprehensive home health care, adult day services, a range of ambulatory health services, transportation, and prescription drugs. Medicare services are not covered; however, VNS CHOICE is responsible for coordinating these benefits, as well as services provided through other funding streams. In the VNS CHOICE model, nurse consultant care managers lead an interdisciplinary team of professionals that includes social workers, rehabilitation therapists, and member service representatives to arrange for and provide services to members. Nurse consultants manage the enrollment process, communicate with the member and caregivers to develop an appropriate plan of care, collaborate with community providers and physicians, evaluate changing member needs and the effectiveness of services, provide nursing services in the home, and offer ongoing care management across all settings.

Community, Hospital, and Nursing Home Care Management

Coordinating services with more than 2,700 providers creates individualized care plans to satisfy most effectively current and future member needs. In 2002, members spent more than 15,000 days at social day centers, received more than 31,000 home-delivered meals, and made approximately 1,000 visits for dental care and 500 visits for eye care. Through active care management, nurse consultants provide hospital staff with relevant member information and care preferences, participate in discharge planning, and ensure a smooth transition back to the community or nursing home. Implementation of care management strategies has yielded positive results. From 1999 to 2002, admits per 1,000 decreased 22%, and the average length of stay for a hospitalized member decreased 20%.

In the nursing home setting, nurse consultants plan and coordinate the admission with a member, caregivers, and physicians; monitor health status; participate in the nursing facility’s care planning process; and serve as an advocate for the member.

Hospitals

The demographics of hospitals are such that older patients currently represent the “core business” of hospitals. Older people make up 63% of patients with cancer, 60% of visits to cardiologists, 53% of visits to urologists, and 52% of visits to ophthalmologists. Of patients in critical care, 46% are aged 65 and older, and these patients account for more than 50% of intensive care unit expenditures.

Several new initiatives, including those documenting the positive outcomes of care delivered by interdisciplinary teams and of transitional care that addresses the “hand-offs” of older patients between hospital and home care, offer evolving roles for geriatric nurses in hospitals. Nurses Improving Care to Health System Elders (NICHE), a program of the John A. Hartford Foundation Institute for Geriatric Nursing at NYU, is an innovative approach whereby hospitals undertake system changes that systematically benefit older patients as well as hospital nursing and other staff. Initiated in 1992 and currently with 140 hospitals subscribed, NICHE provides tools for hospitals to use to assess and improve care to older patients. NICHE has introduced several new nursing roles in hospitals. Three new nursing models have evolved through NICHE.

1. The Geriatric Resource Nurse Model
In the GRN model, unit-based RNs volunteer to become GRNs. GRNs acquire competency in care of older adults through educational programs, clinical rounds, consultations, and geriatric nursing interest groups implemented by an advanced practice geriatric nurse. GRNs improve geriatric care on the unit by modeling best practice and by providing nurses with strategies, resources, bedside consultation, and feedback regarding care for older patients. A GRN’s caseload may be reduced to allow time to maintain the unit’s resources for geriatric best practices. Units typically have more than one GRN, often incorporated on all shifts. Geriatricians, primary care, or internal medicine physicians provide consultation to the GRN and the advanced practice geriatric nurse. The GRN model had been implemented in 42 NICHE hospitals. Among these hospitals, the median number of units is 2 (range 1–14), and the median number of GRNs per hospital is 15 (range 1–89). Almost half the hospitals had a formal educational training process for GRNs; 69% of hospitals rated the GRN model as excellent to very good. NICHE coordinators indicated that GRNs were seen as valuable for their ability to focus on the care needs of the older patients, as a resource and role model to nurses and to the interdisciplinary team. Several coordinators noted, however, that absent institutional support and physician acceptance, implementation and stabilization of the GRN model was tenuous and slow.

2. Geriatric Syndrome Management Model.
In this model, advanced practice geriatric nurses seek to improve nurses’ accuracy and speed in assessing and managing common geriatric syndromes such as delirium, falls, urinary incontinence, and sleep disturbances through initial and ongoing staff consultation and education. Fourteen NICHE hospitals report implementing the geriatric syndrome management model. The GRN model had been implemented in 42 NICHE hospitals. Among these hospitals, the median number of units is 2 (range 1–14), and the median number of GRNs per hospital is 15 (range 1–89). Almost half the hospitals had a formal educational training process for GRNs; 69% of hospitals rated the GRN model as excellent to very good. NICHE coordinators indicated that GRNs were seen as valuable for their ability to focus on the care needs of the older patients, as a resource and role model to nurses and to the interdisciplinary team. Several coordinators noted, however, that absent institutional support and physician acceptance, implementation and stabilization of the GRN model was tenuous and slow.

3. The Acute Care for the Elderly Model (ACE).
ACE units are specifically designed to prevent functional decline among hospitalized elders. Typically, an ACE unit has special physical features that include furniture and amenities tailored to older patients and an activity room used for congregate meals, visiting, and therapies. ACE units have close interdisciplinary collaboration, with joint direction by an advanced practice geriatric nurse and geriatrician and nurse-initiated clinical protocols of care. Twelve NICHE hospitals report fully implementing an ACE unit.

Hospitals that participate in NICHE demonstrate a commitment to providing quality health care to older adults. Integral to NICHE are the following 5 components: 1) a designated individual or group to lead NICHE initiatives; 2) resources to sustain NICHE initiatives, including support for staff attendance at the NICHE Leadership Conference held annually at the Hartford Institute; 3) a designated program of activities on behalf of care of older adults; 4) educational strategies for initial and ongoing orientation of patients, families, staff, physicians, and board members about NICHE; and 5) ongoing evaluation of NICHE-related out-
comes. In addition to implementing geriatric nursing models, NICHE hospitals typically implement the GIAP (Geriatric Institutional Assessment Survey) to assess staff knowledge and attitudes, conduct staff education, promote gerontological certification for professional nurses, and implement plans to evaluate outcomes of care.

Roles for Specialty Nurses in Caring for Older Adults: Specialty Nurses’ Involvement Nurse Competence in Aging (NCA)

Representing a strategic alliance among the American Nurses Association (ANA), the American Nurses Credentialing Center (ANCC), and the Hartford Institute and funded by Atlantic Philanthropies, NCA addresses the need to ensure geriatric competence among the nation’s 2.2 million practicing nurses. Specifically, NCA focuses on the approximately 60 nursing specialties that primarily serve older patients. Together, the associations that represent these specialties have a membership of 400,000 practicing nurses. These nurses work in oncology, critical care, medical surgical units, rehabilitation, hospice, and so on. NCA’s objective is work with the associations and with the nurses to help the specialty adopt a “dual identity” of expertise in the specialty practice and in the care of their primary age population, older adults.13 Thus, NCA seeks to achieve goals at the level of associations, specialty nurses and nurse practice.

NCA has three main areas of activity to achieve project goals. Program Activity 1 relates to promoting geriatric activities of national specialty nursing associations to create a sustained commitment to care of older adults in the specialty nursing associations. To this end, NCA funds specialty associations through a competitive process, provides technical assistance to specialty associations, and helps create association awards. Program Activity 2 relates to promoting national gerontological nursing certification by creating a computer-based certification examination and through a public relations campaign. Program Activity 3 has resulted in the development of a Web-based comprehensive geriatric nursing resource center: www.GeroNurseOnline.org.

As a result of NCA, specialty nurses will be in the position to carve out new roles in caring for older adults. Nurses with sensitivity to geriatric issues and who have achieved geriatric competence within a specialty—for example, in critical care or emergency room care—will develop new models for care delivery. One model that has been proposed is the development of geriatric “champions” within specialties. Modeled on the geriatric resource nurse developed in the NICHE program, geriatric champions would use strategies and materials to provide and encourage best practices in the care for older adults in their work setting. In addition to staff education, some of the strategies and procedures encouraged through NCA to ensure the infusion of best practices include dual certification in specialty practice and gerontological nursing, the introduction of geriatric care into specialty scopes and standards, and modification of specialty care unit policies and procedures to reflect the care needs of older adults.

Nursing Homes

The value of advanced practice nurses in improving care to nursing home residents has long been recognized.14-16 In the past few years, emerging models have begun to explore new ways to use the skills of advanced practice nurses in long-term care. In the Wellspring model,17,18 several nursing homes that are in geographic proximity share an advanced practice nurse who consults on resident issues for staff, helps develop policies and procedures, and conducts education on best practice in geriatric care. This model is now operational in several states and addresses both the shortage of advanced practice nurses and the inability of small homes to employ an advanced practice geriatric nurse full time. Evercare, a fully capitated managed care option for residents in nursing homes, uses advanced practice nurses to deliver primary care to residents in conjunction with physician collaborators.19-20 Because Evercare advanced practice nurses are on-site in nursing homes, they are able to take preventive measures, identify early signs and symptoms, and manage residents’ health care in an ongoing and timely manner, thus preventing unnecessary emergency room and hospital admissions. Finally, the Pioneer movement21 seeks to reshape nursing homes and the role of professional and nonprofessional nursing staff to create an environment that promotes resident-directed care.
In summary, evolving models of geriatric nursing practice suggest exciting opportunities for nurses seeking to focus their practice on care of older adults. Older adults and their families are the primary recipients of nursing care. Nurses not only need to monitor evolving practice models but also actively participate in shaping these models. Only then can we hope to achieve our mission of enlightened, humane care for older adults.

References


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The purpose of this study was to investigate the factors that influenced the quality of care of terminally ill nursing home residents on a hospice unit in a city and county long-term care facility. The findings disclosed that the hospice team had created a cultural environment in which care, community, and compassion were the predominant components of their philosophy of palliative care. Communication at all levels—among staff, family, friends, and residents—was found to be a core hospice value, essential to community development. The results of this study illustrate that exemplary palliative care can be provided when an interdisciplinary team is dedicated to creating an environment where the principles of palliative care can be fully implemented. The authors conclude that there is a developing role for geriatric nurses to participate in further defining and providing palliative care for older people in their homes, hospitals, nursing homes, and residential care. (Geriatr Nurs 2005;26:16-20, 64)

There is a vast literature on death and dying, but despite the fact that most older people who enter nursing homes die in the facility, there has been limited research on how care is provided to terminally ill nursing home residents. About 20% of all deaths in the United States occur in nursing facilities, and nursing homes will increasingly become the site for terminal care. Since 1986, when the Medicare hospice benefit became a permanent part of Medicare coverage, the number of nursing home residents enrolled in hospice care has increased significantly from 9.9% in 1990 to 21.5% in 2002.

The roots of hospice care are found in nursing. One of the first institutions to provide care to people who were dying was St. Joseph's Hospice in England, and it was there, during the 1950s and the 1960s, that Dr. Cicely Saunders refined the ideas that formed the cornerstone of modern hospice care. Saunders trained as a nurse during World War II and later became a social worker. Her concern for managing the pain of dying patients motivated her to study medicine at Oxford University, and in 1967, she founded St. Christopher's Hospice near London.

In 1963, Saunders spoke to medical students at Yale University, and at that time, she met Florence Wald, dean of the Yale School of Nursing. Wald visited St. Christopher's to observe hospice care and to conduct research on establishing hospice services, and in 1974, she was instrumental in establishing the Connecticut Hospice, the first U.S. hospice to offer home care and bereavement services.

This article reports research conducted on a 25-bed hospice unit located within a large city and county long-term care facility (Facility A). The purpose of the research was to investigate the factors that influence the care of terminally ill nursing home residents.

Methods

Setting and Sample

The residents on the hospice unit are cared for on an open ward, similar to the Nightingale wards in British hospitals. Two private rooms are available for residents who require close monitoring for intensive symptom control or agitated delirium. A hospice team, including a full-time hospice-certified physician, a hospice-certified nurse manager, registered nurses (RNs), licensed vocational nurses (LVNs), certified nursing assistants (CNAs), a social worker, an activity therapist, a spiritual counselor, a volunteer coordinator, and trained volunteers provide care to the residents.

Data Collection

Chart review, participant observation, in-depth interviews, and event analysis were used...
to obtain data. The care of 33 residents was observed from the time they were identified as being terminally ill until they died, ranging from 2 days to 7 months. The demographic and clinical characteristics are presented in Table 1. Observations were made several times a week from early morning until late evening, by the principal investigator (JKJ), a project director, and 6 research assistants (doctoral students in nursing and medical sociology). When death was imminent, observations were made at least daily and sometimes several times a day. The data were analyzed using methods described by Bernard, Spradley, and Strauss and Corbin. Using content analysis, the data were coded and systematically analyzed. A full description of the methodology and data analysis has been reported elsewhere.

Results

The hospice philosophy at Facility A is, “To meet the physical, psychological, emotional, social, cultural, and spiritual needs of the terminally ill residents and their families.” This philosophy is manifested in a culture of care, community, and compassion.

Care: The Physical-Psycho-Social-Spiritual Environment

A major theme that emerged in this study was the hospice team’s awareness of the importance of how the environment influenced care. Attention was given to the minutest detail. When entering the hospice unit, there is a combined lounge and dining communal area. The walls are painted a warm, peach color. There are flowers, plants, artwork, books, a cheerful cockatiel, and photographs of the residents and staff taken at social events. Noise is kept to a minimum; soft music can be heard in the background. “If the music is too loud, it shatters the atmosphere,” the hospice physician noted. “Everything has to just be right; if things are wrong, it begins to change the atmosphere. We try to create a home-like rather than an institutional environment. Dead flowers, a scratch in the paint on the wall, these are signs that you don’t care. When everything is right, we’re sending a message that we do care. Everything on the unit is symbolic of caring. As soon as people stop caring, the place loses its caring atmosphere, and the residents know this, and they will feel alienated and isolated.”

Table 1.
Demographics and Clinical Characteristics (N = 33)

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*M = mean.
†SD = standard deviation.
‡ADL = Katz Activities of Daily Living (a larger number indicates a greater level of dependency).

Wonderful aromas emanate from the kitchen, located on the hospice unit, where food is being
Residents, families, and staff participate in the food preparation and gather in the communal area at mealtime, on holidays, for birthday celebrations, and for other social events. A doorway from the communal room opens into a beautiful garden with flowers, chimes, a fountain, and comfortable tables and chairs. The garden allows the residents access to nature. It provides privacy and a peaceful environment for residents and their visitors.

There is a monthly Happy Hour, when a banquet, including alcoholic beverages, is enjoyed. Residents, families, friends, and staff mingle together in conversation. “By serving food, you show people that you care. There’s joy during Happy Hour. One moment residents will be complaining about their hurt, and then during Happy Hour they’re having fun, they’re joyous, and they forget about their hurt. We might have 12 to 13 deaths a month,” the hospice physician explained. “We need to do everything we can to make people happy.”

Every 3 months when a memorial service is held for the residents who have died, the communal room is converted into a chapel-like environment. A table, covered with a beautiful white tablecloth, with candles and flowers, is placed at the front of the room. Chairs are arranged so that the people can be comfortably seated. First, a resident reads a spiritual verse. Following this, members of the hospice team (the CNAs, RNs, and physician) read the names of several residents who died during the previous 3 months. A votive candle is passed around, and everyone is invited to say a few words, remembering a person who has died. Families often thank the hospice team for taking such good care of their loved ones, and the staff note that it was a privilege for them to have been a part of the life of the deceased person. Following the service, food and drink is served to everyone, allowing families to mingle and interact with the staff. The hospice team has created a homelike, supportive, family environment. “You can just feel the love on this unit,” a volunteer remarked.

The physical environment sets the stage for providing physical, psychological, social, and spiritual care. Three times a week the hospice physician and the nurses review the care of each resident. Every symptom (e.g., pain, fatigue, dyspnea, fever, anorexia, anxiety, fear, sleeplessness, constipation, skin irritations, and depression) is monitored, and the most appropriate treatment approach is discussed in detail. When necessary, medication changes are made, and sometimes an alternative, creative approach to managing symptoms is devised. The hospice team had learned, for example, that a tea available in Chinatown alleviates constipation. The physician explained that rather than prescribing a laxative, it is more pleasant and therapeutic for the nurse to sit down with the resident, have a cup of tea, and chat for a few moments. It is noteworthy that although 73.3% of the residents had a diagnosis of cancer and 84.5% of the residents experienced pain, only 1 resident, a man who had used drugs and become opioid resistant, reported moderate to severe pain.

**Community**

Community is defined as a group of mutually interacting individuals with common interests residing in the same area. The hospice is a therapeutic community of which staff, residents, and family and friends are an integral part. The communal room described earlier is similar to a community center; it is a place where everyone gathers for social, cultural, and spiritual events.

Communication at all levels is a core hospice value; it is an essential part of community development. The hospice-trained nurse manager meets daily with the CNAs to give them a report on the residents. The interaction is positive and respectful, and she emphasizes that the “patient always comes first. We always do what is best for the patient.” Residents and families are an integral part of care, and open communication is encouraged. When a resident arrives on the hospice unit the nurse manager meets with the family to explain their philosophy. Families can visit at all hours, and they are invited to participate in all of the hospice activities.

The hospice team helps families communicate with and reach out to the person who is dying. The nurse manager sensed that the father of a resident was afraid to be alone with his dying son. She told him, “I promise you; I will stay with you. I will stay with you and your son all day. You will not be alone.” Initially, the father stood at the end of the bed. Eventually, he was able to touch his son’s feet; gradually, he got closer and closer. When the son was actively dying, the father was able to hold him. “It was wonderful,” the nurse said. “The father really
became involved with his son, and he was holding him when he died.” A few minutes after death had occurred, the nurse said to the father, “Do you know that your son has died?” “No, no,” the father cried out. “He cried very hard,” the nurse said, “but it was rewarding because I had helped him reach out to his son.”

Physician–resident communication on the hospice unit is exemplary. The hospice physician is on the unit from 9:30 AM until 3:30 PM, and he is on call 24 hours a day. The presence of the physician on the unit contributes to positive physician–resident–staff communication and ultimately to a high standard of care. When new residents arrive, the physician greets them, and a detailed history and physical is completed. If a resident complains, for example, of pain or dyspnea, the physician immediately visits the resident and attends to the problem. A resident came to the nursing station and asked to speak to the doctor. Although the physician was writing on a chart, he stopped what he was doing and talked with the resident about his concerns. Another resident called out to the physician as he passed by his bed. “There’s some rattling in your throat, and I’m going to take care of that,” the physician assured him. Using an alternative medical treatment, the physician returned to the resident and administered the treatment. “If that doesn’t help, we’ll give you something else,” he reassured him.

Compassion

Compassion is defined as “Sympathetic concern for the suffering of another and leads to the desire to alleviate or remove the cause of the distress.”\(^{11}\) Compassion comes about through a multiphase process known as empathy. Empathy begins with gaining insight into the patient’s concerns, feelings, and distress. This insight is followed by engagement or identification with these feelings, and this in turn produces compassion.\(^{12}\)

The nurse manager is a caring, gentle, intuitive, and empathetic woman. Even if it means working overtime to complete paperwork, she chooses to be at the bedside of residents who are dying. “The paperwork can wait,” she explains. When asked to describe a resident whom she had cared for recently, she placed her hands over her eyes and replied, “Most of them affect me very individually. If I don’t open my heart to my patients, if I don’t do it from my heart, then the care isn’t good. It’s a humility. It’s mystical. I really don’t know what it is like to die, and I’m learning from my patients all the time.”

The staff observed that a man, dying of lung cancer, was fearful. He was “bothering” the staff and calling his sister frequently. “I decided that I needed to spend some time with him,” the nurse said. She asked the resident if he was afraid. “I’m not afraid; I know about dying; I’m a religious man,” he replied. “I told him that many people are afraid because the most precious thing is our life, and when we think that we are going to lose it, that is very frightening. I was putting myself into his shoes,” the nurse explained. Then, the man said, “Well, I think the nurses don’t want to talk to me, and I’m feeling isolated. I think they’re afraid of talking to me because I’m jaundiced, and they think that I’m contagious.” “Oh my dear,” the nurse replied, “let me tell you about jaundice.” She carefully described the different types of jaundice and explained that his jaundice was due to an obstruction that had occurred due to metastases that was blocking the flow of bile.

“It made all the difference in the world for this man because he understood that the nurses were not avoiding him because they thought that he was contagious. But he had that terrible fear.” She explained to the resident that he might feel a little fearful at times, and if this happened, they would give him a pill to help him to relax. “As I was talking with him, I got the feelings that he had. I had those feelings inside of myself. It goes right into my heart. He cried a lot, and I cried; then he said, ‘I want to call my sister. I’m okay now; I know I’m still jaundiced, but I’m okay. I just want to hear my sister’s voice.’”

“He called his sister and said, ‘I’m all right now. The nurses are here, and they’re taking good care of me, and if I get too afraid, they can give me a pill to relax.’” As the resident left the telephone to return to his bed, the nurse said, “You can’t go to sleep without giving me a hug. He gave me the most wonderful hug; it was so reassuring.”

Discussion

This article describes an interdisciplinary hospice care unit where a culture of care, community, and compassion are the three predominant components of the staff’s philosophy of palliative care. Palliative care is “The active,
total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychosocial and spiritual problems is paramount. The goal of palliative care is the best possible quality of life for patients and their families.\textsuperscript{13} Our data suggest that the hospice unit at Facility A epitomizes the best of palliative care. The staff are dedicated to providing an environment where the principles of palliative care can be fully implemented.

Social and spiritual events such as Happy Hour and the Memorial Service provide a sense of community by which residents and their families can communicate freely and meaningfully with the hospice team. The nonverbal communication that occurs is an inseparable part of the process of caring, the development of community, and the compassionate care observed on the unit. Providing special food and drink, soft music, access to a beautiful garden, sitting at the bedside and sharing a cup of tea with a dying resident, and giving a hug to a man who is fearful are examples of nonverbal communication that contributes to the best of palliative care.

In this 25th anniversary issue of \textit{Geriatric Nursing}, it behooves us to ask, “What is the role of geriatric nurses in the future development of palliative care?” The development of hospice and palliative care programs have, for the most part, occurred in the last 2 decades.\textsuperscript{14} As mentioned earlier, the roots of hospice care were founded in nursing, yet it appears that the role of nursing in the development of hospice care has been limited. In doing an analysis of more than 45,000 pages in the top 50 textbooks in nursing education, it was found that only 2% of the content was devoted to end-of-life care.\textsuperscript{15}

In a study that investigated end-of-life care in nursing homes, we found that residents who were dying did not receive basic care such as adequate food, fluids, a bath, and oral hygiene. Pain, dyspnea, and other symptoms were not alleviated, and their social, cultural, and psychological needs were unmet. None of the nurses in the facilities were specialists in palliative care nursing.\textsuperscript{8,9}

Nurses provide the hour-by-hour and day-to-day care to dying patients. Furthermore, they come from a tradition of listening and understanding their patients’ deepest needs.\textsuperscript{16} Caring is a key concept in professional nursing that requires sensitive interpersonal exchange, the type of communication provided by the nurse manager at Facility A. Clearly, there is a developing role for geriatric nurses to participate in defining and providing palliative care for older people in their homes, hospitals, nursing homes, and residential communities. Palliative care will flourish only if the best and the brightest professionals are attracted to it, and only if we are unafraid to talk about aspects of care that clearly are of value, but may not as yet be as easy to measure.\textsuperscript{16} Doyle noted that “The presence of palliative care services should be seen as a measure of how caring a society is.”\textsuperscript{16} To paraphrase Doyle, the quality of palliative care services for older people could be seen as a measure of how caring we are as geriatric nurses.

\textbf{References}


\textit{continued on page 64}
Benefits and Challenges of Research With the Oldest Old for Participants and Nurses

Marjorie J. Leahy, RN, MN, Debbie Thurber, RN, and James F. Calvert Jr., MD

The Klamath Exceptional Aging Project is a longitudinal aging study of people 85 and over, the “oldest old,” in rural Oregon. Although conducting research with those 85 and over can be challenging, it is increasingly more important that this group be included in research studies given their importance in society. Benefits for the oldest old participating in research include an opportunity for altruism, productivity, and generativity and the expression of power and control. Benefits for nurses conducting research with this group include gaining a unique understanding of the world of the elderly, the honor of being a confidante for them, and the opportunity to provide truly caring nursing to a vulnerable age group. There is also a great sense of satisfaction in adding to the knowledge base needed to attain successful aging. (Geriatr Nurs 2005;26:21-8)

The ability of nurses to meet the unique needs of the elderly will be of increasing importance because of the explosive growth in the population over age 85. Research among the oldest old allows us to understand their special views, motivations, and needs. However, research with the elderly presents special challenges to the participating nurse. Patience, consideration, and an understanding of the limitations and concerns of this group can overcome these challenges.

Understanding what research participation brings to the lives of the oldest old—including meeting social, intellectual, and emotional needs—can greatly increase research productivity among the elderly. This article describes the potential benefits of research participation for the elderly as well as the rewards research with the oldest old may bring in return to research nurses.

Background

Research among the oldest old, persons over age 85, has increased in recent years, an important change because the population of those over 85 is increasing in the United States at a faster rate than those over 65. In sheer numbers, those 85 and over increased from 3.1 million in 1990 to 4.2 million in 2000, an increase of 38% during the 1990s. By contrast, the population 75 to 84 grew by 23%, and the 65 to 74 population grew by less than 2%. Centenarians, the very oldest old, are also a rapidly growing group. The 1990 census identified 37,306 centenarians in the United States, whereas the 2000 census identified 50,454. This rise in absolute numbers of the oldest old is a harbinger of the increasing demographic changes the aging baby boomer generation will bring. The U.S. Population Bureau estimates indicate that in 2030 there will be 8.9 million people 85 years or older in the United States. Of these, 381,000 will be age 100 years and over. Because research must increase to meet the needs of those ages 85 and over, it becomes critical to understand how to engage the oldest old in research and the impact participation has on them as well as on the research team.

The Project

The Klamath Exceptional Aging Project (KEAP) is a longitudinal, community-based investigation of aging and the cause(s) of Alzheimer’s disease. The project is conducted in a rural area in southern Oregon with the oldest old. Participants enter the study through physician referral, caregiver referral, self-referral from advertising, and selected, targeted recruitment drives. Data collection occurs semiannually in the subject’s usual place of residence and includes assessments related to medical, limited neurological, mood, Parkinsonism, memory, and medication use (Table 1). Initial assessments for the project began in the fall of 1999. Assessments and enrollment are ongoing. Thus far, 308 participants have enrolled in the project. All participants have had at least one assessment with some having
had up to 10 since the project began. Participant dropout has been minimal at 0.01% per year.

Challenges

The following comments are derived from more than 4 years of firsthand experience with the special circumstances involved in doing research with the oldest old.

Recruitment and data collection among the oldest old requires patience. It is important to consider normal aging changes and the prevalence of chronic medical conditions in this group. Paying attention to the age-specific needs and concerns of this group increases the probability of participation and helps ensure the quality of the data (Table 2).

The elderly are understandably suspicious of strangers who telephone them wanting something as they are often targets for scam artists. Emphasize that research participation will not involve financial cost to the participant. It is also important to explain the purpose of the research clearly and slowly. If the elderly person has difficulty understanding what the nurse is explaining, offer to speak with a family member. Offering to speak to family helps legitimize the call: the elderly person may or may not choose to have family involved. It may help to offer to send out written materials and plan to call them back at a specific time in order to answer their questions. If the problem seems to be hearing while using the telephone, offer to go to their home and speak with them in person. These strategies provide the elder with time to digest what you are saying and show care and concern that they understand what they are agreeing to do. Extra time allowed to process information can help increase participation rates.

Family members are very protective of their elders, particularly with increasing age or if the elder has health problems or cognitive impairment. The family often acts as a gatekeeper. Elders may prefer to discuss participation with family members before making their decision. It can be especially important to establish contact with the family if a family member has power of attorney. Even family members who have been consulted before research starts may wish to limit research participation. For example, they may wish to specify in which data collection procedures the elderly study subject will participate (e.g., no blood draws). Agreeing to limitations the family may request, if it does not compromise the research protocol, will increase elder participation. In some cases, family members may ask that the elder withdraw from the research if they have not been consulted first and do not agree with the elder’s participation. If the elderly person does not want family to be involved in the decision to participate, and he or she seems competent to make that decision, this wish should be respected. Having an entree such as a physician referral or age-mate referral to the research

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**Table 1. Assessments Conducted for Klamath Exceptional Aging Project**

<table>
<thead>
<tr>
<th>Assessment</th>
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</thead>
<tbody>
<tr>
<td>Detailed family, medical, and psychosocial history (17 pages)</td>
</tr>
<tr>
<td>Self-assessment of health and memory status</td>
</tr>
<tr>
<td>Recent medical history review (health over the previous 6 months, status of chronic conditions, systems review, medication review)</td>
</tr>
<tr>
<td>Blood pressure and pulse sitting, standing, lying down; height and weight; best corrected vision; hearing screen; carotid bruits; finger-tapping test</td>
</tr>
<tr>
<td>Geriatric Depression Scale⁴</td>
</tr>
<tr>
<td>Unified Parkinson’s Disease Rating Scale⁵</td>
</tr>
<tr>
<td>Cumulative Illness Rating Scale⁶</td>
</tr>
<tr>
<td>Activities of Daily Living and Instrumental Activities of Daily Living⁷</td>
</tr>
<tr>
<td>Folstein Mini-Mental State Examination⁸</td>
</tr>
<tr>
<td>CERAD Testing: Boston Naming Test, Verbal Fluency (animals), Word list learning (10 words, three trials), Construction Praxis (copy circle, shape, diamond, overlapping boxes, and cube), Word List Delayed Recall, Word List Recognition⁹</td>
</tr>
<tr>
<td>Clinical Dementia Rating Scale¹⁰.¹¹</td>
</tr>
<tr>
<td>Blood draw on intake</td>
</tr>
</tbody>
</table>
also greatly reduces suspicion and can increase participation rates.

Once the elder has agreed to participate, it can continue to be important to involve the family. A family member may insist that they be present during the interviews. If a research protocol is not compromised, having family members present will assure family members there is no secrecy about the research process. Once a relationship with both the elder and the family has been established and the family comes to trust the nurse, previous restrictions are often relaxed.

Whenever possible, research with the elderly should be conducted at their homes. Travel to a research facility may be a problem because of elders’ inability to drive, visual impairment, mobility limitations, or lack of endurance. In particular, assessment of cognitive ability may be more accurate at the home, where they feel more comfortable. A home visit also provides a fuller picture of the participants’ activities of daily living. Although the cost of the research will be increased because the nurses travel to the participants, this small change in the usual procedure of participants coming to the researchers is an especially important consideration with this age group.

It is important to be flexible when scheduling data collection visits. Family members may want to be present at visits so their schedules may need to be taken into account. The elders may have frequent scheduled medical appointments for health concerns such as pacemaker checks or blood draws for prothrombin times. They may be dependent on someone

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
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</thead>
<tbody>
<tr>
<td>Hearing changes</td>
<td>Speak slowly and clearly; face participant; ensure hearing aids are in; provide written materials as needed</td>
</tr>
<tr>
<td>Vision changes</td>
<td>Excellent lighting; large-print materials; bolded materials</td>
</tr>
<tr>
<td>Slowed mobility</td>
<td>Allow extra testing time if any activity is required during testing; ensure canes and walkers are used for safety</td>
</tr>
<tr>
<td>Slowed response times</td>
<td>Allow adequate time for information processing and response; ensure participant has heard what is being asked</td>
</tr>
<tr>
<td>Chronic illnesses</td>
<td>Schedule when participant is feeling well and reschedule as needed; keep interview short; break data collection into 2 or 3 sessions; break up long periods of sitting; use discretion regarding continuing interview</td>
</tr>
<tr>
<td>Frailty</td>
<td>Collect data over several short interviews; use discretion regarding continuing interview; ensure oxygen is used if needed during long periods of talking; ensure client is comfortable and pain free; invite family to be present</td>
</tr>
<tr>
<td>Transportation limitations</td>
<td>Conduct data collection at participants’ homes</td>
</tr>
<tr>
<td>Family as gatekeeper</td>
<td>Involve family in recruitment; invite family to be present at interviews</td>
</tr>
<tr>
<td>Suspiciousness of strangers who may want something from them</td>
<td>Emphasize that there is no cost for participation; offer to speak with family; provide written materials and time to make a decision about participation</td>
</tr>
</tbody>
</table>
else’s schedule to take them to medical appointments or on shopping trips. They may prefer morning or afternoon appointments depending on when they feel best physically or the time that they get up in the morning. The nurse should put a priority on scheduling data collection visits and then schedule the remainder of the work day around those visits. The burden of research participation is reduced if the nurse puts the research participants’ schedules first.

Unplanned events such as falls and hospitalizations are common among the elderly. Careful follow-up is important to determine whether these events might affect research participation. Data collected too soon after such events may be unreliable because a temporary impairment may have resulted from the illness or injury. It may take longer for an older person to recover completely from an episode of ill health. Several attempts may be required to schedule an appointment before the elder is feeling well enough to participate in research.

Data collection from very old subjects takes more time than for younger subjects. Processing and response times during assessments are slowed because of both normal and abnormal age changes. If there are hearing or vision deficits, providing instructions and collecting data can take extra time. Large-print consent forms and instructions for doing tests, as well as other large-print or bolded materials, may be required for assessments that require the use of vision. When hearing deficits are present, the interviewer may have to speak more slowly and carefully and allow extra time for responses as the information provided is processed. If participants appear to have trouble hearing, ask whether they own hearing aids and also whether they are wearing them. Look at elders, not at the data assessment materials, when speaking, so that they may read your lips. Excellent lighting is required for all testing.

Data collection interviews may be tiring for the participants. Depending on the age and health of the study participant, data collection may need to be scheduled at several visits rather than one long one. It is important to be aware that members of this age group may require frequent bathroom breaks or need to get to a bathroom immediately when one is required. They may need to get up and move around to alleviate or prevent stiffness, have oxygen on if answering a lot of questions even if it is generally only used at night, or require water if doing a lot of talking. The research nurse may need to take the initiative in stopping an interview based on assessment of the participant’s energy level, and schedule another visit to complete the interview. Taking these factors into account ensures participants can concentrate on what is being asked of them.

Psychology of Aging

Psychology helps us to understand what shapes us to be who we are. Psychology research has traditionally emphasized development during the early years of the life span. With greater numbers of people living to greater ages, the psychology of aging takes on increasing importance.

Prominent developmental theorist Erik Erikson proposed in his later work that psychological development occurs throughout the life cycle. He proposed that the last years of life are an opportunity for generativity and the development of wisdom. Psychological development does not stop at adulthood, he purported, but continues to the end of life: “Wisdom, then, is detached concern with life itself, in the face of death itself. … It responds to the need of the on-coming generation.”

Life-span development, examples of which include Erikson’s and Jung’s work, is a theoretical perspective that looks at behavior over the entire life span, from conception to death. This perspective views development as both constancy and change over the entire length of a person’s life. Although there is currently no one theory for this perspective, the life-span development approach orients us to the idea that behavior develops over the entire life course and is neither child centered nor adult centered, but rather an ongoing process.

Tornstam’s theory of gerotranscendence proposes that the reality of old age is separate to itself and not simply an extension of middle age. It posits that we all have the potential to make a shift in our worldview as we age as the result of continuing development toward maturation and wisdom. This shift, or transcendence, changes our perspective on the world and influences our behavior.

Why Do They Do It?

Subjects in KEAP receive no compensation for their time and effort, yet they take great
Altruism

Altruism has been identified as a reason for volunteer work and volunteering for research participation in particular.18–20 Participating in aging research provides an avenue for expressing altruism and acting on a felt obligation to help. The expression of altruism in this age group is consistent with the idea of concern for the upcoming generation that is part of Erikson’s theory. It also reflects the theory of gerotranscendence in the areas of a decrease in self-centeredness and a shift from egoism to altruism. Indeed, altruism is an important attribute for wellness identified by the well elderly.21 It can provide meaningful activity that promotes a sense of value and self-worth.22,23 Although altruism may be expressed in many ways, participation in aging research is certainly altruistic behavior that can be offered only by the elderly.

Concern about the memory loss that may occur with aging is very real to our research participants. Although there is often confusion between what constitutes dementia and what constitutes Alzheimer’s disease, they are very aware of Alzheimer’s through both media sources and personal experience.

Just think, poor President Reagan. Even he got it and I guess he had it pretty bad. It just shows it doesn’t matter who you are, it can still get you. —Alice, age 93

It’s a terrible disease. I watched my neighbor—she had it. You know, it was terrible for her husband. He just about ruined his own health looking after her. —Joan, age 88

Our research volunteers express the hope that they themselves will not lose their memory, not so much because of what that would mean for them but because of what it would mean for their family, loved ones, and friends. It is important to them that a cure for Alzheimer’s disease is discovered or, failing cure, a means of prevention found. Part of their desire to help find a cure is altruistic and comes from a concern for helping others. This is not phrased in personal terms of future benefit for their own children or grandchildren, but rather for society or humankind as a whole. They are very willing to give the research what they can to help find a cure. They devote not only their time but blood samples for genetic investigation and many even donate their brains to the research upon death.

Productivity

Researchers are finding that being productive in old age has important health benefits, including reducing mortality.24 Continuing to be productive can provide survival benefits equal to the benefits of remaining physically active.25 Productivity can influence the sense of self-efficacy and meaning in a person’s life, and therefore positively influence health. Research with the elderly has demonstrated the importance of a sense of purpose and of being involved in meaningful activity as important aspects of successful aging.26,27 Participation in research is a means for the oldest members of our society to continue to be productive, leading to positive consequences for health, well being and aging.

The desire to be productive and able to contribute is a common theme heard from our participants. Many of them keenly feel—and mourn—their loss of productivity, such as no longer being able to deliver Meals on Wheels, do needlework to provide gifts for family and friends, or participate in church and community activities. They often speak of the things they used to do, from baking and gardening to donating quilts to the needy; from singing in the church choir to participating in service groups such as the Lions, the American Legion, or the Eastern Star. These activities are either no longer possible or extremely difficult because of limitations imposed by sight, hearing, or mobility. Clearly, economic productivity is not the only way to offer a valuable commodity and obtain a feeling of productivity.

The opportunity to participate in research is a tangible opportunity for productivity for the oldest old. Mary, when asked to respond to the question, “I think people dislike me,” replied...
“Noooo, it’s not that. It’s more like I’m invisible.”
The need for knowledge about aging, about the challenges and rewards of living a long life, about physical and emotional changes that accompany aging even past 100 is now needed. Those of us in gerontology can help ensure that our most elderly are not invisible by telling them about research opportunities and including them in research in which we are involved.

**Vital Involvement**

Vital involvement is a term that comes from Erikson’s work. The term means “to be alive and to stimulate the environment even as it stimulates us, to challenge the environment to involve us.” Participation in research provides an excellent opportunity for vital involvement by those in an age group where environmental stimulation may be decreasing due to the loss of age mates, declining sight and hearing, and the loss of driving privileges. It is an opportunity for involvement in the world beyond simply getting up and getting dressed in the morning.

Our volunteers are not only intrigued by what they might discover about themselves as research participants but also about the process as a whole. What is it like to be in research? What will they be asked? Will it help to discover something? Participation is an opportunity for vital involvement.

**Power and Self-Esteem**

Feeling powerful and having a sense of control is important to all of us at any age. A sense of control over life and its conditions can be robbed from the oldest through retirement, physical changes, loss of driving ability, and ill health. Power and self-esteem are woven together. When people have high self-esteem, they think of themselves as worthwhile and able to influence outcomes. When people feel powerful and believe they have control over circumstances, they feel good about themselves and have high self-esteem.

A positive self-concept or sense of self-esteem may be particularly important in our oldest members of society as they constantly change and adapt to the aging process. Participation in research can provide just such an opportunity to express some control, and consequently strengthen what may be a waning self-esteem.

The message we strive to send is that our participants are the most important element in the project. We frequently remind them we cannot do the research without them and therefore that “they call the shots.” This, we hope, provides them with a sense of power and control as they participate as illustrated by the comments of Lewis and Florence above.

We also know that choice is a recognized nursing intervention that prevents powerlessness. Thus, our volunteers are provided with choices as often as humanly possible. They are given the choice of coming to the office or having us visit them in their home. They choose to participate in any combination of up to 3 arms of the project. They choose when it is convenient to schedule the interview, and we emphasize that they can reschedule any time if the appointment becomes inconvenient. We indicate that providing results of blood testing to their primary care provider is not part of the research but we are happy to do so if they wish.

These simple choices can foster a sense of having control over what is happening in participants’ lives and underscore how they can influence some outcomes of their participation. Enhancing a sense of power is particularly important in this age group as they adjust to the many changes over which they have no control. Other interventions can also be used that may enhance self-esteem.

Participants often mention the special occasion and thank you cards we send to each volunteer, for example, and say that they are greatly appreciated. The annual Research Volunteer Appreciation Social is well attended and anticipated for months. There we provide snacks, a short talk, and entertainment for participants as a way of thanking them for their time. We take every opportunity to tell participants how much we appreciate them giving their time and that this research would not occur without their help. These gestures reinforce the message that we care about the participants and value them both as people and for their invaluable contribution to research and medical knowledge. This valuing may promote a positive sense of self-esteem in our participants.

**The Nurse’s Role**

Nurses involved in research among the oldest old, in addition to the role of clinical investigator and evaluator, may take the role of social...
contact, confidante, or trusted information source. Many people aged 85 and older have few if any age mates still living. “I am the last one” states Rose, “all my brothers and sisters are gone, and there were 11 of us.” Even though long-term friends may still be alive, they may be too deaf for the telephone, too frail to travel or write, or too forgetful to participate in a meaningful conversation. When the research participants themselves are deaf, frail, or unable to drive, further restrictions on social contact and the ability to interact with a confidante occurs. Although many continue contact with family and often rely on them for various kinds of support, we nurses are not family and have a different relationship with the elders. They look forward to our visits, cards, and the annual social, and they confide in us about numerous things. The elderly, trust nurses not to repeat what they tell us in confidence, particularly to family members. In this way, we play an honored role.

Our research participants rely on us to be objective and trust the information we give. Our specialized knowledge gives them confidence in the information we provide, perhaps promoting self-efficacy and their ability to make appropriate decisions for themselves. At the least, it provides them with fuller information with which to make their decisions. Although working in research may not often be viewed as real nursing, as co-participants with our elderly volunteers in this project, we are definitely providing nursing care in the fullest sense of the term.

Conclusion

To date, of the 308 people ages 85 and older enrolled in the Klamath Exceptional Aging Project, only 13 have withdrawn for reasons other than death or moving outside the research area. Of those 13, 6 withdrew because they or their family thought they were too frail to continue. Clearly, participation in research on aging is meeting ongoing needs in this group. Erikson’s developmental theory postulates that humans need to be needed. Each part of the life cycle deserves to be lived with vigorous meaning or the sense of life itself may be lost.12 Research participation provides for generativity, an important developmental task.12 It provides a means for our oldest old to make a meaningful contribution to their society and their world through the end of their lives. It is an opportunity to give of their wisdom and to contribute in a manner that only those who are elderly can. Participating as nurses on a research project with this age group, being allowed to enter their world, is truly a privilege.

In summary, including the elderly in research improves age-appropriate health care. Participation in research gives the elderly an opportunity to make a contribution, and understanding the inner life of the elderly makes us better people and better nurses.

Some names have been changed to protect the privacy of the participants.

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Facilitating Interdisciplinary Practice Through Mobile Service Provision to the Rural Older Adult

Karen S. Hayward, PhD, RN, SANE-A

Reaching the older adult in the rural communities in which they reside is desirable in an effort to support aging in place. The Idaho State University (ISU) Senior HealthMobile is an innovative, interdisciplinary rural health outreach effort designed to meet the needs of the older adult and support healthy aging. Health and wellness support services are provided through mobile interdisciplinary teams involving students and faculty in nursing, physical therapy, occupational therapy, pharmacy, and dietetics, among other disciplines. Students and supervising faculty provide services in the ISU Senior HealthMobile, in the rural senior centers, and in the home, providing a unique opportunity to be a part of the life of the older adult in the rural community setting. Partnerships and collaborative linkages within the community setting support the enhancement of existing services in collaboration with the ISU Senior HealthMobile. (Geriatr Nurs 2005;26:29-33)

As the U.S. population of older adults continues to increase in number and proportion, innovative models to deliver health care to those in need, particularly in rural areas, are required to support health and quality of life. By 2030, the older population will reach 70 million, or comprise approximately 20% of Americans, with 1 in 8 aged 65 and older.1 At highest risk for institutionalization are the proportion of the elderly population aged 85 years and older, experiencing rapid growth in number in U.S. society.2,1 Generally, a greater proportion of older adults in rural areas experiences poverty and poor health compared with their urban counterparts. Difficulties faced by the older adult particularly in rural areas include poor access to health professionals and resources, transportation, loss of family and community networks, and lack of mental health services among others.3,4

Health care delivery in rural and frontier areas is a challenge related to scarcity of resources and limited availability of health professionals who choose to practice in the rural United States. The health care of rural communities is affected by these disparities, with a top priority of the Department of Health and Human Services to address these issues and strengthen infrastructure, supporting collaboration among government and private-sector agencies to improve the nation’s health.5 In response to the needs of an aging population and in an effort to prepare nursing students for the provision of care to the rural older adult while addressing known disparities, the Idaho State University (ISU) Department of Nursing started a mobile health and wellness project designed to reach seniors where they reside.

Nursing schools are challenged to develop innovative methods for reaching older adults where they live and supporting the desire to age in place. The ISU Senior HealthMobile project was started in July 2000, funded in part through a grant award from the Quentin N. Burdick Interdisciplinary Program of the U.S. Department of Health and Human Services. The project was designed and implemented to deliver mobile health and wellness intervention to the adult aged 60 and older residing in rural communities of southeastern Idaho. An emphasis of the project has been on interdisciplinary practice to encourage students from varied disciplines to work together in a community-based educational setting, facilitated by discipline-specific faculty. The project involves the student in collaborative efforts with local providers to enhance services currently existing in the rural area. Nurses have a vital role in the collaborative interdisciplinary provision of services to rural older adults, who are increasing in number and proportion and demanding health and...
wellness services in contrast to the illness care traditionally received. \textsuperscript{3,6–8}

Nurses must be prepared to care for rural older adults given their increasing numbers and the demographic trend of advancing age. Furthermore, nurses are in a key position to provide health and wellness services in the community setting, with an emphasis toward the care of aggregates and population based care.\textsuperscript{9} Efforts to provide health and wellness services to the aging adult have the potential to ameliorate or postpone health decline in the advanced years and increase the quality of life.\textsuperscript{6,10} Older adults are an important age group to target for health and wellness given the increased risk for chronic illness and disease with advancing age and the impact on health care utilization and expenditure currently recognized as significant.\textsuperscript{10,11}

Reaching The Rural Older Adult Through Mobile Interdisciplinary Services

The Senior HealthMobile project is a partnership of ISU Department of Nursing; the Area V Agency on Aging in Pocatello, Idaho; and the Idaho Area Health Education Center of Mountain States Group in Boise, Idaho. The primary objectives of the Senior HealthMobile project have been to complete comprehensive community assessment in rural areas focused on the discovery of needs and desires of the older adult in relationship to wellness support; provide rural interdisciplinary clinical opportunities for senior baccalaureate and graduate level students through a facilitated faculty–student interactive approach; support the development of positive perceptions among health professions students based on a systems framework conducive to interdisciplinary practice; and provide coordinated interdisciplinary health and wellness services to the older adult in rural areas utilizing a mobile, community-based, service delivery model.

The partnership was established to use resources collectively and enhance the ability to reach multiple rural sites to identify older adults in need or requesting health and wellness services. The project was initially started in three rural counties of southeastern Idaho. In an effort to build support for the ISU Senior HealthMobile, a community-building process was implemented in each area working through project partner networks. Meetings were held with community leaders, existing health care providers, city council members, senior center directors, and older adults in their homes in each rural county to foster support and address the unique needs of each area. Students, faculty members, and project partners were active participants in the assessment of community needs and in the planning process for the delivery of services.

Older adults can access services through their primary provider, through the senior centers, or through self-referral by calling for an appointment. An initial health and wellness assessment is completed on the older adult requesting services. An interview is completed to determine desired services and identify needs. A full-time nursing faculty member serves as field coordinator on the Senior HealthMobile and facilitates scheduling, planning, and implementation of care. Students are organized into teams at the beginning of each semester and as needed throughout the academic year, based on the expressed needs of the older adult receiving services. Services provided by the ISU Senior HealthMobile include health and risk assessment, medication management, fall prevention and home safety evaluation, foot care, health teaching, memory loss assessment, psychosocial support, and nutrition counseling, among others interventions. Services are delivered in the Senior HealthMobile, a motorhome adapted for on-site use, at the senior centers in each area, and at the homes of rural older adults who are unable to access local services. Currently, the Senior HealthMobile serves 5 primary rural areas, arriving a minimum of twice a month in each community.

Interventions are delivered in teams with students in varied disciplines, including nursing, physical therapy, occupational therapy, dietetics, and physical therapy, among others. The student completes clinical practice working in interdisciplinary teams with supervising faculty and project partner staff, with referral to local health care providers as needed. The primary opportunity for the students and faculty has been to provide time to listen and interface with the older adult in meeting needs as well as facilitating access to resources.

Group teaching sessions presented by student teams on wellness topics such as heart health, fall prevention and home safety, nutri-
ional supplements, breast cancer awareness, and self-care, among other topics, are scheduled and advertised in the senior center throughout the year. Marketing of services occurs through word of mouth, prepared flyers on services available, announcements at congregate meals at senior centers, and the local media.

Conceptual Framework

Health promotion is viewed as assisting older adults to identify and utilize resources for daily life that enables them to meet personal needs and function as a part of a community. From a social ecological perspective, health and wellness of older adults is supported along a continuum through interaction with their physical and social environment.6 The ISU Senior HealthMobile was developed to work with seniors where they live, work, and play and to support health and wellness so that they remain in the community and a vital resource as a member of the environment.

The ISU Senior HealthMobile faculty members believe that providing opportunities for the student from varied disciplines to interact with the rural environment, older adults, and each other will facilitate the effective delivery of health promotion. Furthermore, the experience stimulates an interest in participating in interdisciplinary practice to meet the needs of the aging population after graduation. The National Advisory Committee on Interdisciplinary, Community-Based Linkages has recommended integration of “interdisciplinary” and “community-based” concepts into the education of health professionals to expand services to the neediest populations.3,5,7,12 Nursing students encouraged to participate in health care delivery in rural areas working with other disciplines have an opportunity to affect the lives of an aging population and develop positive attitudes toward work with the older adult. Providing interdisciplinary education of health professionals will support a workforce prepared to meet the needs of a changing health care system and provide the best possible health care to vulnerable and underserved populations.5

From a systems perspective, students interact within interdisciplinary teams in the provision of health and wellness services and influence each other in an interdependent, open system. This system is the rural environment or community of which the older adult is an integral part. Through active participation in community-based interdisciplinary wellness care, students learn about the value and contributions of other professionals in practice and the importance of joining with communities to address the needs of the aging adult. Students are also able to interface with vibrant older adults, each of whom has a life history to share and build relationships that will influence future professional practice. Through the ISU Senior HealthMobile, the older adult is provided with compassionate, caring services directed specifically to meeting their individual needs.

Implementation Model

The ISU Senior HealthMobile has been implemented based on a model focused on interdisciplinary practice integrating the concepts of communication, collaboration, systems, and role definition with a community-based application. Interdisciplinary practice is defined as 2 or more disciplines, with a distinct education in a specific major, working together in a coordinated team effort for a common purpose.13,14 Students are moved from the classroom, which is discipline specific or unidisciplinary, to multidisciplinary experiences of project orientation and other group work in preparation for involvement in the rural area. Students are then directed into community-based experiences on the ISU Senior HealthMobile designed to facilitate collaboration and application of knowledge for the provision of health and wellness care to the aging population, building on discipline-specific courses taken in geriatrics. Participants from varied disciplines on the ISU Senior HealthMobile are required to interact, collaborate, solve problems, and work together in the various settings in the rural community facilitated by faculty. Roles are defined through an interactive process of communication as the students make different, complementary contributions as a team to patient-focused care through integration of knowledge, attitudes, and skills. Facilitation of communication by discipline-specific faculty enhances knowledge sharing, group decision making, and learning.14,15

To function effectively, the faculty members recognize that the team members must have a mutual understanding of the role of others, respect the contributions of others’ capabilities, and develop trust, all of which are enhanced
through facilitation.\textsuperscript{16,17} Nursing students function in a leadership role, coordinating care across disciplines and among the varied sites in which services are offered. Participating students from each of the disciplines receive clinical credit for their participation on the ISU Senior HealthMobile and receive a stipend for participation provided through grant funding.

**Partnership Responsibilities and Contributions**

Reaching the older adult through partnership and in collaboration with the community provides the opportunity to coordinate services and achieve objectives. The Area V Agency on Aging located in Pocatello, Idaho, has been instrumental in assisting with community building, interagency coordination, and access to senior centers and the community process, providing the foundation on which services are delivered in each area. Senior centers welcome the students and continue to refer the older adult to the Senior HealthMobile for care. The students are able to reach the older adult involved in activities at the rural senior center and also those who are unable to participate by making visits to the home as requested or by referral. Senior centers can benefit from community-based nursing intervention addressing loneliness, social support, nutrition, and other needs of older adults and by providing the opportunity for preventative care access to seniors that supports independence and quality of life.\textsuperscript{18} Partnerships providing linkages within and across communities support collaborative services enhancing health and wellness intervention and opportunities for students and faculty to work with the older adult, particularly in rural areas where there are fewer resources.\textsuperscript{12,19}

The Idaho Rural Health Education Center provides statistical, marketing, and secretarial support for the project. A steering committee was formed in the initial stages of the Senior HealthMobile project, which includes professionals and consumers in the ongoing planning, implementation, and delivery of services.

**Outcomes**

Through May 2004 with more than 3 years of project implementation, 156 students had participated on the ISU Senior HealthMobile, representing 9 disciplines, providing mobile services throughout rural Southeastern Idaho in an expanded 5-county area. Services have been provided to more than 750 older adults, with many returning for further intervention. Students participating are required to complete a written evaluation of the project upon completion of their rotation on the ISU Senior HealthMobile. More than 60% of the students who have participated to date have expressed a desire to work with older adults after graduation, with many reflecting a desire to work in a rural community. Student comments have been positive overall, with many discovering the opportunities to serve the older adult, and the appreciation received for their involvement in community based services.

Representative student comments include the following:

*My attitude toward geriatric patients has changed. It used to depress me to work with geriatric patients because I thought that all geriatric patients were burdened with multiple health problems and incontinence. Working on the Senior HealthMobile has given me the opportunity to work with some very healthy geriatric patients, and I enjoyed it very much.*

*Before the SHM [Senior HealthMobile], I didn’t think of pursuing a health career working with specifically the elderly, but after my experience with the SHM, I definitely am seriously considering it!*  

The response of older adults to Senior HealthMobile services has been measured through satisfaction surveys. Representative comments received from the older adult on the surveys returned include the following:

*I felt at ease to visit with the nurses, they made me feel real good, and I wasn’t afraid to ask questions.*

*I really liked it. They took their time and gave the best of care to my husband and I and were very friendly.*

**Conclusion**

The ISU Senior HealthMobile project continues to expand and enhance services to rural older adults. Participation of students and facul-
From varied disciplines continues to increase. The project has been funded for an additional three years through the Quentin N. Burdick Rural Interdisciplinary Program, U.S. Department of Health and Human Services. The Idaho American Association of Retired Persons has provided supplemental funding over the course of the project implementation to support fuel costs as the service area continues to expand.

The Senior HealthMobile has been successful in providing interdisciplinary opportunities for students and in reaching the older adult, supporting healthy lifestyles, and in building sustainable community partnerships. The number of older adults accessing the services of the ISU Senior HealthMobile continues to increase with many referring friends and family. Contracts have been developed to support sustainability with local Foster Grandparent and Senior Companion Programs. The ISU Senior HealthMobile supports the wellness of the Senior Companions and Foster Grandparents so that they can serve in the community. Recent expansion of services has involved the collaboration of the ISU Senior HealthMobile in a rural clinic, working with a physician operating out of a local rural school. A recent partnership with the local Veterans Administration clinic will provide the opportunity to offer wellness services to veterans in the rural communities in which they reside.

References


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An abundance of new opportunities have arisen in the legal field for nurses. One such area of specialty practice involves the legal nurse consultant. This article outlines the basics of what job tasks a legal nurse consultant might undertake, the level of knowledge and skill required, and the various areas within the consultant field itself that are open. (Geriatr Nurs 2005;26:34-6)

Graduating from a nursing program in 1963 was a wonderful event in my life. I had always wanted to be a nurse. For the next 25 years, I practiced nursing, continued my education—formally and informally—and loved every aspect of nursing practice. Then I found the emerging field of legal consulting and the role of a nurse expert. Legal nursing includes the legal nurse consultant (LNC), medical records reviewer, the legal assistant, and other related positions including the newest emerging field of forensic nursing. By accident, I found my way into record review and testifying as an expert witness in nursing.

In The Beginning

By 1988, I had completed a master of science in nursing degree and was in a nonnursing doctoral program. I needed a job that would allow flexibility while I was working on field research for my dissertation. After answering an ad in the local newspaper for medical records reviewer, I began reviewing records for breaches in the standards of nursing care in plaintiff cases. The first records were received from an attorney who had been consulted regarding a significant injury of a young disabled man resulting from a hospitalization. At the time, I had no idea that the role of nursing consultant would lead to my incorporating my own company as a nursing expert of standards in nursing care.

My background and MSN were in medical/surgical nursing; however, I had a working background in other areas. Those areas included gynecology, obstetrics, and newborn care. I had worked in hospitals, community health, schools of nursing, ambulatory clinics, and primary care. Therefore, I was experienced over a broad range of areas. This background was beneficial in the types of cases that were presented to me for review. If I did receive a case that was not within my area of expertise, I would discuss it with the attorney and return the work products without any written statements.

LNC Roles: Plaintiff Versus Defense

Consulting can be limited to reviewing medical records for a plaintiff's attorney or for the defense of a complaint against a nurse or nursing staff. Both require in-depth review of all of the records of the case. The differences are that the plaintiff cases require finding breaches in the standards of care, whereas defense cases require identifying nursing care that is given within the standards of care related to the complaint. This is not a role for the faint of heart or personality. Sometimes the claims do not materialize, and no breach is identified in a plaintiff's case, whereas a breach may be found in a defense case. Honesty is the only way that a successful consultant can remain in the field.

The attorneys that request the services must be kept informed of all findings. The decision to continue with a case when your findings are not congruent with their goals for the case can be difficult, especially when pressure to conform to the preconceived ideas of the case is applied. However, proceeding with a case in which the facts do not support the implied claims lacks the professional ethical standards necessary to continue to provide these services. In the end, truth usually prevails. Therefore, maintaining integrity is essential in each case the LNC accepts.

Confidentiality is a natural part of nursing, so this area does not pose a problem with handling private information. Not discussing the case with anyone outside of the law firm that asks
for your consultations is expected behavior. If the LNC has a conflict with any case, he or she must turn down the consultation. If the LNC has reviewed materials before finding that a conflict exists, all matters in the case must be maintained in total confidentiality. When the case is either settled or a decision is made in the court, all records must be destroyed. Shredding is the most efficient method of destroying the records when they are no longer needed, although some law firms prefer that all materials are returned to their offices.

The Affidavit, Deposition and Trial

Another part of the role of the LNC is submitting an affidavit with the findings in the case. Affidavits differ from state to state and have to be written in the form that is legally acceptable in the jurisdiction where the case is filed. An affidavit for the plaintiff usually lists the expert’s credentials, background, and licensing and/or certification(s). It then provides a list of the materials read and considered in the case, and finally the findings are stated in general statements, followed by specific statements of the case analysis. This is usually a precursor to giving a deposition in the case.

The deposition is taken by a court reporter while the LNC is under oath, as if in front of a judge and jury. This event requires an incredible memory of the facts of the case, with the ability to discuss all of the pertinent issues while remaining calm through the sometimes disorganized, even angry examination by the opposing attorney or team of attorneys. If you have passion in the merits of the case, this is the time that you must present your findings logically, accurately, and with scientific or published facts to back up your opinions. This examination (deposition) can last from a couple of hours to a full day, or even continue into another day. Maintaining composure, memory, and accuracy over hours of questioning can be exhausting at times. All parties participating in the deposition can strain one’s patience. It is a fact-finding event, and few bars are held in the content of the questions. Some questions are personal and financial, and others pertain to educational background and work experience.

Some states require that special requirements be met before a nurse can give testimony; other states require only a current license to practice as a registered nurse. The more experience, skills, and education the LNC has, the better the opportunities for taking on complex cases.

If the case continues to trial, the LNC will be expected to testify in court before a judge and jury. This experience is quite different from the deposition in that the judge may have made rulings between the attorneys to dismiss or not allow some of your findings to be discussed in front of the jury. When this occurs, you cannot mention the specific facts, or you will risk being held in contempt of court. At the least, your testimony might be thrown out of the proceedings. If this occurs, the case will usually proceed without the testimony of a nurse for the side that you represent. If this happens, the clients risk adverse outcomes in the case. This reflects badly on your skills as an LNC and can damage opportunities for future work in the field.

Benefits of The LNC Role

The benefits of the LNC role are innumerable. Being a patient or family advocate is part of a professional nurse’s responsibilities. This includes taking the responsibility for maintaining professional job performance while following the scope and standards of nursing care established by the American Nurses Association and the Nurse Practice Acts of the state licensing boards for nursing. Before nurses took on the role of expert witness, it was left to physicians to determine proper actions of nurses in the legal arena. As nurses have assumed the responsibility as experts in the field of nursing, the legal community has accepted that nursing is a field with its own body of knowledge and expertise and is capable of rendering decisions regarding professional actions. Many states will not permit an expert in another field of health care to testify against nursing standards.

Not all LNCs provide depositions or testify at trials, some roles include record management only. The LNC who works in the legal office has a unique position to assist the attorney in locating and obtaining medical records and files from a variety of places. Of course, appropriate consent to obtain the records is always required. These records are then reviewed, indexed, and prepared for another LNC and other medical experts who will read them. This is not simply a clerical activity; it is necessary for the LNC to understand the entire medical record and the order in which the information
needs to be placed for fast identification when the case is being reviewed and readied for deposition or trial.

Other nontestifying LNCs help the attorney develop questions to be asked during depositions or trial appearances when nurses are being questioned. With the expertise of the nursing consultant, the attorney can reasonably rely on the specific knowledge of the nurse to probe for information that is necessary to obtain the facts in the case. Another responsibility that the nontestifying LNC undertakes is to identify records that are missing. When omissions are recognized, actions can be taken to obtain the missing records. Interrogatories are questions that one side of a case can require the other side to answer; one side can also require the other to produce materials missing from the original receipt of records. This new information might have a bearing on the facts in the case. The opposing side must answer the interrogatories by a specific date. When the answers to the interrogatories are returned, the LNC works with the attorney to interpret the medical or nursing responses.

Conclusion

Legal nurse consulting is a specialized field of nursing that has many components. Some of these are nontestifying roles, whereas other positions require the LNC to identify the validity of malpractice or negligence claims and provide testimony. Record preparation, record analysis, legal assisting, and expert witnessing are the main roles of the LNC.

Currently, the LNC role does not require certification, although some private companies provide their own certification. LNC organizations are available in many cities around the country and provide support and continuing education for the members. Organization newsletters frequently announce law firms that are looking for specific practitioners for specific case needs.

Interested professional nurses should realize that this is a feast-or-famine type of work. Until your work and reputation are established, cases might come along once in a while, but rarely consistently; even more rarely is the testifying role sufficient to earn a living without a concurrent practice in nursing. When enough cases come along to feel comfortable in earning a full-time income, a nursing practice is still required by most law firms to prevent being seen as a “hired gun.” This term is usually used for the professional person who works for plaintiff firms only without continuing to work in the field of practice. A hired gun can be a nurse, physician, or other health care professional meeting the former description. To avoid this designation, the testifying expert is better served by continuing her or his nursing career and adding the consulting role as time permits.

Selectivity of cases is absolutely necessary. If the circumstances or specialty of a case is beyond the skill set of the nurse, then the case is best not accepted. Other nurses with the specific skill sets can be found and will usually be a better resource than a minimally skilled generalist.

This is a needed practice area that requires an astute, verbally competent, registered nurse who is willing to maintain clinical competence while providing consulting services to attorneys. Financially, it is a well-paying position with a great deal of responsibility, accountability, frustration; it can be quite stressful at times.

I can truly say that for the past 16 years, I have found satisfaction by combining the LNC role with clinical and teaching positions. If you are interested in this emerging specialty field of nursing, begin by reading a variety of books on the subject and talking with a local LNC.

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Resource

Good gerontological nurse preceptors can help students feel comfortable working with older adults. They can also provide assistance to students in narrowing the theory–practice gap that sometimes seems to exist. Developed in this article is an understanding of preceptoring students and working with them and academic faculty to promote positive gerontological nursing experiences. (Geriatr Nurs 2005;26:37-42, 64)

As educators with a strong belief in the value of seniors’ health experiences, we often hear from undergraduate students that they are not interested in clinical opportunities with older adults nor do they want to work with this population after graduation. They want more “thrills,” “more technical skills,” and “more high-intensity settings,” and they refer to the unpleasant memories of their initial clinical days when they cared for older adults (these are samples of students’ own words).

Unfortunately, the literature substantiates these students’ comments. Studies suggest that students hold negative attitudes toward the elderly or toward gerontological nursing.1–3 Understanding this makes us wonder, as nurse educators, how do we help students change their minds? Whether students believe us or not, they will be working with older adults regardless of the settings in which they chose to practice after graduation. Because students are the gerontological nurses of tomorrow, we need to recruit them into gerontological practice today. We need to help them prepare for the roles such as advocate, educator, and expert clinician that will be required of them as they work with older adults and their families.

We also want them to appreciate gerontological nursing, as we do. We believe, however, that our influence is limited; it is the nurse working on the long-term-care unit, talking to clients in the day-care program, or visiting in the home that probably has a greater influence on students than we do as educators. This is because students view these nurses as credible; they are “at the bedside,” so to speak. If such bedside nurses would precept students, what a positive influence they could be on their learning. It might encourage more students to select gerontological nursing as their career.

A preceptor is a skilled nurse who works with a student within the daily routine of his or her position. Each preceptor is assigned an academic faculty member. They work together to provide a quality learning experience for the student, so it is not a role performed in isolation. If skilled gerontological nurses do not step forward and preceptor learners, how are students expected to function effectively in the work setting when they care for older adults? How will they learn that older adults have much to offer? How will they acquire the knowledge and skills needed to meet the complexities of client care? If students are not provided with this knowledge and do not feel comfortable in the work environment, dissatisfaction occurs, and both gerontological nursing and older clients are devalued. It is well documented that job dissatisfaction contributes to poor client-care outcomes. To acquire the necessary knowledge and skills, students need to work with nurses who promote gerontological practice. In other words, students need to work with committed preceptors.

Although there are benefits for students in working with skilled nurses, there are also rewards for preceptors, including

• keeping up-to-date by discussing the current literature with students,
• feeling valued by talking to a student about the benefits of working with older adults and their families,
• seeing a student develop professionally, and
• receiving credit hours toward recertification, if the preceptor is a certified gerontological nurse.

What Makes An Effective Gerontological Nurse Preceptor?
Researchers have studied preceptors and preceptorship within nursing practice. Themes that emerge within the literature include the following: defining the role of preceptors, preceptor selection, and the value of preceptorship clinical experiences for students. The role of preceptor can be demanding and stressful. Freiburger and others found that preceptored experiences increased students’ self-confidence and competency. A literature search found no articles on preceptorship within gerontological nursing practice, with the exception of one by Shemansky, who described the effectiveness of the first long-term-care preceptorship program implemented at the Masonic Home of New Jersey in 1989.

In gerontological nursing, a preceptor is a role model and resource to a student assigned to a clinical experience with older adults. The preceptor requires a sense of humor, knowledge of the complexities of client care, and skills ranging from lifting, moving, and feeding to listening, supporting, and teaching. These are the skills that are used every day in working with older adults. Other traits are required of preceptors as well, however. Tables 1 and 2 provide information and tips for the nurse who has agreed to be a preceptor.

The preceptor listens to the older adult’s story. The preceptor celebrates the history, life stories, and experiences of the older adult and communicates this to the student. This is demonstrated by asking an older client about the family photograph that is on the bedside table, about the crayon drawing that is hanging on the wall, or commenting on a turn-of-the-century wedding picture. The student also learns from the preceptor’s simple questions how to acquire information about the client that might be useful in planning nursing care.

The preceptor demonstrates professionalism and self-confidence. This ability may show itself in a gerontological nurse’s calm style of interacting with the physician who is contacted about an analgesic order for a palliative home care client or in the quiet response to an angry daughter about a mother’s lost dressing gown. Sometimes the preceptor demonstrates it by apologizing to an older resident for a misinterpreted comment. The student learns appropriate professional behavior from the actions of the nurse.

Table 1. Have You Agreed to Be a Preceptor?

<table>
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<th>Do you know:</th>
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<tr>
<td>The level of student that you will have?</td>
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<tr>
<td>The general abilities of a student at this level in the program?</td>
</tr>
<tr>
<td>The duration of the course? The start and finish dates?</td>
</tr>
<tr>
<td>The number of shifts that the student will work with you?</td>
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<tr>
<td>How to contact the faculty advisor?</td>
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<tr>
<td>Your role in relation to the faculty advisor (e.g., are meetings or phone calls expected of you and how often)?</td>
</tr>
<tr>
<td>The unit and agency’s policies regarding students? (What tasks can a student perform? Are there tasks that a student cannot perform?)</td>
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<th>Do you:</th>
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<tr>
<td>Have a copy of the course outline?</td>
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<tr>
<td>Expect to evaluate the student? Do you have a copy of the evaluation form?</td>
</tr>
<tr>
<td>Have an experienced preceptor on the unit or in the facility who is available to guide you in this role?</td>
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practice. Students need knowledge related to aging and older adults that nursing education programs often cannot provide because of time constraints and curriculum priorities. An example is a preceptor explaining to a student how to implement a program to reduce the possibility of constipation in a long-term nursing home resident or discussing how a bladder-training program might help an older woman regain bladder control. Although basic nursing education programs can ensure that the student receives general content related to incontinence, it is not always possible to provide this level of intervention detail.

Another example is a conversation between the nurse and the student about gerontological nursing standards. These standards are known to many gerontological nurses because of the emphasis professional associations place on them; this is not knowledge that most students are exposed to in their formal classes, however, because of faculty members’ content priorities. The nurse preceptor introduces the student to new knowledge that will help guide care to older adults.

The preceptor is competent in the communication process, whether it is a conversation with a student, a discussion with family members, or a care conference. It requires the ability to listen carefully to the student’s words, to assess body language, and to maintain eye contact. It means the willingness to focus on what the student is saying rather than what one is personally wishing to say next. It may require a readiness to push occasionally for clarity so that the student’s insight is revealed. Behind this is a familiarity with how to ask and sequence questions. Many nurses already have this ability from their work with older clients and families. This skill helps the student move from a surface consideration of a client concern to a more thoughtful reflection of it.

Often students experience anxiety when asked to present at a case conference. If the preceptor participates in the conference and then directs the student to contribute, it seems to reduce the anxiety. Encouraging participation in case conferences also enables the student to gain confidence in contributing to discussions of the health care team.

The preceptor is able to interpret the silence of the student, sense the student’s uncertainly at particular points of the learning process and takes steps to clarify it. Deft at picking up nonverbal cues, the preceptor listens with a “third ear” to pick up the significance of what lies behind the student’s words. We often find that geriatric nurses already have this ability because of their daily interactions with older adults who are cognitively impaired. They know the value of nonverbal behavior and how it can reveal health needs.

The preceptor is able to establish a positive student–preceptor relationship. Through interactions with the student, the preceptor lays the foundation for a relationship to develop between them. Initially, introducing the student to staff on the unit or to other team members may assist in this. The student begins to feel comfortable in the setting. Other strategies include asking students to go for coffee on a break, introducing them to family members, or inviting them to attend a professional gerontological nursing association meeting.

<table>
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<th>Table 2. First Meeting Tips</th>
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<tr>
<td>Identify how to contact each other (e.g., provide phone numbers, e-mail addresses).</td>
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<tr>
<td>Ask the student</td>
</tr>
<tr>
<td>what he or she wants to learn from this clinical experience.</td>
</tr>
<tr>
<td>about his or her past clinical experiences.</td>
</tr>
<tr>
<td>about his or her relevant paid work experiences.</td>
</tr>
<tr>
<td>Tell the student a bit about your own professional nursing experiences.</td>
</tr>
<tr>
<td>Review the course outline together so that you have a common understanding of the course.</td>
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<tr>
<td>Provide a brief description of the unit or agency.</td>
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<tr>
<td>Provide an overview of the type of older residents or clients with whom a student might work during this experience.</td>
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</table>
The preceptor assumes responsibility, in part, for the student’s learning. Facilitating learning is much more than using a bag of tricks to occupy the student for a day or two. It assumes the preceptor’s willingness to be accountable for selected aspects of the learning experience, to deal with the ambiguity that often emerges when a student struggles to connect theory and practice, and to use one’s own decision-making skills to select appropriate learning opportunities for the student. An example is a preceptor suggesting to a student that there might be value in a visit to the home of an older client who attends a day program. The preceptor is aware that seeing the client in the context of his or her own home may help the student understand family dynamics and resources better. It presumes the courage to say “no” to an opportunity if it is not appropriate because of agency policies or the student’s current skill level. Negotiating with other staff members may be necessary as the preceptor explores what learning activities may arise from interactions with other older adults and staff members in the setting. In difficult situations, the preceptor is able to bring decisions back to the student so that he or she can take responsibility for personal learning.

It is important that the preceptor is clear on the specific learning objectives of the course the student is completing. It is the faculty advisor’s responsibility to identify the learning objectives and to communicate this to the preceptor. This is one example of the partnership mentioned earlier.

Key to engaging the student’s commitment to learning and working with older adults is the development of rapport between the student and the older client. The preceptor supports this relationship, creating “icebreakers” to loosen up a student. This may be as simple as introducing the student to the older adult or instructing him or her on how an older gentleman likes his morning coffee. This is especially relevant because of the difficulties some students may have in working with older adults because of ageism they bring with them into the clinical setting.

The preceptor involves the student in activities of the setting; finds ways to draw out quieter students; and encourages each student to play an active role in organizing clients’ data into manageable chunks and implementing it into nursing care. It may mean that a student is invited to participate in a Fall tea or blood pressure monitoring clinics or other seemingly simple activities that draw the student into gerontological nursing. Along with these talents goes the sensitivity to know when the student needs a break, when the pace is too chaotic, and when the student needs to struggle, if necessary, to identify and meet the needs of the older client.

The preceptor uses time and space appropriately. It is not enough to merely select an “older client” for the student. It is important to know how to best arrange the space so that it works for both the older client and the student. This means checking out the client’s nursing needs ahead of time and making sure other staff members are aware that the student is on the unit and the expectations of the clinical experience. It also implies informing the family members of the role of the student and perhaps making introductions between them. Often staff nurses are so familiar with their clients that this is an easy aspect of the preceptor role.

The preceptor has to be a metronome for the student, sensing the rhythm that is present at a particular time of day and pacing specific nursing interventions to capitalize on the “beat” of the older client. Many nurses who have experience working with older adults have this ability. The preceptor has to know how to punctuate time to release tension through a good cry, coffee breaks, or even a joke—whatever it takes to release the student from tension and built-up emotion.

The preceptor is able to be flexible. The preceptor knows how to balance the needs of the student, the resident, and the setting, as well as the requirements of the academic faculty. A certain mental nimbleness is needed, when the unexpected happens, to think and make decisions on the fly. Sometimes working intuitively can make the difference between success and failure for the student. This is not unique to the preceptor role, but a basic job skill. The nurse often has to juggle staff needs, older client concerns, family requests, and administrative practices.

The preceptor has to help the student develop gerontological nursing skills. In practice, this may mean some creative approaches to helping students meet clients’ needs. The pre-
The preceptor sometimes has to tease out the student's knowledge through brainstorming. A staff nurse does this almost daily—how do I get this dressing to stay in place when the older client likes to take it off to scratch his leg? How can I close off this unit to ensure Mrs. Wattingly doesn't wander off? If I paint the toilet seat red, will it reduce Mr. Chow's incontinence?

The preceptor is capable of maintaining objectivity. A skill required of the preceptor is objectivity to assess the student's progress. Whereas one side of the preceptor is like an orchestra's conductor who wants a first-class product, the other side is like a referee who knows the importance of maintaining a neutral stance toward what is coming out of the student. The preceptor sets aside personal opinions about the student to review clinical performance. This is the same ability that a nurse uses in evaluating the work of health care team colleagues.

The preceptor produces good documentation. Coming up with a written record of the student's progress and safety as a practitioner is the bottom line of preceptorship. It is done in partnership with the assigned faculty member. Vital to this task is the ability to keep track of the student's progress and to generate information to help complete the evaluation. Making a report that captures the significance and implications of the student's learning and, in certain situations, having the courage to protect professional conclusions, are characteristics of a gerontological nurse preceptor.

The preceptor is capable of making tough decisions. Sometimes, the student is not meeting the expectations of the clinical experience. The preceptor will need to inform the faculty advisor that the student has not been successful. Although this should come as no surprise to a student if performance indicators have been clearly and consistently communicated to the student and faculty advisor, it often does. Preceptors themselves voice that this is a stressful and uncomfortable experience for them.

Does it sound impossible for one nurse to possess all these skills and agree to be a preceptor? We do not think so. Often, we see staff nurses demonstrating these abilities. An example is a conversation between a nurse and an older spouse regarding possible attendance at a support group to help cope with the loss of a partner. The nurse selected this specific intervention from a range of possible options because of the client's interaction style. The staff nurse drew on her practice knowledge and the psychosocial needs of the older spouse to make this suggestion. Another example is the staff nurse asking an older resident with Alzheimer's disease to fold towels to reduce his wandering into other rooms. It shows creativity. This suggests to us that many staff nurses would be good preceptors. Sometimes our role as educators is to encourage them to recognize that they have these traits.

Strategies For Implementing The Gerontological Nurse Preceptor Role

Staff nurses who wish to become preceptors or improve their skills in this role work within an organizational structure that includes administrative personnel and academic faculty. Attention must be paid to all 3 groups to create an environment where preceptorship is supported.

From a Staff Nurse's Perspective

Preceptors need to reflect on their personal and professional attributes through a comparison with the competencies and standards of their professional association or with national certification standards. This process helps to identify personal learning needs related to the role of preceptor. What skills does the staff nurse feel he or she requires to fulfill this role? There is an implied obligation to meet these learning needs through educational activities. One activity for staff nurses may be working with on-site, institution-based educators who would mentor them in the preceptor role. The experienced mentor can be helpful in role modeling the skills required for preceptoring.

Often academic institutions host preceptor awareness days, workshops, or other educational activities related to working with students in the clinical setting. Such events give veteran preceptors opportunities to learn from the experiences of nursing colleagues in the same role. The events also provide useful insights into the role for staff nurses who have not been preceptors before.

From an Academic Educator's Perspective

Nursing instructors from academic institutions need to be aware of the effect that they have, or can have, on the preceptorship experi-
ence. They can facilitate a partnership between themselves and preceptors that supports the work of each by establishing clear lines of dialogue, clarifying roles and responsibilities, initiating orientation meetings at the start of a student’s clinical experience, providing current literature on preceptorship in the clinical setting, and maintaining communication through on-site visits, phone calls, and e-mails. Identifying the role expectations of the preceptor and student before the beginning of the clinical experience often avoids later frustration. A face-to-face final meeting with the preceptor and student brings closure to the experience for all participants.

Research is part of the mandate of many academic faculty members. Effort needs to be made to study the concept of preceptorship and its relationship to gerontological nursing practice. Do committed staff nurses, working in the preceptor role, make a difference in the socialization of students? Are there positive outcomes? What preceptor skills have the most impact on students’ attitudes toward older adults?

**From an Administrator’s Perspective**

Supporting the preceptor role involves commitment from the preceptor’s institution. Expectations of preceptors should be included within procedure manuals. The administrator’s role is to support the preceptor through such strategies as designating an on-site coordinator for the preceptor. This coordinator may arrange for a preceptor workshop for staff new to this role, offer educational resources (e.g., videos, articles) that describe the role, or provide policy guidance regarding what nursing roles the student can or cannot perform within the setting. The coordinator may participate in periodic meetings with preceptors and academic faculty members to review the process of selecting, orientating, and supporting staff nurses in this role.

A number of established preceptor programs identified in the literature, although not specific to gerontology, provide useful frames of reference. Neumann and associates described a process of centralizing RN preceptorship programs within the department of nursing at an urban medical center. They provided 2 levels of educational offerings to support preceptors, offered a Web site and forums, and promoted the formal recognition of nurses who agree to be preceptors. They also identified a brief description of specific content areas to include in a preceptorship program, as did Baltimore.

Other staff who may be peripherally involved in the preceptorship experience should be orientated to the roles of the preceptor, student, and faculty member. Opportunities for their support of student learning should be part of the orientation.

**Conclusion**

The need for good gerontological preceptors is underscored by the aging trend evident in Western populations. Preceptorship is a challenge, yet it offers the opportunity to work with students and to shape the future of gerontological nursing practice. It can provide the profession with new graduates who want to work with older adults.

Preceptoring relationships evolve over time from the initial stage of orientation of the preceptor role to the student’s expression of the value of gerontological nursing practice. The opportunity to promote care of older adults as a worthwhile and endearing domain of nursing practice and to shape future practitioners is one not to be missed.

**References**

New NGNA Fellows

Fellow status is an honor conferred by NGNA on individuals to recognize outstanding leadership in gerontological nursing for distinguished contributions to the field. The following individuals were inducted into the Fellows Program this year.

Dia Campbell-Detrixhe, MS, RN
Dia is the nurse educator/course coordinator at Redlands Community College, El Reno, Oklahoma, and holds an adjunct faculty appointment at Southern Nazarene University. Dia served as chair of the NGNA Planning Committee and is a past president of the Oklahoma Chapter of NGNA. Dia has been a member of NGNA since 1996.

Marilyn TerMaat, MSN, RNC, CRRN-A, CNAA, BC
Marilyn is department director of care management at the Evangelical Lutheran Good Samaritan Society, Sioux Falls, South Dakota. Marilyn has been a member of NGNA since 1997 and served as an NGNA representative to the Hartford Foundation Panel on Nurse Practitioners.

Martha Sparks, PhD, RN, GCNS
Dr. Sparks is associate professor at the University of Southern Indiana, Evansville. She has been active on the Research Committee, has served as peer reviewer, has written articles for the NGNA newsletter, and has contributed to the core curriculum text. Martha has been a member since 1992.

Rita Chow, EdD, RN, AHN-C
Dr. Chow is director of the National Interfaith Coalition on Aging of the National Council on the Aging. She is a credentialed nurse educator, gerontological nurse, and holistic nurse and has more than 100 publications on nursing and related topics. She has been a member of NGNA since 1990.

Joanne Gladden, PhD, RN-C, GNP
Dr. Gladden is associate professor at College of Notre Dame of Maryland, Baltimore. She has been a member of NGNA since 1998, has served on the NGNA Board of Directors, and chaired the Research Committee. In 1998, Dr. Gladden was the winner of the Judith Braun Award. She has written or cowritten numerous journal articles and has also presented educational sessions at NGNA conferences.

Rebecca Provine, MSN, RN, CS
Rebecca is the director of nursing, Wesley Woods of Emory University, Lilburn, Georgia. She is a current member of NGNA and has been and active member of the NGNA Atlanta Chapter. Rebecca has served as NGNA's representative at several CMS meetings and has been an NGNA member since 1996.

Excellence In Gerontological Nursing Awards

The Excellence in Gerontological Nursing Awards were established to honor a registered nurse, licensed practical nurse, and certified nursing assistant who have consistently provided outstanding care to older adults and have been inspirational role models and mentors to other health care workers.

The 2004 RN Excellence in Gerontological Nursing Award winner is Linda Moore, EdD, RN, CS, ANP, from Mt. Pleasant, North Carolina. Shirley Travis nominated Linda in recognition of her contribution of caring for aging adults. Linda identified serious injection site reactions in patients with multiple sclerosis who were taking Betaseron; she thought there might be a better way to administer these injections. The result, now in use worldwide, is a new
method of administering this highly reactive medication to patients with multiple sclerosis.

The 2004 LPN Excellence in Gerontological Nursing Award winner is Sharon Ruspantine, LPN, from the Masonic Home of New Jersey, Burlington, New Jersey. Sharon is recognized for her contributions to quality care of geriatric residents. Employed by Masonic Home of New Jersey for 27 years, Sharon demonstrates a genuine concern for each and every resident and inspires others to do the same. Always striving to improve herself, Sharon regularly attends inservices and continuing education programs. Gail Sheridan and Judy Wood nominated Sharon.

The 2004 CNA Excellence in Gerontological Nursing Award Winner is Guadalupe Medellin, a patient care assistant at Methodist Hospital, San Antonio, Texas. Guadalupe is recognized for her dedication and excellent care given to patients. She received the Extreme Service Award, Methodist Healthcare System for her dedication and assistance to patients. Nancy Miller nominated Guadalupe.

Innovations In Practice and Judith V. Braun Research Awards

Each year NGNA recognizes excellence in research and clinical practice in gerontological nursing with the Judith V. Braun Clinical Research Award and the Innovations in Practice Award. The Judith V. Braun Award recognizes the scientific contributions of a member or team of nurses who have contributed to advancing the practice of gerontological nursing through research. The Innovations in Practice Award recognizes the creativity and innovation of a member or of a team of nurses who have contributed to the practice of gerontological nursing. The recipients are chosen on the basis of the innovation's creativity, its impact on the organization, the length of time it has been in place, and its contribution to gerontological nursing practice.

The 2004 Judith B. Braun Research Award was presented to Judith Hertz, PhD, RN, for her project, “Perceived Autonomy, Social Support, Psychosocial Developmental Strengths, and Health in Older Adults.”

The 2004 Innovations in Practice Award was presented to Jeanine DeLuca, MSN, RN-C; Luanne Ingram, RN; and Susan Hecker, BSN, RN, for their project, “An Evidence-Based Fall Prevention Program.”

2004 Photo Contest

The NGNA Photo Contest exists to promote and highlight the older adult population in a positive manner. The winning photo of the 2004 Photo Contest was submitted by Deborah Conley, MSN, APRN, BC, CS, an NGNA member from Omaha, Nebraska. The photo is of Marcella Kozak, taken in 2002 on her 87th birthday during lunch with her granddaughters and one great-granddaughter. They wanted to treat their grandmother to an especially memorable event. The restaurant, in Louisville, Nebraska, is called “Art Chicks” and upon arrival you select hats, purses, and other articles of clothing to enjoy during the meal!

Cindy Shemansky Travel Scholarship

The NGNA Travel Scholarship was established to provide assistance to NGNA members who wish to attend the annual convention. Each scholarship is a $1,000 cash prize to be used for registration fees, lodging, and other travel costs. The 2004 recipient of the Cindy Shemansky Travel Scholarship was Sandra Stang, RN-C.

Mary Opal Wolanin Scholarship

Each year NGNA provides two $1,500 scholarships, one for graduate studies and the other for undergraduate pursuits. The 2004 graduate recipient of the Mary Opal Wolanin Scholarship is Cynthia Wilborn, BSN, RN. Cynthia is attending graduate school at the University of Arkansas for Medical Sciences. She is dedicated and committed to improving health care for older adults. The scholarship will help her achieve her goal of becoming a geriatric nurse practitioner and assisting the elderly in the Delta Region of Arkansas.

The 2004 undergraduate recipient of the Mary Opal Wolanin Scholarship is Tammy A. Wilson, RN. Tammy is completing her BSN at Urbana University after receiving her RN 4 years ago. Tammy currently works in a long-term care setting and plans to use her work experience and education in geriatrics.
Distinguished Service Award

The Distinguished Service Award was established to recognize outstanding leadership, participation, and contributions to achieving the goals of NGNA. The 2004 Distinguished Service Award was presented to Priscilla Ebersole, PhD, RN, FAAN, of San Bruno, California. Virginia Burggraf and Robin Remsburg nominated Dr. Ebersole for the award. She has been an active member of NGNA for many years and has served as editor for the NGNA journal Geriatric Nursing for almost 15 years. Mentored by Mary Opal Wolanin, Dr. Ebersole was told to carry on in the profession to create leaders, and she continues to do this. She has written numerous books and chapters and has mentored many NGNA members in publishing articles. Dr. Ebersole helped establish an award to recognize outstanding supervision and management by nurses who work in settings providing care to older adults. She not only promotes best practices in geriatric nursing care, but recognizes and honors the nurses, pioneers, and champions who have made significant contributions to geriatric nursing.

Shore, Shows, and Shopping—
The 2005 NGNA Convention In Myrtle Beach, South Carolina

The 2005 NGNA Annual Convention is scheduled for October 20–23, 2005, in Myrtle Beach, South Carolina. The 2005 Call for Presentations & Posters is available on the NGNA Web site, www.ngna.org, or by contacting the NGNA National Office at (800) 723-0560. The deadline to submit the call for concurrent sessions was January 31, 2005. The deadline to submit the call for posters is March 1, 2005. Poster abstracts can be submitted electronically and are limited to 250 words. Abstracts selected for presentation at the annual meeting will be featured in the 2006 January/February issue of GN.

2005 CALL FOR NOMINATIONS FOR NGNA OFFICERS

Nominations are being sought for the following NGNA offices: vice-president, secretary, director at large (2), and Nominating Committee (3). The National Office must receive nominations no later than April 30, 2005, for the individual to be considered by the Nominating Committee. All current members of NGNA are eligible to be nominated. Self-nominations are also encouraged. Nomination does not guarantee that a person’s name will appear on the final ballot. Complete instructions and nominations can be obtained from the National Office at (800) 723-0560 or by visiting the NGNA Web site, www.ngna.org.
President Cindy Shemansky welcomes convention attendees.

Featured speaker Judith Berg, PhD, RN-C, WHNP, FAANP, during her session entitled Midlife Women's Symptoms: Menopause or Aging?

Pictured here are the 2004 Innovations in Clinical Practice NGNA poster presenters Michele Thoman, MBA, RN, and Tangela Diming, CNA.

Practice Finalists and Award Winner. From left to right are Bonnie Sasso, Kathy Long, Jeanine DeLucca, Luanne Ingram, Susan Hecker.

Pictured here are the 2004 NGNA Fellows Rita Chow, Joanne Gladden, Cindy Shemansky (NGNA president), Marilyn TerMaat, Becky Provine, and Martha Sparks; Dia Campbell-Detrixhe (not pictured).

The NGNA Board of Directors at play. Pictured from left to right in the back row are Neva Crogan, Robin Remsburg, Vicki Schirm, Cindy Shemansky, Barbara McCabe, Jane Hannah, Kay Cresci; in the front row are Shirley Travis and Anita Siccardi.
Innovations in Clinical Practice Award Winner
An Evidence-Based Fall Prevention Program

Jeanine DeLucca, RN, C, MSN,
Luanne Ingram, RN, and Susan Hecker, SN, RN

Patient falls are the largest category of reportable adverse events in acute care settings and contribute to increased length of stay, resource utilization, pain, serious injury and death. It is estimated that the cost to acute care facilities for fall-related fractures exceed 10 billion annually. Our institution had committed to decreasing patient falls through the formation of an Interdisciplinary Fall Awareness Team.

A review of the current literature revealed that published fall assessment scales have low sensitivity and specificity. Many more patients are identified to be at high risk than those who actually have a serious fall. To corroborate this, student nurses from affiliated academic institutions assessed a random sample (N = 60) of in-patients using our fall assessment tool. The majority of patients were identified to be at high risk.

The absence of a valid, reliable tool created a need for a universal fall awareness program. Based on the evidence which postulated that caregivers exert influence on outcomes through control of environment, risk assessment and implementation of evidence-based interventions, we implemented a Fall Prevention Program aimed at ALL patients. This philosophy differed from our former approach, which focused on preventing falls for high-risk patients. Our root cause analysis showed many of our most serious falls occurred in patients not considered high risk.

Methods: All hospital personnel must complete an annual educational program on falls.
We held a fall awareness fair to kick off the campaign. The fall team developed the program content from the evidence.

The Fall Coordinator Role was created. Nursing technical partners (1 or 2 from each clinical area) were selected by the unit director to evaluate intrinsic and extrinsic fall risk factors at prescribed intervals and report findings to the unit Performance Improvement Committee. The fall coordinators received a two-hour education program on fall assessment and interventions to prevent falls. The coordinators receive a Fall Coordinator Pin at a ceremony ending the program.

Quality assurance review forms (QARFs) were added to event reports for falls. QARFs capture critical information such as fall history, location, level of injury, mental status, medications taken within the past 12 hours and interventions implemented before the fall. These data allow us to profile fall patterns in a timely manner without having to perform chart review. Before the implementation of QARFs, fall-related data were either not available or not transformed into useful information necessary for performance improvement.

Fall Coordinators meet quarterly with representatives of the Fall Team to provide feedback on the successes of the program at the unit level. These informal meetings provide opportunity for the team to evaluate the program through personal contact with the fall team. The feedback is then forwarded to unit directors and administrators.

Fall Performance Improvement Data continue to be reported and analyzed by the Manager of the Department of Professional Excellence. The Fall Team members review the data monthly and are available for consultation and action planning with nursing units.

Results: The absence of a uniform method for determining fall rate is a challenge. We use number of falls divided by number of patient days × 1000. This statistic can vary as institutions include different populations in the calculations. There has been a marked decline in the fall rate in our institution since the implementation of the Fall Coordinator Role. In May 2001 the fall rate per patient days was 3.70, whereas in October 2002 the rate per patient days was 1.70.

We are also hoping the data from the Fall QARFs will allow us to eliminate assisted falls from our numbers to further decrease the rate.

In addition, and more importantly, the number of severe falls has decreased by two-thirds since the program inception in 2001, resulting in estimated savings of $136,312.

Lessons Learned:
- All patients are considered to be at risk for falls.
- On-going staff education is always necessary.
- The designation of a unit based coordinator serves as a constant reminder of the need to focus on fall prevention while placing accountability at the unit level.
- Timely and detailed information about each fall allows rapid adjustment to our performance improvement process.

Next Steps: Evidence was an integral part of the development of this dynamic Fall Prevention Program. The challenge will be to continue to foster the enthusiasm of the Fall Coordinator Role. This requires a team commitment. The energetic next steps for the program include:
- Recognition of the Fall Coordinators in our Magnet Attractions, an in-hospital publication featuring the success of the individuals in the role.
- A retrospective analysis of fall data in the Transitional Care Unit (our long term care unit) and the Behavioral Health Unit to enable the design of specific interventions for these areas.
- Distribution of a monthly “Tips on Falls” educational bulletin for the Fall Coordinators to post on each unit.
- Organization of a monthly unit award for decreasing fall occurrences.
- Continuation of the review of products designed to prevent falls across the network.
- Implementation of a Patient Safety Video, which incorporates key concepts fostering active participation of patients and families in fall prevention.

Use of the Clock-Drawing Test to Screen for Dementia in Primary Care

Bonnie Sasso, RN, BSN, Karla Enge, BSN, RN, Barbara Sanchez, BSN, RN, and Judy Totsch, BSN, RN

Background: The incidence of dementia is estimated to be at least 25% in the population age 85 and over. A recent self-assessment indicated we had diagnosed about 15% of our 80-and-over population with dementia. Early diagnosis of dementia enables patients and families to get the right care at the right time. Through a review of literature we identified the Clock-Drawing Test as a potentially efficient tool to assist in screening for previously unrecognized dementia in this population. Five Senior Care Coordinators (SCC) in 5 clinics together with 30 physicians and their clinic staff participated in the project. The SCCs trained the LPNs and MAs (medical assistants) to perform the Clock-Drawing Test as part of the routine check-in procedure on all patients over 80 who presented for an appointment. Those with a previous diagnosis of dementia, those who were ill at the time of the visit, and those who declined were excluded.

Methods: MA/LPN administers the Clock Drawing Test during a physician/mid-level provider visit. If the patient fails the Clock Drawing Test, the physician or provider conducts further evaluation or refers patient to the Senior Care Coordinator. The physician makes a diagnosis after the evaluation is complete. With input from the primary care physician (PCP), the Senior Care Coordinator develops a care plan for the patient.

Barriers: A survey of staff and providers, including the Senior Care Coordinators who were involved, identified time as the major barrier. The MA/LPN group reported that the addition of the time to explain and complete the Clock-Drawing Test added about 5 minutes to the check-in process and on busy days produced unacceptable delays in the provider's schedule. Adding the additional evaluations to already busy SCC practices produced unacceptable delays in further evaluation and treatment planning.

Outcomes: 172 patients consented and were screened using the Clock Test. 48% failed and were referred to the Senior Care Coordinator for additional screening. 20% of those also failed the SPMSQ. Four met the criteria for cognitive impairment or dementia and were given treatment options, community resources, and support for future care planning.

Significance to Nursing: All nursing personnel can be trained in the use of the Clock-Drawing task to increase identification of persons at highest risk for dementia. These patients can then be referred to RN Care Managers for further evaluation, education, and support services. However, the time involved must be included in the development of appropriate staffing needs to meet the increased volume.

Motivators and Barriers to Attending a Diabetes Education Class and its Impact on Beliefs, Behaviors, and Control Over Diabetes

JaNellyn B. Hannah, BSN, RN, BC, PHN, CDE, FNGNA, Janel Alberts, PhD
Office of Quality Management, Orange County Health Care Agency

Introduction: Understanding motivators and barriers to attending diabetes education classes will help health professionals to more effectively encourage their clients to attend classes. Educating individuals with diabetes about their disease, and how to control it, is critical to helping them take responsibility over managing their condition.

Methods: 110 men and women with diabetes voluntarily completed a survey that assessed motivators and barriers to attending a diabetes education class, and the impact of taking a class on diabetes management beliefs and behaviors, and control over diabetes.

Results: The most common motivators for taking a diabetes education class included a desire to care for themselves, wanting to prevent long-term complications, and the desire to eat right. The most common barriers were lack of referral by doctors and not being aware of the availability or location of classes. Analyses revealed that, compared with individuals who had not taken a class, those who had taken a diabetes education class were more likely to believe they had sole responsibility over managing their diabetes, were more likely to have seen a diabetes specialist, and tested their blood glucose somewhat more frequently. However, they were not more likely to have their self-reported fasting blood glucose levels under control.

Discussion: Findings suggest that taking a diabetes education class may help individuals with diabetes to take greater responsibility over managing their condition. Future studies should examine the effects of taking a diabetes education class on control over A1C levels, as well as the short- and long-term impact of taking a class on control over diabetes. Additionally, future studies should examine whether taking a diabetes education class causes changes in diabetes management beliefs and behaviors, which in turn, help individuals to gain control over their condition.

A QUARTER CENTURY OF NUTRITION PROGRESS FOR OLDER ADULTS
Peggy K. Yen, RD, LD, MPH

Over the 25-year life span of Geriatric Nursing, nutrition and well-being have moved to the forefront of care for the aging. The first wave of the baby boom generation becomes eligible for Older Americans Act Nutrition Programs next year when they reach age 60. They are healthier, better-educated, and more affluent than previous generations of older adults and are responsible for the trend toward using nutrients and food as medicine. This period has been marked by increased attention to phytochemicals, antioxidants, dietary guidelines, and the optimal diet for good health.

Carbohydrate, the 1980s food of choice for people watching their fat intake, has become the 21st century’s weight control villain. Diabetes nutrition care has moved from sugar restriction and plenty of starchy carbohydrates to a new focus on counting all carbohydrates equally. The focus on fat has switched from “the less the better” to an emphasis on consuming moderate amounts of monounsaturated fat and avoiding saturated and trans fat.

Carbohydrate—Friend or Foe?
Carbohydrate is blamed for the twin epidemics of diabetes and obesity that developed over the past decades. Glycemic index is a measure of the blood-sugar-raising effect of a food. In comparisons of low and high glycemic index diets in adults with type 2 diabetes, there is no consistently beneficial effect on insulin levels or on HbA1c, an indicator of blood sugar levels over time. The effect of carbohydrate on blood sugar is influenced by fiber content, how processed a food is, and on other foods consumed at the same time.

Metabolic syndrome, a cluster of indicators that includes insulin resistance and abnormal lipid levels, has been clearly defined only recently. About 43% of men and women aged 60 to 69 meet the diagnostic criteria for metabolic syndrome. Limited research shows that consuming mostly whole grains can prevent the negative effect of carbohydrate on blood lipids.

Low-carbohydrate diets can promote weight loss, but so does any diet that restricts common foods. A recent review of low-carbohydrate diets found that weight loss was associated with their lower calorie content and the length of the diet period, not with their lower carbohydrate content. Researchers also concluded that there is “insufficient evidence to make recommendations for or against the use of low-carbohydrate diets, particularly among participants older than age 50 years, for use longer than 90 days, or for diets of 20 g/d or less of carbohydrates.”

The Food Guide Pyramid emphasizes grain products as the foundation of a healthful diet, but older people often ignore the companion guidance to choose mostly whole grain foods. Significant evidence supports the idea that carbohydrate from whole grains, vegetables, fruits, and low-fat milk are part of a healthful diet.

New Emphasis on Wellness, Optimal Diet, and Physical Activity
The idea that weakness and immobility are an unavoidable result of aging has come full circle over the last 25 years. We now know that physical activity keeps older adults strong, improving mental health and quality of life. Elders are maintaining better physical and mental function through weight training, walking, and consuming more fruits, vegetables, low-fat milk, and whole grains. Senior centers are creating fitness programs. The Steps to Healthy Aging program distributes step counters to encourage walking, which research over the past 2 decades has shown to be an effective disease prevention measure. Retired men who walk more than 2 miles a day have almost half the mortality of men who walk less than a mile a day, according to the Honolulu Heart Study.

Antioxidants were introduced to older adults as an antiaging miracle. Supplements of antiox-
idants and the mineral zinc reduced the risk of age-related macular degeneration, but not cataracts, in the Age-Related Eye Disease Study sponsored by the National Eye Institute. Expenses related to vision impairment are largely paid out-of-pocket by older people, making antioxidants a potential financial as well as quality-of-life improvement for elders. Phytochemicals have a similar bright future because past decades have demonstrated their disease-prevention potential. On the negative side, the antioxidant beta-carotene promoted cancer in a study of smokers, and the U.S. Preventive Services Task Force concluded that there is inadequate evidence to recommend for or against the use of antioxidant supplements for the prevention of cancer or cardiovascular disease. A recent analysis combining the results of many studies on vitamin E supplementation concluded that it slightly increased the risk of dying. Although this result doesn’t preclude vitamin E supplementation, it points out the need for careful research to tease out the promising uses for antioxidant supplements.

**A New “Alphabet Soup” of Dietary Recommendations**

The standard for evaluating adequacy of essential nutrient intake in the diets of people is now the Dietary Reference Intake, or DRI ([www.iom.edu/prj0ect.asp?id=4574](www.iom.edu/prj0ect.asp?id=4574)). The Recommended Dietary Allowance is part of a set of standards which include the Tolerable Upper Intake Limit (UL), Adequate Intake (AI), and Estimated Average Requirement (EAR). Even nutrition professionals can have difficulty keeping them all straight, but there are 2 important things for nurses to remember about them. One is that there is now a DRI category for ages 50 to 70 and one for 70+, a change from the previous single category for all people over 50. The other is that the “R” in RDA stands for recommended, not required. This is because the recommended intakes are designed to cover the nutrient requirements of 98% of the population. Most individual older adults have a requirement that is lower than the RDA. The most recent guidelines focus on amounts of nutrients that help prevent chronic disease, not just on prevention of nutrient deficiency diseases.

**Diets of the Future**

Diets of the future will be personalized to an older adult’s genes through the use of genetic testing. Specific diet and activity recommendations will customize the diet prescription. Tailored diets will eliminate the wrangling over the relative importance of carbohydrate, protein, and fat in the diet because each person’s prescription will be geared to physiological need. Resource materials on the current status of nutrigenomics, as this field of study is known, can be found at [http://nutrigenomics.ucdavis.edu](http://nutrigenomics.ucdavis.edu).

**Reference**


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ALL HOME CARE IS NOT CREATED EQUAL—
ONE VIEW: DRAMATIC GROWTH IN
HOME HEALTH CARE INDUSTRY CREATES
UNREGULATED WORKFORCE;
MORE GOVERNMENT OVERSIGHT IS NEEDED

Kathy Janz, RN, MA

The number of consumers purchasing private-duty home-care aide services continues to grow in the United States. Greater numbers of consumers—most of them elderly and dealing with chronic or debilitating health conditions—are turning to home care rather than institutional care for their long-term care needs.

The shift in Medicare’s payments for long-term care is just one manifestation of the trend. Home-care expenditures have risen dramatically while nursing home spending has declined. In 1991, 14% of Medicare’s long-term care spending was in home-care services. By 2003, home-care service spending by Medicare had more than doubled—to 33%—while payments to nursing homes dropped.

The change is fueled by shorter hospital stays, the growth in numbers of people in assisted living communities, and the increasing popularity of long-term care insurance. A by-product of this shift is an explosion in the number of people who work as caregivers in private homes. This largely unregulated workforce has important consequences for health care delivery and nurses who work in the home-care setting.

As a nursing professional for more than 30 years and owner of a home-health agency for 14 years, I wholeheartedly endorse this shift to more care at home. Home care is a humane and compassionate way to deliver health care and supportive services. It can reinforce and support the care provided by family members and friends and, most important, it maintains the recipient’s dignity and independence in the least restrictive setting. Home care allows patients and their families to take an active role in their care. In best-case scenarios, patients are directing their care and in control.

Nonetheless, as the number of companies created to place home health workers in the home balloons, so do the problems associated with them. Although the industry is full of conscientious business people, some private care services are run by unscrupulous operators that allow too many decisions to be made with only the bottom line in mind.

As a full-service agency, my company employs 100 caregivers and 4 nurses who are responsible for the health care of those consumers. On any given day, we look after 80 people, the vast majority of whom are 65 or older. However, my agency may incur expenses up to $8 more an hour than many of my competitors because I take full responsibility for my employees. All of my caregivers are employees with full benefits. I pay employment taxes, workers compensation, and liability insurance for them. Before they are placed in a home, their backgrounds and personal health have been scrutinized.

My lower-cost competitors typically don’t take such pains with the caregivers they refer. Many are registries that don’t employ the caregivers and do little, if any, investigation into their employment history or past. As a nonemployer, they are actually legally prevented from performing the same checks I do for my employed workers. Many rely on potential caregivers to “self-report” their criminal backgrounds. These referral services have no liability because they consider the caregivers independent contractors. The result is that the
client, who is often infirm, is responsible for liability insurance, taxes, and other issues they might be ill equipped to deal with.

The difference in price between an agency that employs and supervises its aides and one that simply refers them can be substantial. Because most consumers are paying for this care out-of-pocket, the temptation to scrimp and hire the lowest-cost service is tremendous. Meanwhile some consumers are simply confused. Faced with a growing and sometimes bewildering number of choices, too many turn to companies that offer them the least expensive option for care without understanding the implications of their choice.

As examples, all of our aides have 1-year paid experience or have completed a certified nursing assistant (CNA) training program. We test and evaluate all aides before placement in the field. My firm also does a background check and a tuberculosis skin test or a chest X-ray. We send them to a physician to ensure that they are free of infection. The background check includes checking references, and a criminal background check which includes a motor vehicle clearance and social security verification.

These may sound like employment issues that have little to do with nursing, but the lack of supervision inherent in the use of placement agencies or registries potentially creates significant health care issues. Often these caregivers are performing medical tasks for which they have not been trained. And the supervision of the home-care worker—especially when they are independent contractors who are employed by a family member in a distant city or state—is often nonexistent.

The aides who work for me are often asked by family members to perform health care tasks, for example, injecting insulin and testing blood glucose levels, handling feeding tubes and IVs, doing dialysis at home, or replacing the dressing on a wound. My aides explain that they are not trained to do these tasks and, if necessary, arrange for one of our nurses to perform the task.

Unlike many competitors, we restrict our aides’ actions, especially when they might have health care consequences. We don’t allow our aides to cut clients’ toenails. They can file them, but to prevent a cut or infection in a patient who has or might have diabetes, we don’t allow them to cut nails. With a caregiver who is not under the supervision of a nurse, even small issues like this can become big problems.

The unsupervised aide who has a little bit of knowledge probably won’t call a doctor right away. In contrast, the employee of an agency who has the ability to call a nurse for guidance is likely to be more proactive and keep small problems from ballooning into bigger ones. Meanwhile, some of my competitors actually advertise that their workers are able to perform medical tasks when they have received no training to do them.

Dispensing medication is another area of concern. I’ve seen patients who were supposed to get 81 mg of baby aspirin to thin blood receive an adult dose of 324 mg of aspirin a day. At my firm, nurses or family members “pre-pour” medication into medi-sets that are given to aides. This ensures that the aide never has to decide whether she is giving her client the right dosage.

It all boils down to oversight. The best person working under the best circumstances needs supervision. Too often home health workers may answer only to a relative who isn’t around very often. Without scrutiny, the relationship between the client and the aide inevitably becomes nebulous and can lead to trouble. We have seen situations in which the aides take on roles that are clearly not theirs to take. We’ve placed aides in homes reeling from situations in which caregivers took inappropriate actions that affected the client’s care.

In one case, an aide moved her family into the client’s home, and the patient, who was demented, was too afraid to complain because she was intimidated by the family. I have fired aides who left their client’s home after putting a friend or relative in charge. This is forbidden, even if the client agrees to it.

A loophole in California law that allows the creation of so-called trust accounts has created a situation even riper for abuse. Under a trust account, the client pays a single fee that includes the caregivers’ wages and the agency fees. The employment agency collects the fee and pays the worker his wages. As a result, the consumer logically assumes that aide is an employee of the agency. Because most trust account agencies charge fees similar to or only a little lower than full-service agencies like mine, consumers are likely to conclude that they’re getting full service coverage.
I realized how referral agencies exploit this loophole when I heard one of their sales representatives brag about how his agency could offer more clinically oriented services free of government restrictions because they used independent contractors. What he meant was that his home health aides would perform some medical tasks without any risk of liability to his agency.

A group of full-service agencies that employ their caregivers formed the Northern California Private Duty Provider Network and created a brochure that explains the situation. We took the brochure to hospital discharge planners who were surprised to learn that “trust account” referral agencies did not employ their caregivers and that the patients were responsible for the caregivers’ payroll taxes and shouldered all the risks inherent with employment.

The confusion has resulted in unfortunate—and sometimes disastrous situations—for seniors, elderly, the disabled, and for care providers. The problem is exacerbated by the largely unregulated nature of the home-care field.

Federal and state rules that govern care in nursing homes don’t apply in private homes. California requires no licensure for home-care agencies. And, like most states, California doesn’t require background checks of home-care workers. California does have a certification process for CNAs, but most agencies use caregivers who do not have this or any other training.

Across the country advocates for the elderly are paying close attention to proposed legislation in California that would begin to address these issues. The initial proposed legislation (AB2704: Underground Economy in Home Care, sometimes referred to as the “Berg bill” after its sponsor, Assemblywoman Patty Berg) would have protected consumers of home care and closed the “trust account” loophole. The legislation passed the Assembly of the California legislature but became bogged down before the Senate’s Appropriations Committee. In order to get this legislation passed, Assemblywoman Berg plans to reintroduce the bill in January calling for full disclosure to the client instead of eliminating the “trust account.”

The National Private Duty Association (NPDA), a trade group for full-service agencies that provide private-duty home care, has worked hard to drum up support for the proposed California legislation and is working with legislators in other states on proposals to improve oversight of the home-care industry. For more information on this situation and the pending legislation, visit the NPDA’s Web site www.privatedutyhomecare.org or call the organization at (317) 844-7105. The California Association for Health Services at Home, which sponsored the legislation described above, also has a Web site (www.cahsah.org), and a fact sheet regarding who pays for long-term care is available at the Health Policy Institute of Georgetown University’s Web site: www.georgetown.edu/research/ihcrp.

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RESEARCH REVIEW: THE ROLE OF THE NURSE PRACTITIONER IN LONG-TERM CARE FACILITIES

Barbara Resnick, PhD, CRNP, FAAN, FAANP

A recent study by Rosenfeld, Kobayashi, Barber, and Mezey, published in the Journal of the American Medical Directors Association, described the national practice patterns of nurse practitioners (NPs) providing care in long-term care (LTC) facilities. The study described the number and characteristics of LTC facilities that use NPs for any portion of care to residents, NP activities, and employment arrangements between NPs, physicians, and facilities. This was a mailed survey and included all physicians who are members of the American Medical Directors Association. Specifically, the survey provided the following information: 1) the number of LTC facilities that have NPs involved in providing care, 2) the number of NPs engaged in care at these facilities, 3) the types of employment and financial arrangements between NPs and LTC facilities, 4) the types of services provided by the NPs, 5) the effectiveness of the NPs as perceived by the medical directors, and 6) the perceived future demand for NPs in LTC.
Hearing loss is the third leading chronic health problem in the United States following arthritis and hypertension. Hearing loss prohibits persons from easy and effective communication and can socially isolate them from their family members and friends. Hearing loss contributes to psychosocial problems. It can cause or aggravate depression, anxiety, and feelings of inadequacy, contributing to decreased functional ability.

Definition/Pathophysiology
Hearing deficit is an impairment of the sense of hearing. Hearing impairment may be classified into sensorineural hearing loss (the most common), conductive hearing loss, mixed hearing loss, central hearing loss, and retrocochlear hearing loss. It may affect the hearing threshold (the volume at which a person can hear sound, expressed in decibels [dB]), discrimination (the ability to differentiate among various speech sounds), or both. Hearing loss may affect one or both ears. It may affect the ears equally (symmetric) or unequally (asymmetric).

Incidence
At least 28 million Americans have some type of hearing loss. Among United States adults aged 65 to 75 years, 30% to 35% have age-related hearing loss, as do 40% of those older than 75. As the United States population continues to age, the incidence of hearing loss is expected to rise.

Common Causes/Risk Factors
- Presbycusis (age-related changes)
- Autoimmune disorders
- Cerumen impaction
- Ear disorders: Meniere disease, otitis media, and otosclerosis
- Foreign body in the ear canal
- Noise exposure
- Ototoxic medications (e.g., salicylates, gentamycin, etc.)
- Perforation of the tympanic membrane
- Retrocochlear lesions (e.g., acoustic neuroma, meningioma, and lesions due to multiple sclerosis)
- Trauma

Clinical Presentation
Only 16% of U.S. primary care providers routinely screen for hearing loss. Behavioral signs such as speaking more loudly or more softly than usual or frequently asking others to repeat themselves indicate the need for a hearing evaluation. Most patients lose their hearing gradually and may not seek medical advice until encouraged by family or friends.

Conductive hearing loss is distinguished by a roughly equal loss in all frequencies (e.g., low to high pitch). Patients often show approximately
normal speech. They tend to speak softly (because they hear their voice as very loud) and generally hear better in noisy rather than quiet situations. With sensorineural hearing loss, which is more common, hearing loss tends to be evenly distributed, with greater loss in the high frequencies. These patients have more difficulty hearing in noisy situations than in quiet ones.1

**Differential Diagnosis**

Differential diagnosis of conductive hearing loss:
- Congenital: Ossicular malformation, ossicular fixation, external auditory canal atresia, and cholesteatoma
- Genetic: otosclerosis, osteogenesis imperfecta, Paget disease, osteoporosis, Crouzon disease, and Marfan syndrome
- Infectious/Inflammatory: Otitis media with effusion (acute or chronic), acquired cholesteatoma, and otitis externa
- Neoplastic: Ear canal tumor (basal or squamous cell carcinoma), glomus tumor, histiocytosis X, and fibrous dysplasia
- Traumatic: Tympanic membrane perforation, ossicular discontinuity, and hemotympanum
- Other: Cerumen impaction, keratosis obturans and foreign body in the ear canal, bony extoses in the ear canal, and external auditory canal stenosis

Differential diagnosis of sensorineural hearing loss:
- Congenital: TORCHES infection, teratogens, perinatal hypoxia, prematurity, low birth weight, hyperbilirubinemia, and inner ear dysplasia
- Genetic: Usher syndrome, Alport syndrome, Waardenburg syndrome, Jervell-Lange-Nielsen syndrome, and otosclerosis
- Infectious/Inflammatory: meningitis, chronic otitis media, syphilis, Lyme disease, other viral diseases (herpes simplex virus, human immunodeficiency virus, cytomegalovirus), and tuberculosis
- Autoimmune: systemic lupus, Wegener granulomatosis, giant cell arteritis and polyarteritis nodosa, and primary autoimmune ear disease
- Neoplastic: temporal bone tumors (primary or metastatic), acoustic neuroma, temporal bone fracture, perilymph fistula, barotraumas, noise exposure, and radiation injury
- Drugs: aminoglycosides, antineoplastics, loop diuretics, acetylsalicylic acid, quinine, vancomycin, and erythromycin
- Vascular: hypertension, vertebrobasilar insufficiency, vasospasm, and inner ear hemorrhage
- Neural: multiple sclerosis
- Metabolic: diabetes, hypothyroidism, and hyperlipidemia
- Other: Meniere disease, presbycusis, and sudden idiopathic sensorineural hearing loss

**Diagnostic Tools**

Otoscopic examination may detect findings that suggest reasons for hearing loss. A patient’s ability to hear may be roughly estimated in a physician’s office using a tuning-fork test (most commonly Rhinne or Webers). Information based on tuning forks is limited; because tuning forks are not calibrated, they have different amplitudes when vibrating, potentially leading to erroneous results.2 Magnetic resonance images may be ordered to rule out potential diagnosis of hearing loss.

Questionnaires such as the Hearing Handicap Inventory for the Elderly Screening (HHIES) have been shown to identify persons with hearing impairment. The HHIES questionnaire consists of 10 questions and takes approximately 5 minutes or less to complete. The reference standard for establishing hearing impairment, however, remains pure tone audiometry. Combining the HHIES questionnaire with pure tone audiometry has been shown to improve screening effectiveness.5

The American National Standard Institute and the American Speech Language Association, in conjunction with the American Academy of Otolaryngology/Head and Neck Surgery, have standardized audiologic testing and quantified degrees of hearing impairment. Hearing is normal if both air and bone conduction threshold levels fall between 0 and 25 dB with a difference of less than 10 dB between the air and bone conduction thresholds. Increasing thresholds reflect increased hearing impairment, with >90 dB indicating profound hearing loss.6

Most patients present with problems of speech perception, such as those with presbycusis, which pure tone testing does not directly evaluate. Speech audiometry evaluates how well a patient perceives sounds. The two standard measures of speech perception that are assessed are the speech reception threshold and the word recognition scale.1

**Treatment**

Although physicians diagnose hearing problems and medically and surgically treat appro-
priate patients, the majority of patients with hearing loss are managed by an audiologist. Audiologists provide testing, counsel and advise patients about hearing loss, recommend and fit hearing aids, recommend and supply assistive learning devices, and provide speech reading and aural rehabilitation services.

Hearing aids can assist the patient with sensorineural hearing loss and patients with irreversible conductive loss. Popular models include behind-the-ear, in-the-ear, in-the-canal, and completely in-the-canal hearing aids. Hearing aids are available in three basic technologies: analog (with traditional circuits), digitally programmable (an analog unit with digitally controllable parameters), and 100% digital (which have analog microphones and receivers, despite its name). Digitally programmable and digital hearing aids are used by about 30% to 40% of hearing-aid wearers.

Those with binaural hearing loss generally need binaural hearing aids. If they wear only one hearing aid, they cannot tell where sound is coming from and cannot hear speech clearly in noisy situations. Wearing both hearing aids enables the brain to compare and contrast sounds from both ears and to perceive amplitude, spectral, and phase cues, which greatly improves speech recognition in both quiet and noisy situations. Because of financial constraints, patients may choose to get the hearing aid for the more affected ear. Higher noncompliance rates have been reported in patients with single hearing aids.

Bone conduction hearing aids are effective for patients with maximal conductive or mixed hearing loss. Bone conduction hearing aid consists of a box and wires leading to the receiver, which is a bone conduction oscillator, strapped across the head. Cochlear implants are appropriate for patients with profound sensorineural hearing loss who derive little benefit from hearing aids. These devices consist of an electrode that is surgically implanted into the cochlea to stimulate directly the auditory nerve with a mild electric current. An external microphone converts sound to an electric signal which is processed, amplified, compressed, and transmitted to the internal component via electromagnetic induction or radio frequency transmission. The failure rate is <1%, and some patients have excellent results, including speech recognition while using a telephone.

Other various devices to aid the hearing impaired are the assistive listening devices that help improve the signal-to-noise ratio. These are available for persons with every type and degree of hearing loss. They are useful in one-on-one conversation or movie theatres and other recreational attractions. Telecommunication devices (TDD) for the deaf enable persons with hearing loss to call other TDD users and type in their messages. Closed-caption decoders are required on new televisions with screens greater than 13 inches.

Realistic expectations are key to successful treatment with hearing aids. Most patients gradually lose their hearing and are not prepared for the reintroduction of sounds that accompany their hearing aid. Aural rehabilitation is beneficial to most patients. The main goal of aural rehabilitation is to optimize communication. Patients help set communication goals and receive instructions, hints, and insight regarding making sense of sounds that they have not heard for a long time. Sessions almost always include training in speech reading. The need to notice facial expressions and gestures are stressed. Training includes teaching patients to become an advocate for their own needs. Often patients do not obtain or use hearing aids because of the embarrassment or perceived stigma or because costs are prohibitive and neither government subsidized nor reimbursed by health insurance. As a result of psychological and financial impediments, only 32% of the geriatric population with moderate to marked hearing loss uses a hearing aid.

References


JENNIFER MALMSTROM, APRN, BC, is currently affiliated with St. Luke Hospital in Florence, Kentucky.
As Geriatric Nursing celebrates its 25th anniversary, I am writing my final drug consult column with great nostalgia. After developing 84 columns, I am retiring from this part of my career because of other demands on my time. The baton for this column will be passed to another gerontological nurse who is dedicated to sharing expertise that is pertinent to the roles of gerontological nurses related to drugs and the elderly. As my finale, I am reviewing the major geropharmacology developments that have been most relevant to gerontological nursing in recent decades. I also will take the editorial liberty of projecting some trends that I hope will occur to improve medication treatments for conditions affecting older adults.

SIGNIFICANT THEMES RELATED TO DRUGS AND THE ELDERLY

Without a doubt, a most consistent theme of geriatric professional literature in recent decades is an emphasis on the need for health care practitioners to recognize the serious adverse effects of polypharmacy in older adults. Two major foci of concern have been subgroups of older adults who are most vulnerable to adverse medication effects: medically frail elders and people with dementia. Another prominent lesson of geropharmacology is that even healthy older adults are at risk for drug interactions and adverse medication effects simply by virtue of age-related changes that occur gradually and have a cumulative effect beginning around age 65.

In the first issue of Geriatric Nursing, a feature article, “Why Do Older Adults Need Different Dosages?” addressed problems experienced by older adults as a result of polypharmacy and age-related changes. The article emphasized the need for health care professionals to evaluate frequently an older adult’s response to drugs and modify drug treatments as needed. Coincidentally, the first drug consult column I wrote 10 years later, “When Medication Harms As Well As Helps,” echoed a similar theme highlighting the importance of identifying the many ways in which medications can impede nutrient absorption. I concluded that column by stressing the role of nurses in identifying medication-related problems and developing solutions that solve the problem without creating another problem. This advice continues to be pertinent today, as is evident from the numerous references in geriatric texts and journals that address the same concerns.

A landmark achievement occurred in 1991 when an international panel of experts in geriatrics and pharmacology developed and published explicit criteria for identifying inappropriate medication use in nursing home residents. The expert panel judged that drugs were inappropriate if better drugs were available or if they were ineffective or had poor safety profiles. These criteria were later updated and expanded to include potentially inappropriate medication use for any person 65 years or older. In recent years, these “Beers’ criteria” have been widely used by nurses and other practitioners, researchers, drug utilization reviewers, and nursing home surveyors. Although most nurses do not prescribe medications, all nurses have key roles in assuring appropriate use of medications and identifying potentially inappropriate use, particularly in older adults.

Closely related to the theme of inappropriate prescribing is the theme of medication safety. Nurses have multiple responsibilities for ensuring safe administration of medications in older adults. For example, we often need to be creative in identifying safe and effective ways of administering medications to people with dysphagia and in assisting older adults with implementing medication self-care practices. Nurses also have important roles in assessing medication adherence, effectiveness, and adverse effects, as has been addressed repeatedly in this column during the past 15 years.

Periodically I have reviewed drug developments that have been pertinent to older adults, with a major focus on treatment of dementia.
For example, I reported medication-related news from the World Alzheimer Congress 2008 and have written several columns about cholinesterase inhibitors and memantine. In the past 6 years, nursing responsibilities for teaching older adults and their caregivers about treatments for dementia have increased significantly because our base of reliable information about cholinesterase inhibitors, memantine, and complementary and alternative therapies has been expanding rapidly. Nurses can use the guide for health education about treatments for dementia from my latest column on dementia as a good starting point for teaching older adults and their caregivers.

Some additional recurring themes of drug consult columns are as follows: controversies and recommendations related to hormonal therapies; good and bad effects of anticholinergic medications; and developments in medications for cardiovascular conditions, including hypertension, hyperlipidemia, and congestive heart failure. Columns also frequently addressed conditions that affect cognitive and psychosocial function, such as delirium, depression, and emotional pain. As I look back on the 84 Drug Consult columns I’ve written for Geriatric Nursing, I am reminded of the tremendous responsibilities we have as nurses with regard to assessment and health education to ensure the safest and most effective use of medications by older adults. I have been privileged to be able to share my knowledge and perspectives in this journal for the past 15 years and end this column by sharing my expectations for the future in relation to medications, older adults, and gerontological nurses.

FUTURE DIRECTIONS RELATED TO DRUGS AND THE ELDERLY

Probably the greatest ongoing issue for geriatric health care professionals is working toward appropriate prescribing of drugs for people over age 65. Despite the widespread recognition of the importance of the Beers’ criteria, recent studies conclude that inappropriate prescribing continues to be a common problem. My hope is that nurses assume major leadership roles in implementing programs to address this serious problem. For example, an easy-to-use best practices tool for using the Beers’ Criteria in nursing practice is available from the Hartford Institute for Geriatric Nursing at www.hartfordign.org.

In closing, my greatest wish for gerontological nurses is that we recognize the considerable influence we have with regard to medications for older adults. Even though most of us don’t prescribe, we all have important and numerous opportunities to assess medication-related needs of older adults and communicate with prescribing practitioners about our assessment findings. Moreover, nurses are the health care practitioners who are in the best position to identify therapeutic and adverse effects of medications and to educate older adults and their caregivers about both the good and harmful effects of medications. I hope that each nurse who works with older adults uses her or his knowledge and influence to have a positive impact on the safety and effectiveness of medications for older adults because this is one of our most important responsibilities.

References


CAROL A. MILLER, RN-C, MSN, is a gerontologic nurse specialist with Care & Counseling, Miller/Wetzler Associates in Cleveland, Ohio.

Editor’s Note: Carol A. Miller, RN-C, MSN, has an outstanding record among the columnists for Geriatric Nursing. She has provided current and significant drug information for each issue of the journal since 1989 (a total of 84 columns). Her expertise will be greatly missed, but she has been kind enough to recommend others to continue on with the column.
Health Promotion and Disease Prevention in the Older Adult: Interventions and Recommendations
E. A. Swanson, T. Tripp-Reimer, and K. Buckwalter, Editors
2001, Springer, 270 pages, $44.95 hardcover

The Healthy People 2010 objectives, launched in 2000, included addressing the health needs of a larger, more diverse, and older population. The focus of this text is on proactive interventions derived from evidence-based research and practices that can promote health and prevent diseases, particularly among older adults. This is of particular importance as health care costs continue to rise. In an era of managed care, controlling costs without jeopardizing quality care is critical. This text illustrates the need for a paradigm shift from an illness-and-disease treatment orientation to one of prevention. Nurse executives and health care administrators would derive much from the research-based evidence in this text. The author presents several benefits of proactive health promotion interventions that are cost-effective and can lead to increased longevity and quality of life.

Chapter 1 identifies types of exercise in which the elderly can participate: endurance, balance, strength, and flexibility. The major issues concern the guidelines for exercise as identified by the author based on research with young adults. Clarity is needed as to what amount of each type of exercise may yield the desired health effects. The recommended guidelines for physical activity by organizations such as the American Heart Association, Centers for Disease Control, and the National Institutes of Health do not mention flexibility, which is necessary with advancing age. The author formulates evidence-based recommendations that include combination training (elements of flexibility, endurance, strength, and balance training), which yields the most beneficial health outcomes.

The following chapter presents the role of essential nutrients in promoting health and preventing disease among the elderly. Three prevention strategies are identified: primary prevention strategies focus on education about healthy foods, secondary prevention strategies involve screening and identifying underlying pathologic conditions relating to oral health, and tertiary prevention utilizes nutrition therapy to improve, maintain, or restore health. A challenge to these approaches is that dietary guidelines for the elderly have been identified as vague and too general, and thus in need of stratification.

The evolution of chronic diseases is presented in Chapter 3, along with a discussion of published studies on arthritis self-management programs. In one study, the effects of self-efficacy on health status among three randomly assigned groups that participated in exercise, cognitive technique, or both exercise and cognitive technique programs were investigated. Results indicated no difference in outcomes among the three groups, suggesting that self-efficacy was more important in determining health status than individual or combined behaviors.

The focus of Chapter 4 is on oral health problems of functionally independent, functionally dependent, and frail older adults. For health professionals, early identification and awareness of the problems of plaque, loss of dentition, and lesions are necessary for prompt referral services. Oral and dental health problems are preventable.

Chapter 5 presents an historical perspective from the viewpoint of smoking as a glamorized behavior to recent efforts at smoking cessation efforts. Studies have shown that smoking is not only an addictive behavior but also a significant risk factor for respiratory diseases and several cancers. A theoretical basis for understanding smoking and its addictiveness is presented; however, none fully explains reasons for smoking.

In Chapter 6, the issue of falls among the elderly is presented as one of the most serious public health problems, the most likely reason for hospitalizations among older adults, and the grounds for the largest number of claims reported against nursing homes. The Yale Frailty and Inquiries: Cooperative Studies of Intervention Trials (Yale FICSIT), designed to reduce biomedical, behavioral, and environmental risk factors for falls, suggests that it is itself cost-effective, safe, and effective in reducing falls among the elderly.

The problem of urinary incontinence is addressed in Chapter 7. The author presents a
conceptual model that assumes urinary incontinence is a public health problem with multiple etiological factors in which the environment plays a major role. Interventions are targeted at reducing or modifying environmental factors at the primary (caregiver education), secondary (screening and monitoring), and tertiary (promoting skin integrity and management) levels.

Chapter 8 highlights the point that cancer risk increases with age because the ability of the body to respond to physiologic stress decreases with advancing age. Primary prevention interventions, such as reducing exposure to known carcinogens and reducing weight through adequate nutrition and exercise, are critical. In secondary prevention, emphasis is on early detection, elders’ utilization of screening services, and prevention of disease progression; management is the focus of the tertiary stage.

In Chapter 9, the author emphasizes the genetic/hereditary and preventable risk factors associated with premature coronary artery disease and the impact that modifying these risk factors can have. Studies presented suggest that modification of factors such as fat intake, smoking, and sedentary lifestyle, as well as organized nurse management clinics, can lead to significant health improvements.

The primary focus of Chapter 10 is on influenza and pneumonia vaccines for older adults. Major factors that influence immunization rates include type of practice (e.g., Veterans Administration, staff model HMOs), type of practitioner (e.g., physicians in specialty clinics and nurse practitioner-run clinics), and issues related to the patient (e.g., appointment record and history of previous vaccinations). A continuous quality improvement framework is recommended to implement a comprehensive, systemwide approach to increase vaccination.

Chapter 11 is a summary of the literature on interventions with African American patients with diabetes. A focus on diabetic education interventions with multiple family discussion groups is presented as an effective strategy in changing elder beliefs among African Americans with diabetes about their disease.

In the final chapter, the author makes the case that although prevention strategies seems to work effectively, health care providers do not always ask the most basic questions or take the most simple actions that can be effective and less costly (for example, promptly identifying depression may explain underlying reasons for a patient’s underutilization of health services). The author challenges health care providers to focus on interventions that are based on sound theory and empirically verified models, rather than merely identifying risk factors and modifying them.

Primary prevention of disease will continue to be a key focus of health promotion interventions, not only as a cost-effective intervention but also as a means to improve quality of life for individuals and families. These concepts are discussed thoroughly in this text.

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Continued from page 42


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Each year, we call on the expertise of a large group of very specialized geriatric nurses to review the many manuscripts we receive for potential publication. The manuscripts we receive reflect the depth and breadth of the different areas of knowledge essential for optimal patient care. The input and assistance of these individuals is invaluable in ensuring that *Geriatric Nursing* remains scholarly, current, and accurate. We thank the members of the editorial board and the panel of review for their assistance in evaluating manuscripts during 2004.

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