

Examiners of Nursing Home Administrators

NEWSLETTER

Summer 2005

Remaining 2005
Board Meeting Dates
July 13
August 10
September 14
October 12
November 9
December 14

Inside:

Chairman's Message 2

Role of the
Supervising NHA 3

Best Practice Protocols
Improve Quality of Care
in PA Nursing Homes 4-5

Pressure Ulcers:
Etiology and Management 6

Disciplinary Actions 7

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Chairman's Message

by Barry S. Ramper, II, NHA

On behalf of the members of the State Board of Examiners of Nursing Home Administrators, I welcome you in the introduction of our newsletter. The Board, consisting of fifteen members, represents all facets of our industry. Twelve members are appointed by the Governor. Appointed Board members serve a term of four years with eligibility to serve two full consecutive terms. Two members each are representative of not-for-profit, for-profit and county-owned facilities. Three members are designated as consumer representatives. Additionally, there are three members actively involved with the care of chronically ill seniors while representing occupations and professions other than Nursing Home Administration. Totaling to fifteen is a representative from the Department of Health, the Office of Attorney General and the Commissioner of Professional and Occupational Affairs.

This group of dedicated individuals meet on a monthly basis to conduct business as defined in the Nursing Home Administrators Act 122 and according to Pennsylvania Code, Title 49, Chapter 39. These two references are the basis in which all decisions are based regarding NHA licensure, continuing education, temporary permits and disciplinary proceedings. These two references can be obtained by contacting the Board Office or by visiting the Board website.

Being a Nursing Home Administrator is clearly demanding but also rewarding. In many regards, the decisions, responsibility and opportunities are unique and unlike any other profession. The highest priority of the Board is the creation of an Administrator-In-Training (AIT) program in Pennsylvania. Currently, Act 122 and the Pennsylvania Code contain no provision for licensure while gaining experience in an AIT program. Numerous states in the United States have this licensure opportunity. The legislative process for the creation of an AIT program continues to date. When finalized, an effective AIT program will provide structured opportunity for licensure and create curriculum opportunity for educational institutions.

Your commitment and dedication to seniors in Pennsylvania is greatly appreciated. In being a licensed and practicing NHA, I understand the challenges faced on a continual basis. The responsibility and satisfaction attained from fulfilling this responsibility is second to none. Pennsylvania's seniors en-

trust the last segment of their life to us at which time we are required to ensure the highest level of quality care and quality of life exist. On behalf of the Board of Examiners of Nursing Home Administrators, I thank you for your commitment and dedication.

Biennial Renewal Increase Proposed

The State Board of Examiners of Nursing Home Administrators (Board) has proposed an increase in the biennial renewal fee from \$108 to \$297. The new fee will be assessed at the June 30, 2006 renewal.

The increase is necessary to reconcile the Board's expenses and revenue. The Board is required by law to support its operations from the revenue it generates from fees, fines and civil penalties. In addition, the Board is required by law to increase fees if the revenue raised by fees, fines and civil penalties is not sufficient to meet expenditures over a two-year period. The biennial renewal fees fund nearly all of the Board's costs.

Biennial renewal fees were last raised from \$85 to \$108 by rulemaking finalized on December 31, 1994. The 1994 increase was first applied to the 1996 biennial renewal.

The proposed rulemaking was published in the [Pennsylvania Bulletin](#) on April 23, 2005. The final rulemaking should be completed before the June 30, 2006 renewal.

Role of the Supervising NHA

by Eva J. Bering, RN, MSN, MHA, NHA

The Board frequently has questions posed to them as to the intent of the 1000 hour practice and supervision requirement and the method to document assurance of compliance with this requirement. The 1000 hours are specifically intended to provide practical application and experience of nursing home administration in a broad and general manner. The areas of expected practice include a minimum of 250 hours in patient service and care, 300 hours in general administration, and a minimum of 250 hours in health and social services delivery system. The remaining 200 hours are to be distributed as needed to obtain the best results for each individual candidate.

There are several areas under qualifying criteria to be eligible for admission to the licensing examination that require 1000 hours of supervised practice of nursing home administration under the supervision of a full time nursing home administrator. Section 39.5(b)(1)(iii)(B); Section 39.5(b)(2)(iii)(B); Section 39.5(b)(3)(iii)(B); and Section 39.5(b)(5)(ii) of the Board's regulations address this requirement.

The supervising administrator has a very significant and responsible role to certify this experience. Rotations through various departments usually are insufficient to meet the intent of this requirement. The intent is to provide hands-on practical application of the areas of educational training as presented in the 120 hour core course. This may include knowledge in the areas of administration; organization and management of a nursing home; an understanding of the role of government in health policy and regulation; risk management and safety; health support services; reimbursement; fiscal management; personnel management; preparation for licensure; and strategic planning. The requirement is intended to provide experience and practice in nursing home administration so that the candidate possesses a general base of knowledge so as to be prepared to oversee and administrate a nursing home independently. A defined rotation through various departments without actual practice in these areas is insufficient to meet the intent of the requirement.

The Examination Committee reviews all submissions to assure that both the candidate and the supervising NHA offer consistent descriptions of the hours and activities used to document the hours in each area. Within the areas the Committee will evaluate whether there has been a broad

and general involvement in the specific area. Only nursing facility time qualifies to meet the intent of the requirement. Involvement in a personal care facility or CCRC does not meet the 1000 hour requirement and will not be considered.

Even though there is not a prescribed method to document the hours per category, there is an expectation that the qualifying hours define actual practice and experience. This can be documented in any variety of ways. The main qualifier is whether or not there has been actual exposure to hands-on practical experience. Some candidates choose to provide a weekly diary of the necessary hours, others submit a list of activities, still others submit a general narrative. All are acceptable.

The certifying administrator is expected to provide a 1000 hour plan that meets the needs of the candidate and best complements their overall learning and preparation to access the examination. It is hoped that the 200 non-defined hours are distributed as needed to best meet the needs of the candidate.

As practicing administrators mentor candidates to prepare for the examination and subsequent licensure, they bear accountability to meet the intent of the supervision requirement. More than that, they have an unspoken professional responsibility to guide and direct experiences to best prepare future administrators qualified to administrate a nursing facility and uphold standards of conduct and professional practice.

Best Practice Protocols Improve Quality of Care in PA Nursing Homes

William A. Bordner, Director
Division of Nursing Care Facilities

The Pennsylvania Department of Health's Nursing Care Facilities Best Practices Project is a state-initiated creative quality improvement project that has developed, implemented and successfully tested three Best Practice protocols: Pain, Depression and Activities of Daily Living (ADLs) in nursing homes. Quality indicators for residents in the test facilities improved significantly and at a much higher rate than for residents in the control facilities. Results of the project to date show that the introduction of one of the three Best Practice protocols in nursing facilities, with intensive initial and regular weekly support from trained nurse educators, is an effective method for improving the quality of care that nursing facilities provide to residents who have or are at risk for problems in these areas. The project has recently initiated the testing of two new protocols: Pressure Ulcers and Urinary Incontinence.

The project was initiated in April 2001 to identify the most serious quality care problems in Pennsylvania's nursing facilities, develop and implement sound best practices to address these problems and analyze the results to ascertain if the best practices employed would improve the health outcomes for the nursing home residents across the Commonwealth. The project addressed the following primary objectives: assessment of the quality of care across multiple domains in all nursing care facilities in Pennsylvania, identification of the quality areas where improvement is most needed, development of a set of best practice protocols designed to improve resident quality of care, implementation of the protocols in a representative sample of Pennsylvania nursing care facilities, evaluation of the effectiveness of the protocols in achieving improved health outcomes for nursing home residents, and if successful, dissemination of the quality of care protocols to all interested nursing facilities.

The project identified nursing facilities that were good performers based on their resident quality indicators. These facilities were neither successful in every aspect of resident care, nor did they have any continuing problems. After the identification of eligible nursing facilities, they were asked to voluntarily participate in the project. The participating facilities were matched along several demographic characteristics including size, type of ownership (county,

profit and non-profit) and geographic location. The project team then randomly picked the test facilities and matched them with like control facilities. Data that were used in measuring outcomes included the provisional quality indicators that are risk adjusted by the federal Centers for Medicare & Medicaid Services (CMS) and standard CMS Minimum Data Set (MDS) quality indicators for the appropriate time periods.

Phase I of the project analyzed differences in resident outcomes between test and control nursing facilities as well as longitudinal resident outcomes within a facility. There was no additional cost for the nursing facilities to participate in the project since the protocols were budget neutral and the federal Minimum Data Set (MDS) was used to analyze the results. All of the protocols involved interdisciplinary coordination and consistent management of the residents. Project nurse educators facilitated the project by implementing and monitoring the best practice protocols at participating facilities. A key requirement for participation is the support of the nursing facility administrator, director of nursing, on-site project coordinator, and interdisciplinary staff that interact with residents including physicians, nurses, therapists, social services, and even cleaning and maintenance.

The results of Phase I, which concluded in May 2003, showed significant improvements in resident health status in the test facilities that implemented one of the three protocols ((Pain Management, Depression Management and Activities of Daily Living (ADL) in eating and dressing)) compared to the non-protocol control facilities. Outcomes in pain management, depression management, and activities of daily living in eating and drinking all showed significant improvement over the test period. Ten test facilities implemented one of three best practice protocols over a 12-month period and the outcomes were compared to ten matched control facilities. At the end of the first phase of the project, evaluation of the test facilities' quality of care indicators showed significant improvement in each of the three areas studied: Pain Management, Depression Management and Activities of Daily Living (ADL) in eating and dressing. The most surprising element was the determination that there was interdependence between the three protocols. As ADL capacity improved, residents became less depressed. As pain was re-

Best Practice Protocols Improve Quality of Care in PA Nursing Homes...con't

duced, ADL capacity was improved. This effect was not apparent in the early stages. To further explore this relationship, several multiple protocol sites have been added to Phase II of the project.

Phase II began in June of 2003. The residents of 60 Pennsylvania nursing facilities are participating in the project as either test or control facilities. The project continues to support the initial nursing care facilities in the three original protocols, implements these protocols in additional nursing facilities, releases the pain protocol for use by any Pennsylvania nursing facility and develops and implements two new protocols: improving urinary continence and reducing pressure ulcers in newly added test and control facilities. When Phase II of the project is completed in May 2005, it is anticipated that the positive quality of care outcomes will continue to be realized for the initial three best practice protocols (Pain, Depression and Activities of Daily Living) and will be shown for the two new best practice protocols (improving Urinary Continence and reducing Pressure Ulcers).

During October 2004, the Pennsylvania Department of Health sponsored a Best Practices Workshop at the South Mountain Restoration Center for the thirty-three nursing care facilities participating as Phase 2 test sites in the Department of Health's Nursing Care Facilities Best Practices Project. The workshop was designed to provide an opportunity for these nursing homes that include for profit, non-profit and county facilities throughout the Commonwealth to and discuss and share their best practice experiences with leaders from the Department of Health, Pennsylvania Association of County Affiliated Homes, South Mountain Restoration Center and the Best Practices Project Team.

Administrators and clinical staff from the long-term care facilities participating in the Best Practices Workshop brought broad geographical representation from across the state. Facilities participating in the workshop ranged in size from 76 to 568 beds, with a nearly even representation of not-for-profit and profit facilities, as well as two county facilities. Five test facilities voluntarily brought materials for display during the poster session, and selected individuals from those facilities relayed their experiences to participants. This participation demonstrated each facility's commitment to further enhance the quality of care provided to residents

in the Commonwealth and its support for the overall betterment of quality care issues in nursing homes nationwide. The workshop demonstrated the enthusiasm and dedication by all the participants and the willingness of the nursing facilities in Pennsylvania to embrace new methods to improve quality of care for their residents. Participants were encouraged to share the information they learned from the workshop with their facility staff and to continue to network with other participants they met from this workshop to enable a more productive and effective process to improve resident quality of care.

The Best Practices Workshop provided information that complements the current Department of Health, Nursing Care Facilities Best Practices Project, designed to implement and evaluate the impact of "Best Practice" protocols in the areas of activities of daily living (eating and dressing), pain management, depression management, improving urinary continence and reducing pressure ulcers in a sample of the Commonwealth's nursing homes.

The findings from this project are very important for nursing facility providers because it shows that good treatment protocols that are carefully managed can improve the quality of resident care and result in better healthcare outcomes for residents. The success of this project when compared to other quality initiatives may be attributed to several factors: the project enrolled essential interdisciplinary nursing facility administrators and staff, substantial ongoing technical assistance and comprehensive training by the nurse educators, aggressive monitoring to assure protocol compliance, and the use of real quality indicators and benchmarks to evaluate resident outcomes.

Pressure Ulcers: Etiology and Management

by I. William Goldfarb, M.D., FACS, FCCM
 Vice Chairman, Department of Surgery
 The Western Pennsylvania Hospital
 Pittsburgh, PA

The development of pressure ulcers is a common occurrence in hospitals, extended care facilities and in the home environment when patient status is characterized by immobility. These lesions, which are often referred to as decubitus ulcers and "bed sores" are iatrogenic in nature. In other words, they are considered to be preventable. Importantly, their occurrence does not serve as an indication of failure on the part of caregivers. It is well recognized that even in those clinical situations associated with the best preventative measures these lesions can still occur as sequelae of progressive debilitation. Be that as it may, there are important preventative measures that can serve to significantly reduce the incidence of occurrence. In order to understand the rationale of prevention it is important for caregivers to appreciate the etiology of these lesions.

On a practical basis these lesions occur as a result of a triad of factors: pressure, moisture and shearing forces. The presence of all three factors is associated with a high incidence of occurrence. Pressure primarily leads to alterations in tissue perfusion which creates tissue ischemia - the most important contributing factor for the development of tissue necrosis and infection. The presence of moisture serves as a basis for skin maceration which predisposes the skin to greater destruction in the presence of shearing forces. In its simplest form, the patient who is constantly lying on his/her back may develop ischemia of tissue that exists over a bony prominence such as the sacrum. Add to that clinical setting maceration of the skin from wet bedding and shearing forces secondary to improper repositioning techniques and the end result is a preventable pressure ulcer. Most pressure ulcers are classified based upon the depth of tissue involvement. The most commonly accepted classification is:

Grade I: Limited to the epidermis. An acute inflammatory reaction with an ill-defined area of soft tissue edema, redness and warmth. This is a reversible lesion.

Grade II: Involves epidermis, dermis and subcutaneous fat. An inflammatory response. This is a reversible lesion.

Grade III: A full thickness skin defect with undermining of deep tissues. This is not a reversible lesion.

Grade IV: A full thickness defect with penetration into fascia and associated involvement of muscle and bone. This is not a reversible lesion.

The first step in management is recognition. It is imperative that caregivers regularly inspect areas at risk in order to provide for identification as early as possible: REMEMBER, Grade I and II lesions are reversible!! Once identified, management consists of either topical or surgical modalities. There are a myriad of topical modalities that are extremely effective. While it is not possible to detail these various modalities within the scope of this article, it is reasonable to detail the properties that should be provided by an effective topical treatment. In addition to being easy to utilize and provide for patient comfort it should also provide bacterial or bacteriostatic activity and serve to limit permeability (so as to reduce maceration) and shearing forces. These types of agents are ideal for the treatment of Grade I and II lesions. Surgical intervention, in the form of debridement, is the treatment of choice for deeper lesions. Once debridement has been performed the lesion can then be treated with the same types of topical agents that are used for the more superficial lesions. It is important for family members and providers to have realistic expectations with respect to the outcomes that can be achieved with Grade III and IV lesions. Healing and/or wound closure (in the absence of more extensive surgery) is an unrealistic expectation. Debridement is performed as a means of reducing odor and limiting the risk of systemic complications.

Disciplinary Actions

Following is a chronological listing of disciplinary actions taken by the Board from May 31, 2004 through March 31, 2005. Each entry includes the name, certificate or registration number (if any), and last known address of the respondent; the disciplinary sanction imposed; a brief description of the basis of the disciplinary sanction and the effective date of the disciplinary sanction.

Every effort has been made to ensure that the following information is correct. However, this information should not be relied on without verification from the Prothonotary's Office of the Bureau of Professional and Occupational Affairs. One may obtain verification of individual disciplinary action by writing or telephoning the Prothonotary's Office at P.O. Box 2649, Harrisburg, PA 17105-2649; (717) 772-2686. Please note that the names of persons listed below may be similar to the names of persons who have not been disciplined by the Board.

Elizabeth Hildenbrand, license no. **NH-002679-R**, of Blue Bell, Montgomery County, had a formal reprimand imposed on her license and was ordered to complete 10.5 hours of continuing education because she failed to comply with continuing education requirements established by the State Board Examiners of Nursing Home Administrators. (1-12-05)

Update on AIT Program

Over one year ago, the Board authorized an administrator-in-training (AIT) program to permit applicants an alternative means of qualifying to sit for the nursing home administrator examinations. The AIT program will permit a person with a baccalaureate or a master's degree to serve as an AIT under the supervision of a licensed nursing home administrator (NHA), who will serve as a mentor or preceptor. A baccalaureate degree person will have to gain 1000 hours of experience in the practice of nursing home administration, and a master's degree person will have to gain 800 hours of experience. Each AIT program will be an individual program approved in advance by the Board, and must be a detailed goal-oriented training plan with supporting documentation which relates educational objectives, subject areas of the required core of knowledge, estimated number of hours for mastering each objective, and the total number of hours involved. The AIT program must consist of no less than 20 hours nor more than 60 hours per week. At the end of an AIT program, comprehensive reports must be submitted by the preceptor and the applicant which will demonstrate the comprehensiveness of the program. If the Board is satisfied that all requirements have been met, the applicant will be authorized to sit for the examinations. The primary difference between the proposed AIT program and the present situation is that under the AIT program, the applicant can be serving, or working, in the nature of an intern, whereas under the present situation, the applicant must serve six to twelve months working as an assistant nursing home administrator. Many, if not most nursing homes, simply cannot afford hiring and paying for an assistant administrator, thus denying interested individuals the opportunity of gaining the requisite experience. An AIT on the other hand, need not be paid and need not have to directly supervise any subordinates, and can serve in the nature of an intern. The Board believes that by offering this alternative means of qualifying to sit for the examinations to a person who has met rigid standards of higher education will encourage such persons to enter the field of nursing home administration.

The Board is currently in the process of considering regulations to implement the AIT program. A regulatory change is necessary before the AIT program can become effective. It will more than likely be sometime in 2006 before the necessary regulatory change covering the AIT will go into effect.

P E N N S Y L V A N I A

State Board of Examiners of

**Nursing Home
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