PADONA / LTCN
Pennsylvania Association of Directors of Nursing Administration

DEDICATED TO SERVICE
COMMITTED TO CARING

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PADONA ENews

How to Reach Us at :

Candace McMullen
Chair, Board of Directors / Executive Director
cmcmullen@padona.com

Susan Piscator,
Consultant
spiscator@padona.com

Terri Gabany,
Area I President
tgabany@grovemanor.care

Coming Soon
Area II President

Lois Pasco
Area III President
lpasco@actslife.org

Candace Jones,
Administrative Director
cjones@padona.com

Sue Keogh,
Webmaster
skeogh@padona.com

Dear PADONA Members:

At the September Board of Directors meeting I shared with the board my desire to resign as Chair of the Board. Candace McMullen is doing an impressive job as the Executive Director and I concluded the time was appropriate for her to assume the Chair position as well. The board confirmed her position effective immediately.

It is truly hard to believe 31 years ago I started PADONA with a vision of providing relevant education and support to the Directors of Nursing in Long Term Care and in their daily undertakings. Having been both a Director of Nursing and an Administrator myself for a number of years, I felt a void in both of those areas. My goal was to show the DONs they were very consequential and had a supporting organization backing them by responding to their educational requirements in the clinical, management, and regulatory arenas.

PADONA has been successful because of so many people stepping up to the plate and offering their advice and expertise. I can never thank each of you individually but want you to know I will never forget you either.

Until the close of the 2019 convention, I will remain as a consultant to the board. I will be at the Hotel Hershey in April to hopefully have the chance to say how much I appreciate all of your support and efforts over the years and to wish each of you success in your future endeavors caring for our beloved long term care residents.

Thank You,
Susan

Dear PADONA Members,

October is an exciting time for us here at PADONA! Our first “Mitigate Your Risk” webinar series begins October 2 with Bette McNee, from The Graham Company, assisting us with best practices in medical record documentation. Later this month, Eileen Keefe, an Attorney from Jackson Lewis, PC, will help us navigate a host of human resources issues over two webinars. I do hope that you will take advantage of the excellent speakers and topics that we have lined up through this webinar series. This is a great opportunity to educate your interdisciplinary and management team without leaving your facility! I want to give a special shout-out to PADONA’s Education Committee for their expertise and assistance with putting together this webinar series. I am so thankful to have such a great committee to guide our educational programming efforts!

October is also our annual PADONA Leadership Development Course. Sophie Campbell and I will be teaching the 4-day program in Grantville, PA! To date, we have a more than 30 participants registered for the course with openings for a few more. Former participants have given wonderful feedback about this program, so I encourage you to join us in a few weeks.

I want to thank each of you who participated in our convention survey. We had almost 200 participants provide feedback! Our 2019 convention will offer a choice of educational sessions and include topics with both administrative and clinical themes! Stay tuned for our 2019 convention program to be released sometime this month!

In closing, I want to thank Susan and Paul Piscator and the PADONA Board of Directors for their support as I navigate the Executive Director and Board Chair responsibilities. As many of you are aware, Susan Piscator started PADONA a little over 30 years ago! She has been the biggest supporter and champion in furthering the profession for Directors of Nursing in long-term care! Susan has been supported by her husband Paul throughout her tenure at PADONA. PADONA will miss both of them greatly! We wish them much happiness, good health, and success as they transition to the next phase of their life!

In Your Service,

Candace McMullen
PADONA Executive Director

Leadership Development Series

Let's Talk About Leadership

Last month we looked at six critical elements of being a leader. In the upcoming articles, I'd like to take each one of those elements and drill down on them. Communication is a huge topic, so I plan to spend more time writing about that element. This month, I'd like to focus on ***nonverbal*** communication.

Be An Awesome Nonverbal Communicator

We are always communicating! Even when we say nothing we are transmitting a message. Imagine you are in a meeting and following a team member's proposal presentation, you say nothing. That lack of response can be perceived in many ways…agreement, politeness, disinterest, reticent; however, accompanying the silence with a nod, a smile, or even a frown helps clarify the message you want to be received. Perception is reality.

Just as we can send clear nonverbal messages, we can also send *mixed messages*. Mrs. Smith's daughter asks you how her mother is doing. You don't make eye contact, you don't smile, there is no expression on your face, and you respond in a flat tone "She's fine." The nonverbal communication sends a much different message than the words spoken.

As you can see, communication is more than what you say but how you say it. Words matter, but more importantly is what accompanies them. What tone are you using? What nonverbal message are you expressing?

In our culture, eye contact is a signal that you are focused and paying attention. When a staff member comes to you with an issue, you can create a stronger connection with him/her simply by making direct eye contact. When delivering an important message, making eye contact is a sign of credibility. Eye contact conveys confidence and assertiveness.

Your posture also can convey confidence. How do you feel when you are holding a meeting and you look around to see slouched bodies? Do they appear interested? Think about how you stand or sit when someone is addressing you. Slouching suggests disinterest. Be aware of your posture and aim to sit up straight and stand tall.

The best nonverbal means for connecting is a smile. A smile sends a positive message. It attracts others to you. It helps others feel comfortable in your presence. Of course, there are situations when smiling is inappropriate. You wouldn't address your team with a big smile while asking them to cut the budget by 10%. Your smile needs to be appropriate to the situation and authentic.

Gestures are also important signals in communication. They can differ with different cultures so understanding your audience is important. Some people naturally talk with their hands to help tell the story. If you are welcoming people, it can be appropriate to use open palms and raised arms. Open gestures indicate a willingness to listen.

Placing your hand near your heart, can signal caring or honesty. To show confidence and strength, use a solid, whole-hand handshake. Just as some gestures can be positive, there are a few that can send negative messages. For instance, fidgeting, placing your hands behind your back, or crossing your arms over your chest are gestures that you want to avoid as they tend to communicate disinterest or closed-mindedness.

Another key nonverbal communicator is your voice tone. The volume and speed of your speech can also send messages. Some things to think about…Are you projecting your voice? Do you sound energetic about the proposal you are making? Are you giving instructions slowly enough to allow people to absorb what you are saying? Do you sound friendly?

Avoid the use of fillers such as "umm," "like," "you know," as it detracts from your confidence when you are delivering a message. In some instances, such as telephone communication, voice tone is the only nonverbal communication means we have to help with message delivery.

Be aware of your nonverbal language. If there are habits you need to break, work on paying attention to those and changing behaviors. Make new, engaging habits to become an awesome nonverbal communicator!

-Anne Weisbord
aweisbord@awlearningconsultants.com

Anne Weisbord, president of Career Services Unlimited, has been a communications/leadership consultant for over 20 years. She has worked with health care professionals in a wide range of settings helping them become more compelling, confident, and articulate speakers and leaders. She has been a keynote speaker and presenter at senior care facilities, nursing organizations, and in staff development in hospitals. She has had personal experience working closely with long term care staff. www.awlearningconsultants.com.

Clinical Pearls

Changing The Way We Treat Diabetes

Gina Klein, RPh Consultant Pharmacist, PharMerica Corporation

Diabetes has become a growing epidemic in the United States. We have gone from having roughly 7 million adults diagnosed in 1980 with diabetes to an estimated 23 million in 2015. A diabetic is one of the healthcare industry's top clients spending nearly $180 billion in the way of medical goods and services. This doesn't include missed work days or the cost of disability.

Since 2008 the A1C (also known as glycohemoglobin) has been used as the test to determine the average blood sugar concentrations for the previous 2-3 months. It had been used as early as 1998 but was not yet considered a reliable source of information. The A1C has been used as a treatment target. These treatment goals have been set at anywhere between </=6.5 or <7. They are now dependent on the individual and the patient's overall health. Treatment should always begin with a lifestyle change in diet and exercise. The next step depends on the A1C level that was originally drawn. A medication is started and an A1C goal is set. Today's medication choices include biguanides, sulfonylureas, glinides, TZDs, DPP 4 inhibitors, alpha glucosidase inhibitors, and GLP-1 agonists to name a few. It is hard to believe that with all of these choices of therapy the number of patients reaching their A1C goal is still only 51%!

So what are we doing wrong? Could it be not choosing the right drug for the right patient? Could it be the order in which we initiate the drug therapy? What is sure is that whatever we are doing it is not working. This year the ADA (American Diabetes Association) has put out an algorithm that they feel could help solve this dilemma. Here is where we have to change our way of thinking. It starts with taking a baseline A1C. Therapy is then based on what that percentage is. Treatment is a step-by-step approach. First line therapy is always metformin for the Type 2 diabetic. After 3 months the A1C is taken again. If the A1C >/= 7.5, a second line agent should be added. This includes usually a sulfonylurea, an alpha glucosidase inhibitor, TZDs, or a glinide. Again, after 3 months the effectiveness of the medication should be tested with another A1C. If it is still >/= 7.5 we can add a third agent. Insulin is then considered almost as a last resort for the Type 2 patient unless you are dealing with an A1C >9. A far cry from the treatment we use today.

Now you ask, what does this have to do with us? You don't write orders. You don't prescribe. But you are the ones who prick the fingers for glucose readings. You are the ones who inject the resident with their insulin, and in the near future your homes will be the ones to receive an Ftag from the surveyors for still using a sliding scale insulin to regulate the resident's blood sugar levels. This will be considered as not providing adequate care. They will also be looking at this for the Type 1 diabetic.

Unfortunately the order for the sliding scale insulin regimen often comes from the hospital discharge orders but we don't have to keep them on it. Wouldn't it be great if we could discharge the resident from our facilities with not only a much easier way to treat their diabetes but also with a way that has been shown to be more beneficial to them? Sliding scale insulin doses are based on what the resident's blood glucose is at a given time. A dose is given as a reaction to that level. As they say, this is reactive rather than proactive. Sliding scale use has been shown to cause wide, fluctuating glucose levels and does not provide for a stable blood glucose. The goal of treatment should be to have that resident's blood glucose be at a lower and linear level. Studies have also shown that sliding scales can cause what is referred to as "insulin stacking". This occurs when the resident is receiving a bolus dose of insulin and follows it too quickly with a "corrective" dose from his sliding scale. It does not take into account that the bolus dose is in the system for perhaps up to 6 hours. What occurs next is hypoglycemia due to too much insulin.

The preferred approach is to use what is called Basal-Bolus therapy. This allows insulin levels that are closer to a normal physiologic response in the healthy individual. This method can be used for the Type 1 or Type 2 diabetic. A basal Insulin such as Lantus, Levemir, Basaglar, Tujeo and Tresiba are given in the late evening.

The basal insulin at night helps the resident to start out the next day with his blood glucose at a level lower than they usually are. It has been shown that if blood glucose levels are lower in the morning, you have a better chance to keep it lower throughout the day. You usually begin with a 10 unit dose and adjust the dose 1-2 times weekly, 2-4 units at a time until the fasting blood sugar target is reached. The resident remains on their oral medication also. Another A1C is obtained and here is where your choices begin if the A1C goal has not been met. Bolus doses are doses of rapid acting insulins with the analog insulin being preferred. Rapid-acting analog insulin is the human insulin that has been chemically modified so that it has a rapid onset of action and it's action is short lived. It makes sense, then, that there will be less chance of hypoglycemia occurring. Some examples are Humalog, Novolog, and Apidra. A daily insulin dose is calculated for the resident using their weight and what their daily blood glucose levels have been. If it is determined that the basal insulin alone is not enough, you divide that calculated daily insulin dose in half. Use half of the units for the basal insulin evening dose and the other half you divide by 3; these are given before meal times using the rapid-acting analog insulin. This allows for the carbohydrates in the meals to be taken care of quickly yet the insulin doesn't linger in the body for a long time. This prevents that stacking I spoke about earlier when a sliding scale dose would be given for the next meal which would work on top of the insulin already in the system. If the resident is not eating or is unable to eat, you would hold that bolus dose. You are being proactive rather than reactive! If the number of units you calculate for the 3 meal time doses is very low, you could try giving only 1 dose at the largest meal of the day.

In the Type 2 diabetic, before you would begin the bolus insulin, you could try a GLP-1 Agonist. These are Byetta, Victoza, Ozempic, and Trulicity for example. The effect of diabetes on the GI tract causes a decreased incretin effect. Incretin is the metabolic hormone that causes insulin secretion from the pancreas and decreases glucagon secretion. There are 2 incretins in a healthy individual, GLP-1 and GIP. Giving these agents that mimic incretin allows the effects of increased physiologic insulin instead of insulin injections. Of course this can be done with a Type 2 diabetic because they still can produce some insulin. These GLP-1 agonists are given once or twice a week depending on the product and by slowing gastric emptying the diabetic may have a 5-15 pound weight loss which can be a benefit for the overweight Type 2 diabetic. These are also found to have a great effect on lowering A1C.

Because of the many core defects and other comorbidities the diabetic can suffer from, treatment can take many forms and use different mechanisms of action. Since diabetes can affect many different organs and systems, not all medications have to work via the same pathway. This allows for the multiple lines of therapy that exist. The pancreas can be affected, causing decreased insulin response. The liver begins to increase its production of glucose. Muscles begin to decrease their use of glucose after a meal. Kidneys begin to reabsorb glucose. Adipose tissue undergoes an increase in breakdown. The brain becomes unresponsive to insulin's appetite suppressive effect. Using a combination of oral medications that use these different pathways (when able), analog and basal insulins and GLP-1 agonists can address these crazy bouncing blood glucose levels, multiple blood glucose testing, and let's not forget the never ending injections of insulin into that resident's fragile skin. Much better for everyone!

1. Considering Injectables, Lilly USA, LLC 2018
2. Considering Injectables, Lilly USA, LLC 2018
3. Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm-2018 Executive Summary Endocr Pract. 2018 Jan;24(1):91-120
Garber AJ, Abrahamson MJ, Barzilay JI, Blonde L, Bloomgarden ZT, Bush MA, Dagogo-Jack S, DeFronzo RA Einhorn D, Fonseca VA, Garber JR, Garvey WT, Grunberger G, Handelsman Y, Hirsch IB, Jellinger PS, McGill JB, Mechanick JI, Rosenblit PD, Umpierrez GE
4. Treating Hyperglycemia and Diabetes With Insulin Therapy: Transition From Inpatient to Outpatient Care Frank Lavernia, MD, Founder Medscape J Med. 2008;10:216
5. The Incretin System: Glucagon-Like Peptide-1 Receptor Agonists & Dipeptide Peptidase-4 Inhibitors in Type 2 Diabetes Lancet 2006;368:1696-1705

Vendor Spotlight

PADONA's October Vendor Spotlight is ***Baker Tilly Accountants and Advisors***! We are so grateful for Baker Tilly's support of so many of our educational programs. Baker Tilly Consultant, Sophie Campbell, serves on the Board of Directors and is Chair of the Strategic Planning Committee. Sophie frequently provides educational programs for PADONA members and has served as co-faculty for the Leadership Development Program over the past several years.

I think this comment from one of the participants of Sophie's program genuinely represents her valuable contributions to PADONA:

> *Thank you for Sophie. She is the best. I wish I knew half of what she knows. What a GREAT person to have on the board. We at PADONA are so lucky to have her.*

Baker Tilly's healthcare practice is comprised of tax, audit and advisory professionals that work with hundreds of hospitals, health systems and health plans developing new strategies for growth. The team has a vast array of financial, operational and strategic expertise covering the full spectrum of advisory services, including value-based service management, risk readiness, managed-care contracting and revenue cycle management.

Conducting Effective Incident Investigations

Conducting timely and effective investigations into resident incidents can be especially challenging! Many factors contribute to investigative prowess…staff knowledge, internal processes, regulatory requirements, as well as the seriousness of the incident all play a role in the integrity of information gathered in our investigative process. Conducting effective investigations is critical for providers to identify the facts surrounding the incident. These facts are essential to effectively applying nursing process. Understanding the root cause(s) is the essential first step in identifying interventions to prevent recurrence, monitoring effectiveness, and modifying the care plan interventions, as needed.

The quality of any investigation depends highly on the competence of those conducting the investigation. Investigators must have the expertise to conduct a credible investigation. Staff responsible for conducting investigations must understand what information is needed, how to obtain the needed information, how to evaluate information received and compare to facility policies, procedures, and expected practice, as well as how to mitigate the likelihood of future recurrence. Incident investigations play a critical role in your success managing your business risk.

Conducting an effective investigation is equal part art and science. One common error is to pre-judge the outcome of an investigation before all the witnesses have been interviewed and all the relevant documents have been reviewed. Resist the temptation to jump to conclusions. Keep an open mind to all possible explanations or scenarios. Allow the investigation to unfold.

Eliminating the immediate causes is like cutting weeds, while eliminating the root causes is equivalent to pulling out the roots so that the weed cannot grow back.

Describe What Occurred in FACTUAL Terms

- Establish a timeline of events that precipitated the event and describe the actual event in an organized, logical and factual manner.
- The time line should adequately tell the "story" of the incident. If not, expand the scope inclusive of what happened immediately before and after the event.
- Each step in the time line should derive directly from the preceding step. If each step is not derived logically from the one preceding it, it usually indicates that one or more steps in the sequence have been left out. Missing steps can be added to the time line, as they are identified.
- Ensure that each step in the timeline is relevant to the incident under investigation. Each step should be evaluated with a “yes”, “no”, or “not sure” with respect to direct relevance to the incident. Be sure to include only the "yes" and "not sure" steps in the final event timeline.
- Only include factual items in the timeline. Be sure to eliminate any opinions or items that cannot be confirmed through interview, record review, or observation. It is very common for staff to surmise or include opinions or hearsay in written or verbal statements. A good investigation clearly begins with the facts and vets out the non-factual items.
    - Separate facts from opinion.
    - Direct Evidence from Circumstantial Evidence.
    - Witness Testimony from Hearsay.
- Ask the Right Questions
    - WHO Was Involved in the Accident?
    - WHEN Did the Accident Occur?
    - WHERE Did the Accident Occur?
    - WHAT Were the Persons Involved Doing at the Time?
    - WHY Did the Accident Happen?
- Strategies to assist you with fact-finding:
    - Visually inspect the scene/location of the accident before anything is disturbed.
    - Make notes of any visual findings of the scene that describe the conditions of area, equipment involved, location of pertinent items, etc.
    - Identify the individuals who have (or may have) direct knowledge of the incident and interview those individuals as soon as possible.
    - Obtain written statements from involved individuals who may have insight into the incident or timeframe precipitating the incident. Written statements should include only facts, i.e., what the interviewee actually observed or heard.
    - Reenacting procedures, such as care procedures, can provide valuable insight into the functionality of equipment, proper utilization, and resident response.
    - Evaluate for changes in the resident’s condition, behavior, medication regime, prior history of incidents/accidents. Often, subtle changes compared to the resident’s baseline can be relevant to your investigation findings.

Conducting effective interviews is an acquired skill. Some tips that may improve the quality of the elicited information include:

1. Interview witnesses promptly, separately and privately.
2. Put the interviewee at ease, show concern, be non-threatening, and explain the purpose of the investigation.
3. Ask the witness to give their version of events.
4. Avoid any suggestion of blame.
5. Avoid giving information that may impact their version of the events. Listen more…speak less.
6. Ask questions to clarify your understanding.
7. Avoid questions that require a YES or NO Answer. Ask open ended questions that require more detail.
8. Document concerns identified during the interview. Body language, posture, eye contact, facial expressions, recall of information, general demeanor, and conflicting information can all provide relevant insight into the credibility of the interviewee.

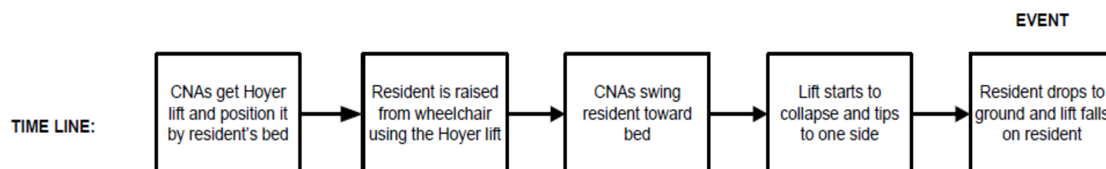
Let's work through the following example of an incident:

Acknowledgement: This example draws on extracted information from the VHA National Patient Safety Improvement Handbook (March 2011), Error Reduction in Health Care: A Systems Approach to Improving Patient Safety, 2nd ed. (Jossey-Bass, 2011) and the Minnesota Adverse Health Events Measurement Guide (Minnesota Department of Health, 2010).

Sample Incident:

Resident suffered a serious injury during his transfer from a wheelchair back to his bed. This tall and larger man (300-pound) was placed in a Hoyer lift and elevated into the air above his wheelchair. As the CNAs turned the lift toward the bed it began to sink because the lift arm couldn't handle the resident's weight. In an attempt to complete the transfer before the patient was below the level of the bed, the CNAs swung the lift quickly toward the bed. The lift tilted dangerously to the side and the legs started to move together, narrowing the base of support. The resident dropped to the ground and the lift fell on top of him

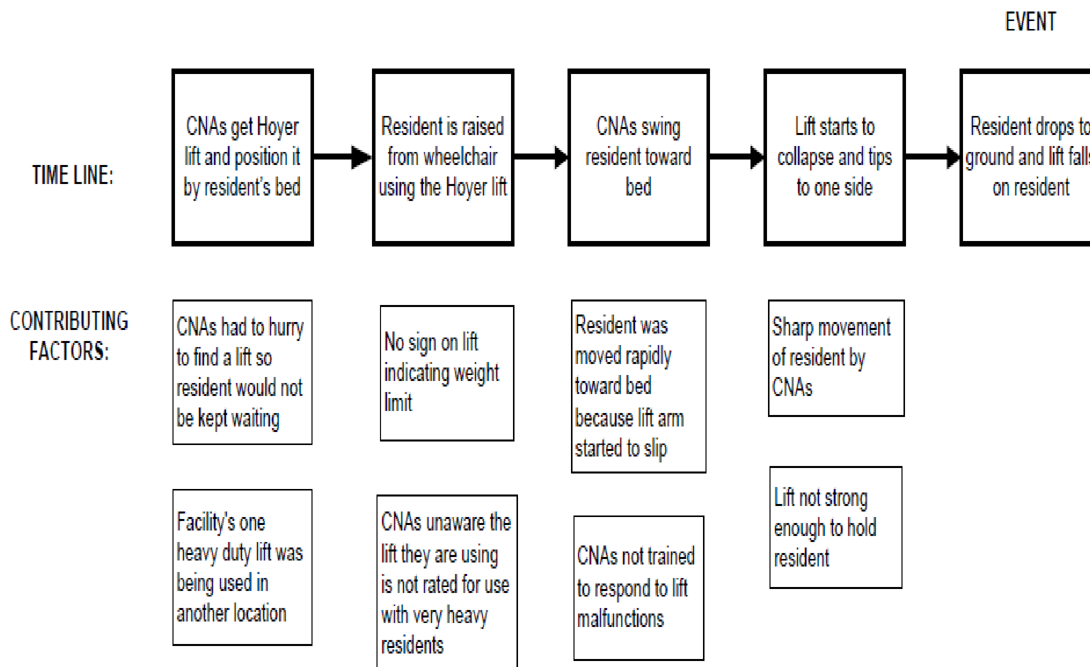
Factual Timeline:



Identify the Contributing Factors

"***What was going on at this point in time that increased the likelihood the event would occur?"***

These are the contributing factors – situations, circumstances or conditions that collectively increased the likelihood of the incident. By itself, a contributing factor may not cause the incident, but when it occurs at the same time, the probability that the incident will occur increases. It is important to get the perspective of people personally involved in the event when identifying the contributing factors at each step. These may be the only individuals aware of the actual circumstances affecting what happened.



Identify the root cause(s)

"The One Step In A Sequence Of Events That If Removed…The Accident Would Not Have Occurred"

All incidents have a direct cause. This is the occurrence or condition that directly produced the incident. In the resident incident, the tilting and collapsing Hoyer lift is the direct cause of the accident. However, the direct cause is not always the root cause.

Root causes are underlying faulty process or system issues that lead to the harmful event. Often, there are several root causes for an event.

Contributing factors are not root causes. The team should examine the contributing factors to find the root causes. This can be done by digging deeper – asking repeated "why" questions of the contributing factors. This is called the "five whys" technique.

The "Five Whys"

1. CNAs didn't have the equipment needed to care for the resident

Why is that?

2. Needed equipment is sometimes hard to find

Why is that?

3. Not enough specialized equipment to care for residents with unique needs

Why is that?

4. The anticipated number of residents with unique needs and their equipment requirements are not known

Why is that?

5. The strategic planning and budgeting process does not include projections of the equipment needs of residents with unique physical and psychological needs

The root cause(s) are the underlying reasons why the incident/events leading up to the incident occurred.

Root causes generally reflect ***management, design, planning, organizational or operational failings*** (e.g., a damaged piece of equipment had not been repaired; failure to use the equipment properly was routinely overlooked by supervisors to speed up the care of the residents).

Corrective Actions

Corrective actions should be geared toward BOTH short-term solutions to fix a contributing factor AND long-term solutions that address the root cause.

In the Hoyer lift example above, short-term corrective actions might include; purchase of an additional lift for residents weighing over 250 pounds, establishing an internal system to communicate residents requiring use of a specific lift, and/or education of staff on the various lifts and contraindications.   These short-term corrective actions may mitigate the contributing factors to avoid a repeat issue in the immediate future.

However, at least one corrective action should be developed to reduce or eliminate each identified root cause. In the instance of the Hoyer lift, establishing a formal process for evaluating current and future equipment needs for the resident population, as part of the ongoing strategic planning and budgeting process, may mitigate a similar recurrence on a long-term basis.

Avoiding Common Investigative Pitfalls

Weaknesses in incident investigation can derail the entire investigative process. Superficial incident investigations lead to ineffective corrective actions, and more importantly, increase your risk of a recurrence of the same/similar incident.

A few common pitfalls to avoid include:

1. Failing to report near misses.
2. Failing to report seemingly minor incidents or incidents without injury.
3. Failing to devote the appropriate time and energy to the incident reporting and investigation process.
4. Failing to include other team members who have contributing information, such as maintenance, rehab staff, and direct caregivers in the investigation process.
5. Failing to learn from previous incidents.

Submitted by:

Candace McMullen, RN, NHA, MHA, CLNC, CNDLTC
PADONA Executive Director

PADONA's 31st Annual Convention

Wednesday, April 3, 2019 through Friday, April 5, 2019

We are changing the schedule for our 2019 convention based on the responses to our recent survey (we will be offering a choice of educational sessions and include topics with both administrative and clinical themes). As a result the actual schedule will be distributed later than usual this year. But please save the date – registration information will be available soon!

Welcome New Members

- Laura Cervi - Clepper Manor, The Nugent Group - Area I
- Angela Cole - Homewood at Plum Creek - Area II
- Kate Davies - Cornwall Manor - Area II
- Renee Gwinn - The Village at Luther Square - Area I
- Catherine Hasson - St.Edmond's Home for Crippled Children - Area III
- Doris Logan - Berks Heim Nursing and Rehabilitation - Area III
- Dawn TuersFeldman - Gracedale, County of Northampton - Area III
- Amy Wagner - Albright Care - Riverwoods - Area II
- Jason Zofchak - Southwestern Nursing Care Center - Area I

SAVE THE DATES!

In response to suggestions from our members on our recent Needs Assessment survey, PADONA will be offering an educational webinar series entitled ***Mitigate Your Risk.*** This series will build core skills and share best practices as well as innovations in risk management areas. Our first webinar session will be held on Tuesday, October 2nd from 11:00 AM - 12:30 PM and continue every other week. The webinar sessions will consist of a 60-minute presentation followed by a 30-minute question and answer period.

Here is what we have planned for the first five sessions:

SESSION 1
DATE: **10/02/2018, 11:00 AM - 12:30 PM**
TOPIC: ***SOUND DOCUMENTATION STRATEGIES***
PRESENTED BY: BETTE MCNEE, RN, NHA
The Graham Company
Insurance Brokers and Consultants

SESSION 2
DATE: **10/16/2018, 11:00 AM - 12:30 PM**
TOPIC: ***NAVIGATING THE EMPLOYMENT LAW LANDSCAPE: TIPS TO SPOT PROBLEMS & PREVENT EMPLOYMENT LAWSUITS***
PRESENTED BY: EILEEN KEEFE, ESQ.
Jackson Lewis PC

SESSION 3
DATE: **10/30/2018, 11:00 AM - 12:30 PM**
TOPIC: ***AN OVERVIEW OF PENNSYLVANIA WHISTLEBLOWER LAWS (AND WHY YOU SHOULD CARE!)***
PRESENTED BY: EILEEN KEEFE, ESQ.
Jackson Lewis PC

SESSION 4
DATE: **11/13/2018, 11:00 AM - 12:30 PM**
TOPIC: ***MITIGATING RISK IN THE AREAS OF PRESSURE INJURY, FALLS, AND WEIGHT LOSS: A THERAPY APPROACH***
PRESENTED BY: JULIA L. BELLUCCI, MS, CCC/SLP
Director of Clinical Education and Compliance
Premier Therapy

SESSION 5
DATE: **11/27/2018, 11:00 AM - 12:30 PM**
TOPIC: ***MITIGATING RISK OF NARCOTICS DIVERSIONS***
PRESENTED BY: ROB LEFFLER, VICE PRESIDENT OF CLINICAL SERVICES
PCA Pharmacy