

# MDS TIPS AND CLINICAL PEARLS

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## TO PREVENT STROKE: F.A.S.T. TAKE CHARGE!!

*Katy Nguyen, MSN, RN ♦ QIPMO Educator*

According to the Center for Disease Control, stroke is the fourth leading cause of death in the United States and is a significant cause of morbidity, disability, and death. The common causation of stroke is a vascular accident to the brain happened by a blood clot, which can have serious effects on speech, cognitive abilities, and basic motor skills. There are two types of stroke: hemorrhagic and ischemic. Ischemic strokes account for about 87% of all strokes. There is also a mimic stroke-like symptom called transient ischemic attack (TIA). These symptoms appear and last less than 24 hours before disappearing, are warning signs prior to actual stroke, and need to be taken seriously

Up to 80% of strokes are preventable from nursing monitoring and early recognition of the symptoms. Staff and resident education is a key! Educate your staff, especially the CNAs, bath aids, and any direct care staff to recognize and report those symptoms promptly for immediate interventions. Also, educate your residents to report changes or any sudden symptoms (SUDDEN numbness or weakness of face, arm or leg, especially on one side of the body; confusion, trouble speaking, or

understanding; trouble seeing in one or both eyes; trouble walking, dizziness, loss of balance or coordination; severe headache with no known cause).

Residents with high blood pressure, heart disease (atrial fibrillation), high cholesterol, diabetes and other circulation problems are at risk, which can be controllable by good medical attention and nursing care. Monitor and develop a good care plan for residents who are at risk for stroke.

Below is the chart from American Stroke Association to introduce an easy way to remember the sudden signs of stroke.

(From American Stroke Association)

*IF YOU WOULD LIKE TO PROVIDE AN EDUCATION ON THIS TOPIC TO YOUR STAFF, PLEASE CONTACT YOUR AREA QIPMO NURSE*

References:

*CDC-Stroke*

*American Stroke Association*



**F** **FACE DROOPING** – Does one side of the face droop or is it numb? Ask the person to smile. Is the person's smile uneven?

**A** **ARM WEAKNESS** – Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?

**S** **SPEECH DIFFICULTY** – Is speech slurred? Is the person unable to speak or hard to understand? Ask the person to repeat a simple sentence, like "The sky is blue." Is the sentence repeated correctly?

**T** **TIME TO CALL 9-1-1** – If someone shows any of these symptoms, even if the symptoms go away, call 9-1-1 and get the person to the hospital immediately. Check the time so you'll know when the first symptoms appeared.

## CLINICAL CORNER

*Carol Siem, MSN, RN, RAC-CT  
QIPMO Educator, Team Leader*



DOES YOUR FACILITY HAVE THE URINARY TRACT INFECTION BLUES???

How can we be proactive when dealing with urinary tract infections?

The CDC has put together a protocol that may be of assistance for your physicians. It drills down to symptoms and organisms, and when treatment should be initiated. It can be found at the following link:

[http://www.cdc.gov/nhsn/PDFs/LTC/LTCF-UTI-protocol\\_FINAL\\_8-24-2012.pdf](http://www.cdc.gov/nhsn/PDFs/LTC/LTCF-UTI-protocol_FINAL_8-24-2012.pdf)

Being organized when calling the physician when symptoms of a potential urinary tract infection are present is also very advantageous. Many homes have started using the SBAR (Situation, Background Assessment and Recommendation) approach to calling the physician. The following link is the SBAR for a potential UTI.

<http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-safety-resources/resources/nh-aspguide/module1/toolkit1/utisbar-form.pdf>

What is your facility doing to decrease the number of urinary tract infections?

- When was the last time you did a skills day to ensure peri care is being done properly?
- When was the last time you reviewed the products used for peri care; is there something better than your current products?
- What type of incontinent apparel are the residents wearing; do they have a wicking property?
- Are fluids being encouraged? Check the dining room after the meal! How many untouched glasses of liquid are you finding?
- How are you tracking your UTIs? By organism, room location, male/female, recent hospital stay, catheter status, etc.

Just like any other challenge in long term care the answers may not be easily seen or simple but working together solutions can be found.

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## MDS NOOK

*Carol Siem, MSN, RN, RAC-CT ♦ QIPMO Educator, Team Leader*

Just like October in years past, CMS always gives the MDS Coordinator new challenges... this year was no different. The IMPACT (Improving Post-Acute Care Transitions) Act and the QRP (Quality Reporting Program) new items/clarified items of the MDS were put into play. The change makes sense if put into context into why we have to do it. CMS wants to compare Skilled Nursing Facilities, Home Health, Acute Rehabilitation and Long-Term Acute Hospitals on care and outcomes. The comparison is based upon the first 3 days of admission on function, skin and falls for traditional Medicare residents. Then at discharge or last covered day on Medicare the resident is reviewed again for comparison. CMS wants to see how their money is being spent and what types of outcomes are being achieved.

On the QIPMO website - <http://www.nursinghomehelp.org/supgr.html#web> - you access our recent webinars on MDS Section GG and general manual updates. CMS also posted a list of questions from the training that was done over the summer regarding Section GG. You can directly access it at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/June-2016-SNF-QRPParticipant-Questions-.pdf>. The files contain a lot of clarification and examples of coding Section GG.

# MDS3.0

WANT <sup>ON</sup> OUR E-MAIL LIST? SEND YOUR E-MAIL, NAME, TITLE, <sup>AND</sup>  
FACILITY INFORMATION TO [MUSONQIPMO@MISSOURI.EDU](mailto:MUSONQIPMO@MISSOURI.EDU)!

# Caption this!



WHO SAYS QIPMO IS ALL WORK  
AND NO PLAY?!

APPARENTLY NOT OUR  
LEADERSHIP COACHES!

Send in some fun captions to go along with Nicky and Libby's recent goof-off session at the MHCA CNA Conference - submit them to us at [musonqipmo@missouri.edu](mailto:musonqipmo@missouri.edu) and we'll share them in our next newsletter!

# IT'S TIME <sup>TO</sup> MOVE IT, MOVE IT!

Wendy Boren, BS, RN ♦ QIPMO Educator

*WELCOME TO HAPPY DALE NURSING CENTER! WE HOPE YOU ENJOY YOUR STAY WITH US. OH! AND HERE'S YOUR FREE WHEELCHAIR!!*

I can hear you all groaning as you read this. It's okay. I am too. In a time when we're working hard to erase the idea of institutional nursing homes the thought of a lonely old lady hunched over in a wheelchair hits a little too close to home. Unfortunately, that *is* what we see and what we think of when we think "nursing home." It's time we focused a little more on the *home* and a more succinctly on the nursing part.

On October 1 CMS released a new quality measure: Percentage of long-stay residents whose ability to move independently worsened. Doesn't that just make you depressed?! They also brought us Section GG as a way to measure the self-care and mobility care continuum basically from hospital and in-patient rehab to home. Do you see where they're going with this? Let's keep people healthier and more active longer. And, bonus! It will reflect in your quality measures. So what does this mean for you? Time to actually kick-start that restorative nursing program.

F-309 states that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest level of physical, mental, and psychological well-being. Enough said, right? A study on resident's needs in the *International Journal of Nursing Practice* found that the single most significant need as stated by the residents themselves was mental and emotional support (Natan, 2008). What better way to knock someone down emotionally than by saying, "Sorry, you can't walk anymore. We're afraid you're going to fall!" I remember my father saying that to me the first time I wore high heels and I totally proved *him* wrong! Not only are we always saying that, we're

encouraging immobility and loss of physical strength because we don't feel like we have the time or the staff to keep people moving. In fact, the opposite is true if we just refocus and break it down. What you *can't afford* are falls, incontinence, depression, pressure ulcers, and new wheelchairs!

I overheard a therapist once say that every time you work with somebody is an opportunity for RESTORATIVE THERAPY. When someone mentions restorative therapy we tend to think in terms of a formal, weights-in-hand, therapy session. It's time to think beyond that. Try this: for one day, recruit one CNA in your home and have them record how many times they physically interact with a single resident. Then multiply that by the number of residents that CNA is responsible for and then add 5 for the average minimum number of interactions with their nurse. You can add 2 more if they go to activities. Chances are your number will be in the hundreds! That is how many opportunities you have for a restorative nursing program and more of a chance to keep that new QM on the up and up.

The purpose of restorative therapy is to prevent secondary complications from an initial issue treated by physical, occupational, or speech therapy; to restore function or partial function; help residents do for themselves; and develop untapped resources (Weisburg, 2016). So, think of Bob. He had a stroke and was treated by PT and OT for 3 months for partial paralysis. He finished Med B therapy services so now he's on his own. Except that Bob still has to use the restroom, eat, walk, brush his teeth, and like himself. Even though he's no longer on a standard therapy program, our staff is going to help Bob use his muscles to do all those things (it's called ADLs). It's just a matter of teaching them how and circulating him into the MDS-

*continued on page 5*

For more information <sup>on</sup> QIPMO <sup>and</sup> Leadership Coaching, visit us <sup>at</sup> [www.nursinghomehelp.org](http://www.nursinghomehelp.org)

prescribed restorative therapy program every 6 months or so for specific help.

So how do you make it work? First of all, everyone has to buy in. The “that’s-not-my-job” philosophy won’t work here. Everybody from therapy, family, CNA, nurses, administration, and sitters have to buy-in. Here’s how to get started:

- 1) Assess for a baseline and obtain a mobility history. Have a “mobile” conversation with the resident and family... what kind of job did they do? Was there repetitive motion? Did they play sports? Is there any medical history that would impede balance or cognition? Do they like kickball or bowling or dance? This has to be more than the standard “Do they fall a lot?” kind of question. Individualizing the history will help you gear up the best personalized program possible.
- 2) Educate your staff and families on functional decline and why it’s so important to keep people moving, even if it’s in minute ways. Having a purpose and doing self-care tasks aren’t up there with running a marathon but it gives a sense of self-awareness that is all too often lost in a nursing home setting and it’s a finish line you never stop crossing.
- 3) Observe and talk to the care team. And remember, the most important members of the care team in this instance will be your CNAs and your therapists. **Focus on their abilities rather than their disabilities!**
- 4) Formulate a personalized plan. Get to the meat of the subject. Ok, Bob walks really slow with the quad cane and he’s a little unsteady but it’s better to allow the extra time for Bob to do it himself with Sally watching him, rather than plopping him down in the wheelchair to go to the dining room.
- 5) And, finally, add in a formal restorative therapy as often as they can get it (every 6 months).

One of the biggest problems with the traditional-designated restorative nursing programs is the lack of dedication to the program and the ease in which we seem to pull staff to do other tasks. No more short-staff switch-ups if you want this to work. Try the “All-In” model, which makes all staff responsible and specialized in their training. The All-In model makes all CNAs carry out the daily resident programs and document them as part of their ADLs. Make sure you remind them that they are doing these things anyway - now they just get credit for them! You might even give a good charting incentive once a month

because, well, we all know how that goes! As with any therapy-type program, ask your therapists to consult and assist with interventions and treatments. This can be anything from brushing hair for the lady with the lousy rotator cuff to the guy in room 207 with arthritic fingers and those pesky button-downs! Finally, designate a specific nurse to supervise and maintain the program.

Lastly, think of what capturing a true restorative program on your MDS’s can add to your payment systems. It’s time skilled nursing stops being reactive. Get proactive on mobility for your residents and see what an impact *Moving It* can really have!



*The Power of Restorative Nursing: Linda was admitted to Marshfield Care Center over 3 years ago on complete bedrest. After spending 5 years on bedrest, her dream was to walk out of the facility and return home. With her determination, a Restorative Nursing Plan, and Restorative care aide, Jennifer, her dream became reality in September 2016.*

# *MOLANE, MHCA, Health Systems, Inc. and MC5 present:* ***The Sleep Seminar***

## **Undisturbed Sleep at Night – A Key to Good Health**

CMS and long-term care providers have never considered sleep as an integral part of the plan of care and services provided for the resident. This Restorative Sleep Vitality Program (RSVP) is a combination of nationally recognized evidence-based, sleep hygiene research studies and the application of cutting edge practices to enhance residents' sleep and wake. Most recently research has discovered a link between Alzheimer's disease and poor sleep hygiene. Empira has challenged some of the standards of practice and operational procedures for providing care and services in LTC communities. With sleep in mind, they have reviewed their best practices, made adjustments and are sharing those practices and results for seminar participants.

### **Sue Ann Guildermann, Director of Education, Empira Skilled Nursing Facilities, Eden Prairie, Minnesota.**

Sue Ann has over thirty-five years experience providing education, leadership and consultation to non-profit and for-profit long term care organizations. Sue Ann is a Registered Nurse with a BA and MA in communication and adult education. She currently designs and produces educational seminars and conferences for Empira, a consortium of 24 skilled nursing facilities in Minnesota. For the last eight years, she has created educational programs for both the management and direct-line staff to assist in the implementation of a national and state quality improvement grant. The purpose of this grant was to reduce resident falls in skilled nursing homes. In January 2012, Empira's Fall Prevention program was awarded the Minnesota Commissioner of Human Services, Circle of Excellence Award for "their contributions to the wellbeing of human services clients." Sue Ann is currently executing a recently awarded three-year grant to eliminate sleep fragmentation and sleep deprivation in their Empira members' nursing homes. Sue Ann has edited, designed and written educational manuals, printed materials and videotapes. She has taught at the University of Minnesota in the School of Public Health.

### **November 29, 2016 – ST. LOUIS AREA**

St. Charles Community Commons, Spencer Road Library  
427 Spencer Road, Suite 255, St. Peters, MO  
[www.mc5stlouis.eventbrite.com](http://www.mc5stlouis.eventbrite.com)

### **November 30, 2016 – MID-MISSOURI**

Health Systems, Inc.  
3750 Osage Beach Pkwy, Suite #200, Osage Beach, MO  
[www.mc5osagebeach.eventbrite.com](http://www.mc5osagebeach.eventbrite.com)

### **December 1, 2016 – KANSAS CITY AREA**

Elks Lodge  
100 NE Brizendine Rd., Blue Springs, MO  
[www.mc5kansascity.eventbrite.com](http://www.mc5kansascity.eventbrite.com)

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