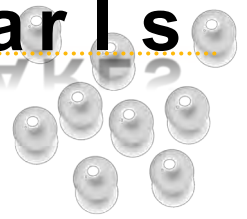


# MDS Tips and Clinical Pearls



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## RESIDENT RIGHTS ON DISCHARGE

Libby Youse, BGS, LNHA ♦ Leadership Coach

October was RESIDENT'S RIGHTS month. The goal is to educate and promote RESIDENT'S RIGHTS so that **hopefully**, they are practiced all year long in our long-term care communities.

When a resident is settled in a nursing home, and has made it his or her home away from home, being told to leave can be very traumatic. Nobody wants to be evicted, yet there are times that nursing homes just cannot take care of a person any longer.

### FEDERAL LAW ALLOWS HOMES TO ISSUE A WRITTEN NOTICE OF DISCHARGE TO A RESIDENT FOR THE FOLLOWING REASONS:

- The resident's needs cannot be met by the home any longer.
- The resident's **health** has improved and she or he no longer has a need for nursing home care.
- There is a need to protect the health and safety of other residents or staff that is **endangered** in some way.
- The resident has failed, after reasonable notice, to **pay** the facility charge for an item or service provided at the resident's request.
- The home stops operating.

After a decision has been made to discharge a resident, nursing homes are required to follow certain processes before discharging the resident. The days of attempting to "**dump**" an undesirable resident by transferring a resident to the hospital and then denying them to return to the home are long gone. Residents can fight back and contest discharges without the proper notice.



### RESIDENT'S RIGHTS DURING DISCHARGE/TRANSFER:

- Right to **appeal** the proposed transfer or discharge and not be discharged while an appeal is pending.
- Receive 30-day written notice of discharge or transfer. 60-day if home is going to stop operating.
- **Preparation and orientation** to ensure safe and orderly transfer or discharge.
- Notice of the right to return to the facility after hospitalization or therapeutic leave.
- Safe transfer or discharge through sufficient preparation by the nursing home.

 **Sinclair  
School of Nursing**

University of Missouri Health System  
University of Missouri Health System

continued on page 2

**Residents' Rights BINGO**

Randomly Rights BINGO includes:

- Master Game Board
- 24 Game Cards
- 75 "RIGHTS" Cards
- 48 Game Candy Tablets
- CD - Residents' Handbook
- Ombudsman

[www.chukandcindy.org](http://www.chukandcindy.org)

1. The reason;
2. The effective date;
3. The location which the resident is being transferred, discharged or going to;
4. The appeal rights and process for filing an appeal;
5. The name and contact information for the long-term care ombudsman.

*Resource:*

[http://theconsumervoice.org/uploads/files/long-term-care-recipient/CV\\_NHrights\\_factsheet\\_final.pdf](http://theconsumervoice.org/uploads/files/long-term-care-recipient/CV_NHrights_factsheet_final.pdf)

*Nicky Martin, BS, LNHA ♦ Leadership Coach*



§483.70(e) Facility Assessment F838 states: “The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and *at least annually*.”

§483.73 E-0001 states: “Under this condition/requirement, facilities are required to develop an emergency preparedness program that meets all of the standards specified within the condition/requirement... the emergency preparedness program *must be reviewed annually.*”

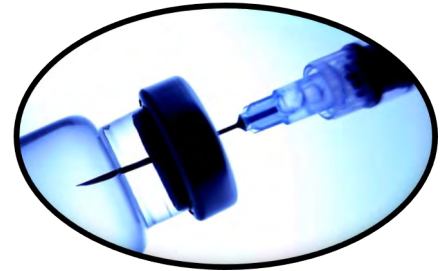
WANT<sup>ON</sup> OUR E-MAIL LIST? SEND YOUR E-MAIL, NAME, TITLE, AND  
FACILITY INFORMATION TO [MUSONQIPMO@MISSOURI.EDU](mailto:MUSONQIPMO@MISSOURI.EDU)!

# V A C C I N A T I O N S

Melody Schrock, BSN, RN ♦ QIPMO Clinical Educator

## FLU, INFLUENZA, PNEUMOVAX, PREVNAR... WHEN? WHERE? WHY? HOW?!

The FLU and PNEUMONIA season is upon us; if it ever really left? Questions are being asked: **When** do we start giving the flu shot? **When** is the right time to administer the Pneumovax®23? **What** about the Prevnar13®? **When** is it REALLY flu season?



Homes in Missouri are currently reporting active cases of FLU. The Centers for Disease Control and Prevention (CDC) recommends administering the vaccine **upon receipt** (with proper consent and notifications) and further recommends the use of any form of licensed vaccine during the 2018-2019 flu season. The flu vaccine should be administered *prior* to active season and takes approximately TWO 🖐️ weeks after vaccinations for antibodies to build up that protect against the flu. It is further recommended to be vaccinated prior to the end of October and offered throughout the flu season.

There are two available PNEUMONIA vaccines: the Prevnar13® (PCV13) and the Pneumovax®23 (PPSV23). **NOTES** to follow with the Prevnar13® and the Pneumovax®23.

- They should **NOT** be administered during the same visit.
- When both are indicated, the Prevnar13® should be given **before** the Pneumovax®23.
- If either is given earlier than the recommended window, **do not** repeat the dose.
- Vaccines are recommended to be **at least** 1 year apart\*
  - ♦ Prevnar13® at least 1 year for immunocompetent adults to administer the Pneumovax®23
  - ♦ Prevnar13® at least 8 weeks apart for adults with certain medical conditions to administer the Pneumovax®23
  - ♦ Pneumovax®23 at least 1 year for all adults, regardless of medical condition, to administer the Prevnar13®

The CDC has an easy to follow “Pneumococcal Vaccine Timing for Adults” PDF at the following link. It provides an algorithm to follow for those individuals 65 years and older. <https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf>.

In regards to the “FLU SEASON” the RAI manual states, “Influenza can occur at any time, but *most* influenza occurs from **October** through **May**. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.”

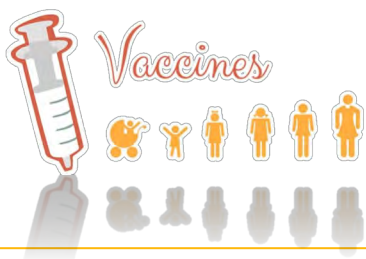
Vaccination for individuals living and working in your homes is vital. The risk for illness is greater in living communities and the risk for complications is multiplied due to decreased immunity with advanced age.

Read more about vaccines <https://www.cdc.gov/vaccines/vpd/vaccines-diseases.html>.

References:

[www.CDC.gov](http://www.CDC.gov)

<https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf>



# GASTROSTOMY TUBE AND THE NURSING PLAN OF CARE

Katy Nguyen, MSN, RN ♦ QIPMO Clinical Educator

A GASTROSTOMY TUBE is a tube that is placed directly into the stomach through a small opening in the abdomen called a stoma. The gastrostomy tube allows nutrition, fluids and/or medications to be put directly into the stomach, *bypassing* the mouth and esophagus. The most common type we see in nursing home is a PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE. Although there are many different types of enteral nutrition, this article addresses the nursing care plan and management for residents who receive the gastrostomy tube that is **commonly** called G-tube or PEG tube.

First, Appendix PP in the State Operational Manual (SOM) provides good information for clinical practice guidelines for care management in nursing homes. In addition, the Clinical Element (CE) pathway also addresses a good guidance for developing a good policy and procedure for nursing care in this areas. Under F-693 of the SOM, Center for Medicare & Medicaid services (CMS) addresses the considerations of use of G-tube, in which an informed consent may be needed to address the reasons, risks, and benefits along with the best nursing assessment to guide the informed decision. A comprehensive assessment is needed for the resident's nutritional status including the ability to consume food, the potential or actual of malnutrition, and dehydration as well as other

complicated medical conditions. The guidance also suggests the assessment of psychosocial factors that may lead to social isolation and the reduction of freedom or movements. A good comprehensive assessment will help the clinicians to determine if having the G-tube can be permanent or a temporary through clinical management such as correcting malnutrition and dehydration; promoting wound healing; and allowing the resident to gain strength.

Because the aspects of this decision, the nursing home obtaining an informed consent PRIOR TO ADMISSION is important if the resident had a feeding tube placed before admission or in another care setting. In addition, the physician and interdisciplinary care team must **review** the basis for the initial placement of the feeding tube and the resident's current condition to ensure that its continued use is consistent with the resident's treatment goals and wishes.

It is **IMPORTANT** that the home have a policy and procedure to guide staff with the technical aspects of feeding tubes. The chart below can help you to incorporate into the plan of care for management of G-tube (information is adapted and retrieved from CMS F-663 and CMS 20093, Clinical element pathway).

*continued on page 5*

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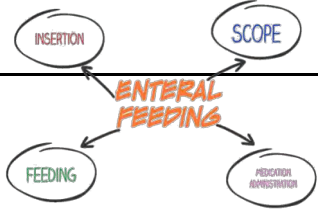

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# TECHNICAL AND NUTRITIONAL ASPECTS

## WHAT TO DO

<p><b>Monitoring</b> (before beginning a feeding and before administering medications)</p> 	<p><b>Checking gastric residual volume (GRV)</b></p> <ul style="list-style-type: none"> <li>• Not recommended for individuals who are alert and able to report symptoms that indicate a feeding is not well tolerated.</li> <li>• May be appropriate when initiating tube feedings or for individuals who are unable to report symptoms such as bloating, nausea, or abdominal pain.</li> <li>• Actions to take based upon the amount of GRV vary depending on the individual and the clinical condition.</li> <li>• pH (acid/base scale) of GRV may indicate correct placement i.e. pH &lt; 5 generally indicates gastric contents versus intestinal contents but medications and feeding formulas can alter pH levels.</li> <li>• Changes in GRV appearance may also be helpful in confirming placement but should not be used in isolation.</li> <li>• Observing changes in external length of tubing may indicate a change in position but can only be used if the exit site was marked upon initial placement; this method does not apply to low profile G tubes (tube that sits at skin level).</li> </ul> <p><b>Auscultation is no longer recommended</b> for checking placement of the feeding tube. Movement of air would likely be heard whether the tube was in the correct or incorrect location. X-ray confirmation is the most accurate method for verification of tube placement when concerns arise regarding dislodgement or placement.</p>
<p><b>Care of the feeding tube</b></p>	 <ul style="list-style-type: none"> <li>• Securing a feeding tube externally;</li> <li>• Providing needed personal, skin, oral, and nasal care;</li> <li>• Examining and cleaning the insertion site in order to identify, lessen or resolve possible skin irritation and local infection;</li> <li>• Using infection control precautions and related techniques to minimize the risk of contamination; for example, in connecting the tube and the tube feeding; and</li> <li>• Defining the frequency of and volume used for flushing, including flushing for medication administration, and when a prescriber's order does not specify.</li> <li>• Record length of the tube where bumper base is located every shift.</li> <li>• Cleanse site every shift with normal saline moist gauze to remove crust or drainage.</li> <li>• Flush tube with 30 milliliters of water every 8 hours and prn after giving medication or feedings per the tube. Consult with the physician; PEG tube feedings, supplements, normal saline, and water are to be given as directed by the attending physician or per nutrition services as directed in the order.</li> </ul>

<b>Feeding tube re-placement</b>	<b>Assess and document the following for tube replacement:</b> <ul style="list-style-type: none"> <li>• When a long-term feeding tube comes out unexpectedly or a tube is worn or clogged;</li> <li>• When to examine a feeding tube and the infusion plug to identify splits or cracks that could produce leakage;</li> <li>• Instances when a tube can be replaced within the facility and by whom;</li> <li>• Instances when a tube must be replaced in another setting (e.g., hospital, ambulatory surgery center).</li> </ul>
<b>Education to staff</b>	<b>How does staff try to minimize the risk for complications including:</b> <ul style="list-style-type: none"> <li>• Physical complications (aspiration, leaking around the insertion site, intestinal perforation, abdominal wall abscess or erosion at the insertion site);</li> <li>• Implementing interventions to minimize the negative psychosocial impact that may occur as a result of tube feeding;</li> <li>• Providing mouth care, including teeth, gums, and tongue;</li> <li>• Checking that the tubing remains in the correct location consistent with facility protocols;</li> <li>• Elevating the head of bed at least 30 degrees during feeding and for 30 to 60 minutes after feeding unless contraindicated.</li> </ul>
<b>Enteral nutrition</b>	<b>Assess and document:</b> <ul style="list-style-type: none"> <li>• Types of enteral nutrition formulas available for use;</li> <li>• How to determine whether the tube feedings meet the resident's nutritional needs and when to adjust them accordingly;</li> <li>• How to balance essential nutritional support with efforts to minimize complications related to the feeding tube;</li> <li>• Ensuring that the selection and use of enteral nutrition is consistent with manufacturer's recommendations;</li> <li>• Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders; and</li> <li>• Ensuring that the product has not exceeded the expiration date;</li> <li>• Ensuring that additional water ordered for flushes or for additional hydration is administered per orders.</li> </ul> 
<b>Flow of feeding</b> 	<b>Manage and monitor the rate of flow, such as:</b> <ul style="list-style-type: none"> <li>• Use of gravity flow;</li> <li>• Use of a pump;</li> <li>• Periodic evaluation of the amount of feeding being administered for consistency with practitioner's orders;</li> <li>• Calibration of enteral feeding pumps to ensure that pump settings accurately provide the rate and volume consistent with the resident's care plan; and</li> <li>• Periodic maintenance of feeding pumps consistent with manufacturer's instructions to ensure proper mechanical functioning.</li> </ul>

## COMPLICATIONS

INDICATORS	WHAT TO DO
<ul style="list-style-type: none"> <li>• Aspiration, leaking around the insertion site</li> <li>• Feeding tubes can perforate the stomach or small intestine, with resultant peritonitis</li> <li>• Tubes may clog for various reasons, including plugging by formula, pill fragments, or the precipitation of medications incompatible with the formula</li> </ul>	<p><b>Identify and address actual or potential complications related to the feeding tube or tube feeding and to notify and involve the practitioner in evaluating and managing</b></p> <ul style="list-style-type: none"> <li>• Elevating the head of bed at least 30 degrees during feeding and for 30 to 60 minutes after feeding unless contraindicated.</li> <li>• Good airway management.</li> <li>• Ensure optimum oral hygiene regime.</li> <li>• Use the gravity method only for bolus feeding.</li> <li>• Contact the patients dietitian and consider referral to Speech Language Therapy if you are concerned about aspiration.</li> <li>• Flushing feeding tubes regularly and in association with medication administration, as indicated by current professional standards of practice and provided in the resident care policies, can help reduce the risk of clogging.</li> </ul>
<ul style="list-style-type: none"> <li>• Interactions between the formula and various medication and enteral nutrition product may cause nausea, vomiting, diarrhea, abdominal cramping, inadequate nutrition and aspiration.</li> <li>• Abdominal wall abscess, or erosion at the insertion site</li> </ul>	<ul style="list-style-type: none"> <li>• Ensuring the cleanliness of the feeding tube, insertion site, dressing (if present) and nutritional product;</li> <li>• Providing the type, rate, volume, and duration of the feeding as ordered by the practitioner and consistent with the manufacturer's recommendations;</li> <li>• Checking gastric residual volumes (GRV) and contacting the resident's physician per facility policy or as ordered;</li> <li>• Ensuring that additional water ordered for flushes or additional hydration is administered per order;</li> <li>• Examining and cleaning the skin site around the feeding tube and equipment;</li> <li>• Storing feeding syringes in a clean area.</li> </ul>

### References:

SOM-App PP. F663

CMS 20093(CE pathway)

American Society for Parenteral and Enteral Nutrition (ASPEN)



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

# ALZHEIMER'S AND DEMENTIA: PART II

Crystal Plank, BSN, RN, RAC-CT



QIPMO Clinical Educator

It can be very difficult understanding what a resident with **DEMENTIA** is trying to communicate. It can be difficult to know what they are feeling, difficult for them to say what they mean and difficult for us to understand them.

Residents with dementia need the staff to communicate in **short, simple** sentences expressing one **1** main idea at a time, allowing the resident with dementia plenty of time for the information to be understood. It is also important in the way in which we give the information. "Here is your breakfast at this table" instead of "It is time for your breakfast". Being very **SPECIFIC**, lessens anxiety for our residents. When you walk into their room, remember to tell them your name and something that they can relate to or something important to them. Give them a compliment; this usually will help them feel more comfortable with you. We can also turn a **negative** into a **positive** situation. For example, instead of saying, "Don't do that now", try, "It is a good time to go for a walk."

When we speak to our residents, we should use the name they prefer and talk to them as adults. We should give simple directions, one-step at a time and speak **slowly** and **clearly**. Say *exactly* what you mean and offer multiple cues.

Facial expressions and body language play an even bigger role in communication with our residents with dementia. Our **VERBAL** communication must match our body language to communicate effectively.

If I walk and face the resident from the front they may see my body language as confrontational, even if I do not mean to communicate that all. If I move from the front, come beside them at their eye level, and place my hand under theirs it makes them feel like they have control. You can also move your hand/arm to the underside of

## Forms of nonverbal communication

- Eye Contact
- Facial Expressions
- Posture
- Haptics or Touch
- Gestures
- Personal Space



their arm, which helps them; feel like you are part of them. You become an **EXTENSION** of them and this assists them with being able to do more than they could before. For instance, if you have

your hand/arm under theirs and you are assisting them to eat; they may be more involved in the eating process than you just plain feeding them. They also may eat *more* food.

One of the most **important** things that I have learned over the years of caring for residents with dementia is that you have to **gain their trust** before you begin any task. We have to ensure our residents are comfortable with us especially when it comes to accomplishing basic tasks. Our resident with dementia may not remember our name or faces, but they remember how we treat them and how they feel when they are around us.

As caregivers, we need to enter **their world**. We should not expect them to understand "facts" as we do. We should validate and understand their feelings. Never argue the "facts" with them. More than anything, we need to learn to listen. We need to be **comforting, reassuring, and be patient**. We need to show that we are interested by maintaining eye contact and continuing to listen. We need to look for the **feelings** behind the words. The tone of voice and other actions may help you understand what our residents are really trying to say. It is okay to offer a guess if you are not sure what they are trying to communicate. We can encourage pointing or gesturing if speaking becomes too difficult.

Do not take anything personal, it is not about you but **ALL** about our residents.

(Information from the Alzheimer's Association and Teepa Snow's *Positive approach to Care*)

## Coming soon in a supplement...

"**HARD TO LOVE: ADDRESSING SEXUALITY IN LONG-TERM CARE: A PERSON-CENTERED APPROACH TO INTIMACY AND DEMENTIA**"

*Be on the lookout in early winter!*