MDS Tips and Clinical Pearls

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IN THIS ISSUE

Bringing Back Visitation
Where is the Harm?

Debbie Pool, BSN, RN, LNHA, ICP ✧ QIPMO Clinical Educator

Back on March 13, 2020, CMS issued revised guidance on visitation in QSO-20-14-NH. This guidance indicated that "**Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an *end-of-life situation*.**" CMS QSO-20-30-NH dated May 18, 2020, outlined guidance on a 3-phase plan for the reopening of nursing homes. The phase 1 guidance essentially reiterated the March guidance restricting non-essential healthcare personnel and included screenings, face coverings, social distancing and hand hygiene practices. Additional guidance was then issued by DHSS on June 15, 2020 allowing LIMITED OUTDOOR VISITATION following certain criteria and restrictions. Some of you have found creative ways to incorporate outdoor visitation and others have found the scheduling, monitoring of time, social distancing and disinfection somewhat cumbersome. I'm not sure that anyone back in March or even in June expected a form of visitation restrictions to still be in place in September, but here we are.

Many of you may have loved ones living in a long-term care setting and are experiencing this situation first hand. Others like me, hear or read the stories and wonder how families are surviving. It would be unbearable for me not to visit my parents if they were still alive. My sister asked what would we have done as our mother was in a SNF prior to her death and suffered with short-term memory issues. She wouldn't understand why her girls weren't there to visit. My reply was we would find a way to bring her home. That may sound flippant to some but I would have moved mountains ⛰ if necessary.

The shutdown happened quickly and with little if any warning. All of a sudden, our residents and families were s-e-p-a-r-a-t-e-d. We resorted to phone calls, face time, zoom, and closed window visits to maintain contact. But something was missing... human touch. We relied on our staff to not only be ***caregivers*** in full PPE but also to provide ***comfort*** in the absence of family. I know what you are saying, we do that every day. Yes we do, willingly and proudly and for some we are FAMILY, but put yourselves in their shoes. Wives haven't been able to hug

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their husbands, (you heard the story of the wife who took a job as a dishwasher to see her husband with dementia), children haven't been able to hold the hand of a dying parent or grandparent, missed birthdays and graduations. The list goes on and on.

So where is the HARM in reopening our homes to visitors? A co-worker said many years ago when answering a question on Medicare residents going out on pass: "it isn't a **|p|r|i|s|o|n|**." I'm beginning to wonder! Ask your residents and many will say they feel like they are in prison. We train our staff that this is the resident's home. If they were living in the community, they might limit visitation but I'm confident they would allow their family to visit.

We know that most COVID-19 **INFECTIONS** are brought into facilities by healthcare personnel. We have strict screening and testing procedures along with infection control practices to limit the spread of infection. With POC testing now available, it's time to develop a visitation procedure for families. I know this seems scary, but our residents have rights. We preach that every day. We need to address the social isolation and depression that many are feeling by looking to open our homes back up. It doesn't look like this crisis is going to end any time soon, so we must develop a plan for the future.

The Minnesota Department of Health (health.mn.gov) has a program called the *Essential Caregiver Guidance for Long-term Care Facilities*. This voluntary program recognizes the role of family members and other caregivers in the support and advocacy of residents. It allows LTC facilities to designate essential caregivers (EC), after input from residents, to provide companionship and assistance with ADLs. The program goal is to ensure high-risk residents receive individualized person-centered care. It improves residents' quality of life while alleviating caregiver tasks for staff. The EC's time in the building is limited to up to 3 hours or until caregiver tasks are complete. They receive education on proper PPE use, hand hygiene, social distancing and other infection control practices. The guidance provides additional criteria for a home's program development.

The holidays will be here before we know it. It's time to rally the troops, whether it be residents, families, ombudsmen, long-term care organizations, state, and federal agencies, elected officials or anyone who will listen. If we don't yell charge while moving forward, I'm afraid we are going to hear the CRIES and WHIMPERS of our lonely and sad residents.

QIPMO COVID-19 Resource Page

NURSINGHOMEHELP.ORG/EDUCATIONAL/IMPORTANT-INFORMATION-HELPFUL-LINKS-ON-CORONAVIRUS-COVID-19

Project Director
Marilyn Rantz, PhD, RN, FAAN

Project Coordinator
Jessica Mueller, BA

Project Support
Ronda Cramer

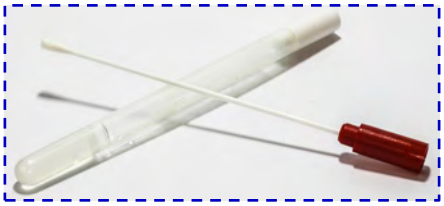
LTC Leadership Coaches
Nicky Martin, MPA, BS, LNHA, CDP
Mark Francis, MS, LNHA
Libby Youse, BGS, LNHA, CDP

QIPMO Clinical Educators
Wendy Boren, BSN, RN
Katy Nguyen, MSN, RN
Crystal Plank, BSN, RN, RAC-CT
Debbie Pool, BSN, RN, LNHA, ICP
Melody Schrock, BSN, RN, RAC-CT
Carol Siem, MSN, RN, RAC-CT, ICP, GNP-BC (retired)

University of Missouri
Sinclair School of Nursing

TESTING

Mark Francis, MS, LNHA ✧ QIPMO Leadership Coach



Testing has been promoted for *months* as one of the keys to managing the COVID-19 monster. It only makes sense. You can only manage a challenge you know about and can identify. You can hopefully keep the virus out of your building if you know who has it before they come in. You can help slow the spread of this virus in your home, but only if you know where it is. All of these steps come back to testing. Remember when you were a kid and you worried about an invisible **MONSTER** lurking in your dark bedroom? COVID-19 is that invisible **MONSTER** stalking around in the dark. Testing gives you "night vision goggles" to see the **MONSTER**. There are multiple times you will want to test and for various reasons. Let's look at these variables and try to sort out all the moving pieces.

THERE ARE THREE SITUATIONS WHERE TESTING IS REQUIRED:

1) **Symptomatic testing**: Any time a resident or staff member shows symptoms of COVID-19, they should be tested.
2) **Outbreak testing**: Any time you have a confirmed case of COVID-19 (staff or resident), you must test all staff and residents
3) **Routine testing**: Test all staff routinely (based on county positivity rate)

There is also a fourth situation for testing on a voluntary basis. This testing is used when you are planning to move from phase one to phase two in the Missouri re-opening process.

Let's look at each one of these with a magnifying glass to expand the details. Remember, with all of these reasons for testing, it is important to come up with ***written policies*** to direct what you are going to do and how to do it.

1) **Symptomatic testing**: When your routine screening of residents, staff and visitors picks up on any COVID-19 symptoms, you will want to do an immediate test. This can be done with a point-of-care antigen test in your building, or a PCR test performed by an outside laboratory. If results are positive, you will report to DHSS and your county health department (in addition to your routine NHSN reporting). All results are reported to the state BRDI* by the lab or by your facility depending on who did the test. Any positive results also trigger the "boxed-in strategy" for your facility. See #2 for details.
2) **Outbreak testing**: Any new case of COVID-19 among staff or residents (except a resident admitted with the virus) is considered an outbreak. You will need to test all previously negative staff and residents every 3-7 days until 14 days have passed with no new positive results. Test results are reported the same as in #1.
3) **Routine testing**: All staff now must be tested on a routine schedule based on the county positivity rate where your facility is located. **Green** counties test staff once per month. **Yellow** counties test staff once per week. **Red** counties test staff twice per week. If your county moves to a higher positivity rate, begin the higher testing rate immediately. If your county moves to a lower positivity rate, continue testing at the more frequent rate until at least 2 weeks at the lower rate. All test results reported as in #1.
4) **Re-opening process**. The ***final*** reason for testing is for those facilities who are moving along the phases of re-opening. This is a voluntary process for each facility. All staff must be tested (with all negative results) within 14 days prior to moving to phase 2. (This may have been met with the routine testing.) See guidance for re-opening for all criteria: health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/pdf/missouri-guidance-on-reopening-of-long-term-care-facilities.pdf. Again, test results are reported as in #1.

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While all these testing rules and schedules seem a little overwhelming, remember that all of these things help you see and fight the monster!

The following are some resources that give you more details on the whole testing process.

- Bureau of Reportable Disease Informatics
  Missouri Department of Health and Senior Services
  PO Box 570
  Jefferson City, MO 65102
  Telephone: 573-526-5271 | Fax: 573-526-6417 | Email: dhss.rdn@health.mo.gov
- Algorithm for interpreting antigen test results: www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf
- Reporting requirements for testing algorithm: nursinghomehelp.org/wp-content/uploads/2020/09/Reporting-Algorithm-QIPMO-0920.pdf

The New Cats in Town

Carol Siem, MSN, RN, GNP-BC (retired), RAC-CTA, ICP ✧ QIPMO Clinical Educator

COVID-19 has changed our lives in so many ways. Life in long-term care will **NEVER** be the same. QIPMO has been working with nursing homes in MO for over 20 years. During that time, it has grown from nurses helping guide MDS coordinators and DONs through the ever-changing landscape of long-term care. QIPMO now includes an administrator extension helping the facility's NHA(s) to navigate the administrative issues.

The year 2020 will go down in history as one of the hardest years of our experience.

We will come out on the other side **STRONGER**, but I am sure we will have horror stories to share as well as celebrations and accomplishments.

But there are other types of facilities that take care of the aging population. We're talking Residential Care Facilities, Assisted Living Communities, and Independent Living Facilities. Who is there to help them? Never fear! QIPMO has now added yet another expansion service to help these communities - **the CAT Team** (COVID Accountability Team). For those who have been around the industry, the names will likely sound familiar: Sharon Thomas (retired QIPMO nurse) is covering survey regions 3, 4, and 5; Carol Siem (semi-retired QIPMO nurse) is covering regions 6 and 7; and the new kid on the block is Rob Siem (yep... Carol's husband who is also a nurse – they've been together for 44 years and he understands long-term care) who is covering regions 1 and 2.

We are to help this group of facilities in navigating the reopening in these rough waters. (Please see the maps at the end of this newsletter!)

Our contact information is:

Sharon Thomas - thomassg@missouri.edu
Carol Siem - siemc@missouri.edu
Rob Siem - rws266@missouri.edu

Just like QIPMO, we're a free, non-regulatory, service to help answer questions!

For more information on QIPMO and Leadership Coaching, visit us at www.nursinghomehelp.org

Understanding Time, Risk, and Rest: Staffing Problems in a Pandemic

Wendy Boren, BSN, RN ✧ QIPMO Clinical Educator

There's no question that staffing has been a problem in all facets of healthcare long before COVID-19: double-shifts, covering weekends, exhaustion, frustration, too much time on call-ins. The staffing system in healthcare has been **BROKEN** for a long time. Add a highly infectious **disease** and a multitude of unknowns and even some of the most diligent of our staff are putting in their notice. So what do we do about it? We have to have people! There are **4** key parts to the staffing issue during COVID-19. By *understanding* and *acknowledging* these issues, hopefully you can spend more time caring and less time crying!

1) **Time, Risk, and Rest**... staff are hired to do a job. Those of us in healthcare have a higher calling to care but at the end of the day, we need a job and we need to get paid for that job. However, many of us also have spouses, children, and even older family members to care for. So how do we mitigate the risk to ourselves and family including giving the extra time? One idea many companies have had is hazard pay or "pandemic pay." Corporates and owners, especially in homes who have had outbreaks, have stepped up to the plate to truly take care of their employees via:
   - Hazard pay (more than a $.50 increase per hour)
   - Free meals and sometimes even meals for their families
   - Lodging and accommodations, including laundry services
   - Rest, respite, and mental health services

   The homes where I've talked to staff in these situations, the majority of staff are staying! They've made sure their employees know they are going to be taken care. If they're 5 minutes late checking in after three 12-hour shifts, they will not be written up. In short, they're taking a *human perspective* of staffing.

2) **Emotional Impact**... the hardest part of doing what we do is the *emotional* part, especially in long-term care. You can't be a good nurse or CNA unless you *emotionally* connect to your residents on some level. This connection mentality between leadership and staff on the floor is the same seen in homes with staff with high longevity. The *emotional* payment for staff in a pandemic are simple but require an honesty and legitimacy that will either carry you through COVID or call you out on the kind of company you are. In order to give that time and risk, employees want 5 things:

   i) *Hear* me. Hear their concerns. Invite them to talk to you. Bring them out in a comfortable setting, individually, and just say, "Hey, how are you?"; "What do YOU think?"

   ii) *Protect* me. Simple fact—I'll put my life on the line for theirs if you'll put your license on the line to protect me!

   iii) *Prepare* me. Talk to me. Tell me what's going on. Keep me informed in simple, brief communications. It will help me be less scared and more educated.

   iv) *Support* me. I may lose it. I'm working a lot of hours. I'm tired. I'm worried about my family, my residents, myself. The little things—lunch, chocolate, a hug!—these are the things that will help me get through the day. A gas card, a bonus, an extra two days off to mentally reset—that's what will support me.

   v) *Care for* me. At the end of the day, that's what I need to know more than anything. I need to know that I matter. I had one home tell me that their residents made cards for the workers and their families just to say "thank you" for taking care of me and Thank-you for letting me borrow your mom. Caring counts, big time!

3) **Physical Impact**... what we do is physically hard work and it's even harder when there's less people to do it. So this is the time to get creative with our staffing! Here's a few ideas

   Cross-train! Create a long-term staffing crisis plan and utilize everyone you

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have as efficiently as you can. Dietary staff can help with activities and vice versa, the receptionist can help with folding clean laundry. Cross-train to people to assist in feeding, walking residents, pouring drinks. This isn't rocket science people! We tend to silo ourselves into specific jobs. In a staffing crisis, we don't have time for that. It's all hands on deck. And it will serve you well even after the pandemic. *Need proof?* Look to the Eden Greenhouse models.

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Create teams and work 7-on; 7-off. I know of several homes using this strategy. Depending on the size of your home, the number may fluctuate a bit but they've divided their staff—all their staff—so that at one time there are approximately 1/3 of their staff off for 7 days, then it rotates through a 21-day cycle. This has proven to be beneficial because if a person or group gets exposed then there are others to plug the holes and everyone gets some real rest.

Be flexible in your scheduling. This isn't the time to lay down hard fast rules. You need the help. They're there to help you. Normal disciplinary measures in terms of tardiness, etc. may need to be refigured just to make sure you have the people. The key to this—be as fair and consistent as possible and keep good documentation.

4) **Future Planning**... it would be great if after COVID we had a **SURGE** in healthcare staff. We have dreams of a run on nursing schools and potential employees banging on our doors but let's be honest, those dreams haven't helped us in the past 10 years. It's time to ~~**STRIKE**~~ while the iron is hot and get the future staff ball rolling!

We have a unique situation where long-term care and healthcare in general is getting more national attention than ever. Right now we're considered heroes! And we know that doesn't come along every day. Families are watching us closer than ever. It's time to appeal to that. Reach into that pot of compassion and persuasion and personal platitude of human goodness to plant the idea of being in healthcare!

⋆ Email your congressman about reducing costs for nursing schools!

⋆ Write a letter to the editor about nurses and CNAs in your community!

⋆ Be active in your state healthcare associations about embarking on national nursing campaigns!

⋆ Beef up your company PR campaign at local high schools and colleges via their career fairs.

This is the time. Before something else takes over. Talk to your kids, talk to their friends, post on social media about what it means to be in healthcare. What we've been doing isn't working. But right now we have a chance to not be exhausted and frustrated.

If we campaign right, if we treat our current employees right, maybe we, ourselves, can actually start enjoying our weekends, too.

American Academy of Nursing Designates Five Renowned Nurse Leaders as Living Legends

Marilyn Rantz, PhD, RN, FAAN, is the premier expert in quality measurement in nursing homes and research programs to improve elder care. A nurse for 50 years, her pioneering work and innovative spirit is evidenced through the profession's paradigm shifts in measuring nursing home quality, utilizing new technologies to help seniors live independently, and gaining fair reimbursement for nursing services. Dr Rantz also initiated legislation to set the stage for nurses practicing to the full scope of their education and training and has received more than $87 million in various grants to further her work. She is Executive Director for the Aging in Place Project, which allows seniors to "age in place" through the creation of Sinclair Home Care and the Quality Improvement Program for Missouri which has transformed the care Missouri nursing home residents receive—both models being designated as Academy Edge Runners. Dr Rantz is a Curators' Professor Emerita, University of Missouri Sinclair School of Nursing.

Every1 Can Help Some1

Crystal Plank, BSN, RN, RAC-CTA ✧ QIPMO Clinical Educator

I believe that our focus changed when the PUBLIC HEALTH EMERGENCY took hold and it has kept us on our toes ever since. Many people changed jobs and many retired or left long-term care all together. Negativity is easy to find everywhere we look. Keeping a positive focal point is essential to our mental health.

We have many life roles and as a long-term care healthcare worker we touch residents, team members, family members, and vendors around you in either a positive or negative way. As restrictions bombard our daily routines in and outside of our workplace, we have an influence that is more impactful than ever before. An *unknown author* said, "*When you're a nurse, you know that every day you will touch a life, or a life will touch yours.*" I believe that is true in our profession.

Carl Jung said, "*The sole purpose of human existence is to kindle a light in the darkness of mere being.*" You are that ***shining light*** to the residents entrusted to your care by doing everything that you are able to do by changing routines, activities, bringing technology to residents that have never had that experience before and most of all, being attentive and listening to the needs of our individual residents during this time.

As we continue down this road let us all remember what *Ronald Reagan* once said: "*We can't help everyone, but everyone can help someone.*"

That is the importance of teamwork. Every person on the team has played an important role in the care of their residents during this pandemic. Each of us can provide light so our residents are not in darkness. You are the most courageous people I know and I am so proud to have you in this profession. "*Nurses (Caregivers) are humans by birth and heroes by choice.*" ~ *Renee Thompson*

Please Don't Burst Our BUBBLE

Sharon Thomas, BSN, RN ✧ QIPMO Clinical Educator (retired)

We have been ***missing you*** and are starting to make site visits again. Our visits will be outside and, for a time, will be LIMITED to Administrators, DONs and MDS Coordinators. We will be wearing masks and maintaining social distancing of at least 6 feet.

Please, when we come to your home, respect our need to stay healthy. As much as we have missed seeing each other in person, we cannot celebrate with a handshake or a hug.

See you soon!

Want on our e-mail list? Send your e-mail, name, title, and facility information to MUSONQIPMO@MISSOURI.EDU!

A NEW CAT IN TOWN

We're hoping to gather some more information from this side of LTC, so if you could please fill out our survey so we can learn how to further help you, we'd appreciate it greatly - www.surveymonkey.com/r/CATCOVID.

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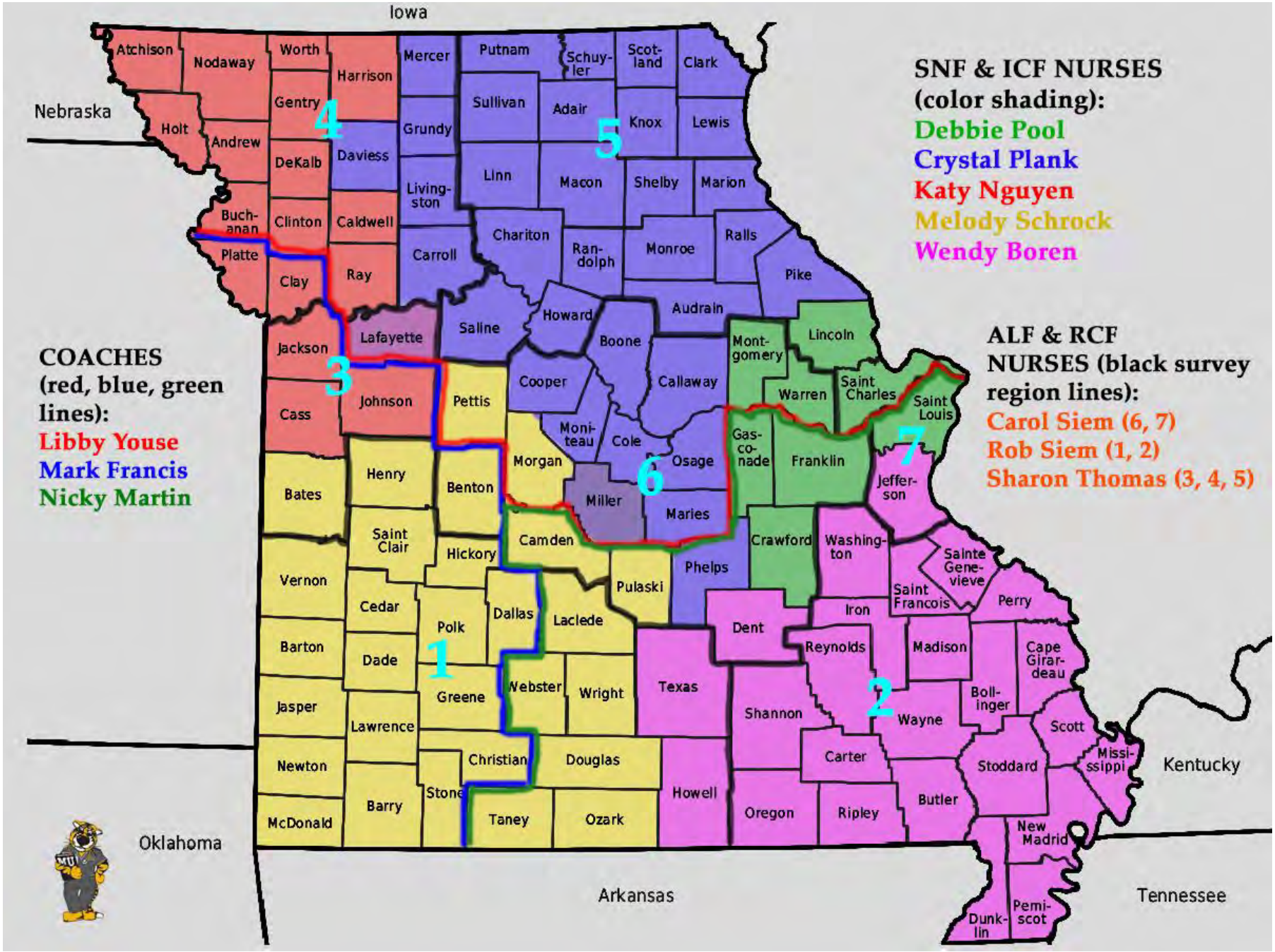
Iowa
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Oklahoma
Arkansas
Kentucky
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Mercer
Putnam
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Lafayette
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Saint Charles
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Moni-teau
Cole
Gas-co-nade
Franklin
Morgan
Osage
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Cape Girar-deau
Jasper
Lawrence
Shannon
Wayne
Boll-inger
Scott
Newton
Barry
Christian
Douglas
Howell
Carter
Stoddard
Missi-ssippi
McDonald
Stone
Taney
Ozark
Oregon
Ripley
Butler
New Madrid
Dunk-lin
Pemi-scot
1
2
3
4
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6
7
SNF & ICF NURSES (color shading):
Debbie Pool
Crystal Plank
Katy Nguyen
Melody Schrock
Wendy Boren
COACHES (red, blue, green lines):
Libby Youse
Mark Francis
Nicky Martin
ALF & RCF NURSES (black survey region lines):
Carol Siem (6, 7)
Rob Siem (1, 2)
Sharon Thomas (3, 4, 5)

Division of Regulation and Licensure
Section for Long Term Care Regulation
3418 Knipp Drive, Suite F
P.O. Box 570
Jefferson City, MO 65102-0570
Phone: (573) 526-8524
Fax: (573) 751-8493

Long Term Care Regions

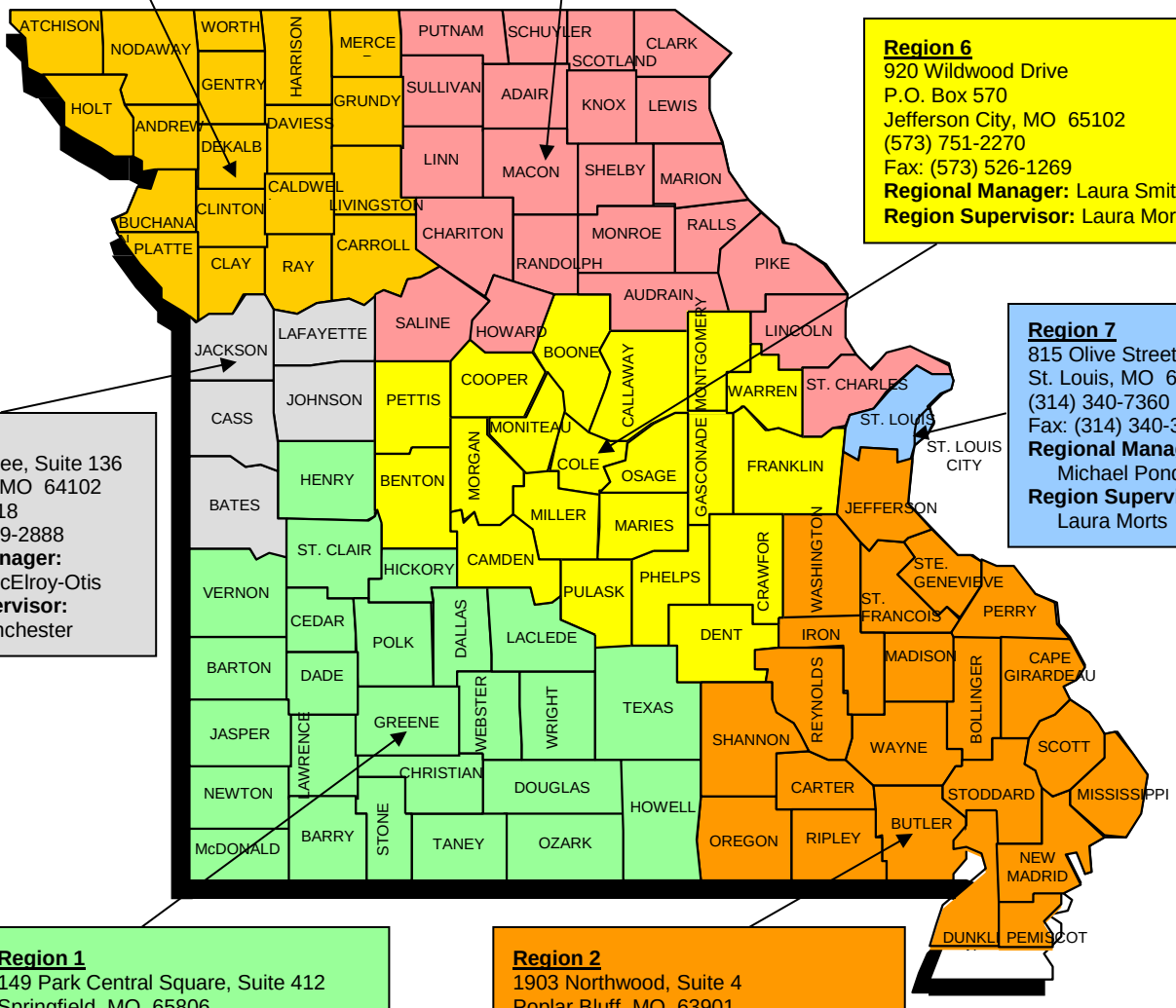
Region 4
207 East McElwain Drive
Cameron, MO 64429
(816) 632-6541
Fax: (816) 632-1810
Regional Manager: Candice Talbot
Region Supervisor: Sheila Winchester

Region 5
1716 Prospect Drive, Suite C
Macon, MO 63552
(660) 385-5763
Fax: (660) 385-4706
Regional Manager: Amy Rehard
Region Supervisor: Shay Patterson

Region 6
920 Wildwood Drive
P.O. Box 570
Jefferson City, MO 65102
(573) 751-2270
Fax: (573) 526-1269
Regional Manager: Laura Smith
Region Supervisor: Laura Morts

Region 7
815 Olive Street, Suite 10
St. Louis, MO 63101
(314) 340-7360
Fax: (314) 340-3414
Regional Manager:
Michael Ponder
Region Supervisor:
Laura Morts

Region 3
1410 Genessee, Suite 136
Kansas City, MO 64102
(816) 889-2818
Fax: (816) 889-2888
Regional Manager:
Michele McElroy-Otis
Region Supervisor:
Sheila Winchester



Region 1
149 Park Central Square, Suite 412
Springfield, MO 65806
(417) 895-6435
Fax: (417) 895-6290
Regional Manager: Ruth Tuttle
Region Supervisor: Sheila Winchester

Region 2
1903 Northwood, Suite 4
Poplar Bluff, MO 63901
(573) 840-9580
Fax: (573) 840-9586
Regional Manager: Cindy Rexroad
Region Supervisor: Shay Patterson

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