MDS Tips and Clinical Pearls

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IN THIS ISSUE

To Vaccinate or Not to Vaccinate

Melody Schrock, BSN, RN, RAC-CT, IP ✧ QIPMO Clinical Educator

The year **2020** brought us numerous challenges, changes and trials.

WE CRIED

WE GREW

we learned

We entered **2021** continuing a PANDEMIC that was declared a national public emergency in March **2020**. It's been 10 long, grueling months and still we continue:

continue learning

continue adjusting to changes

continue, unfortunately, with more loss & even more tears

There is, however, a light at the end of this dark tunnel. With continuing advances and research, multiple entities have and continue to work towards containing this COVID demon.

With that being said, it is important to address one of the greatest advances in a relatively short period of time - the COVID vaccine. There are fears related to this vaccine. Which are understandable. I, myself, had hesitation about whether or not to take the vaccine. However, I was forced to take a step back and look at the bigger picture. It isn't just about me. It isn't just about you. It's about our residents. Our families. Our community. Our nation. Our world.

I hate immunizations; it isn't the needle, but the after effects. I ache all over and my joints feel like they are on fire. But, if a resident with rheumatoid arthritis (or any other disability) who endures pain every day, is willing to speak up and say they want to take the COVID vaccination, then why would I not step up and do so? There are leaders in homes stepping forward to be examples for residents, staff and family by taking the vaccine. If it isn't too bad for residents or my parents, it is not too bad for you or me. Together, we can make the light brighter.

Will YOU step forward, too?

QIPMO Leadership Coach, Mark, and QIPMO Nurse, Mel, getting vaccinated! ♥

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

During These Depressive Times

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

For many, the holidays are a time for joy, love and family. For others it can be a time of deep sadness, loneliness and depression. The COVID-19 PANDEMIC has challenged us in ways we **never** thought possible. Residents have been isolated from friends and family for months. Staff are stressed due to long hours, frequent testing, and residents and co-workers dying. All these issues can lead to DEPRESSION.

Major Depressive Disorder (MDD) affects more than 16 million adults or 6.7% of the US population 18 years of age or older. Missouri ranks 13th, with 22.8% of our population diagnosed with DEPRESSION in **2019**. I'm sure if we took a poll today, it would show that those numbers have drastically increased these past few months.

Major Depressive Disorder, also known as clinical DEPRESSION, is a mood disorder causing one to experience sadness or a loss of interest. MDD affects how we *think*, *feel* or *act* leading to emotional or physical problems including metabolic or cardiovascular changes, substance use/abuse, and even suicide. This disorder can affect people of all ages, from children to our seniors. We have seen examples of this through news stories as children and teens have tried to adjust to remote learning, lack of sports and other interactive activities. Our residents have been placed in ISOLATION or restricted to their rooms unable to see friends within the home, visit with family or friends in person, or leave the facility to enjoy a car ride or a meal at a local restaurant.

DEPRESSION has no age limit, with many experiencing the same set of symptoms: sadness, emptiness, hopelessness, irritability or anger, anxiety, loss of appetite with weight loss, overeating with weight gain, and sleep disturbances. Younger children and teens may develop a clinginess to others, demonstrate poor performance or poor attendance at school, verbalize negative thoughts and worthlessness, experiment with alcohol or drugs, or self-harm. Older adults may demonstrate personality changes, memory difficulties, complaints of aches and pains such as headaches or back aches, limit socialization or outside activities, and even suicide, especially in older men. Participants in my regional healthcare coalition calls have recently mentioned an increase in the number of suicide attempts with, unfortunately, a number of successful attempts.

Let's focus on those residents currently in our care. Frequently, DEPRESSION goes undiagnosed, partially because people are afraid to admit to DEPRESSION due to the **stigma** that something is "wrong" with them or it may be that we haven't done an accurate assessment to identify a resident with depressive symptoms. When completing the resident interview for Section D Mood of the MDS, the interviewer asks questions that assist with identifying the aforementioned signs and symptoms of DEPRESSION. Information on the frequency of symptoms is also elicited. From this information we are able to obtain the PHQ-9 score. For PDPM purposes, a resident is considered depressed if D0300 Resident interview score is ≥10 but not 99 or D0600 Staff interview score is ≥10. The Special Care High category would be selected according to the Nursing function score and the presence or absence of DEPRESSION. A PHQ-9 score ranging 5-14 reflects mild to moderate DEPRESSION with the clinician using his/her clinical judgement for treatment based on symptom duration and functional impairment. A score of 15-27 indicates moderately severe to severe DEPRESSION. Treatment generally includes an antidepressant, psychotherapy, or a combination of both.

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Additionally we have another tool in our toolbox: the Geriatric DEPRESSION Scale (GDS). This short-form tool is 15 yes/no questions asking the resident to identify his/her mood in the past 7 days. This tool may be used for residents with a short attention span, mild to moderate cognitive impairment, or those who easily fatigue. A score of 5 or greater suggests DEPRESSION. The clinician can then choose treatment according to the **severity** of depressive symptoms.

Medications and psychotherapy are great adjuncts to resident care but let's ask ourselves… what other options are available? I can think of several: a kind word, a friendly smile, and human touch. The PANDEMIC has turned our world upside ↑ down ↓ with quarantining of residents, wearing PPE where residents can't identify faces or hear our words, and staffing challenges which limit the amount of personal time staff can spend with residents. Might *you* be depressed sitting for hours on end, alone in a room, with *no one* to talk with except when you receive your meal tray or direct care?

In spite of these challenges, we continue to provide person-centered care. Have you learned anything **new** about the residents in your care during these challenging times? Unusual sleep patterns, activity likes or dislikes such as music or art therapy, exercise, meditation, massage therapy, or journaling: many of our activity departments have met the challenges with doorway bingo, singing and exercise programs, in addition to **1:1** activities.

As many struggle to put one foot in front of the other, let us remember that each of us is unique but may share the same struggles in silence. If you or someone you know needs assistance, don't be afraid to reach out.

There is no shame in asking for help - There for the grace of God go I

SAMSA National Helpline: (800) 662-HELP (4357) - free, confidential, available 24/7/365.

Resources:

- https://www.newsweeek.com/states-highest-rates-depression-1554263 - States with the Highest Rates of Depression Andrew Lisa, Stacker News
- www.cms.gov - MDS 3.0 Version 1.17.1
- geriatrictoolkit.missouri.edu

Project Director
Marilyn Rantz, PhD, RN, FAAN

Project Coordinator
Jessica Mueller, BA

Project Support
Ronda Cramer

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

CAT Team
Carol Siem, MSN, RN, RAC-CTA, IP, GNP-BC (ret)
Rob Siem, BSN, RN, IP
Sharon Thomas, BSN, RN, IP

QIPMO
Partnering with You to Promote Quality

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

ICAR Facilitators
Janice Dixon-Hall, IP
Shari Kist, PhD, RN, CNE, IP
Nicky Martin, MPA, BS, LNHA, CDP, IP
Steve Miller, MA, IP
Sharon Thomas, BSN, RN, IP

University of Missouri
Sinclair School of Nursing

The Role of the Charge Nurse

Katy Nguyen, MSN, RN ✧ QIPMO Clinical Educator

The role as **NURSE SUPERVISOR** or **CHARGE NURSE** in long-term care settings is very important for the successful management of a specific unit or in the whole facility. Especially during the current PANDEMIC, the day-to-day challenges of a **CHARGE NURSE** have changed in significant ways. This article emphasizes the complexity of this role in a nursing home, recognizes that the job can be stressful during the crisis, and how much the **CHARGE NURSE** needs a lot of support from the administration and the organization to complete the role successfully.

While the director of nursing (DON) is a nurse manager overseeing all shifts in the whole nursing department, the **CHARGE NURSE** is responsible for the period of time s/he is working on a particular shift or unit. S/he reports to either the director of nurses (DON) or assistant director of nurses (ADON). This mean s/he needs to have knowledge of clinical nursing care and medical issues on resident care in order to direct other nursing staff such as certified nurse assistants (CNAs), certified medication technicians (CMTs), restorative assistants (RAs), etc., providing them guidance, advice and making them aware of the issues related to residents, staff, and visitors. The role of the **CHARGE NURSE** requires excellent leadership, good communication and interpersonal skills; these are ***necessary*** components for the role. The position helps with promoting staff morale during the shifts, creating a healthy and pleasant environment, motivating and leading the nursing staff, and working effectively with different personalities.

The most common non-clinical issues faced by the charge nurse involve resident and staff concerns, supplies, and equipment. For example, resident concerns may be related to a staff and resident, resident and another resident, and even a resident and a family member. The **CHARGE NURSE** is required to listen to the resident's concerns and work to reach a resolution. The **CHARGE NURSE** may be required to plan and coordinate with other clinical professionals or administrative staff participating in the plan that is to play a part of the solution. Staff concerns are usually related to staffing issues, staff members not getting along, staff disagreements with assignments, and/or the concerns of improper care practices and quality of care delivery. For this complexity, the **CHARGE NURSE** is ***required*** to listen, communicate, coordinate, investigate and even to be a mediator. In a typical day, the non-clinical duties of are to coordinate daily administrative duties, including schedules, nursing assignments and residents' care, and observe work performance of CNAs, CMTs, and other staff nurses in delivery of direct care. The **CHARGE NURSE** delegates responsibility for the direct care of specific residents or tasks based on the need of the residents, provides shift report to the coming shift, serves as liaison of other clinical care professionals and replaces the called-in staff; supervises nursing staff monitoring their needs; liaisons with doctors, administrators and DON and communicates any protocol changes to staff.

For the clinical duties, the **CHARGE NURSE** manages administration of medications, orders medications from the pharmacy, takes phone orders and receives recommendations from physicians and other clinical professionals, performs counts of control drugs, carries out treatment plans, and makes referrals and documentation of nursing's plan and interventions. (*Sounds simple, right?!?*) Beyond *those* duties, the charge nurse has to observe, monitor and evaluate resident's physical and emotional status, oversee resident

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admissions, transfers and discharges, respond to emergency or critical situations, record in residents' medical records, monitor for risk management, **AND** coordinate liaison with residents and families.

During a PANDEMIC, the clinical concerns are how to monitor and assess the residents who are in isolation or placed in the **COVID** unit or the designated rooms, how to admit, readmit and discharge the residents, how to decide to quarantine or isolate the suspected or presumed cases and keep staff and other residents practicing the transmission-based precautions. **ON TOP OF THOSE**, the **CHARGE NURSES** have to understand the changed regulations, keep up with professional guidance, and provide support for the family members on disease progression, emotional distress, fear and anxiety.

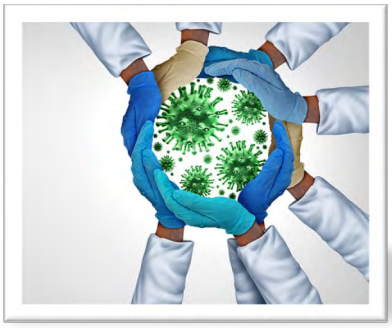
The QIPMO team **GREATLY** appreciates your contribution to the nursing home. Your role as a **CHARGE NURSE** is a very important component of the quality care delivery system to the residents. We recognize your roles in different dimensions from supervisory, team support and management. Please feel free to contact your QIPMO nurse or leadership coach for any support, professionally or emotionally if needed. We are here for you. Thank you!

References:

- AHRQ: CUSP module 2018; STEP program 2017.
- American College of Health Care Administrators (ACHCA): Essentials Core Functions.

INFECTON CONTROL ASSESSMENT AND RESPONSE

QIPMO has partnered with the Missouri Department of Health and Senior Services (DHSS) in response to the novel Coronavirus known as **COVID-19**.



In doing so, QIPMO has formed a new **INFECTION CONTROL ASSESSMENT AND RESPONSE** (ICAR) team with a primary goal of assisting Missouri Long-Term Care Facilities to navigate the challenges of the **COVID** PANDEMIC and other infectious diseases.

Members of the ICAR Team are available for ***voluntary***, ***no cost*** visits (virtual and/or in-person) to any residential care, assisted living, and skilled nursing facility in Missouri.

These visits are intended to be consultative and collaborative in nature with a **non-regulatory** focus to evaluate infection control practices.

Facilities interested in assessing their infection prevention programs and partnering to enhance patient safety through quality facility assessment, staff education and training can contact the QIPMO ICAR Team at musonicarproject@missouri.edu. *Please be sure to include your facility name, your name, and your title in your email*. Visit us at nursinghomehelp.org/icar-project/ for more resources, in addition to the attached press release.

WANT ON OUR E-MAIL LIST? SEND YOUR E-MAIL, NAME, TITLE, AND FACILITY INFORMATION TO MUSONQIPMO@MISSOURI.EDU!

Housekeepers

Another Important Team Member

Libby Youse, BGS, LNHA, CDP, IP ✧ QIPMO Leadership Coach

cleaning and *disinfecting* have always been an important part of nursing home care. It became even more clear to us in **2020** that we all must step up our game and improve our *cleaning* practices and our training systems in our homes. Pathogens can survive for long periods of time if proper *cleaning* and *disinfection* are not completed properly.

Environmental surfaces in a building are divided into two categories. Surfaces with ***minimal*** *hand touch* contact such as the floor and ceiling and surfaces with ***high*** *hand touch* areas such as light switches, doorknobs, bedrails, handhold bars, nurse's desk, and common areas.

When *cleaning* anything that is visibly soiled it should be cleaned with soap and water and removed from the area. Then a proper *disinfecting* agent should be used to clean whatever surface you are cleaning. I don't say that to be confusing but there are so many. If you are *cleaning* and *disinfecting* a glucometer you might be using the purple wipes and that glucometer now needs a drying time of four minutes after it is wiped down with the disinfectant. On a floor you are going to use a hospital disinfectant that is registered with Environmental Protection Agency (EPA) and it will also require a contact drying time period.

www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19

In our buildings we must have clear housekeeping policies just as we have clear nursing policies. Just like nursing policies, they are not any good behind a LOCKED OFFICE DOOR. A good way to keep housekeepers on track is check ✓off sheets. Housekeepers have a lot to be responsible for at this point because they have to know the order that cleaning the ***low*** *touch* surfaces, ***high*** *touch* surfaces, bathroom, and floor is important and that some things have to be completed multiple times per day.

A good thorough orientation program for new housekeepers along with a continuous training program is vitally important. I don't want to say life or death, but with COVID maybe? Training programs need to include the proper PPE donning and doffing, CDC guidelines, and EPA guidelines. They must learn each and every disinfectant in your building and its contact time. If products must be mixed, the right measuring tools to mix properly need to be provided and not guessing at amounts. Housekeeping staff need to have competency tests to ensure that they understand the *cleaning* and *disinfecting* process.

Last but not least,

housekeepers need to be reminded just how important their positions are on your team.

Every once in while when you really want to know something important about a resident… you might need to go ask a housekeeper.

EMPLOYEE ENGAGEMENT

Mark Francis, MS, LNHA, IP ✧ QIPMO Leadership Coach

If I were to ask, what is the greatest asset in your long-term care facility, you would probably say the employees. While that is true, I would argue a distinction. Employees are not your greatest asset, **ENGAGED** employees are your greatest asset! (You can probably think of certain previous employees that created great joy… by leaving.)

Employee engagement is defined as the extent to which employees feel passionate about their jobs, are committed to the organization and put discretionary effort into their work. Wouldn't we all love a building full of workers like that?!! The GALLUP organization has been measuring employee engagement for 20 years now. They report that only about $^1/_3$ of employees nationwide are engaged at their job. While they don't have specific numbers for the long-term care industry, I would guess that we are pretty similar to other industries when it comes to employee engagement.

GALLUP'S employee engagement work is based on more than 30 years of in-depth behavioral economic research involving more than 17 million employees. Through rigorous research, GALLUP has identified 12 core elements -- the Q12 -- that link powerfully to key business outcomes. These 12 statements emerged as those that best predict employee and workgroup performance.

The *Twelve Questions* are:

1) Do you know what is expected of you at work?
2) Do you have the materials and equipment to do your work right?
3) At work, do you have the opportunity to do what you do best every day?
4) In the last seven days, have you received recognition or praise for doing good work?
5) Does your supervisor, or someone at work, seem to care about you as a person?
6) Is there someone at work who encourages your development?
7) At work, do your opinions seem to count?
8) Does the mission/purpose of your company make you feel your job is important?
9) Are your associates (fellow employees) committed to doing quality work?
10) Do you have a best friend at work?
11) In the last six months, has someone at work talked to you about your progress?
12) In the last year, have you had opportunities to learn and grow?

If you want to survey your own staff, you will need to get permission from GALLUP to use their questions since they are copyrighted. However, a site called *Hive* has a similar list of questions that is open sourced (free to use however you wish!!)

HACKING GALLUP'S Q12—AN IMPROVED ALTERNATIVE

While a current snapshot of employee engagement is a valuable starting point, the bigger question is: What can I do to increase engagement in my staff? Gregg Lederman, in his book *Crave* (copyright 2018, Brand At Work), identifies three basic needs or cravings we all desire to have met by our work. These are *AUTONOMY*, *COMPETENCE*, and *SIGNIFICANCE*. If you can help your employees get these three cravings met, you will find yourself surrounded by a group of **ENGAGED** and **GRATEFUL** people. Most importantly, they will regularly go above and beyond expectations to meet the needs of the residents you care for. (Plus, they are less likely to be looking for a different job!) In following issues of the QIPMO newsletter, we will discuss these universal needs in more detail. See you then!!

No More BUTS!

Wendy Boren, BSN, RN, IP ✧ QIPMO Clinical Educator

At every point in the career of any DON or administrator in long-term care, there's a single thought:

How can I make this better?

It's part of who we are. It's what drives us to improve life for our residents, our staff, our company. But those thoughts are always contingent on "but…". If we've learned but anything from **COVID** it's that tomorrow is NOT guaranteed, crazy things DO happen, and processes, even the most *well-planned* and *practiced*, breakdown. We must do the best we can, while we can, and all of you reading this are a testament that you can, and have, done just that.

So, for **2021**, I challenge you to borrow from the old Nike logo and *Just Do It*!

Let's make it simple (and if you need another QAPI project, call it "culture change").

Send out a survey asking employees and residents to list the *top 5 things* they'd like to see changed in **2021**. You may be surprised when it's as simple as fixing the handle on the bathroom sink or lowering the mirror on the closet door!

Pick a day of the month - like the second Thursday morning (because not everything cool has to happen on a Friday afternoon!) and make that *donut day* or whatever suits your fancy. It will give everybody something to look forward to. Whatever it is, keep it simple so it doesn't require a lot of planning or doing - nobody has time for that. And who doesn't like *donuts*?! (Okay, settle down, health nuts.) One home I know of even has muffins and bagels donated by their local Panera!

Leave a basket of thank-you notes sitting out for whomever to use. It's nice to be able to say thank-you to those who help us and if you're a resident, sometimes finding a way to do that is hard. Maybe it's just a basket of construction paper hearts that they can grab from their wheelchair and hand to that special CNA who took the time to sit with them when they were lonely or homesick.

Start a reading club. I'm an avid reader and I don't see that changing no matter how old I get! Again, make it a "thing" - every Wednesday evening from 6:30-7:30 or in the afternoons… everyone is welcome; give them a designated spot, provide drinks. Social distance if necessary.

Do a reverse care plan! Instead of writing a care plan about your RESIDENTS, send out a quick bio with that survey and showcase your STAFF. It's nice to know who is taking care of you and you may even find some common interests between staff members or staff members and residents. Just make sure you profile it at eye level for residents in wheelchairs so they can easily read about them too.

It doesn't matter what it is - the bigger and brighter the better in my opinion after the oppression of **2020**! It's just time to make some dreams come true. I know one thing is for sure - **2020** taught me to VALUE MY LIFE more than ever - my home, my family, my friends, my colleagues. Instead of letting **2021** be dictated by regret and regression, stand out! Make a difference! Involve your families. Make a community with your community… **2020** showed that we could; let's show **2022** that we DID!

And for all you have done already and all you are still doing
Thank you and God Bless

QIPMO COVID-19 Resource Page

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

INFECTION CONTROL ASSESSMENT AND RESPONSE PROJECT: A COLLABORATION BETWEEN THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES AND THE QUALITY IMPROVEMENT PROGRAM FOR MISSOURI NURSING HOMES

The Quality Improvement Program for Missouri's Nursing Homes (QIPMO) is partnering with the Missouri Department of Health and Senior Services (DHSS) in response to the novel Coronavirus known as COVID-19. In doing so, QIPMO has formed a new Infection Control Assessment and Response (ICAR) team with a primary goal of assisting Missouri Long-Term Care Facilities to navigate the challenges of the COVID-19 pandemic and other infectious diseases.

Members of the ICAR Team are available for voluntary, no cost visits (virtual and/or in-person) to any residential care, assisted living, and skilled nursing facility in Missouri. These visits are intended to be consultative and collaborative in nature with a non-regulatory focus to evaluate infection control practices. Visits will consist of:

- completion of a standardized assessment of infection control processes, focusing on highly transmittable infectious diseases
- observations of infection control practices
- preliminary feedback with supplemental educational resources

Participating facilities will receive a comprehensive feedback report following the visit. Additionally, the QIPMO ICAR team will be available to participating homes for follow-up assistance and education as requested.

It is the goal of this project to visit (virtual or in-person) 60% of all long-term care facilities in Missouri by the end of 2022. Assisted living facilities and residential care facilities, along with prioritized skilled nursing facilities, will be among the first recruited for an ICAR Team assessment. In person visits will only take place once facilities reopen and can safely allow visitors.

Funding for this project was made possible through the ELC Enhancing Detection Emerging Issues (E) Project: Funding for the Detection, Response, Surveillance, and Prevention of COVID-19 which is supported through the Paycheck Protection Program and the Health Care Enhancement Act of 2020.

Facilities interested in assessing their infection prevention programs and partnering to enhance patient safety through quality facility assessment, staff education and training can contact the QIPMO ICAR Team at musonicarproject@missouri.edu or at (573) 882-0241. *Please be sure to include your facility name, your name, and your title in your email request*.