MDS Tips and Clinical Pearls

Volume.8
Issue.4
August 2021

IN THIS ISSUE

This Is Your Legacy

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

Have you ever looked at your children or coworkers and wondered…

"When I am gone, what will be my legacy?"

I think we've all thought about that at some time or another. And I think COVID has peaked that question again in all of us. Someday… what will *we* leave behind?

Some people think of legacies as plaques on a wall or trophies on a bookshelf. Others think **BIG** and mark the world like Mother Theresa, Bill Gates, and Mahatma Gandhi. But for most of us, I think the ***real*** legacies we leave behind are much simpler.

As we've made it back into homes (and now somewhat back out again, sadly), everything you've endured the past 18 months can be seen and felt in your home. There's an energy there, a change from what it used to be. Some of you meet us with that same fire and resilience that sustained you through the worst and, like fierce warriors, you're readying your armies for battle again. Perfectionists have turned into survivalists because somewhere along the way it became more about meeting the needs of those right in front of you—holding a hand taking that time to listen changing a bed . You also prepare to fight again, but with wariness, humbling fatigue, and hugs that are just a little harder than maybe they were before. And some of you have

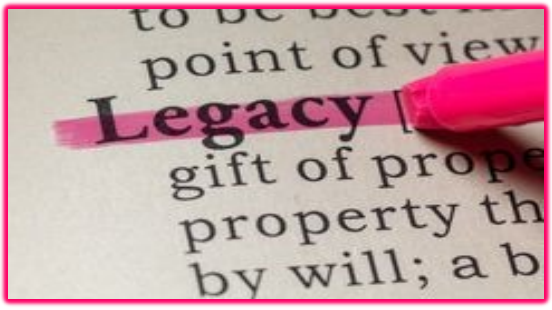
checked out

because you've had to… because mentally your heart and your head need a break. You're going through the motions and doing your best to come day-to-day-to-day. And you also will fight again

because you don't know what else to do.

I'm saying this now—take that time. Take that time for you and for your family, ***both*** at home and at work. Even the best warriors need time off the field. And for all of you, we'd like to offer some words of hope.

continued on page 2



Sinclair School of Nursing
University of Missouri Health System

continued from page 1

What I've seen when I walk into your homes is strength… true, down-to-the-core, nobody's-going-to-mess-with-my-people, **strength**! **Resilience**: mental walls are up (albeit a bit unsteadily sometimes), but again with the powerful truth behind it that those most precious to you are being protected the best way you know how. And **ingenuity**! Necessity is indeed the mother of invention and I've seen amazing creativity over the past 18 months through home visits and video calls. It's truly amazing what determined people with duct tape, shower curtains, and a Lowe's card can do so that they make sure their residents see their families. **That is your legacy, my friends.**

That is what you've done more than anything else. You've built trust, kindness, compassion, and teamwork along with those partitions. It's the **kindness** they'll remember. You've had to make some **hard** choices and do some **hard** things—mostly on very little sleep, supplies, and few hours with **your own families**. But your work, those frustrations, were for the greater good.

We've talked for years about creating a **home**. You may not see that now and you most certainly probably do not feel it when we've had to tuck people away for too long. Those physical places are just space. **You've created a home.**

A place where people feel safe and healthy and happy. Keep going! You're doing an amazing job in a really hard time. **YOU are creating heroes and are one yourself.**

Your kind word, your **hard** hug, your shared tears, your extra hour—this is your legacy. What an incredible gift to leave behind.

God bless.

Project Director
Marilyn Rantz, PhD, RN, FAAN

Senior Project Coordinator
Jessica Mueller, BA

Project Support Specialist
Ronda Cramer

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

University of Missouri
Sinclair School of Nursing

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

When Should I Schedule an ICAR?

Shari Kist, PhD, RN, CNE, IP ✎ *QIPMO ICAR Clinical Evaluator*

Have you been waiting until the time is right to schedule an Infection Control Assessment and Response (ICAR) evaluation for your facility?

The time IS right!

We are into a new phase of the COVID-19 pandemic – dealing with new outbreaks, particularly of that pesky **DELTA VARIANT**. By completing an **ICAR** assessment of your existing infection prevention practices, you can identify opportunities for education and policy revision. We have learned over the past 18 or so months that COVID can get into a building even if you thought you were prepared. An **ICAR** visit provides an extra set of eyes l⦿⦿king at how you implement key infection control procedures such as PPE usage, hand hygiene, housekeeping, managing COVID positive **+** residents, and testing. Unfortunately, we cannot guarantee that COVID won't get in, but we *CAN* provide you with guidance on implementing CDC recommendations in your facility.

An ICAR visit typically takes 1½ - 2 hours and can be either onsite or virtual. Most of the visit is completed in a meeting-like setting followed by a shorter tour of your facility. This tour is intended to validate infection prevention strategies like staff/visitor **screening**, hand sanitizer **availability**, staff PPE **use**, housekeeping **practices**, and COVID unit **plans**. While the **ICAR** team member uses a standardized questionnaire to evaluate your processes, a visit often leads to a discussion of challenges faced with implementing CDC guidance. We've been able to assist with problem-solving in areas such as:

- PPE storage for reuse
- Placement of hand hygiene dispensers
- Screening of staff and visitor
- Resident assessment and placement

Each home receives a detailed report following the **ICAR** visit. The report includes the assessment of your building as well as links to state and CDC guidance that can be used for policy revision and staff education. An ICAR report can be used as an internal QA document that guides future QA audits and initiatives.

ICAR evaluations are available to *ALL* skilled, assisted, residential, and intermediate care facilities in MO at no charge. Members of the **ICAR** team are **NOT** surveyors; they're evaluators providing feedback in a manner that is readily applicable to *YOUR* building. If you are interested in learning more or would like to schedule an **ICAR** visit, please email musonicarproject@missouri.edu or call (573) 882-0241.

The! Time! IS! right!

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

ENHANCED BARRIER PRECAUTIONS: WHAT'S NEW?

Katy Nguyen, MSN, RN ❁ QIPMO Clinical Educator

In 2019, CDC issued a guidance to introduce a new precaution called ***Enhanced Barrier Precautions (EBP)*** which is a new approach to expand the use of PPE for specific resident activities to prevent the transmission of novel or targeted MDROs. According to the CDC, novel or target MDROs identified in 2019 are ***pan-resistant organisms, carbapenemase-producing Enterobacteriaceae, carbapenemase-producing Pseudomonas spp., carbapenemase-producing Acinetobacter baumannii, and Candida auris*)**. **This article briefly addresses the CDC guidance of EBP requirements in nursing home. More information can be found in CDC website, or you can contact your QIPMO nurse for training information.**

EBP falls between **Standard** and **Contact Precautions** and requires gown and glove use during specific high-contact resident care activities that have been found to increase risk for MDRO transmission. Examples of high-contact resident care activities are: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care (any skin opening requiring a dressing) [CDC 2019]. This guidance is specifically intended at a minimum to be triggered by the presence of a novel or targeted MDRO in at least ① one ❶ resident.

The difference between the **contact precautions** and the ***EBP*** is that while contact precautions require the use of gown and gloves on every entry into a resident's room and the resident is given dedicated equipment and stays in the private room; the ***EBP*** does *NOT* require gloves and gowns for resident's activities (*UNLESS* those listed under high contact care activities) and the residents are not restricted to their rooms or limited from participation in group activities. However, the ***EBP*** *CANNOT* be replaced with **Contact precautions** that are still used for infected or colonized residents in certain situations, including but not limited to, units with suspected or documented MDRO transmission, *C. difficile*, norovirus, etc.

Your facility should address the use and application of ***EBP*** following the CDC guidance. For example, how to implement the ***EBP*** if residents are placed on EBP, including posting clear signage outside the resident's room, making PPE available outside the room, access to alcohol-based hand gel outside the resident's room, and providing education to staff, residents, families, and visitors for other infection prevention measures such as hand hygiene, environmental cleaning, and cleaning/disinfection of medical equipment.

The policy also indicates what and how to apply ***Enhanced Barrier Precautions*** to residents infected or colonized with other epidemiologically important MDROs and the required PPEs including gown, gloves, and face protection (in case of risk of splash or spray). The table on the next page shows the differences between **contact precaution** and ***EBP*** (excerpt from CDC guidance).

continued on page 5

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

continued from page 4

SUMMARY OF PPE USE AND ROOM RESTRICTION WHEN CARING FOR RESIDENTS COLONIZED OR INFECTED WITH NOVEL OR TARGETED MDROS IN NURSING HOMES

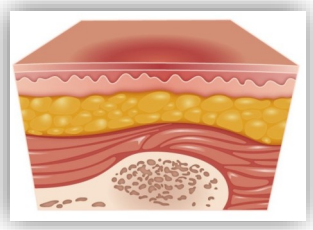
PRECAUTIONS	APPLIES TO:	PPE USED FOR THESE SITUATIONS:	REQUIRED PPE	ROOM RESTRICTION
Standard Precautions	All residents	Any potential exposure to: ★ Blood ★ Body fluids ★ Mucous membranes ★ Non-intact skin ★ Potentially contaminated environmental surfaces or equipment	Depending on anticipated exposure: gloves, gown, or face protection (change PPE before caring for another resident)	None
Enhanced Barrier Precautions	All residents with *any of the following*: ★ Infection or colonization with a novel or targeted MDRO *when Contact Precautions do not apply*. ★ Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) *regardless of MDRO colonization status* who reside on a unit or wing where a resident known to be infected or colonized with a novel or targeted MDRO resides Facilities may consider applying Enhanced Barrier Precautions to residents infected or colonized with other epidemiologically important MDROs based on facility policy.	During high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing 	Gloves and gown prior to the high-contact care activity (change PPE before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray)	None 
Contact Precautions	All residents infected or colonized with a novel or targeted multidrug-resistant organism *in any of the following situations*: ★ Presence of acute diarrhea, draining wounds or other sites of secretions or excretions that are unable to be covered or contained ★ On units or in facilities where ongoing transmission is documented or suspected For infections (e.g., *C. difficile*, norovirus, scabies) and other conditions where Contact Precautions is recommended see Appendix A – Type and Duration of Precautions Recommended for Selected Infections and Conditions of the CDC Guideline for Isolation Precautions	Any room entry 	Gloves and gown (don before room entry, doff before room exit; change before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray)	Yes, except for medically necessary care

Wounds, Wounds, Wounds!

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

Just when we thought life was getting back to a new normal… here comes the Delta variant rearing its ugly head! It seems as though homes can't catch a B R E A K. One area we ***shouldn't*** *take a break from is*

PRESSURE ULCER/INJURY PREVENTION



We have seen an uptick of homes reporting pressure ulcers/injuries (PU/PI) during the COVID public health emergency. In Region 7, wound prevention and wound assessment and documentation are the most requested forms of staff education. According to QCOR https://qcor.cms.gov, F686 Treatment and Services to Prevent/Heal Pressure Ulcers ranks #7 in frequency of citation with 39 citations in 6% of Missouri homes for fiscal year 2021. The intent of F686 is to ensure residents receive care to "promote healing, prevent infection and prevent pressure ulcers from developing" while providing care consistent with professional standards of practice. Each home should have policies and procedures which address frequency of assessments, monitoring, measurements, and documentation. Policies should also outline steps for risk identification with interventions for wound prevention.

The citations vary from failure to have a process to ensure CNA reporting of new NEW! or worsening worse skin conditions and soiled or missing dressings, failure to perform routine weekly skin assessments, failure to notify the physician in a timely manner when a new pressure ulcer is identified, failure to obtain treatment orders and complete treatments as prescribed, and failure to accurately identify and stage a wound as a PU/PI. Some of these citations have risen to a "G" level which is not ideal. This has the potential to lead to fines $ especially if this is a repeat citation for the home.

So WHERE DO WE START? I say, back to the basics of wound prevention. If we focus on wound prevention to keep PU/PI from developing, then maybe the numbers requiring assessment and documentation by nurses will be less. As a new QIPMO nurse in April 2019, my first educational session was with *Carol Siem* as we visited a St. Louis area home. We discussed moisture, mobility, and nutrition in wound prevention. Carol brought M&Ms with her to aide staff in remembering the moisture and mobility component. I continue to provide M&Ms during my wound prevention education. They aren't very nutritious, but it is a nice snack.

The moisture component of PU/PI prevention includes toileting of the resident, use of briefs, pull ups or under pads to absorb moisture, limiting exposure to urine or feces by routinely checking and changing and application of a moisture barrier to protect the resident's skin. Keeping a resident mobile plays an important role in prevention. Repositioning the resident in a wheelchair every hour or in bed every two hours is the current standard of practice. The nurse should notify the CNA if a resident has special positioning requirements. A lift pad is necessary when repositioning a bedbound resident to prevent a friction or shear injury. Pillows and wedges should be placed to prevent skin to skin contact. All residents at risk for pressure ulcer/injury development should be placed on a pressure redistribution surface in addition to a cushion in the wheelchair. Residents should have their heels offloaded when in bed by either pillows or specialized boots.

continued on page 7

continued from page 6

Residents may be placed on nutritional interventions depending on the severity of the wound. These may include foods fortified with protein, addition of vitamins, minerals, supplements, or powdered additives to juices or water. Residents should be encouraged to drink a minimum of 1500 ccs of fluid daily with frequent offerings at each resident contact. All nursing staff should perform daily skin inspections, reporting any identified changes to the nurse. These changes should be evaluated and reported to the practitioner with orders carried out as prescribed.

As part of your home's ***quality assurance*** program, the incidence and prevalence of pressure ulcer/injury development should be monitored monthly. A root cause analysis for facility-acquired PU/PI should be performed to identify the "why" reason for development. HSAG has a tool, *Facility Acquired Pressure Ulcer Investigation Form,* to assist in your analysis - www.hsag.com. Don't forget about my favorite tools the *CMS Critical Element Pathways*, 20078 *Pressure Ulcers, 20120 Positioning, Mobility and ROM,* and *20125 Bowel and Bladder Incontinence* located at www.cms.gov.

Your review should also include monitoring of the pressure ulcer short- and long-stay quality measures and those long-stay measures that may affect pressure ulcer/injury development: residents whose ability to move independently worsened, residents whose need for help with daily activities increased, and low-risk residents who lose control of their bowel and bladder. Consider development of a performance improvement project (PIP) to aide in improvement of your quality measure star.

The challenges of severely ill residents, low staffing, and COVID fatigue are overwhelming on a daily basis. Although we may not be able to provide relief for those challenges, the QIPMO team is available to assist with your educational needs.

Please reach out to your QIPMO nurse or Leadership coach to schedule training!

EMPLOYEE ENGAGEMENT: Make It OR Break It?

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

We talked in a previous newsletter (Feb 2021) about the importance of **EMPLOYEE ENGAGEMENT** for a long-term care facility. In this issue I want to discuss the first of ③ critical elements that will ***make*** or break employee engagement. (We will discuss the other ❷ in the next issue.) Researchers have been looking at employee engagement for many years and consistently come up with ③ basic needs of all workers. These researchers sometimes use different labels, but the ③ overall human needs that drive employee engagement the most are Autonomy, Competence, and Purpose. All work has the potential to fulfill these ③ needs, but some jobs do this much better than others. Let's shine a little more light on each of these areas and see how your organization can maybe do better at meeting the needs of your staff.

The first universal human need that drives engagement is **Autonomy**. Autonomy is defined as "a feeling of choice that engenders willingness. It encourages people to fully endorse what they are doing." (Lederman 2018) So, are you promoting autonomy in the staff at your facility? One thought that helps you evaluate yourself is this: Do you see your employees as ***resources*** or ***partners***? Resources

continued on page 8

continued from page 7

are important, but simply tools to be used as needed. Partners are your equals; to be treated with utmost *respect* and *gratitude*.

As you attempt to promote autonomy, there are ④ different aspects to a task that can be used to give your co-workers some choices in their jobs. These ④ aspects are: **Task** → what they do; **Time** → when they do it; **Technique** → how they do it; and **Team** → with whom they do it. You may not be able to offer a choice in *all* four areas, but probably in at least one.

Another topic that is crucial to increasing autonomy is your ability to delegate well. Most of us have had to work on at least one of the following delegation skills. Good delegation involves the following ❺ "rights".

1) Choose the right **person**
2) Give the right **information**
3) Provide the right **resources**
4) Initiate the right **communication**
5) Finish up with the right **responses**

Here are the details to make each of these steps work well.

1) Right **person**. Make sure you pick the right person with the skills/characteristics for the job. (You probably wouldn't pick a person who is outgoing and prefers to be with a group of people to do your MDS assessments. You probably want someone who is analytical and works well by themselves for that.)
2) Right **information**. When you delegate, give the reason for the task and the end result you want
3) Right **resources**. Make sure your co-worker has any necessary tools and training to do what you are asking
4) Right **communication**. Let your co-worker know what they need to report back to you and how often.
5) Right **responses**. Give them the trust they need and the thanks they deserve for doing the job.

Hopefully these thoughts guide you in the process of giving your co-workers more autonomy. Look for our next newsletter and learn about the remaining ❷ areas that drive employee engagement: **Competence** and **Purpose**.

QIPMO COVID-19 Resource Page

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