MDS Tips and Clinical Pearls

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☆☆☆☆☆-Star Staff

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

As the whole long-term care community struggles with immense staffing challenges, we at QIPMO want to do something to help.

While we certainly don't have all the solutions to your staffing shortages, we do have a program that can help. We have been working for the last year on a program designed to ↑ increase ↑ employee engagement and ↓ decrease ↓ turnover. We are calling this the 5-Star Staff program. The 5-Star Staff program is built around concepts that are PROVEN to increase the amount of job satisfaction employees experience on a daily basis.

The 5-Star Staff program begins with a system of frequent, + positive + feedback for your staff. Feedback is a core part of job success and employee engagement. The 5-Star Staff program provides the abundant feedback that your staff crave. It encourages them to continue providing exceptional care for your residents. This feedback results in your staff being more fully engaged and less likely to leave your facility.

In addition to creating abundant feedback, the 5-Star Staff program helps build a STRONG, healthy coaching relationship between your department managers and the staff they supervise. The benefits of a coaching relationship between a manager and her staff are widely recognized.

5-Star Staff provides the structure and tools to build the kind of relationship between manager and employee needed to motivate your staff to stay, even when times are 💪 tough. 💪

5-Star Staff also includes tools to strengthen the hiring/onboarding process and promote creative improvement ideas from your staff. All of these tools are designed to help create the kind of work relationships that individuals WANT to be a part of and stay involved with.

QIPMO can provide all of the training necessary to start this program and then maintain the results in your home on a long-term basis. We start by educating and training your leadership staff and then rolling out the program for all of your employees. We offer regular, planned follow-up meetings with your leaders to give more advanced coaching training, answer questions and brainstorm any challenges they might encounter.

If you are interested in knowing more about the 5-Star Staff program and how it can help with your staffing challenges, contact your QIPMO Leadership Coach (see page 2).

Out with the Old And in with the New: Tube Feeding Monitoring

Crystal Plank, BSN, RN, RAC-CTA, IP ● QIPMO Clinical Educator

Survey tag F693 **Tube Feeding Management/Restore Eating** includes monitoring the feeding tube appropriately. How are your nursing staff monitoring your resident's feeding tube? Auscultation is **NO longer recommended** for checking placement of the feeding tube.

Auscultation is unreliable and may still be heard when the tube is in the incorrect location. Even when the stethoscope is appropriately placed over the epigastric area the sounds may not indicate it is in the stomach but in the lung, esophagus, or duodenum. **X-RAY** is the most accurate verification for tube placement when there are concerns about the tube placement.

The State Operations Manual (digital copy page 357) says the following:

How to verify that the tube is functioning before beginning a feeding and before administering medications, which may include:

- **Checking gastric residual volume (GRV):**
  - **Not recommended** for individuals who are alert and able to report symptoms that indicate a feeding is not well tolerated.
  - May be **appropriate** when initiating tube feedings or for individuals who are unable to report symptoms such as bloating, nausea, or abdominal pain.
  - Actions to take based upon the amount of GRV vary **depending** on the individual and the clinical condition.
  - pH of GRV may **indicate** correct placement i.e. pH < 5 generally indicates gastric contents versus intestinal contents but medications and feeding formulas can alter pH levels.
  - Changes in GRV appearance may also be **helpful** in confirming placement but should not be used in isolation.
- **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).

So, if your staff are still using auscultation, you will need to update your policy and procedure. I would also set parameters to hold the tube feeding or medication and for contacting the physician. You will need to in-service your staff on the appropriate procedure for monitoring feeding tubes in your home. Staff will need to return demonstrate the procedure also and repeat this at least annually. For those residents in your home already, I would have mobile **X-RAY** verify appropriate placement and establish a baseline length of the feeding tube when the **X-RAY** is performed. Then have the nurses document length of the tube before the administration of medications, fluids, or nutritional feedings. If the length of the tube varies, use the perimeters for contacting the physician and/or obtain an additional **X-RAY** may be warranted.

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

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Lastly, make sure you care plan that the resident has a tube feeding and whether it continuous or bolus, as well as referring to the MAR prescribed, frequency, and flushes. Be sure to include raising the head of the bed and monitoring for signs and symptoms of aspiration, constipation, and GERD.

Resources: State Operations Manual Appendix PP

GIVING THANKS

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

It's October, the weather is cooling, leaves are turning, and Christmas decorations have been in the stores for several months. For me, the past few months have flown by as we reentered homes providing in-person consultation, education, and performing process of care audits. Homes are anxiously awaiting their annual survey which may be anywhere from 18-24 months overdue.

This past year has challenged us in many ways. COVID cases were rampant as we rang in the new year. We thought we were turning the corner come spring and then the Delta variant struck turning our world upside down. The news today is once again positive as COVID numbers begin to ↓ decline ↓ with vaccination rates increasing in some areas while we wait for the approval that younger children may soon be vaccine eligible. There is also much turmoil over the mandatory vaccine requirement put in place by many corporations and organizations in addition to the federal government mandate. We continue to wait for federal guidance on what exactly this mandate will entail.

With everything we have endured, at this time of year I find myself thankful. Thankful that Ⓜ provided me the opportunity to work from home when so many others lost their jobs due to the need to home school their children, loss of childcare, and businesses limiting hours, closing temporarily, and unfortunately, some closing permanently.

I am thankful for the countless hours the scientists worked to develop a vaccine so quickly with their hope of saving lives. I am thankful to have received the Pfizer vaccine earlier this year, and the booster once I became eligible.

I am thankful to work alongside a TALENTED TEAM of nurses and leadership coaches. You too, Jess and Ronda! Your friendship, emotional support, virtual hugs, and guidance was unwavering and cannot be measured.

I am thankful for the dedicated caregivers who spent countless hours caring for critically compromised residents, many camping out in their homes for days on end. They put their personal lives on hold, isolating themselves in hotels or campers to keep their families and residents safe. Many sat with a resident, holding their hand as they took their last breath. Saying THANK YOU is not enough but I know you are not in it for the thanks.

Finally, I am thankful for the love and support of family, friends, and each of you. I have dedicated the majority of my years to working in healthcare. I chose nursing, *but nursing also chose me*. It has afforded me many opportunities for which I am thankful. Despite the negative publicity our industry receives, we are proud to stand with our fellow long-term care partners knowing the love and care we show our residents is critical to their well-being.

Stay well! Stay strong! Be thankful for the blessings in your life!

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

ACCOUNTS PAYABLE

Libby Youse, BGS, LNHA, IP ǒ QIPMO Leadership Coach

Nursing homes are trying so hard to be homelike and person-centered which is really the thing that should be at the top of the list of worries. Whether we like it or not, nursing homes are a business. Instead of taking care of our folks we are overwhelmed with $dollars$, ¢cents¢, and the bottom line. Even a small nursing home with a minimal number of beds it is likely a multimillion-dollar company business.

Let's talk about Accounts payable (A/P). A/P is ***MORE*** than just paying the bills. It affects your bottom line and your cost report. Expenses need to be put under the right category and expensed on the General Ledger (G/L) correctly; not just put under a budget number. Department Managers should be **EMPOWERED** to code the invoices for their respective departments. This will help achieve buy-in and accountability for maintaining their departmental budgets. This will involve a bit of training for the Department Manager coding the invoices and they will need to have a list of correct G/L account numbers.

Some tools you as an administrator need to manage A/P are listed below:

* **Balance Sheet** - Statement of financial position
* **Income Statement** - Statement of activities
* **Check register**
* **Budgets** are routinely set annually – *actual* budget compared to *projected* budget. The projected budget is an estimate of your revenues and expenses that will possibly happen in a fiscal year. An actual budget reflects the true picture of how much revenue an account has generated or how much money an account has paid out in expenditures at a given point in time during a fiscal year. Usually, you will want to look at the current month and the year-to-date thus far.

Your Accounts Receivable (A/R) manager has to be comfortable asking for the money – up front on past due when needed? Some software should allow you to customize the settings on sending automatic payment reminders for specific residents, specifying the intervals to send the reminders, and the ability to include a personalized message. If an amount on the Aging Report hits 90 days, the A/R Manager should have a log or documentation on what is being done to collect this debt on ***EACH*** past due account. Monthly Statements go out on the last day of the month and if that is a Saturday/Sunday, then they go out on Friday.

* **Aging Report** – Collections is a difficult job, but unfortunately bad debt comes about. Asking for money can be tricky. If done at admissions by the Social Service Designee or the Admissions Manager, sometimes a negative outcome can be avoided. Sometimes even though the collection procedure has been followed to a tee, homes still get caught holding the bag.

  WHY DOES THAT HAPPEN?

  Paperwork, pay source changes, Medicaid renewal applications missed, issues with Medicare coding, dealing with insurance claims.

  - Medicaid→30 days – call your DHSS County Nursing Home Unit---Livingston, Lafayette, Madison, Ozark, or Miller County.
  - Medicare→30 days – calling to see if coding is correct or why it's not paying.
  - Insurance→60 days – call to see if all paperwork has been received.

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QIPMO COVID-19 Resource Page

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

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- Private pay→60 days - conversations directly to person responsible for paying the bill.

* **Write-Offs and Estimating Bad Debts** at year end.

The A/R Aging Report is beneficial for estimating the total amount to be written off. Invoices that are past due for longer periods of time have a higher probability of default. The sum from each outstanding date range provides an estimate regarding the number of uncollectible receivables. Bad debt write-offs are typically decided by the administrator, corporation, or if a district or non-profit home, the board at the last month's meeting at fiscal year-end collection efforts should be exhausted before bad-debts are written off.

If your home is needing help with fiscal services - budgets, payables or receivables, office training, year-end, office policies - please give your Leadership Coach a call. We are always glad to help!

Red Light, Orange Light, Yellow Light... Blue?

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

September 10th brought revisions to QSO 20-38 NH (www.cms.gov/files/document/qso-20-38-nh-revised.pdf). This QSO adds verbiage discussing the level of community transmission for testing frequency, versus the previous county positivity rate. This confusion seems to stem from the fact the positivity rate can be ↓ below ↓ 5% (formerly a blue county) while the transmission rate can still be ↑ high ↑ (red). This has left some homes confused and many are asking,

"WHICH ONE DO WE FOLLOW?!"

Breaking it down, two factors are used in calculating the level of community transmission.

1) Total New Cases: "A county's rate of new COVID-19 infections, reported over the past 7 days per every 100,000 residents", AND the
2) Percent Positivity rate: "percentage of positive COVID -19 tests in a county over the past 7 days"

A higher number of total new cases together with a higher percent positivity correlate to a higher level of community transmission. If the two numbers are in different levels of transmission, then the *HIGHER* level is used for the reported transmission rate. The following chart indicates the ranges for each level.

Community Transmission Levels	Low Transmission	Moderate Transmission	Substantial Transmission	High Transmission
Total new cases per 100,000 persons in the past 7 days	0-9.99	10-49.99	50-99.99	≥100
Percentage of NAATs that are positive during the past 7 days	0-4.99%	5-7.99%	8-9.99%	≥10.0%

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This information then guides a home to the frequency of routine testing for staff. It is important to note the QSO states to follow the Community Transmission Level to determine the testing interval as outlined in the following table (items in red are modifications from previous QSO).

Table 2: Routine Testing Intervals by *County COVID-19 Level of Community Transmission*

Level of COVID-19 Community *Transmission*	Minimum Testing Frequency of Unvaccinated Staff[+]
Low *(blue)*	*Not recommended*
Moderate (yellow)	*Once a week**
Substantial (orange)	*Twice* a week*
High *(red)*	Twice a week*

[+]Vaccinated staff do not need *to* be routinely tested.
*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

Following the appropriate frequency of testing increases compliance as outlined F886: Infection Control. If you have further questions about your County's Level of Community Transmission, please contact your QIPMO nurse or Leadership coach.

BUT WAIT! There's MORE! The community transmission rate also guides CDC **PPE** recommendations: (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html). Counties in the *Substantial* (orange) or *High* (red) counties of community transmission, should note the CDC recommendation to *consider* use of N-95 for resident care and to use an approved N-95 or higher or equivalent as well as protective eyewear when administering potentially aerosol-generating procedures. Still have questions about what **PPE** to wear and when? Check out **QIPMO's PPE Protocol** tool at nursinghomehelp.org/educational/qipmo-ppe-protocol/.

Sources:
www.cdc.gov/coronavirus/2019-ncov/more/aboutcovidcountycheck/index.html
www.cms.gov/files/document/qso-20-38-nh-revised.pdf
covid.cdc.gov/covid-data-tracker/#county-view|Missouri|Risk|community_transmission_level

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More Than a thousand Words

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

They say pictures are worth a thousand words and art is a reflection of feelings. Feelings are at an all-time high. We're living in a world of high cortisol. Our bodies are tuned to fight or flight. We barely flinch at an "emergency" because we've lived one for 20 months and it's exhausting. Artists all over the world are channeling that energy into positions for hope, strength, and endurance. Take a look at some of the amazing street art and photos and remember, you are not alone in this fight. Reach out. Stay safe. Know you are loved.

If you need to talk, text Show Me Hope at 1-800-985-5990.

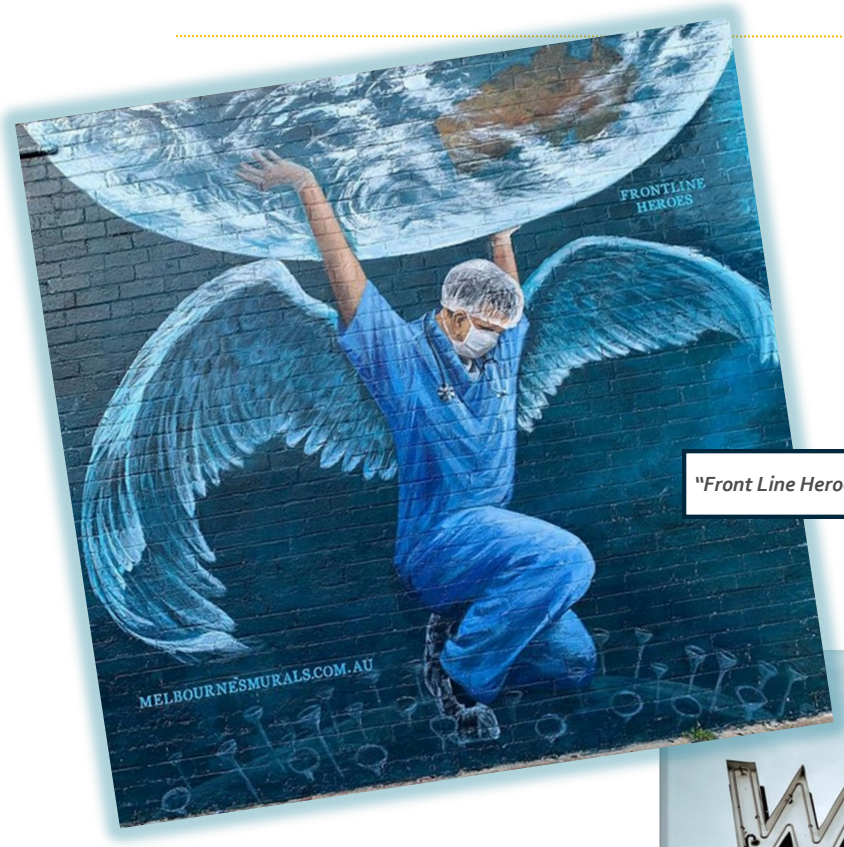
"Nurse Sofia smashing the virus," by Mr Dheo in Portugal.

By artist @tanaka_tatsuya, whose work is part of a Miniature Life exhibition in Fukushima, Japan. Via @tanaka_tatsuya / Instagram

"One Team" Photo by Matt Utton and Jennifer O'Sullivan Hainault, London from the Hold Still Collection

Credits

- www.npg.org.uk/hold-still/
- www.thenationalnews.com/
- inspiringcity.com/
- www.moshowmehope.org/



"Front Line Heroes" Mural from Melbourne Murals

Credits

- inspiringcity.com/
- unsplash.com/

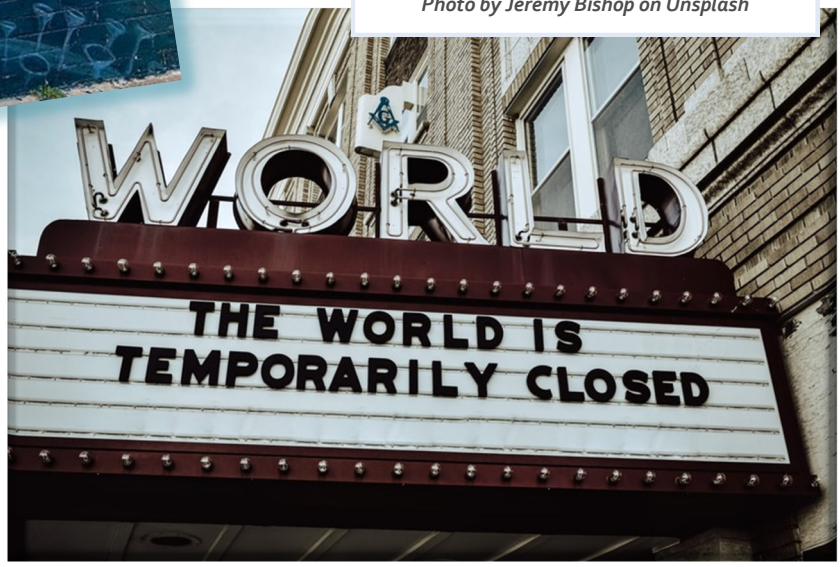
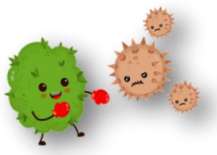


Photo by Jeremy Bishop on Unsplash

Have YOU Completed Your



Infection
Control
Assessment and
Response

Evaluation?

For more information visit: nursinghomehelp.org/icar-project/

To request an onsite or virtual assessment with an ICAR team member: musonicarproject@missouri.edu or (573) 882-0241.

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