MDS Tips and Clinical Pearls

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Punching Out Parkinson's and Other "Therapies"

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What do you want to do when you grow up?

Ever wanted to be a boxer or a ballerina?

OR HAVE YOU SIMPLY WANTED TO HAVE THE TIME TO GARDEN?

As I write this column, particularly (kind of) post-COVID, I find myself writing not just for your residents but to you as well. Whatever we're treating at work, somewhere we're treating it at home, too, usually within own families or friend groups. So, keeping that in mind, **what do you want to be when you grow up** or what about your residents? I think they qualify now.

Whenever someone gets diagnosed with a terminal condition—Parkinson's, Lou Gehrig's, even blindness—for a moment, life just stops. ⃠ Then two groups of people emerge, people who live despite it, and people who live with it. A lot of times living *with* something means becoming complacent, scaling back, or giving up certain things because we can't see how to get past that disease. But people who live *despite it*, are proactive. They figure out how to make or continue the life they want because that life is more important than the diagnosis. I can tell you hundreds of stories on both sides of the coin and you see them every day in your homes.

Luckily, for the "despiters," there's some brilliant people out there who decided not to give up. One program, known as Rock Steady, has gotten people of all ages with new or developing Parkinson's out of their chairs and into the gym to help regain some strength and balance. Over time, they see a reduction in tremors, and best of all, it gives them a purpose! Now boxing programs in many cities and communities have programs tailored for people living despite Parkinson's. The programs start out slowly and simply with trainers and sometimes occupational therapists to gage safety and baseline capabilities, but from there, they just grow! I can speak to this personally. A close friend of our family is 56. He was an engineer at one of the lock and dams on the Ohio River. He

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served in the **Army**. He started showing signs of Parkinson's at 53 with all the typical symptoms and it was obvious that it was a quick downward slide to zero quality of life. Having always been active, having Parkinson's not only broke his routine, but it also broke his spirit. Then he joined the gym with a boxing program. He'd never boxed in his life but now, twice a week, he's slamming a punching bag, jumping rope, and boxing a body bag. He tells us that it's helped him regain his ability to walk a straight line and gives him something positive to look forward to. He wasn't ready to retire, and his retirement plans sure didn't involve being an invalid. I think any of our residents would say the same. It's time for us to think out of the box and start doing better for our peeps!

The key 🗝 to a good exercise regimen for people with terminal conditions *isn't* fancy or expensive, or even too cumbersome. It's a combination of things we do every day (or things we wish we took more time for and don't!) It's singing along with music (working those mouth muscles—think neurological!); it's dancing and wiggling our butts, waving our ☞ arms ☜ (balance, mild strength training—just don't over correct!); it's playing the piano, painting, punching a bag or a balloon… the possibilities and the benefits are endless. Check out this YouTube video of a gentleman whose quality of life has grown with Parkinson's ***instead of the other way around***. It's amazing what a little inspiration can do. Reach out to me at borenw@missouri.edu if you need ideas or connections.

GO CRAZY!

Let's help our residents live despite their diagnoses.

Resources:

- *https://my.clevelandclinic.org/health/articles/9200-exercise-for-people-with-parkinsons-disease*
- *https://www.parkinson.org/advancing-research/our-research/parkinsons-outcomes-project*

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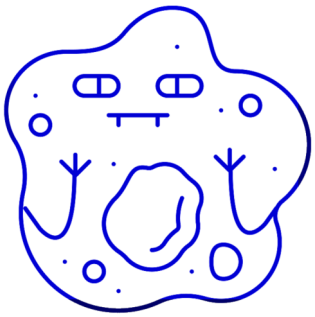
Will the Flu Strike You?

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

While listening to the evening news, a report on RSV cases running higher than expected in October caught my attention. Hearing that made me wonder what this year's FLU season will look like.

The CDC estimates the annual FLU disease burden by season. For the 2019-2020 season CDC estimated 36,000,000 symptomatic illnesses, 16, 000,000 medical visits, 390,000 hospitalizations and 25, 000 deaths. Estimates are not available for the 2020-2021 season due to minimal influenza activity. We know from Missouri homes and listening to multiple HealthCare Coalition, CMS, and CDC calls that influenza numbers were down and COVID numbers were OFF THE CHARTS.



Preliminary estimates for the 2021-2022 season were 9,000,000, 4,000,000, 100,000, and 5,000 respectively (www.cdc.gov). The weekly CDC Influenza map shows Missouri as green/minimal for the current 2022-2023 season. During Week 40, ending October 8, the Missouri Weekly Influenza Surveillance Report identified a total of 80 laboratory-positive4 influenza cases (51 influenza A, 29 influenza B and 0 untyped) (www.health.mo.gov).

Influenza (FLU) is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. Some people, such as those 65 years and older, young children, and people with certain health conditions (e.g., heart disease, asthma, or diabetes) are at higher risk of serious FLU complications. There are two main types of influenza (FLU) viruses: types A and B. The influenza A and B viruses that routinely spread in people (human influenza viruses) are responsible for seasonal FLU epidemic each year. FLU symptoms included fever, cough, runny nose, sore throat, muscle aches, headaches, fatigue with some experiencing nausea and diarrhea. If you have mild symptoms, fluids, rest, and analgesics are generally all you require. In more serious cases, medical care, and antivirals (i.e., Tamiflu®) may be necessary.

So, how can we protect ourselves and others from the FLU? First, let's continue to follow the core principles of infection control by masking, performing hand hygiene and social distancing.

Secondly, **GET VACCINATED**! Everyone six months or older should receive the influenza vaccine each season. Standard-dose flu shots are manufactured using a virus grown in eggs. Several different brands of standard dose FLU shots are available, including Afluria Quadrivalent, Fluarix Quadrivalent, FluLaval Quadrivalent, and Fluzone Quadrivalent. A cell-based flu shot (Flucelvax Quadrivalent), containing a virus grown in cell culture, is approved for people 6 months and older. This vaccine is completely egg-free. A recombinant FLU shot, Flubock Quadrivalent, is egg free and approved for those 18 years and older. Two high dose vaccines for those 65 years and older are available: Fluzone High-Dose Quadrivalent and Fluad Quadrivalent. *If needles are not your thing*, FluMist Quadrivalent is available for those 2-49 years but is not recommended for individuals who are pregnant, immunocompromised, or with certain medical conditions. Check with your medical provider to see which vaccine is best for you.

Lastly, stay home if you are sick!! Please don't bring your germs to work. We saw the effect that COVID -infected staff had on their coworkers and residents when they came to work ill.

Stay well, safe, and blessed during this holiday season!

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

Remember Your Why

Nicky Martin, MPA, LNHA, QCP, CDP, IP QIPMO Leadership Coach, Team Leader

Libby and I wrapped up our third Administrator 101 Class recently in Jefferson City. It was a long, beautiful, colorful, and winding drive home and all I could think about were the *faces* in the room.

The faces of the future and what their chance in the drivers seat will look like for them.

That ***beautiful***, **colorful**, and winding drive home was somewhat of a representation of long-term care in my mind. The hills and curves I faced on my drive are much more easily maneuvered than the hills and curves you face in your roles as long-term care leaders. The changing leaves are reflective of the changes LTC has seen the last few years.

I realize that our frontline workers face obstacles, too, and am not discounting that at all. However, it's the administrators that get the 3:00am phone calls to alert them that **MR. JONES** decided he wanted a drink and decided to climb out his window to go to the liquor store… but we got to him before he had both legs out the window. Or the Director of Nursing awakened by the phone ringing at 4:30am to listen to a **desperate voice** on the other end telling them that they can't be at work in an hour because they are out of gas on the side of the road with no family or friends to help.

But why? *Why* do we continue to work in an industry that the bureaucrats seem to only want to beat down after ten rounds with the deadliest pandemic in U.S. history in a 12-round bout; an industry that the media will rip apart any chance they get; and an industry that seems to be the last place anyone wants to work?

What is your why?

For me, it is the aged smile that greets me as I enter a home or the little lady in a sweater asking me if I saw her son when I came in. ***What is it for you?***

About two hours into my drive, I was overcome with sadness. It saddened me to think about how worn down you might be by the never-ending hills and curves each of you face on a 24-hour-a-day basis. Decisions must be made daily to ensure those in your care receive the quality of life and quality of care they have entrusted you to provide. Sometimes those decisions are easy, like, "Sure, we can do an impromptu ice cream social this afternoon!" It's the tougher ones like, "Who is going to make **that phone call** to the daughter, who had just left to grab a quick bite to eat after two long days of not leaving her mother's side, to tell her that her mother passed away minutes after she left", that tend to pull you in different directions and leave you with that feeling you've just been ⁂throat punched by Thor.⁂

Whatever decision you're making, as long as you make it with the best intentions, you've made the best decision you can.

Remember your why.

I hope the road flattens and straightens for each of you and becomes more easily maneuverable. Until then, I'll leave you with the words from a fellow administrator that brought me joy and yanked me out of that moment of sadness: "Just remember, even on your worst days, why you chose to be in this industry. Impacting human life and influencing those around you to be better… in a positive spirit, ***control what you can and remember you are making a difference***."

EMPLOYEE ENGAGEMENT

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

As all of us are focusing on recruiting and retaining staff, more attention is being given to employee engagement. If you find yourself wondering just *how* engaged your staff are, the following is a group of questions that can help you measure that. These questions are open-source, so you can use with no copy right cost. If you decide to use these questions, here are a few suggestions to get the ***most* benefit** from the process.

- Keep the responses *ANONYMOUS*. You won't get individual feedback, but the responses will be more honest.
- Do an initial survey of *ALL* staff and repeat every 3-6 months to measure changes and progress.
- *SHARE* results with your staff (initial and all following surveys) so they can see progress.
- When you get your initial results, average all scores for each question, pick *ONE AREA* to work on for 6-12 months and monitor progress.

HERE ARE THE 12 QUESTIONS. YOU CAN USE A 5-POINT LIKERT SCALE FOR EASY SCORING.

1-Strongly disagree 2-Disagree 3-Neutral 4-Agree 5-Strongly Agree

1) I have a clear understanding of what is expected of me in my role.
2) I believe I have everything I need to do my job to the best of my ability.
3) I am able to apply my strengths and skills in the work I do.
4) People are well recognized for their contributions here.
5) My manager takes the time to get to know me as a person.
6) My manager is supportive of my personal development goals and aspirations.
7) I feel comfortable voicing my opinions, even if they are different from my managers'.
8) I know how my specific role contributes to the success of this organization.
9) People in my team are held accountable for their results/performance.
10) I have a good relationship with the other people in my team.
11) My manager and I have regular conversations about my personal development.
12) I believe there are opportunities for me to develop my career.

FROM ALL OF US AT QIPMO AND ICAR... WE HOPE EVERYONE HAS A SAFE AND HAPPY HOLIDAY SEASON!

ICAR Corner

Revised Infection Prevention and Control Guidance... AGAIN!

The Interim Infection Prevention and Control recommendations for healthcare personnel regarding COVID were revised as of 9/23/2022 (cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html). This guidance applies to all U.S. settings where healthcare is delivered, including nursing homes and home health. Some of the changes may have raised some questions for you and your facility. Here are some of the questions encountered by the ICAR team.

*Masking is now up to the discretion of the facility... **right**?*

Yes *and* no! There has been some leniency provided the community transmission level is not HIGH (RED) for your county. The issue is that community transmission rates fluctuate frequently – sometimes more often than once/week. They may drop to Moderate (YELLOW) one day and be back to High (RED) a few days later. Your facility should have a solid process (who checks transmission, how it is communicated to others, signage, supplies, etc.) in place to monitor and adapt to community transmission changes. Be sure to check the CDC COVID Data Tracker site at covid.cdc.gov/covid-data-tracker/#county-view often. You will need to enter the *STATE*, *COUNTY,* and select data type of *COMMUNITY TRANSMISSION*.

When community transmission **is** high (RED), everyone that could encounter residents should wear source control. If community transmission **is *NOT*** high, facility leaders may choose not to require universal source control.

Masking is ***recommended*** in the following situations:

- Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze) – remember cold and flu season is here; *or*
- Close contact/higher risk exposure with someone with SARS-CoV-2 infection, for 10 days after their exposure; *or*
- Reside or work in an area of the facility experiencing a SARS-CoV-2 outbreak; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 day; or
- Source control has been recommended by public health authorities.

*Are we **still** supposed to screen staff and visitors that enter our facility?*

While documented screenings are no longer required, a "passive screening" approach is recommended. This can be accompanied by having signage at all facility entrances and by the visitor and staff sign-in area. Those entering the building should alert (remember to include a phone number to call) the facility if they have:

1) a positive viral test for SARS-CoV-2;
2) symptoms of COVID-19 (it is a good idea to include a list of symptoms); *or*
3) close contact with someone with SARS-CoV-2 infection (for patients and visitors) or a higher-risk exposure (for healthcare personnel (HCP).

This is also probably a good time to tidy up the screening area/

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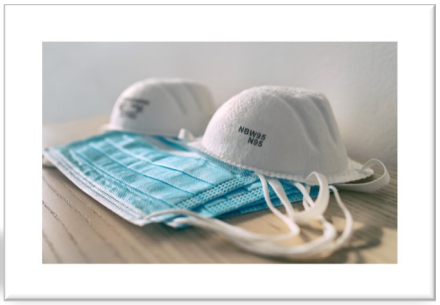
entrance. If there are too many signs (especially ones with conflicting instructions), people will walk on by!

*Should unvaccinated new admissions **still** be quarantined?*



Unvaccinated new admissions/readmissions no longer need to be quarantined unless they are experiencing either COVID symptoms or tested positive for COVID. The following is recommended to manage admissions, especially when community transmission is high (RED):

- Testing is *recommended* at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

  If testing has occurred within 24 hours of admission to the facility, this can serve as the "admission" test.

- They should also be advised to wear source control for the 10 days following their admission.

Residents who leave the facility for 24 hours or longer should generally be managed as an admission.

Since we no longer have a COVID unit, can we leave a COVID positive resident in their room?

A resident with suspected or confirmed SARS-CoV-2 infection should be in a single-person room with full PPE available outside the room. The door should be kept closed (if safe to do so). Ideally, there would be a dedicated bathroom.

- If cohorting, only patients with the same respiratory pathogen should be housed in the same room. Multi-drug resistant organism (MDRO) colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Some homes using the shelter-in-place approach will assign one CNA to care for only the COVID positive residents to reduce risk of cross contamination. *Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.*

*Since routine testing is no longer based upon vaccination status, **when** should we test?*

- Anyone with even mild symptoms of COVID-19, **regardless of vaccination status**, should receive a viral test for SARS-CoV-2 as soon as possible.
- Asymptomatic residents with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
  - Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior **30 days**. Testing should be considered for those who have recovered in the prior **31-90 days**; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period.

As always, the ICAR and QIPMO teams are available for assistance. If you would like to schedule an Infection Control Assessment and Response (ICAR) evaluation, email us at musonicarproject@missouri.edu.