MDS Tips and Clinical Pearls

Volume. 11
Issue. 1

RECRUIT, RECRUIT, RECRUIT

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

Nearly every long-term care home is currently facing the challenge of locating and hiring enough staff to care for your residents. The following is a list of ideas and resources to use in your effort to recruit staff for your facility. Feel free to use any/all of these and add your own.

Contact and work with a variety of community organizations where your home is located. Building relationships in your local community not only helps with recruitment, it also helps improve your image.

- **High schools**: this is a great place to recruit for entry-level positions. In addition, these young people often have a long-term goal of additional training for more skills/responsibility. Work with their existing health care career focus or help them start something. Utilize students for volunteer positions as well as paid staff.

- **Colleges**: Work with any trade schools as well as 2/4 year colleges.

- **Nursing schools**: Offer part-time employment for students. Offer your facility as a clinical rotation site for nursing students. Ask if you can make a presentation to their students about your home or long-term care in general.

- **CNA training programs**: Similar to nursing schools, offer part-time positions and for your facility as a site to do their clinical hours.

- If possible, offer to pay for **additional training for your existing staff**. This is a great way to reward your best employees and funnel them into positions of greater responsibility. For example, some facilities pay for nursing school for existing staff who show good work ethic and leadership potential.

Be as **FLEXIBLE** as possible. Offer options such as shorter shifts, part-time hours and PRN positions (with no benefits but higher pay). Talk with your existing staff and new recruits about changes that would make them want to stay and/or be a part of your home. The key to all of these potential opportunities: **BUILD AND CULTIVATE LONG-TERM RELATIONSHIPS**!

ADVERTISING: Use specific job search sites to advertise for applicants, but also take advantage of any/all social media to attract attention to your

home and what you do. If you are not familiar with social media sites, talk with your existing staff who are and get their help in using these tools.

JOB APPLICATIONS: Allow potential employees to do their application on line. Some organizations even start the interview process on line. Key point: Make sure you have a designated person and process to respond to all types of electronic communication very quickly. If you don't respond within hours (maybe minutes), you will lose a potential hire to someone else.

KEY TAKEAWAYS: 1. Build strong relationships with many different individuals and organizations who can send you potential staff. 2. **DON'T BE AFRAID** to use technology, especially social media to attract and hire. If you aren't personally knowledgeable about this, find a staff member who is and get their help.

THE IMPORTANCE OF DISCUSSING ONE'S HEALTH CARE WISHES

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

No one likes to talk or even think about what will happen in case of a serious health issue/emergency.

Unfortunately, these events are very common. If preferences are not discussed and documented, our residents may receive care that they didn't want. Many people don't realize what "**DO NOT RESUSCITATE**" or "**DNR**" even means. Some people may think that **DNR** means they will not get good care or that they will just be left to die. In reality, it *simply means* that if a person is found without a heartbeat, **CPR** will not be performed.

In many homes it is the position of the Social Service Designee to have these discussions with the resident and/or the resident family. Is the Social Service Designee trained to have those in-depth discussions? Discussion of the resident's wishes and the details of an **ADVANCE DIRECTIVE** need to be an open honest discussion. If the resident

approves, have a discussion with the family about the resident's choice. This will make the family aware of expectations when that health issue arises. Help them to understand why the resident made these decisions.

The next people that need to know about the resident's choice are ALL staff. Staff need to know where to find that information about each resident whether it calls for **CARDIOPULMONARY RESUSCITATION** (**CPR**) or **DNR**. Some homes have dots on the doors, but do ALL staff know what the dots mean? On each shift there must be at least one person certified in **CPR**. Does the person doing the schedule know who is certified? Are the staff that are certified current with their certifications? What about putting a big **C** on the schedule next to that person's name so that everyone knows who that person is? It is also important that the Director of Nursing and Administrator can be assured that somebody on each shift is certified.

Practice mock Code Blues, put Annie in room 203 and call mock Code Blue and see who comes

running, who brings the back board, who brings the crash cart, who gets the clipboard and starts documentation of time the code started. Does staff know what the code colors mean? Is the crash cart stocked properly, need a list? There is a Crash Cart Policy and Supply List on our website, nursinghomehelp.org go to the search bar at the top and type in crash cart. Does the staff know where to look for the documentation that says **CPR** or **DNR**? Mock *Code Blues* are a training procedure that truly can make a difference in life and death. Don't forget the van driver in this training and are they certified in **CPR**, because they need to be?

Not doing **CPR** on residents that have made the decision to have **CPR** done on them leads to loss of life and an *Immediate Jeopardy* (IJ) tag along with a *Civil Monetary Penalty*. In Missouri, nurses cannot pronounce someone deceased so if that resident chose **CPR** – **START CPR** regardless of whether you think it is too late, go by the documentation from that very important conversation.

✋ I C A R   C O R N E R ✋

There is a hand hygiene tag line that says "**Clean Hands Count**". It can also be said that "**Clean Surfaces and Rooms Count**". When it comes to cleaning resident rooms, vigilance and attention to details are important but at the same time this is the residents' home – a fact that must be respected. An Infection Control Assessment and Response (ICAR) evaluation includes a review of EVS practices. Here are a few commonly seen concerns with supplemental resources:

* **Cleaning/Disinfectant Products**: using products with an extended contact time (10 minutes). The surface may not stay wet for the entire time, thus limiting the disinfectant properties.

  * *Recommend*: Select a product with a shorter contact time if possible. Otherwise, be sure to educate staff on the need to reapply the product. The EPA has lists of products that are registered against common pathogens (e.g., List H includes products registered with EPA for claims against MRSA and VRE).

* **Appropriate cleaning** of shared equipment such as Hoyer lifts, BP cuffs, etc.: it is known that shared equipment should be cleaned between uses. But often homes do not have well established processes to carry this out – specifically disinfectant wipes are not readily available in locations where they are needed.

  * *Recommend*: Work with direct care staff to establish a process whereby disinfectant wipes are available but do not create a risk for accidental ingestion.

* **EVS carts**: no consistent manner for organizing, securing, and cleaning.

  * *Recommend*: Carts should be organized so that necessary tools and products are readily available and that chemical are in a secure (locked) area of the cart. Carts generally should not enter the resident room and be cleaned daily. Toilet brushes should be stored separately and at the bottom of the cleaning cart.

* **Microfiber mops**: Many homes are using microfiber mops that can be changed between rooms and laundered daily. We've been hearing complaints that they are not cleaning effectively and some have even switched back to string mops.

* *Recommend*: Ensure that mops are being used as intended with adequate time and effort. This may require re-education of staff. Refer to manufacturer instructions for your specific mop.

Here are some essential concepts related to EVS practices:

* Common areas should be cleaned daily. Resident rooms should be cleaned daily with a scheduled deep cleaning.

* Having a standard order for resident room cleaning can help ensure that no surfaces are missed. Here is a link to an infographic on resident room cleaning.

* Hand hygiene should be completed when moving from a dirty to a clean area, when a task is completed, and when soiled.

* Ongoing audits of room cleaning should be conducted as part of your overall QA plan. Here are two links that include audit tools:

  https://www.cdc.gov/hai/toolkits/appendices-evaluating-environ-cleaning.html

  https://apic.org/resources/topic-specific-infection-prevention/environmental-services/

You may be experiencing frequent EVS staff turnover. This is a great resources for orientation and ongoing education: https://apic.org/resources/topic-specific-infection-prevention/environmental-services/. The tabs for both CDC STRIVE Program and For Healthcare Professionals has good info.

Keep in mind that the ICAR team is available for onsite visits to discuss your current infection prevention and control program and to assist with staff education. We can be reached at musonicarproject@missouri.edu or 573-882-0241.
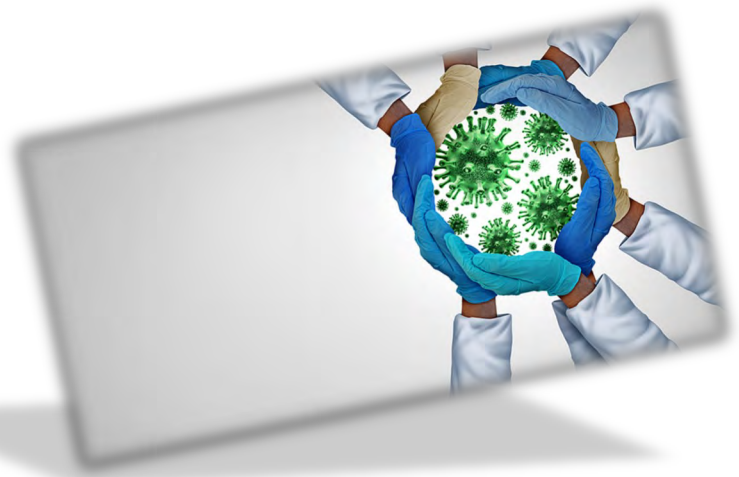
Clinical Educators
Wendy Boren, BSN, RN, IP
Katy Nguyen, MSN, RN, IP
Crystal Plank, BSN, RN, RAC-CTA, IP
Debbie Pool, BSN, RN, LNHA, QCP, IP

Project Director
Marilyn Rantz, PhD, RN, FAAN

Senior Project Coordinator
Jessica Mueller, BA

Project Support Specialist
Ronda Cramer

QIPMO · Leadership Coaching · ICAR
Partnering With You to Promote Quality

University of Missouri
Sinclair School of Nursing

ICAR Facilitators
Shari Kist, PhD, RN, CNE, IP
Carolyn Gasser, MPH, RN, IP
Linda Hagler-Reid, MBA, LNHA, IP
Nicky Martin, MPA, BS, LNHA, CDP, QCP, IP
Sue Shumate, RN, BS, CHTS-IS, IP

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

Are You Meeting the Baseline Care Plan Requirements?

Debbie Pool, BSN, RN, LNHA, QCP, IP ✎ QIPMO Clinical Educator

The QIPMO clinical educators complete a significant number of chart reviews each year. As part of the review process, we assess both the **baseline** and **comprehensive** care plans to ensure regulatory guidance is followed and the care plan reflects the resident's goals, objectives, and current care requirements. In my recent reviews, I have identified potential concerns that may lead to a citation.

First, let us look at the regulatory guidance for *F655 Baseline Care Plan*. The baseline care plan (BCP) should strike a balance between conditions and risks affecting the resident's health and safety and what is important to the resident within the limitations of the baseline care plan timeframe. The BCP should include initial goals based on admission orders, physician orders, dietary orders, therapy services and social services with PASRR recommendations, if applicable. Information from the transferring provider and a discussion with the resident and resident representative (RP) round out the process.

The baseline care plan must be developed and implemented within 48 hours after admission to the SNF outlining instructions for the provision of effective and person-centered care that meets professional standards of practice. The care plan should address the resident's health and safety needs to prevent a decline or injury, (e.g., elopement, fall risk, skin impairment, supervision needs, behavioral interventions or ADL assistance).

The final regulatory requirement addresses providing the resident/RP, if applicable, with a written summary of the baseline care plan by the completion of the comprehensive care plan. The summary must be written in a language and conveyed in a manner the resident/RP can understand. The physician order sheet and/or medication administration record are not written in a language most residents/RPs can comprehend. The summary must include the initial goals of the resident, a list of current medications and dietary instructions, services, and treatments to be administered by the facility and/or personnel acting on behalf of the facility and any updated information based on the details of the comprehensive care plan, as necessary. The format is at the facility's discretion, however, the medical record must contain evidence that the summary was provided to the resident/RP, if applicable. The facility may choose to provide a copy of the BCP itself, as long as it meets the requirements of the summary (www.cms.gov, SOM Appendix PP).

The intent of the regulation is to promote continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events which may happen early in the resident's stay. The baseline care plan is the beginning of

---

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

the comprehensive care plan so a connection should be evident between the two.

Now that we understand the regulatory requirements, we need to review the process for completion of the baseline care plan. Ask yourself the following questions. ***Who*** is completing the baseline care plan - the admission nurse, charge nurse, or MDS Coordinator when he/she returns on Monday? ***Are*** you meeting the 48-hour timeframe? ***Does*** the BCP include a resident signature and date as well as the nurse signature and date? ***Was*** the resident/RP given a copy of the completed baseline care plan or summary? ***Does*** the medical record include documentation of the resident's receipt of the BCP? These are all potential areas of non-compliance that may open you up to a F655 citation.

A home may choose to complete the *comprehensive care plan* (CCP) instead of the baseline care plan. In this instance, the CCP must be completed and implemented within 48 hours of admission and comply with the requirements for the CCP, with the exception of completion of the care plan within 7 days of completion of the comprehensive assessment. Completion of the CCP will not override the RAI process. If a CCP is completed in lieu of the BCP, a written summary of the CCP must be provided to the resident/RP, if applicable, and in a language the resident/RP can understand. I am aware of several homes choosing this option, but they generally admit short-term rehab residents.

The baseline care plan should also address the resident's discharge plan. At times this is left blank or "no" is checked. Discharge planning begins at the time of admission addressing the resident's goal for discharge. The goal may include discharge to home, ALF, residing long-term, or hospice/end-of-life care. The discharge plan may change during the stay requiring updating of the comprehensive care plan to reflect the change.

Lastly, surveyors are reviewing your baseline care plans. For fiscal year 2023, F655 has been cited 23 times in Missouri at mostly a D or E level. Surveyor probes include identifying if the baseline care plan was developed and implement within 48 hours of admission to the facility, did the BCP contain the requirements previously outlined (goals, orders PASRR, etc.), and was the BCP revised and updated as needed to meet resident's needs until the comprehensive care plan was developed?

Was there an emergency room visit or hospital admission prior to the completion of the comprehensive care plan requiring updates to the baseline care plan? If a resident experienced an injury or adverse event prior to the development of the comprehensive care plan, should the baseline care plan have identified the risk for injury/event, (e.g., risk factors were known or obvious such as falls, wound care, dialysis, respiratory care or hospice)? Did the facility provide the resident/RP, if applicable with a written summary of the baseline care plan that contained initial goals, summary of current medications and dietary instructions, services and treatments, and any updated information based on the comprehensive admission assessment?

One can easily develop an audit tool to include the regulatory requirements and surveyor probes to ensure facility compliance. ***Do not forget*** to include a review of polices to identify your procedure for completion. At times not following our policies is what creates the citation.

WHAT'S IN THE WATER?

Linda Hagler-Reid, MBA, LNHA, IP ◆ *ICAR Advisor*

A review of water-borne illness - what you need to know!

Legionellosis, commonly referred to as Legionella, is associated with two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac fever, a milder illness without pneumonia (https://ndc.services.cdc.gov/case-definitions/legionellosis-2005/).

Legionella is a serious type of pneumonia (lung infection) caused by Legionella (LEE-juh-nell-a) bacteria. People can get sick when they breathe in small ◆ droplets ◆ of water or accidently swallow water containing Legionella into the lungs (https://www.cdc.gov/legionella/index.html).

WHY IS THIS IMPORTANT TO ME?

Why are healthcare facilities at higher risk for having Legionnaires' disease cases and outbreaks than other types of buildings? Healthcare facilities, such as hospitals and nursing homes, usually serve the populations at **highest risk** for Legionnaires'. These include older people and those who have certain risk factors, such as being a current or former smoker, having a chronic disease, or having a weakened immune system. Also, healthcare facilities can have large complex water systems that promote Legionella (the bacterium that causes Legionnaires' disease)

growth if not properly maintained. For these reasons, the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) consider it essential that hospitals and nursing homes have a water management program that is effective in limiting Legionella and other opportunistic pathogens of premise plumbing (waterborne pathogens, for short) from growing and spreading in their facility (Legionella: Healthcare Water Management Program FAQs | CDC).

WHAT DO THE EXPERTS SAY:

* Legionella bacteria are found naturally in freshwater environments, like lakes and streams but is also found in most public water supplies. The bacteria can **become a health concern** when they grow and spread in human-made building water systems like:
  * Showerheads and sink faucets
  * Cooling towers (structures that contain water and a fan as part of centralized air cooling systems for buildings or industrial processes)
  * Hot tubs
  * Decorative fountains and water features
  * Hot water tanks and heaters
  * Large, complex plumbing systems
* The favorable temperature range for Legionella to multiply is 77–113°F, 25–45°C; but Legionella may grow at temperatures as low as 68°F (20°C).
* While **ice machines** store ice far below the low point for growth of Legionella, the bacterium can be stored in a dormant form in the ice that then becomes active once the ice melts in drinks or in the mouth of the person ingesting a drink with ice.

https://www.cdc.gov/legionella/about/causes-transmission.html

WHAT CAN YOU DO TO PROTECT YOUR RESIDENTS?

The Centers for Disease Control provides a toolkit for providers to utilize to assure that the water supply that you are responsible for is safe from contamination. That toolkit can be found at https://www.cdc.gov/legionella/wmp/control-toolkit/index.html.

Other resources include:

The ASHRAE Standard 188- Legionellosis: Risk Management for Building Water Systems - https://www.ashrae.org.

The EPA's Technologies for Legionella Control in Premise Plumbing Systems: Scientific Literature Review - https://www.epa.gov/ground-water-and-drinking-water/technologies-legionella-control-premise-plumbing-systems.

How *Legionella* affects building water systems and people

1. Internal and external factors can lead to *Legionella* growth in building water systems.

   Construction Biofilm Water temperature fluctuations

2. *Legionella* grows best in large, complex water systems that are not adequately maintained.

3. Water containing *Legionella* is aerosolized through devices.

   Cooling towers Showers Hot tubs Fountains

4. People can get sick when they breathe in small droplets of water or accidently swallow water containing *Legionella* into the lungs. Those at increased risk are adults 50 years or older, current or former smokers, and people with a weakened immune system or chronic disease.

www.cdc.gov/legionella

03/30/21