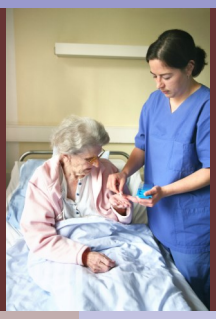
Fall 2017



NORTH DAKOTA DEPARTMENT of HEALTH

Long Term Care Highlights

The Importance of Using Non-Pharmacological Interventions

By Kathy Laxdal, Health Facilities Surveyor

Today, if you need to know about a topic, what is the first thing you do? Grab your phone, tablet, or computer and search for the information. If you search for the word **redirection,** it states, "to change the direction or focus of." This article addresses resident behavior and how you can help your staff accomplish successful redirection of a disruptive behavior. This is especially important when using PRN (as needed) medications. Ask yourself, what individualized non-pharmacological approaches have you developed for the resident that becomes upset every day at 4 p.m.?

During the survey process, if a surveyor is reviewing a resident's list of medications and the list includes a PRN psychotropic medication, the State Operations Manual (SOM) directs the surveyor to investigate how and when that medication is used. Is the facility trying non-pharmacological interventions before utilizing a medication? Does the facility have a process of communicating to staff individualized non-pharmacological interventions? What interventions are staff using and are they effective? If a medication was used, what did the licensed staff member document as interventions prior to administration of the medication? The surveyor will review the care plan, behavior plan, or other tools that address interventions that are specific to that resident. Did the staff develop a plan that is effective and limits the use of medications that may result in decreased physical, mental and psychosocial well-being and negatively impact the resident's quality of life?

Care plans or behavior plans should be specific and individualized to the resident. A plan should have simple, functional steps, which staff can implement when the resident is experiencing a difficult time. Such as: 1. They love cookies. 2. Talk about teaching school. 3. They had a dog named Spot. 4. They had a favorite sister named June. Some of your staff may be unfamiliar with the resident and lack simple individual information or preferences that can reduce agitation and anxiety. Just using the term redirect can mean something different to each person and may intensify the situation. A list of individualized interventions can be helpful when a resident is upset at 7 p.m. on a Saturday evening.

The following are examples from care plans of two different facilities and two different residents:

1) "The resident has a behavior symptom related to dementia evidenced by hollers out frequently and is unable to express to others what is bothering her. Interventions: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location, as needed. Provide opportunity for positive interaction, attention. If reasonable, discuss resident's behavior. Explain/reinforce to resident why behavior is inappropriate and/or unacceptable."

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2) "The resident has a behavior symptom related to Dementia evidenced by wandering continuously in her wheelchair around the facility, history of grabbing at others." Interventions stated, "Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Provide opportunity for positive interaction, attention with eye contact, offer hand."

Though the above information is not wrong and should be part of all staff education, it lacks the individualized non-pharmacological interventions necessary to implement before the administration of a potentially unnecessary PRN medication.

While assuring that only those medications required to treat the resident's assessed condition are being used, reducing the need for and maximizing the effectiveness of medications are important considerations for all residents. Therefore, as part of all medication management (including antipsychotics), it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating facility staff and providers, in addition to implementing non-pharmacological approaches to resident behaviors, prior to, and/or in conjunction with, the use of medications may minimize the need for medications or reduce the dose and duration of those medications.

Examples of non-pharmacological interventions may include:

- Increasing the amount of resident exercise, intake of liquids and dietary fiber in conjunction with the individualized bowel regimen to prevent or reduce constipation and the use of medications (e.g. laxatives and stool softeners);
- Identifying, addressing, and eliminating or reducing underlying causes of distressed behavior such as boredom and pain;
- Using sleep hygiene techniques and individualized sleep routines;
- Accommodating the resident's behavior and needs by supporting and encouraging activities reminiscent of lifelong work or activity patterns, such as providing early morning activity for a farmer used to awakening early;
- Individualizing toileting schedules to prevent incontinence and avoid the use of incontinence medications that may have significant adverse consequences (e.g., anticholinergic effects);
- Developing interventions that are specific to resident's interest, abilities, strengths and needs, such as simplifying or segmenting tasks for a resident who has trouble following complex directions;
- Using massage, hot/warm or cold compresses to address a resident's pain or discomfort;
- Enhancing the taste and presentation of food, assisting the resident to eat, addressing food preferences, and increasing finger foods and snacks for an individual with dementia, to improve appetite and avoid the unnecessary use of medications intended to stimulate appetite;
- Arrange staffing to optimize familiarity and consistency for a resident with symptoms of dementia.

As we all move forward to the new survey process, refer to the sections regarding Behavioral Health Services F740 —F745 and Pharmacy Services F757 — F760. The underlying theme is person-centered, individualized care and approaches regarding residents' behavior and adjustment.

Incident Reports; A Safeguard You Can't Do Without

By Bobbie Houn, Health Facilities Surveyor

Have you ever questioned the value of an incident report or neglected to complete one? Consider the following.

The primary purpose for completing an incident report is to identify and correct problems as they arise in your facility. Your Quality Assurance Department will often use the reports to identify trends, revise policies, and implement new systems in an effort to prevent further occurrences.

The incident report should trigger an immediate investigation of the event that occurred. All staff members involved in the situation should be interviewed in an effort to preserve the facts surrounding the incident. The findings of the investigation may be helpful when you explain the incident to the resident and/or family member, and may minimize their negative feelings and/or perceptions.

You should complete an incident report anytime a resident, visitor, and/or staff member is injured, or a policy/procedure is not followed. Examples of reportable incidents include elopements, equipment malfunctions, falls, medication errors, missing property, etc.

It is up to you to complete a report, usually by the end of your shift. If you have concerns, you should not consider the incident too insignificant to report, fear staff reactions, and/or hesitate due to fear of disciplinary action. You are much more likely to face disciplinary action if you fail to complete an incident report, especially following an incident resulting in serious injury.

Incident reports are intended for in-house quality assurance purposes, but may end up as evidence in a lawsuit. Therefore, the following information should be included:

* Date, time, and location of the incident.
* Date and time the incident was discovered.
* Record your assessment of the resident.
  - ~ Identify any symptoms the resident displays.
  - ~ Identify the nature and extent of the resident's injuries.
  - ~ If your report form includes a diagram of the body, ensure your written statements match what's marked on the diagram.
* Name of the physician who was notified and the date and time he/she was contacted.
* Name of the family member who was notified and the date and time he/she was contacted.
* When you describe the event, stick to the facts! Avoid conjecture, affixing blame, and/or expressing your opinion.
  - ~ Determine the sequence of events, including what lead up to and/or immediately followed the incident.
  - ~ Identify what staff were doing at the time of the incident.
  - ~ Identify the condition of the environment.
  - ~ If possible, identify the cause of the incident and/or any contributing factors.
* Name each staff member involved in the incident and include their job title.
* Attach written statements and/or quote those interviewed.
* Include any interventions you implemented to prevent further occurrences.

After you have completed the incident report, you must also record the incident in the resident's chart. In the event of a lawsuit, an attorney could argue that a medical record containing little or no information is misleading. The medical record should mirror the incident report. Document the date and time of the incident, a brief description of what happened, your assessment of the resident, information regarding family and physician notification, and any interventions you implemented to prevent further occurrences.

Completing the incident report is as important as documenting in the resident's medical record. This is true no matter how minor the incident or how busy you are. Remember the incident report you complete may end up protecting you and your facility from potential liability.

References:
http://www.modernmedicine.com, legally speaking, incident reports;
http://wwwlinkedin.com, workplace safety;
http://blogs.hcpro.com, nurse managers, best practice

Fire Door Annual Testing
By Monte Engel, Division Director, Life Safety & Construction

In nursing facilities, annual inspection and testing in accordance with the 2010 NFPA 80 is required for all fire door assemblies. Non-rated doors, including corridor doors to resident rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements. But, non-rated doors should be routinely inspected as part of the facility maintenance program as all required life safety features and systems must be maintained in proper working order. Life Safety Code deficiencies associated with the annual inspection and testing of fire doors will be cited under K211 – *Means of Egress - General*.

Fire door assemblies shall be visually inspected from both sides to assess the overall condition of the door assembly. At a minimum, the following items shall be verified:

1) No open holes or breaks exist in surfaces of either the door or frame.
2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.
3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.
4) No parts are missing or broken.
5) Door clearances do not exceed ¾" under the bottom of the door and 1/8" between the top and vertical edges of the door and frame.
6) The self-closing device is operational; that is, the door completely closes when operated from the full open position.
7) If a coordinator is installed, the inactive leaf closes before the active leaf.
8) Latching hardware operates and secures the door when it is in the closed position.
9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.
10) No field modifications to the door assembly have been performed that void the label.
11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.

CMS regulatory adoption of the 2012 Life Safety Code was July 5, 2016, therefore the required annual door inspections and testing should have been accomplished by July 6, 2017. However, considering the level of reported misunderstanding of this requirement, CMS has extended the compliance date for this requirement by six months. Full compliance with the annual fire door assembly inspection and testing in accordance with 2010 NFPA 80 is required by January 1, 2018.

Refer to CMS S&C 17-38-LSC and NFPA 80 for further information.

Fire Alarm Test Records
By Monte Engel, Division Director, Life Safety & Construction

K345 – *NFPA 101 Fire Alarm System – Testing and Maintenance*

A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance, and testing are readily available.

A component of the fire alarm system testing includes testing of all alarm initiating devices, supervisory alarm initiating devices, and alarm notification devices. NFPA 72 requires the test record to contain an itemized listing of each of these devices, that include the device type, address, location, and test results.

Test records must contain this itemized listing of test results. Coordinate with your fire alarm service company to ensure they provide you with the necessary information to comply with this requirement.

Medicare Billing—Do You Have The Correct Contact Information For An Appeal?

By Lisa Fries, Health Facilities Surveyor

There are two types of appeal. The standard appeal and the expedited appeal.

The standard appeal is an appeal filed with the Fiscal Intermediary or Medicare Administrative Contractor. The beneficiary is provided with a Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) **or** denial notice at the termination of Medicare Part A benefits. Information for North Dakota's Fiscal Intermediary or Medicare Administrative Contractor is Noridian. Information for Noridian is:

Noridian Healthcare Solutions, LLC
Medicare Part A
PO Box 6709
Fargo, North Dakota 58108

The expedited appeal is a quick appeal that goes to the Quality Improvement Organization (QIO) (which is Kepro for North Dakota). The notice of Medicare Provider Non-coverage (form CMS-10123) informs the beneficiary of the right to an expedited review. Information for Kepro is:

KEPRO
Rock Run Center
5700 Lombardo Center, Suite 100
Seven Hill, Ohio 44131
1-844-430-9504
TTY 1-855-843-4776

Nurse Aide Registry Users

By Bruce Pritschet, Division Director

The nurse aide registry has been extremely busy with renewals and initial applications, and endorsements to and from other states. Much of the time spent by our staff is following up on missing information on renewals or initial applications and endorsements. In an effort to be more efficient and less reactive, we are asking the following of individuals on the nurse aide registry:

Please remember to go online and update your mailing address when it changes. You will not get your notifications if your address is not correct. CNAs that are working beyond their expiration dates can all be traced back to incorrect mailing addresses on the Registry.

If you don't have access to the internet at home, ask at work if you can go online during breaks to update your information. The link to update your information is https://www.ndhealth.gov/hf/registry/address-search.aspx

In addition to mailing addresses, we are placing more emphasis on email addresses. In the future, most registry transactions will be accomplished online. To make registry response times better, please update your email address on the registry when you go in to update your mailing address. The phone number for the Nurse Aide Registry is 701.328.2353.

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