Office of Health Facilities Licensure and Certification

South Dakota Department of Health

December 2019
Partnership News

Partnership News

& Best Practice

SD Department of Health
615 East 4th Street
Pierre, SD
57501

Phone: 605.773.3356

Please visit our website at:

http://doh.sd.gov/providers/licensure/

Internet Quality Improvement and Evaluation System (iQIES) for Home Health Agency's

The Quality Improvement and Evaluation System (QIES) is being upgraded to make the system more reliable, scalable, secure, and accessible. The enhanced system, referred to as the internet Quality Improvement and Evaluation System (iQIES), aims to reduce provider burden and enhance the Centers for Medicare & Medicaid Services (CMS) ability to serve our customers.

The initial rollout of iQIES will not change how providers or vendors submit data. However, iQIES will require a new user management system because virtual private network (VPN) and CMSNet are no longer needed to access this system. All users will have to create an account and establish credentials in the HCQIS Access Roles and Profile system (HARP), which is a secure identity management portal provided by CMS.

HHAs remember to register for iQIES to be effective in January 2020. For iQIES access instructions and important information, providers are referred to the following link: **https://qtso.cms.gov/news-and-updates/register-iqies-account-action-required**. For any general iQIES questions, providers should inquire with: iQIES_Broadcast@cms.hhs.gov.

Inside this issue

Helping Frontline Staff................2
Reusable Medical Devices...........3
Restorative Nursing Care............3
TB Skin Testing 4
On-line Controlled Substance Registry. 4
New Administrator? 5
Where There are Drugs 6-9
Chronic Pain & Opioid Misuse.....10
Abuse is More than a Bruise........11-12
Role Interchangeable? 13
Successful CNA 14
Shingles 15
Waived Lab Program 16

Office of Licensure and Certification RAI Coordinators

Please feel free to contact either Susan Bakker or Jean Koch for questions relating to MDS assessments. Questions may be submitted using the email at **DOHOLCMDS@STATE.SD.US**. Please note all reimbursement issues should be referred to DSS.

Helping Frontline Staff with Residents Exhibiting Difficult Behavior

"There are only four kinds of people in the world. Those who have been caregivers. Those who are currently caregivers. Those who will be caregivers, and those who will need a caregiver."
~ Rosalyn Carter

It is important to understand the needs of frontline staff. The certified nursing assistants (CNAs) need to understand why residents may be challenging. Ensure the direct care staff knows the difference between dementia vs. psychiatric disorders such as hallucinations, delusions, etc. Explain to staff that there may be medical reasons for a resident's behavior such as a possible urinary tract infection, lab abnormalities, or the initiation of a new medication. Once the medical condition has been appropriately treated those difficult behaviors may subside.

Validate the staff member for trying to help in a challenging situation. Sometimes the staff person may need to vent. They may be confused about why there is a difficult behavior in a nursing home. Often, they might say that they did not know they were working in a psychiatric hospital and they may feel as though they are untrained and unprepared. Assure the staff person that you will assist them to have the tools they need to help their residents. It might help to explain that there are no long-term psychiatric hospitals and that the elderly, even with psychiatric problems usually go to nursing homes.

Have a point person that is a resource and can be contacted by the CNAs for advice. Most importantly this is a time to show appreciation for frontline staff. When they feel appreciated, they are likely to go the extra mile and be more successful in their interactions with residents. Take time to have each person speak and share their concerns.

Address stress management with the staff. Ask each person to talk about how they handle stress. A debriefing meeting assists staff involved in a difficult situation to talk about their feelings. Allow staff members to express their feelings and concerns. After the meeting, there may be new light shed on a difficult situation. Your frontline staff will be rejuvenated, and ready to face the challenges ahead.

"Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around."
~ Leo Buscaglia

New Survey Process for Duodenoscopes/ Endoscopes/ Reusable Medical Devices

The Center for Medicare and Medicaid Services (CMS) is highlighting the below listed policy changes to alert facilities that surveyors will be observing these practices to assess compliance with the regulations.

CMS strongly supports the Centers for Disease Prevention and Control (CDC) recommendations that facilities assess their reprocessing and sterilization procedures, including: training of personnel who reprocess medical devices; adherence to cleaning, disinfection, sterilization, and device storage procedures; and infection control policies and procedures. Recent survey results, after multiple media reports and investigations of infectious disease outbreaks, continue to reveal problems with the cleaning and disinfection of reusable medical devices.

First, in accordance with policy memorandum S&C-15-32, surveyors entering a facility, will inquire whether that facility performs Endoscopic procedures. If so, surveyors will request a copy of the manufacturer's instructions for use for cleaning and disinfecting the endoscopes. Further, surveyors must observe endoscopes being reprocessed (from start to finish) and should ask the responsible staff to explain and demonstrate how they adhere to the manufacturer's instructions.

Second, policy memorandum S&C- 14-44 makes clear that facilities that sterilize reusable surgical instruments must not use immediate use steam sterilization as a routine method of sterilization.

Restorative Nursing Care

So often, while on a survey, it is heard the care plan for restorative care can't be carried out because of scheduling and "pulling the restorative aide" to complete other duties.

Restorative nursing care provided by the certified nurse aide (CNA) involves cueing, prompting, and encouraging. An important part of a CNA's regularly assigned tasks is to help a resident or patient to retain skills and improve whenever possible; those tasks involve cueing, prompting, and encouraging.

The CNA basic training curriculum does include training the resident or patient in self-care according to individual ability; use of assistive devices in transferring, ambulation, eating, and dressing; maintenance of range of motion; proper turning and positioning in bed and chair; bowel and bladder control care training; and the care and use of prosthetic and orthotic devices.

A restorative CNA works with a registered nurse (RN), physical therapist (PT), and/or an occupational therapist (OT); usually sets up the necessary equipment, cleans equipment, and assists as needed. Think outside the box. Throughout the day, while working with and caring for residents and patients , there is opportunity for the CNA to incorporate restorative activity. Consider active and passive range of motion that occurs with dressing, bathing, or brushing teeth. There are multiple tasks. Restorative nursing is often viewed as an expanded role of the CNA. Why not train all CNAs to complete the expanded tasks?

A Walk-to-Dine program is a classic example of focusing on increasing level of strength and mobility of the resident or patient. Everyone, not just the RN, PT, or OT are involved. Once assessed and planned for help with exercises such as walking do not need constant direct supervision of a nurse or therapist.

Re-thinking restorative nursing care may save your care plan.

Tuberculin Screening Requirements

The Office of Health Care Facilities Licensure & Certification is aware some of those providers who perform skin testing screening for Mycobacterium tuberculosis (TB); are having trouble in obtaining adequate supplies of tuberculin purified protein derivative (PPD), utilized to administer the Mantoux tuberculin skin test.

In the absence of enough supplies, providers are encouraged to be vigilant in conducting individual TB risk assessments and consult with their medical director for further follow-up. Document the unavailability of the PPD and what was carried out relevant to the individual(s).

Controlled substance registrations (new, renewals, and changes to an existing registration) can now be done on-line

The South Dakota Department of Health is pleased to announce beginning on July 1, 2019, all new applications and renewal registrations, verifications, and changes to an existing registration, will be completed online with the South Dakota Department of Health's new registration system. Payment using the online Controlled Substance Registration system must be made by using Mastercard or Visa credit and debit cards.

If you are a practitioner, and do not have a federal Drug Enforcement Administration (DEA) certificate to move to South Dakota and are applying for a new DEA number at a South Dakota location, you must write "pending" where it asks for the DEA registration on the state application, and you must also apply to the DEA for a new DEA number, since you are not moving a number to South Dakota.

When submitting an application, please be sure to have all of your information ready, including any supporting documents needing to be uploaded, such as a copy of the updated federal DEA certificate. After the application has been submitted and the payment has been made, the Department will review the application, email the registrant if additional information is needed, approve or deny the application, or pend the application until we receive the new DEA number.

After July 1, 2019, you can log in at any time to view the application status or print registration. Controlled substance registration certificates or letters will no longer be mailed. Any controlled substance registration can also now be a primary source verified on the website.

Special points of interest:

- ***Nursing Home Compare:*** ***http://www.medicare.gov/nursinghomecompare/?AspxAutoDetectCookieSupport=1***
- ***Hospital Compare:*** ***https://www.medicare.gov/hospitalcompare/search.html***
- ***Home Health Compare:*** ***https://www.medicare.gov/homehealthcompare/search.html***
- ***CMS Memos:***
- ***http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html***
- ***Licensure and Certification website:*** ***https://doh.sd.gov/providers/licensure/***

Are you a new administrator in a facility? Do you know if your "governing body" has reported this change in administration to our office?

The Office of Health Care Facilities Licensure & Certification would like to take this opportunity to remind our health care partners of their obligation to notify our office when a change in administrator occurs.

According to the Administrative Rules of South Dakota (various rules depending on provider type), the "governing body" shall notify the department in writing of any change of administrator. We request this notification be sent prior to the departure of the current administrator, if possible. This will help ensure we have adequate time to update our records appropriately.

The Office of Health Care Facilities Licensure & Certification and the Centers for Medicare and Medicaid Services (CMS) currently communicate strictly via email with providers. For this reason, we would also like to request the administrator's email address be included in the letter.

- Acceptable forms of communication for this change are:
- Send a written request to Chris Qualm, Administrator, South Dakota Department of Health, 615 E 4th Street, Pierre, SD 57501;
- Fax a written request to Chris Qualm, Administrator, South Dakota Department of Health, 605-773-6667;
- Email a request to **Chris.Qualm@state.sd.us** and **Julie.Jenssen@state.sd.us**

Although there is no administrative rule governing the notification of changes in the Director of Nursing position, we would like to request the administrator, please notify our office of these changes as well.

Please feel free to contact Julie at 605.773.3356 if you have any questions.

Emergency Preparedness

Emergency Preparedness Regulations for all Provider and Certified Supplier Types: Interpretive Guidelines
https://doh.sd.gov/providers/preparedness/SDHAN.aspx

Need help with you Emergency Preparedness planning? Need to know how to connect with a **HealthCare Coalition in SD?**
Go to **http://doh.sd.gov/providers/preparedness/hospital-preparedness/system/**

CMS Emergency Preparedness Site:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html

Health Alert Network:
https://doh.sd.gov/providers/preparedness/SDHAN.aspx

Where there are drugs, there will always be attempts at diversion *Source—Pharmacy Purchasing Products at https://www.pppmag.com/article/2119#table*

A common belief among health care workers is that diversion "could not happen at this facility" because the staff knows and trusts one another. The same reason is often given for signing off as a witness to waste that was not actually witnessed: "I trust her; she would never divert." On occasion, a pharmacist will state that their institution is one of the lucky ones, where diversion is not a problem. Facilities that have identified minimal diversion in the past may develop a false sense of security, and thus have negligible ongoing surveillance. Likewise, in states where surveillance requirements for health care facilities are outlined in state regulations, organizations may conclude that if they simply meet the baseline requirements, they are doing enough.

In reality, every facility that manages controlled substances is at risk and will have diversion. If diversion is not being discovered, it is almost certainly due to insufficient attention or ineffective surveillance, not because diversion is absent. Diversion occurs at small critical access hospitals, prestigious academic medical centers, children's hospitals, physicians' offices, surgery centers, nursing homes, and other types of facilities. Rather than simply react to diversion after it occurs, it is important to identify anomalous drug usage early and take swift, preventive action.

One of the most effective methods facilities can use to detect possible drug diversion is through surveillance or auditing of automated dispensing cabinet (ADC) transactions. Many facilities use a combination of ADC data and diversion-detection software to help focus their auditing efforts; these reports facilitate identification of suspicious trends long before a staff member may exhibit recognizable behaviors of impairment. Identifying potential diversion as early as possible is the first step in a comprehensive diversion-prevention program, as behavioral manifestations are a late sign of diversion.

Identifying Diversion

The tools available to help organizations detect drug diversion have improved significantly in recent years. Analytics programs have evolved and become more focused on current trends in diversion, and ADC vendors are increasingly focusing on integrating electronic health record (EHR) data into their reports. Even with this progress in technology, many organizations still find their controlled substance auditing to be inadequate and struggle to make their diversion-surveillance process sufficiently robust.

The importance of diversion surveillance and investigation of possible diversion should not be underestimated. If a facility does not review and act on the content of generated reports, it is still accountable for the contents therein. Furthermore, experience has proven that diverters will test the system to identify weaknesses that allow them to divert undetected. If diverters determine that diversion monitoring is not a priority, and no one is watching, they will take full advantage of the situation. The result for patients, staff, and the institution is potentially disastrous.

Ensuring Comprehensive Auditing

Comprehensive diversion surveillance is critical to an effective diversion-prevention program. Identify every area in the institution where controlled substances exist (including areas with manual storage), define who has oversight for each of these areas, and evaluate what diversion auditing, if any, is being conducted. Specific areas that may be at risk for inadequate surveillance include anesthesia, emergency transport services, outpatient clinics and care centers, and even pharmacy.

Once the scope of controlled substance usage is determined, the organization should develop a policy and procedure (P&P) that clearly describes its expectations for surveillance in all areas. Those responsible for diversion surveillance need to know what data or reports will be generated, how often the data must be reviewed, expected time frames for

completing audits, thresholds that necessitate further review, what that additional review should entail, how the review will be documented, and to whom they can go for support and guidance.

Maximizing a Diversion-Surveillance Program

Health care institutions should review their diversion-surveillance and auditing P&Ps at least annually to ensure they are comprehensive and accurately reflect real practice. Consider whether the organization has been successful in identifying diversion, and if diversion has been identified, how it occurred. Strive to identify diversion through surveillance of ADC data, as opposed to waiting to do so through behavioral clues.

The Role of Pharmacy and Nursing

Pharmacy staff and nursing leadership commonly assume responsibility for the majority of diversion surveillance. Unless the process is well defined, there may be inconsistencies in what data is reviewed, which can result in duplicative efforts and gaps in the surveillance program. Pharmacy staff and clinical leaders typically serve in multiple roles, with diversion surveillance one of many responsibilities. It is not uncommon for pharmacy staff to limit their surveillance to a cursory review of the reports prior to sending the information on to clinical leadership. There is value in involving clinical leaders in diversion surveillance, as they are often in the best position to understand workflows, patient acuity, and staff assignments. Their supervisory role, however, is conducive to bias that may impair their ability to view data objectively. For these reasons, diversion surveillance should not be in the purview of pharmacy staff and clinical leaders alone.

The Role of the Diversion Specialist

There is considerable value in establishing a diversion specialist or diversion program manager to oversee diversion auditing and operations. The diversion specialist provides value as they are inherently unbiased by a close relationship with clinical staff, and can accumulate significant diversion expertise by performing surveillance frequently. The specialist can conduct audits of specific controlled substance handling practices, such as patient-controlled anesthesia (PCA) and controlled substance infusions, and use the results to help the institution change practice and mitigate risk. Even if there is a limited likelihood of developing a full-time diversion specialist position, many organizations that start with a part-time position see the value of the role within the first 6 months, and the role then evolves into a full-time position.

If a facility does not have the resources to hire a full- or part-time diversion specialist, it is extremely important that an individual within the organization assumes responsibility for the operations of the diversion program. Without clear-cut ownership, it is likely that the program will be fragmented and reactive.

Streamlining ADC Data

Automated drug dispensing systems and diversion analytics programs are capable of producing daunting amounts of information. Facilities may struggle to determine which reports are valuable and where to focus their surveillance efforts.

Organizations that attempt to review all or most of the reports they are capable of generating often experience report fatigue, which manifests in ineffective reviews and backlogs. We have yet to encounter a facility with the resources to review every report available, and even if such a situation exists, the usefulness of doing so is dubious. A list of primary and secondary reports facilities can use as a guide to determine which reports they will review regularly is available in TABLE 1 on page 16. Secondary reports are typically used to provide additional information when the primary reports fail to clarify the situation. Other reports may provide limited value and should

not be generated for review under most circumstances. Identifying which reports are most critical for regular review helps streamline data to a manageable level while effectively identifying possible diversion.

Stop Diversion Reports Chart - Click here to view TABLE 1.

Facilities should take advantage of ADC data to highlight poor controlled substance handling practices. Once a staff member has been counseled, the ADC data also can be used to monitor future performance. Transaction data may reveal workarounds or risky practices, such as pulling medication too far in advance of administration, pulling too much medication (over-pulling) and returning complete doses frequently, pulling excessively large doses, delayed wasting, and frequent wasting of complete doses. Transaction data can reveal when staff is carrying controlled medications in their pockets; inevitably, they will take medications home accidentally, and the first transaction of their next shift will be a telltale waste transaction even though no medication has been pulled. If poor drug handling practices are present at an institution, surveillance reports will include significant noise, ie, red flags that represent careless practice rather than diversion. Facilities should work to reduce the noise so that surveillance is more effective. Correcting poor practice reduces the risk of diversion and also makes diversion more apparent when it occurs.

Diversion program stakeholders should work with Human Resources to develop a process for counseling staff and implementing progressive discipline when poor practices are found. Ongoing education can also improve poor drug handling practices and elevate awareness about the danger of diversion.

Scope of Surveillance

To identify diversion, it is vital to include all controlled substances in ongoing surveillance; organizations should also consider monitoring transactions for noncontrolled substances that are known to be diversion risks, such as propofol. Some facilities limit their auditing to only a few drugs they feel are most likely to be diverted. However, experience has shown that there are few controlled substances that are not diverted. Another common pitfall is limiting the transaction review to only those drugs for which a staff member's transactions are outliers. In order to pinpoint diversion, the auditor needs to review how the staff member handles all drugs and use those transactions as a comparison point. Does the individual frequently waste complete doses of one opioid, but not others? Does the staff member delay administration of one opioid, but promptly administer doses of all others? Focusing on only a few drugs removes an important reference point and may cause auditors to miss signs of diversion.

Because PCAs are a common target of diverters, PCA keys should be managed as a controlled substance and stored alone in a limited quantity in a secure pocket or bin in the ADC. Access to the keys should occur under the appropriate patient name, and staff should verify the number of keys with each transaction. PCA key surveillance should be ongoing, and the legitimacy of transactions should be verified in the same manner auditors confirm that controlled substance transactions are appropriate.

Once there is suspicion of diversion, auditors may find that monitoring transactions for commonly diverted noncontrolled drugs is useful to help clarify the situation. For example, we commonly see diversion of ondansetron, presumably to treat symptoms of nausea associated with opioid abuse, in conjunction with opioid diversion schemes. Moreover, injectable promethazine and diphenhydramine maybe diverted to use as a substitute for an opioid. Acetaminophen is frequently diverted to use as a substitute for a diverted oral opioid. In advanced opioid diversion schemes, naloxone also may be diverted.

Where there are drugs, there will always be attempts at diversion (continued)

Barriers to Effective Surveillance

There are several issues that can limit the effectiveness of a diversion-surveillance program, including poorly defined roles, confusion over which drugs should be reviewed and how, report fatigue, a false sense of security, and a lack of resources dedicated to data review. Many facilities have not allocated resources exclusively to diversion detection. Even with advances in technology, diversion surveillance remains labor intensive. For that reason, resources must be allocated appropriately.

Gaining administration's buy-in to the critical nature of diversion prevention is the first step in obtaining buy-in for additional resources. Executive leadership must be educated about the scope of the problem and gaps that are present in existing processes. Presenting an outline of the time commitment required using current auditing methods is helpful, as well. Above all, emphasize the risks of diversion to patients, staff, and the institution. Highlighting information about recent DEA investigations and financial settlements can help convey the risks of inadequate attention.

Conclusion

Where there are drugs, there will always be attempts at diversion. Identifying and addressing anomalous usage through the review of ADC data and analytics reports is essential to diversion management.

The risks associated with diversion warrant that organizations devote appropriate resources to diversion surveillance. Done correctly, surveillance can help facilities detect diversion in a timely manner and respond accordingly, reducing the significant risks to patients, health care workers, and the community.

Kimberly New, JD, BSN, RN, is the founder of Diversion Specialists, LLC, *a consulting service providing solutions for all aspects of institutional drug diversion. She is a specialist in controlled substance security and DEA regulatory compliance, working with health systems across the country to establish and expand drug diversion programs, with the overriding goal of improving patient safety. Kim is also the cofounder and executive director of the International Health Facility Diversion Association.*

Lucas Overmire, BA, a partner at Diversion Specialists, LLC*, has previously worked as an educator for a major manufacturer of automated dispensing cabinets. He is a specialist in pharmacy automation and analytics and is currently the creative director for the International Health Facility Diversion Association.*

Pocket Guide: Tapering Opioids for Chronic Pain - Opens in a new window : Quick-reference tool for when and how to taper and important considerations for safe and effective care; https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf and

CDC Opioid Prescribing Guideline Mobile App - Opens in a new window : Apply the recommendations in clinical practice, including a morphine milligram equivalent calculator, key recommendations, motivational interviewing techniques, resources, and glossary; https://www.cdc.gov/drugoverdose/prescribing/app.html and

Applying CDC's Guideline for Prescribing Opioids Series - Opens in a new window : Interactive, web-based training featuring 11 self-paced learning modules with case-based content, knowledge checks, and integrated resources; https://www.cdc.gov/drugoverdose/training/online-training.html

Chronic Pain & Opioid Misuse

Did you know up to 29 percent of patients prescribed opioids for chronic pain misuse them?

Every day, more than 130 people in the United States die after overdosing on opioids.[1] The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.[2]

How did this happen? In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive.[3,4] Opioid overdose rates began to increase. In 2017, more than 47,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin, and illicitly manufactured fentanyl, a powerful synthetic opioid.[1] That same year, an estimated 1.7 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers, and 652,000 suffered from a heroin use disorder (not mutually exclusive).[5]

What do we know about the opioid crisis?

Roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them.[6]

Between 8 and 12 percent develop an opioid use disorder.[6]

An estimated 4 to 6 percent who misuse prescription opioids transition to heroin.[7–9]

About 80 percent of people who use heroin first misused prescription opioids.[7]

Opioid overdoses increased 30 percent from July 2016 through September 2017 in 52 areas in 45 states.[10]

The Midwestern region saw opioid overdoses increase 70 percent from July 2016 through September 2017.[10]

Opioid overdoses in large cities increase by 54 percent in 16 states.[10]

References and to read more: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis

Avoid Opioid

https://www.avoidopioidsd.com/

South Dakota Opioid Resource Hotline 1.800.920.4343

Abuse is More than a Bruise

Though countless residents are well-cared for, abuse continues to be more prevalent than we wish to believe. Over three-fourths of nursing home abuse cases are perpetrated by caregivers.

A 2016 congressional report presented a review of nursing home records conducted over a two-year period showed that nearly 1 in 3 nursing homes were cited for violations that had the potential to cause harm and almost 10 percent of all nursing homes have violations that caused actual harm, serious injury or placed them in jeopardy of death.

Abuse can involve:

Physical Abuse is a condition or event that causes physical harm. Physical abuse may be intentional such as hitting or pinching, or it may be due to neglect, including overuse of restraints and lack of physical care. Look for unexplained injuries such as bruises, broken bones, or burns.

Sexual Abuse is unwanted sexual attention or exploitation. This includes sexual attention given to a resident/patient who is unable to express his or her wishes or is cognitively compromised, such as the resident with dementia. Look for development of sexually transmitted diseases, genital or anal pain, injury, or bleeding.

Psychological Abuse is not easily identified but can include yelling, criticizing, humiliating, or otherwise shaming the resident/patient. Residents who are experiencing psychological abuse may exhibit behavioral changes. Look for fearful behavior, anxiety, severe and unexplained changes in moods or personality, fear of interacting with nursing home staff or caregivers, refusal to see family members or close friends, withdrawal from social support system, or hesitation to talk openly.

Financial Exploitation occurs a caregiver takes advantage of access to a resident's/patient's financial matters, steals or otherwise compromises the resident's financial status. This could include direct theft, theft from banking accounts or applying for credit in the resident's name.

Neglect is often unintentional and a result of inadequate staffing. Neglect occurs when a resident/patient's needs are not taken care of such as personal hygiene care or when the resident is not provided food, clothing or water. Neglect can contribute to several medical conditions such as bed sores, skin infections, malnutrition and dehydration.

Resident to Resident Abuse/Altercation occurs when one resident abuse or has an altercation with another resident, which may be physical, sexual or psychological. Did the resident act willfully in the altercation? Willful means the individual intended the action. The resident knew or should have known the action could cause physical harm, pain, or mental anguish. A resident with cognitive impairment may still commit a willful act.

What is Psychological Abuse?

When healthcare personnel inflict psychological abuse, it causes residents to feel extreme sadness, fear, and anxiety. Psychological abuse can be more difficult to observe than physical abuse. In addition, because some types of psychological abuse are nonverbal, they may be very subtle and hard to notice. Often psychological abuse is inflicted at the same time as other forms of abuse that cause a resident to feel helpless and depressed. Some types of psychological abuse include:

- Intimidation and threatening a patient.
- Ridiculing and insulting a patient.
- Making a patient feel guilty or distressed.
- Yelling or shouting at a patient.

Abuse is More than a Bruise *(continued)*

Some nonverbal forms of psychological abuse are:

- Ignoring a patient or giving them the silent treatment.
- Isolating them from friends or family.
- Preventing them from participating in social activities.
- Frightening or intimidating the patient.
- Threatening to withhold food or water.

What Are the Signs of Psychological Abuse?

Psychological abuse is not as obvious as physical abuse. The signs of psychological abuse can be difficult to identify at first. As the abuse progresses, the resident may become timid, withdrawn, and/or depressed. Some residents may react oppositely and become more agitated and aggressive after being abused.
Some Indicators of Psychological Abuse:

- Depression and withdrawal.
- Refusal to interact or speak with others.
- Sudden change in personality or behavior.
- Agitation.
- Excessive fear or nervousness.
- Unusual behavior such as sucking, biting, or rocking.

As the effects of psychological abuse worsen, it may start to have serious consequences for the victim's health. If the victim is feeling depressed, he may feel excessively stressed or lose his appetite. These effects may weaken his immune system and make him more susceptible to illness. Some other physical indicators of psychological abuse are:

- Loss of appetite.
- Lack of sleep or insomnia.
- Sudden weight loss.
- Refusal to eat or take medications.
- Increased vulnerability to injury and infection.

What Do I Do If I Suspect Abuse?
You do not need to prove abuse in order to make a report. If you believe psychological abuse is occurring, you should:

- Take immediate and necessary actions to intervene and protect the resident.
- Remove the abuser from the facility.
- Report the abuse to local law enforcement and Dakota At Home.
- Submit a report to the Department of Health using the online reporting system (Launchpad) the pertinent data necessary to comply with the requirements of all applicable administrative rules and statutes.

Please contact Shelly Walstead at 605.367.4640 or Jolene Hanson at 605.367.7499 or email **DOHOLCComplaint@state.sd.us** with questions and/or concerns regarding mandatory reporting requirements.

Sources:

http://www.nursinghomeabuseguide.org/
https://doh.sd.gov/documents/Providers/Licensure/Reporting.pdf

Is the Role Interchangeable?

What is the difference between a certified nurse aide (CNA), hospice CNA, restorative CNA, unlicensed medication aide (UMA), patient care technician (PCT), and medical assistant (MA)?

CNAs are the front-line workers in nursing homes. Their primary duty is direct care, they are often the first to identify changes in a resident's condition; they are often thought of as "the eyes and ears" of the facility. Their skillset and role are considered delegated from the licensed nurse.

A CNA must complete a minimum of 75 hours and include 16 hours of supervised clinical training prior to competency testing and placement on the State registry. To maintain certification, all CNAs must complete 12 hours of continuing education annually and have 12 hours of work utilizing the skillset.

Hospice CNAs have completed the same minimum of 75 hours and include 16 hours of supervised clinical training prior to competency testing. There is no separate registry for the hospice CNA. They receive additional training from the hospice nurse about expectations of care for the patient receiving hospice services.

A supervising nurse must assess a CNA's ability to follow the patient care plan for completion of assigned tasks, create successful interpersonal relationships with the patient and family, comply with infection control policies and procedures, report changes in patient condition. They maintain CNA certification and registry status. It is dependent on the provider policy if they require certification and registry status.

Restorative CNAs complete the same minimum of 75 hours and include 16 hours of supervised clinical training prior to competency testing and placement on the State registry. There is no separate registry for the restorative CNA. They usually receive additional training from the restorative nurse, physical therapist, or occupational therapist about setting up necessary equipment, cleaning equipment, and how they may assist the resident through cueing, prompting, and encouragement.
They maintain CNA certification and registry status.

UMAs may or may not be CNAs. It is a delegated role from the licensed nurse. An UMA must complete a minimum of 20 hours of training that includes 16 hours of course work about medication administration and 4 hours of clinical/lab experience prior to a 65 multiple choice question competency test and placement on the State registry. A clinical skills checklist is maintained by the facility and the UMA receives a certificate of completion. To maintain registry status the UMA must have 12 hours of employment within the previous 2 years of renewal.

PCTs mainly focus on working with patients in conjunction with nurses. Their skillset is quite similar to CNAs such as providing patient care, bathing, patient assistance, obtaining vital signs, and performing CPR. Many PCTs do start out as CNAs. PCTs need to have a high school diploma or GED and have completed a training program and competency testing usually resulting in patient care technician/assistant (CPCT/A). PCTs are employed in hospitals or nursing homes.

MAs are trained in clinical and administrative work. The clinical side of their role involves recording vital signs, compiling medical history and administering medications under the direction of a supervising physician. The administrative duties include greeting patients, scheduling appointments and assisting patients with completing insurance paperwork. Just as the name implies, a physician needs to be involved with this worker; not many nursing homes have a physician present for other than scheduled rounds.

The CNA, hospice, restorative, UMA, and PCT roles have licensed nurse delegation and supervision oversight.

How Do You Create a Successful and Effective CNA?

Creating a successful and effective CNA is not an easy task. Start with the interview, how do you determine if someone is caring, compassionate, optimistic, and a good team player? Ask those questions that give some perspective about their personality, interests, and values. Will they fit your culture?

Moving forward once hired, what resources do they require to succeed and ultimately do their best work for your residents and patients? To answer that we need to know what the skillset is about. CNAs are the front-line workers in a nursing home and often thought of as "the eyes and ears" of the facility. They are the staff that spend the most time with residents and patients. Their tasks involve more than the heavy lifting of assisting residents and patients with personal care and comfort, such as bathing, oral hygiene, grooming, toileting, positioning, and helping them improve their ability to function.

Expectations for the job include:

- Ability to read, comprehend, and follow policies, procedures, care plans, and other written announcements.
- Determine the meaning of medical jargon, technical terms, abbreviations or words that may have several meanings.
- Follow directions involving concerns such as specific care or use of personal protective equipment.
- Ability to find and apply information contained in the resident/patient record, order forms, diagrams, or equipment guidelines.
- Ability to compare information and determine need to report to the nurse.
- Observation skills that entail the need to pay attention to and remember basic details of straight forward procedures; concentrate on the important elements of a procedure and remain focused.
- Applied mathematics using calculator and computer.
- Ability to write and use basic business English.

CNAs spend at a minimum approximately a third of their work time following policies and procedures; documenting and recording their actions and other information; taking vitals, obtaining weights, recording intake and output, and determining what to report to the nurse about their observations.

Some additional resources that may be necessary for success may include:

- Additional time for completing training course; may need assistance with reading and comprehension, especially if their primary language is not English.
- Assistance with simple mathematics – use of a calculator and computer.
- Assistance with team building/team player skill.

While every individual hired to perform CNA duties brings to the job their own personality, interests, and values; they may not possess all the knowledge and skills but given an opportunity and the necessary resources they may succeed and be effective. The residents and patients ultimately benefit.

Providers interested in joining the OLC listserv can subscribe at
https://listserv.sd.gov/scripts/wa.exe?A0=SDOLC ,
CLIA: **https://listserv.sd.gov/scripts/wa.exe?A0=SDCLIA**
RHC: **https://listserv.sd.gov/scripts/wa.exe?A0=SDRHCLINICS**
Click on the ***Subscribe*** function found on the right side of the page. Receive newsletters as well as updates and information on licensing, survey, certification, rules, and regulations.

Shingles [Herpes Zoster]:

Per the CDC [Centers for Disease Control & Prevention] as of 8/14/19:
Clinical Overview:

- Herpes Zoster (Shingles) Is caused by the reactivation of the varicella-zoster virus. The same virus that causes chickenpox.
- People with shingles will have a rash in one or two areas of the body and most commonly appears on the trunk of the body along the thoracic area.
- The rash is usually painful, itchy, or tingly. These symptoms may precede the rash eruption by several days. They may have headaches, sensitivity to bright lights, and fatigue. Nerve pain is the most common complication and can persist for weeks, months, and occasionally years post rash onset.
- The rash develops into clusters of **vesicles.** New vesicles continue to form over 3 to 5 days. They will progressively dry and crust over and commonly heal in 2 to 4 weeks.

Transmission:

- Active shingle lesions are infectious, through direct contact with vesicular fluid, until they dry and crust over.
- People who have active shingle lesions can spread the infection and cause others to acquire chickenpox who have never had that vaccination or the chickenpox before.
- Those at most risk are pregnant women and for those who have never had chickenpox.
- Shingles can be spread through contact with droplets from the nose and throat of someone who is infected. The droplets carrying the virus are released into the air when the infected person coughs or sneezes.
- Droplet and contact isolation precautions should be used until the vesicles are dry and crusted over.

Per the LTC Version 1.17, October 2019, Resident Assessment Instrument 3.0 User's Manual:
Coding tips for Section M1040D, open lesion(s), other than ulcers, rashes, cuts; pages M-28 thru M-30:

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and **vesicles**, should be coded in this item.

Coding for Section O0100M, Isolation for active infectious disease (does not include standard precautions); pages O-5 & O-6:

- Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection with highly transmissible pathogens that have been acquired by physical contact or droplet transmission.
- Do not code this item if they are standard precautions.
- Code for "single room isolation" only when all of the following conditions are met:
  1. The resident has active infection with highly transmissible pathogens that have been acquired by physical contact or droplet transmission. Those precautions must be in effect.
  2. Precautions are over and above standard precautions.
  3. The resident is in a room alone because of an active infection and cannot have a roommate.
  4. The resident must remain in his/her room. This requires that all services be brought to the resident.

Ensure you have researched your policy and procedures and have a plan in place for:

- Protection of the resident(s), staff, and visitors.
- Educating your staff regarding your policies and procedures when working with residents who have the active shingles virus.

The information in this article is a brief summary of the identified above resources. If you have questions regarding this matter, please contact Jean Koch at (605) 995-8985 or Susan Bakker at (605) 367-7495 or email us at **DOHOLCMDS@STATE.SD.US.**

Have you given your Waived Laboratory Testing Program a "check-up" recently?

It is good to take a hard look at your waived laboratory testing every year. Your waived laboratory testing program should have a "check-up" to prevent/identify any issues before they become serious.

The "check-up" should include at a minimum the following areas:

1. Does the testing menu still fit your facility's and resident/patient's needs? Are there newer testing methods/options available? This is a good time to consider if the current test method (s) or equipment needs upgrading or replacing.
2. Have you reviewed the package insert for changes or updates? The package inserts that come with the kits, testing strips, or quality control (QC), etc., must be reviewed in case the manufacturer has changed or updated the procedure or their testing recommendations. Failure to follow the proper procedure can result in inaccurate patient results.
3. Have you checked the expiration dates? Are you using the correct expiration date? Some reagents and QC material have an opened expiration date. Is the date of opening documented on the bottle? This is a good time to look for test strips or bottles of QC that may have been placed in cupboard corners, drawers, or other nooks and crannies to hide out in. Any expired testing supplies must be discarded in an appropriate and safe manner. The use of expired reagents or QC materials can result in inaccurate patient results.
4. Are all staff trained and competent in waived testing procedures? Are all testing personnel performing the test procedure in the correct way? Slight alterations to a procedure may not seem all that important, but failing to follow the manufacturer's procedure can result in inaccurate patient results.
5. Have you reviewed the quality control records for missing or out of control results? Out of control results could indicate issues with the technique, kit ,or the analyzer. These issues could result in inaccurate patient results.
6. Have you reviewed the calibration, if applicable, and maintenance records? Are the manufacturer's instructions followed? Good maintenance routines could potentially extend the analyzer's life while ensuring accurate patient results.

If you identify issues with your waived testing program, take the time now to correct them. Then monitor the corrections to ensure the issue has been corrected and remains corrected. Waived testing should be monitored all year round to prevent a little issue from becoming a big issue. Your patients and/or residents are depending on you to provide them with accurate test results and good quality care!

Contact Connie Richards at **connie.richards@state.sd.us** or Denise Broadbent at **denise.broadbent@state.sd.us** with questions.

Laboratory topics of interest and compliance with federal regulations are posted at **https://listserv.sd.gov/scripts/wa.exe?A0=SDCLIA**. If you have not signed up to receive emails regarding postings you can do so at that site.

SOUTH DAKOTA DEPARTMENT OF HEALTH
Healthy People • Healthy Communities • Healthy South Dakota

doh.sd.gov