Nursing Home ECHO

COVID-19 Action Network

Virginia Nursing Homes * VCU Department of Gerontology
VCU Division of Geriatric Medicine * Virginia Center on Aging

For educational and quality improvement purposes, we will be recording this video-session. By participating in this ECHO session you are consenting to be recorded. If you have questions or concerns, please email, nursinghome-echo@vcu.edu.

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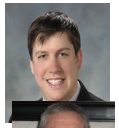
Agency for Healthcare Research and Quality

Institute for Healthcare Improvement

Leading with a Great System of Communication: Diagnosing its Reliability

Your Hub Team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CE/CME Disclosures and Statements

Disclosure of Financial Relationships:

The following planners, moderators or speakers have the following financial relationship(s) with commercial interests to disclose:
Christian Bergman, MD – none; Dan Bluestein, MD – none; Joanne Coleman, FNP-none; Laura Finch, GNP - none;
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ECHO is All Teach, All Learn

Agenda

- Introduction
  - Virginia COVID-19 Status (data)
  - Guidance/Regulatory Updates (CDC, CMS)
  - From the Literature
- Circling back: Addressing Concerns raised last week
- Weekly Content with Interactive Quality Improvement
- Wrap up
- Open Discussion
  - COVID-19 Active Issues
  - QI Content, more in-depth conversation
  - Questions for Group Discussion

Session Learning Objectives

Leadership Communication

By the end of this session, participants should be able to:

1. Create a system of communication using accurate and reliable methods that provide just-in-time crucial information.
2. Use the art of huddles and leadership rounds to share information with staff.
3. Apply up-to-date technology to enhance, execute and evaluate communication.

COVID-19 Updates

- Data, Data, Data
- CDC/CMS What's new?
- Latest from the literature

Data Updates

In this section, we will cover weekly updates regarding data around COVID-19 transmission, variants, and forecasting

June 14 Data update VA

COVID-19 in Virginia: Summary

Dashboard Updated: 6/14/2021
Data entered by 5:00 PM the prior day.

Cases, Hospitalizations and Deaths

Total Cases*		Total Hospitalizations**		Total Deaths	
677,812		30,182		11,318	
(New Cases: 68)^					
Confirmed†	Probable†	Confirmed†	Probable†	Confirmed†	Probable†
527,559	150,253	28,642	1,540	9,553	1,765

* Includes both people with a positive test (Confirmed), and symptomatic with a known exposure to COVID-19 (Probable)

June 4 Data Update Virginia

	STATE	STATE, % CHANGE FROM PREVIOUS WEEK
NEW COVID-19 CASES (RATE PER 100,000)	1,457 (17)	-42%
VIRAL (RT-PCR) LAB TEST POSITIVITY RATE	2.9%	+0.2%*
TOTAL VIRAL (RT-PCR) LAB TESTS (TESTS PER 100,000)	69,291** (812**)	-23%**
NEW COVID-19 DEATHS (RATE PER 100,000)	66 (0.8)	-20%

	LAST WEEK	CHANGE FROM PREVIOUS WEEK
RATE OF NEW COVID-19 CASES PER 100,000	17	-42%
VIRAL (RT-PCR) LAB TEST POSITIVITY RATE	2.9%	+0.2%
NEW CONFIRMED COVID-19 HOSPITAL ADMISSIONS / 100 BEDS	2	-7%
RATE OF NEW COVID-19 DEATHS PER 100,000	0.8	-20%
COMMUNITY TRANSMISSION LEVEL	MODERATE TRANSMISSION	

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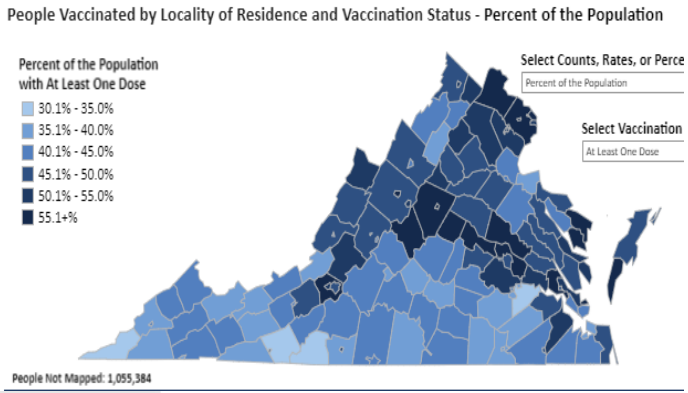
June 14 Virginia Vaccine Update



COVID-19 Vaccinations in Virginia

Total Doses Administered - **8,629,238**

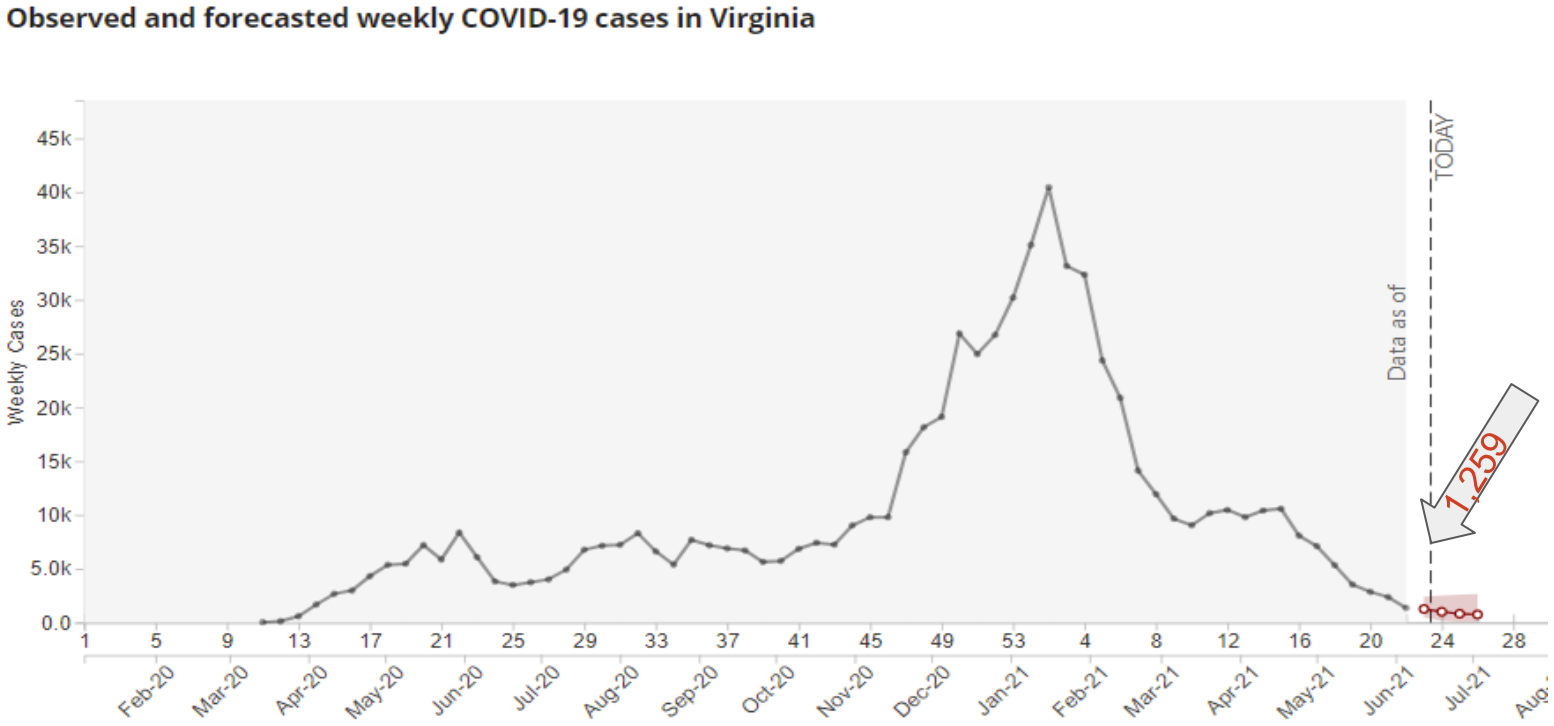
People Vaccinated with at Least One Dose*	% of the Population Vaccinated with at Least One Dose	People Fully Vaccinated^	% of the Population Fully Vaccinated
4,856,722	56.9%	4,062,990	47.6%

% of the Adult (18+) Population Vaccinated with at Least One Dose
69.0%

Almost 70

% of the Adult (18+) Population Fully Vaccinated
58.8%

Prediction, updated June 9



CDC/CMS Updates

In this section, we will cover weekly updates from CDC, CMS, VDH, or novel research findings that impact nursing homes.

CDC Updates

no new updates

https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

CMS Updates

Nursing Home Vaccination Data

- Original deadline was 6/13 at midnight; >2500 NH did not report any data. Extension for 1 week offered.
- Virginia Vaccination Rates:
  - Residents: 77.36% (35th out of 50 states)
  - Staff: 57.87% (25th out of 50 states)

https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

https://www.mcknights.com/news/breaking-cms-issues-reprieve-for-2500-nursing-homes-yet-to-report-covid-vaccination-rates/

https://www.cms.gov/newsroom

OSHA/ETS Updates

Emergency Temporary Standard

- https://www.osha.gov/sites/default/files/covid-19-healthcare-ets-reg-text.pdf
- https://www.osha.gov/coronavirus/ets
- Passed in Jan 2021,
- Subpart U Table of Contents
  - 1910.502 Healthcare
  - 1910.504 Mini Respiratory Protection Program
  - 1910.505 Severability
  - 1910.509 Incorporation by Reference

Requirements of the ETS

Develop and implement a COVID-19 plan

Patient screening and management

Standard and Transmission-Based Precautions

Personal protective equipment (PPE)

Aerosol-generating procedures

Physical distancing

Physical barriers

Cleaning and disinfection

Ventilation

Health screening and medical management

Vaccination

Training

Anti-Retaliation

Recordkeeping

https://www.osha.gov/coronavirus/ets

https://leadingage.org/regulation/osha-issues-temporary-emergency-standard-healthcare-settings

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Mini Respiratory Program

What is the mini respiratory protection program?

The mini respiratory protection program (29 CFR 1910.504) is one part of the OSHA COVID-19 Healthcare Emergency Temporary Standard (ETS). **It applies only to specific circumstances specified under the ETS, generally when workers are not exposed to suspected or confirmed sources of COVID-19** but where respirator use could offer enhanced worker protection. The mini respiratory protection program does not replace or substitute for OSHA's normal Respiratory Protection standard (29 CFR 1910.134), which applies to:

- Circumstances under the ETS when workers are exposed to suspected or confirmed sources of COVID-19.
- Any other workplace hazards that might require respiratory protection (e.g., silica, asbestos, airborne infectious agents such as Mycobacterium tuberculosis).

https://www.osha.gov/coronavirus/ets

Mini RPP vs. normal RPP

Table 1. Key requirements of the mini respiratory protection program vs. the respiratory protection standard

KEY PROGRAM ELEMENT[1]	MINI RPP[2] (1910.504)	NORMAL RPP[3] (1910.134)
Medical Evaluation		✓
Fit Testing		✓
Written Program		✓
User Seal Checks	✓	✓
Training	✓	✓

[1] This is not a comprehensive list of required program elements
[2] These are key requirements pertaining to employer-provided respirators (as opposed to worker-provided respirators)
[3] For additional information about the Respiratory Protection standard's requirements, see: NIOSH/OSHA's "Hospital Respiratory Protection Program Toolkit Resources for Respirator Program Administrators" at: www.osha.gov/sites/default/files/publications/OSHA3767.pdf

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RPP = Respiratory Protection Program

Mini RPP vs. normal RPP

Table 2. Applicability of the mini respiratory protection program vs. the Respiratory Protection standard

COVID-19 ETS PROVISION	MINI RPP (1910.504)	NORMAL RPP (1910.134)
1910.502(f)(2) – for exposure to person with suspected/confirmed COVID-19		✓
1910.502(f)(3) – for AGP[1] on person with suspected/confirmed COVID-19		✓
1910.502(f)(4) – in place of facemask when respirator is not required	✓	
1910.502(f)(5) – for Standard and Transmission-Based Precautions		✓

[1] AGP = aerosol-generating procedure (as defined by 1910.502)

RPP = Respiratory Protection Program

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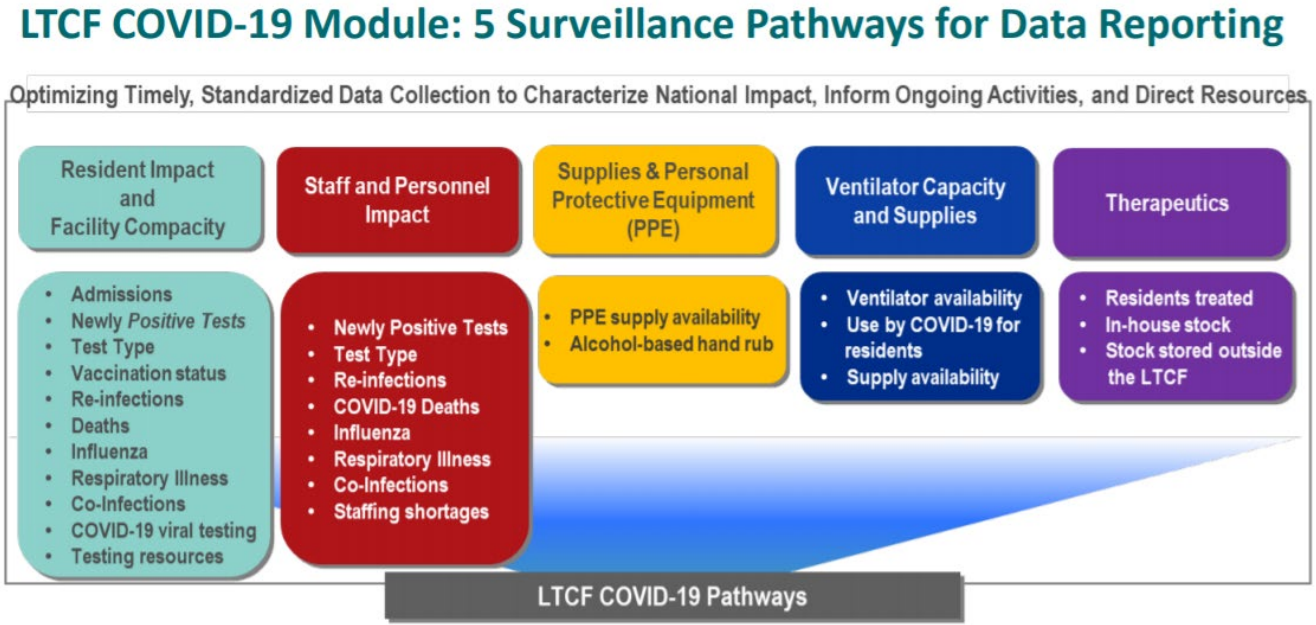
NHSN/COVID-19 Updates

no new updates

- Video on reporting weekly cumulative COVID-19 Vaccination Rates: https://www.youtube.com/watch?v=NKQlhs_pWkM



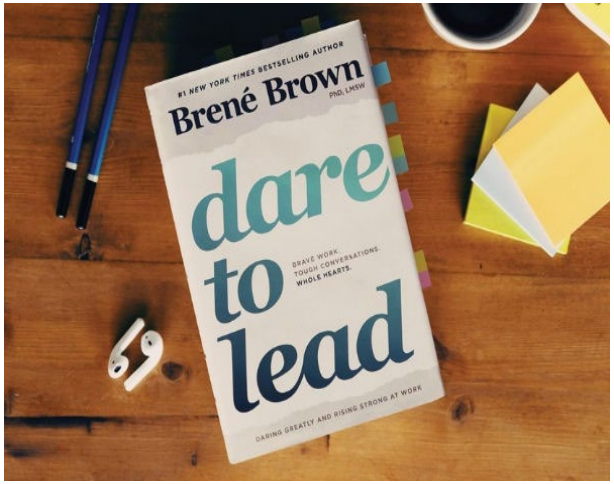
Address of Concerns raised last week

Concern raised about new hires with not as much clinical training.

After speaking to tech centers and a school of nursing we discovered that yes, some clinical hours were forgiven, but only until Dec. 2020. After that all clinical hours must be met. Thus some were unable to graduate and will attend in the fall to make up time. The SON did not adjust their hours due to national regulations. However in all cases it could be true that the rigor of clinical hours was diminished.

From the Literature

"One day you will tell your story of how you overcame what you went through and it will be someone else's survival guide." – Brene Brown



Dare to Lead is an empirically based **courage-building program** designed to support leader agility, team effectiveness and culture change. The most significant finding from Brown's latest research is that courage is a collection of four skill sets that are teachable, measurable and observable. The foundational skill set is "rumbling with vulnerability." The other three skill sets: **Living into Our Values, Braving Trust, and Learning to Rise**.

Dare to Lead | Brené Brown (brenebrown.com)

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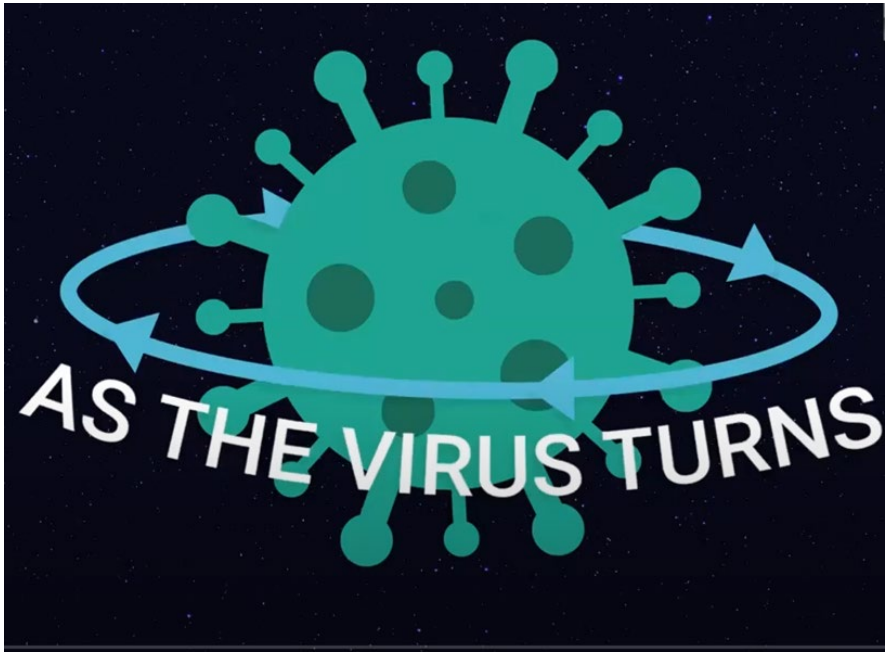
Leadership Communication: Session 1

Check-in

If you haven't already, please introduce yourself in the chat with

1. Your name
2. Your Nursing Home
3. One or two words that represent how you are feeling today and name your leadership hero if you have one



As the Virus Turns - Episode 11
https://youtu.be/jypavoddrqU

Opening Discussion

Share the biggest wins and challenges in communication this year in your nursing home. What was the most difficult thing/idea to communicate? What made communication easier?

Leadership Communication: Create a System of Communication

Slides courtesy of David Farrell, MSW, LNHA

Critical Change Opportunities

Create a system of communication - Right Information at the Right Time improves outcomes and retains staff

1. Use huddles to share and receive critical information with staff
2. Effective leadership rounds enable you to observe care being delivered, connect by pitching in to help staff or residents
3. Communication mechanisms - must be reliable during an emergency
4. Use technology to support timely communication

The Art of Effective Huddles

Huddle Time is On Time

- **10 - 20 minutes**

How to Huddle:

- Start at a time that works best for the most point of care staff
- Position point of care staff in the middle of huddle
- Point of care staff provide **relevant** information about their residents
- IDT **listens** and provides additional information and context
- Problem-solve as a team and make a game plan

*Designate staff cover to cover call lights for CNAs

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The Goals of the Huddle

- Share the mission, improve morale and motivation
- Everyone has the same information and is up to date
- Everyone feels heard and valued
- Everyone knows the latest guidance
- Huddles improve communication and relationships across disciplines
- Everyone is a part of identifying issues, sharing unique perspectives and participating in group problem-solving

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Leadership Rounds in Emergencies and Everyday Demonstrate you Care

Purposeful, Intentional Leadership Rounds

- You are in the spotlight
- High visibility of leaders matters to staff
- Keen observations notice the good care and infection control
- Just in time training, feedback or help
- Be verbal and use positive modeling to set the tone
- Make eye contact, smile and greet all people in the hallways
- Linger

Captain on the bridge.

Effective Emergency Preparedness Framework

Four Core Components:

- Emergency Plan
- Policies and Procedures
- Communications Plan
- Testing and Training

Communications Plan

- Contact information
- Primary and alternate means of communication for staff and agencies
- A means of sharing resident and staff information while maintaining privacy
- Consent
- A means of sharing resource information with other facilities
- Additional information and resources
- Review and Update

What were your lessons learned regarding tracking these core components?

What additional information have you had to communicate due to the pandemic?

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Best Practices for Solutions

- Establish easily activated communications channels
- Follow chain of command
- Backup resources (loss of power or internet)
- Maintain coordination with other health care organizations
- Account for your residents and staff
- Accuracy checks to avoid false information

<u>Methods We Have Heard from You</u>
Telephone Calls
Text groups
Email Marketing Software
Call in Line
Emailed Newsletter
Mailed Letters
Web based video conferences
Any others??

Developing or Maintaining an Effective Communication Loop

- Closed Loop
- Read back
- SBAR
- Checklists
- Huddles
- Debriefs

John, RN calls out: *I need an epi pen for Mr. Walton*

Sheila, RN responds: *You need an epi pen for Mr. Johnson*

John replies: *Negative, the epi pen is for Mr. Walton*

Sheila replies: *You need an epi pen for Mr. Walton*
John Replies: *Yes*

This is an example of?

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Nursing homes should be at the forefront of technology *to help connect and care* for all residents.

21st Century Technology in Nursing Homes

- Know the rules, regulations and timeframes
- Policies and procedures
- Resources for technology
- Education and training for the workforce
- Privacy compliance

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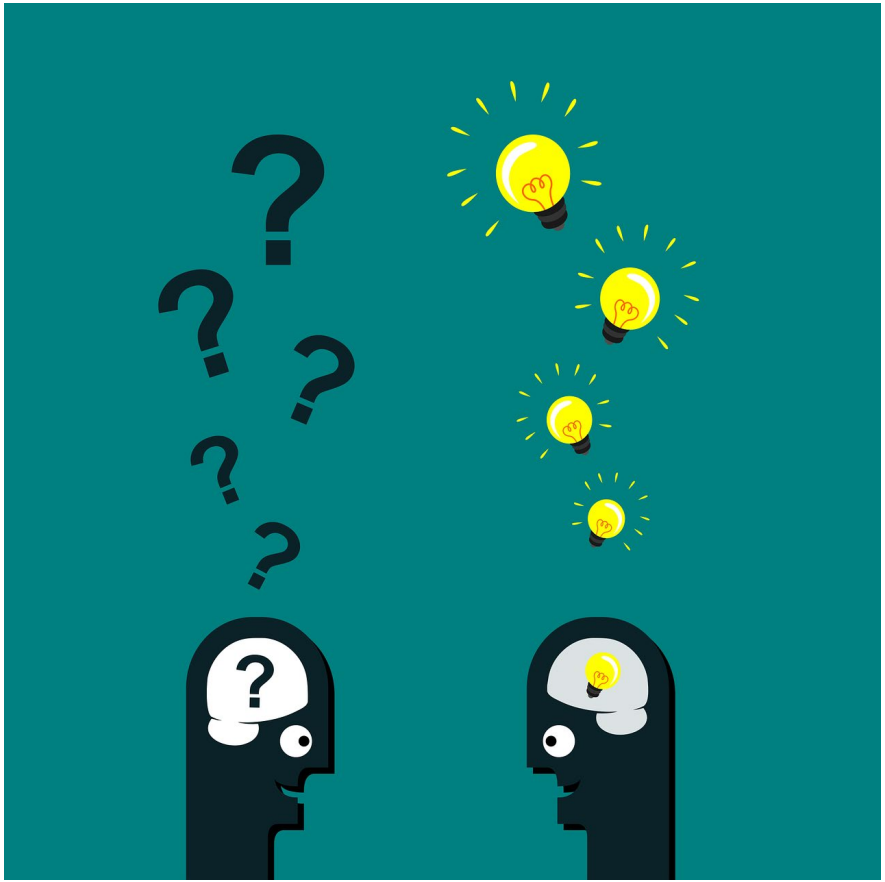
Open Discussion

- How did you deliver ‘bad news’?
  - Was message different based on audience (residents, staff, families)?
  - How about other areas (outbreaks, staff getting sick?)?
  - Route of message (email, phone, etc.)?
- What data did you share?

QI Minute: Assessing the Reliability of Your Communication With ‘Ask 5’

AHRQ ECHO National Nursing Home COVID-19 Action Network

How do I know if my communication about a process is reliable before it breaks down?



Lay Out the Five Attributes of Your Process

1. **Who** does it?
2. **When** should it be done?
3. **Where** is it done?
4. **How** is it done?
5. **What** is needed to do it?

Ask 5…About 5

- Ask 5 staff involved in the process to describe the five attributes of the process
  - IF 5 direct staff can describe the work with the 5 attributes then:
    - You know you have a process in place that people know about
    - You have a good chance that you can achieve 95% performance AND sustain the process over time
  - IF 5 direct staff cannot describe the work with the 5 attributes then:
    - Determine if all 5 cannot describe the work (is there a training/education problem.
      - Determine if it is a COMMON or INFREQUENT failure.
      - Observation of ONE PERSON does not mean it is a common failure.
    - Determine which of the attributes are problematic and work to improve that aspect

Addressing Gaps: Common vs. Infrequent Failure

Common

(More than 1 of the 5 Cannot Articulate the Attribute or Process)

- Don't rely too heavily on education as THE FIX
- Get CURIOUS to determine WHY this is occurring
- Inform staff on the WHY:
  - WHY is this process important
  - WHY do we do it this way
- Get CURIOUS – WHY are they NOT following the process
- Develop a plan to fix ONE attribute
- Keep it SIMPLE!

Infrequent

(Only 1 of the 5 Cannot Articulate the Attribute or Process)

- Infrequent does NOT mean you have a bad process.
- Don't try to make it perfect – you will use up too many precious resources.
- Talk to that one person to reeducate or determine WHY it is occurring.
  - Determine if there is a simple fix
- MOVE ON to focus on another process

Leave in Action: 3 Things to Try This Week

1. Review your current practice re: huddle
   - What's working well?
   - What could be improved?
2. 'Ask 5' staff about a core process In your Nursing home and compare their response to what you would expect. What does it tell you about how you might need to adjust how you communicate about this process and what supports are in place?

Wrap-up

Next Week

Topic: Leadership Huddles with Staff

Resources

https://covid.cdc.gov/covid-data-tracker/#forecasting_weeklycases

https://www.youtube.com/watch?v=jypavoddrqU

Rumbling with Vulnerability | Results Coaching Global

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Thank you!