ICNC- New Haven Chapter
Meeting Notes
June 20, 2014 12-3 PM
CVH – Merritt Hall

The meeting was called to order at 12:20 PM with the following members in attendance:
Barbara O'Grodnick, Chris Orris, Karlene Brown, Judy Wrenn, Linda Hjort, Raeann Paparello, Ann O'Dea, Sue Dubb and 3 new members: Melody Solano, Beth Samuels and Kim Gray.

Sue opened the meeting with introductions of those at the meeting. She then proceeded to provide the group with an update on infectious disease that she had recently received while attending the June Quarterly CAPHN meeting.

MER CoV update: 3 cases to date in the US. All were HCWs with a history of working with MER CoV patients in Saudi Arabia. All 3 have recovered without incident. DPH is expecting that there may be a surge of cases in the US with the upcoming pilgrimage to Mecca for those of Islamic faith who are participating in the Hajj. This year the Hajj is set for June 28 through July 28. It is the largest known pilgrimage of its kind, as it draws people from all over the world to gather in Mecca for a short period of time. A second lesser known pilgrimage occurs in October, which for this year will run from October 2-7. It is known as Umrah. Although similar to Hajj – some of the same rituals are completed, it is not considered a substitution for completing a full Hajj – as is required once during the lifetime of those who practice the Islamic faith. Also of note, is the influx of international college students in late summer/early fall who may be coming from Middle East countries such as Saudi Arabia, Qatar, Yemen, Oman, Kuwait, United Arab Emirates and Jordan, where most of the MERS CoV cases have been found. Sue also mentioned that there has been some connection to contact with sick camels. She identified a case where a gentleman in Saudi Arabia was identified as positive for MERS CoV, who eventually died. He was known to have been caring for his sick camel. When the saliva of the camel was tested and compared to samples taken from the deceased gentleman, an exact match was found of the MERS CoV.

Chikungunya Update: (Pronounced Chicken – gun – ya). This is a mosquito borne disease that is now considered endemic in the Caribbean. There have been 3 cases in CT in the past year. For patients reporting with high fever and symmetrical arthralgia, a travel history should be obtained. It is anticipated that we will continue to see cases of Chikungunya in CT and the rest of the US due to the large amount of travel to the Caribbean by US residents. If a person is bitten with a mosquito in the Caribbean and contracts Chikengunya and then returns to CT and is bitten by a mosquito at home, the CT mosquito can now infect someone else with Chikungunya.

Measles update: Three cases identified in CT this year. All were imported into the state secondary to travel. For patients presenting with fever and widespread rash, consider a diagnosis of Measles and inquire about a travel history. There is currently a very large outbreak in the Phillipines, as well as in Ohio and California. Inquire about vaccination history…especially for small children.

TB Update: TB is continuing to trend downward in the state. Many of the cases are brought in by foreign born folks and are primarily of the MDR type. The recommendations to healthcare facilities and

other health-related fields such as EMS, in light of prolonged shortages of Tubersol and INH is that most of these places, with the exception of larger urban areas fall within a low risk category and should not be doing annual TST screenings. The current recommendation is for institutions that fall into the category of high risk settings, or are mandated to do so by OSHA regulation, perform an intial two-step TST on hire and after that, have the employees complete a TB risk assessment questionnaire. This falls within the current CDC recommendations. Should there be a high index of suspicion that a person has been exposed to someone with ACTVE TB, then a contact investigation will be completed by local public health authorities to determine those at highest risk of exposure and targeted TST testing will be performed in conjunction with your local health department.

Chris Orris updated the group about information from the State ICNC Board meeting that was held earlier this month. She advised the group that dues will be increased to $38 annually. She noted that this is the first time that dues have been increased in well over 10 years. Chris also spoke about updates to our new website and explained how active member ship dues must be paid between October 1 and January 31 in order to have access to the "Members Only" section of the website. Each year the password which allows access to that section of the website will be changed. Once dues are current, the new password will be sent to the member. This has been done to ensure the membership is getting something special for their dues. This will also assist in sorting who the active members are when applications begin to roll in for the Annual Spring Seminar. Members will also now be able to pay for their membership and seminars through the website with PayPal. An added convenience for the members…Each chapter continues to have their own sections. Some new features such as Blogs and RSS Feeds have been added to help keep the current information flowing. It will be a tremendous resource for new members, especially those new to IP. Members were encouraged to check it out and provide suggestions for additional material.

Next the group moved into: **"Who has been surveyed recently?"**

Beth Samuels of Lutheran Home in Southbury shared her recent experience with surveyors at her facility with the group.

- **Dignity and Dining** was a big focus of their survey. Timeliness of delivery of trays. For those residents with trays on their chairs for positioning, the state is looking for these folks to be in the dining room at a table high enough for the positioning tray to be slid under the regular table so the resident can eat of the regular table as the other residents do, or, if possible to have the positioning tray removed during the meal, so that the chair can be pulled up close enough to the table for the resident to eat from the regular table. Also looking at positioning of people at the table in the dining room…if there are more than one resident at the table who might require assistance with their meals, i.e., one might need cueing, another may need hands on assist…they want to ensure that both residents are receiving assist at the same time…in other words…don't feed one completely and then move to the second…both should be assisted through their meals together…hence the need for proper positioning of the CNA to accomplish this. Finally, if a resident falls asleep in the dining room during mealtime, they should be removed from the dining room. If they appear to just be a little sleepy, you can attempt to reposition to see if this helps awaken them enough to continue with their meal…if the re-positioning doesn't work, take them back to their room and try again in a while.

- They came in and asked for the **MDRO LIST.** Beth said this was one of the first things they asked for when they arrived. This needs to maintained as a separate sheet…even though the information can probably located by reviewing shift reports, and other such places.
- **Alarms as restraints.** CMS is now looking at reviewing use of alarms as a form of restraint. We have always been taught that these devices are supposed to assist staff in providing an early warning about a resident who might be getting up without assistance, leaving them at higher risk of a fall. She stated that studies are being done as we speak that show that due to alarm fatigue, these alarms are really not doing anything to reduce the number of falls. An example she cited was often when mats are used on the floor next to the bed, for those with dementia it is often perceived as a large amount of water on the floor to be avoided, so residents attempt to climb around it and end of falling anyway. Alarms included in this discussion were seatbelt alarms, Tabs and Velcro seat belts
- Beth shared that there is currently a government funded study being conducted in Minnesota or Michigan that is looking at sleep disruption that occurs as a result of our nursing home routines (turning and repositioning, vital signs, toileting) that are seen as disruptive to the resident sleep patterns…enough so that they are not achieving the deep restorative sleep required to maintain healthy cognition and overall well-being. This study is looking at 5 LTCFs and having them allow residents to sleep through the night without disturbing their sleep for what we have engrained as necessary routines to see if they can ultimately improve the overall health of the residents and reduce their fall risk. There have certainly been plenty of studies that link lack of sleep to increased fall risk, especially for those over 70. This is groundbreaking stuff folks…so we'll keep you up to date with the details as they unfold.
- Directly in line with the sleep deprivation…they were looking at noise levels during second and third shift as a contributing factor to disrupted sleep. Also looking for lowered lighting…in other words, an environment conducive to inducing sleep.
- **Looking at Grievance logs** to see if facilities have conducted the training required by the new legislation that was passed last year. Focused on education related to retaliation.
- **IV Therapy Education for Support personnel** . Beth stated they were particularly interested in education for support personnel that work with IVs…i.e., CNA staff. What they can and can't do with an IV…What they can and can't do with a pump. They are looking for a post test that covers all of these topics in their education files.

Kerry Brown shared that they had just completed their survey last week at Whitney Center. Surveyors at her facility were focused on:

- Flu and Pneumovax Policies
- Environmental rounds
- Asked specifically about Insulin pens
- Asked about cleaning/decon protocols for fingerstick monitor. Need to ensure that you are using the correct product…Medline was able to give a list of about 5 products that would be appropriate. They also asked to see the cleaning log for the machine.
- Asked for OSHA 300 – specific for needlestick injuries
- Asked about CMS "Hand in Hand Training"
- Also asked about grievance log…interested in frequency of complaints

Melody asked some questions of the group as a new IP practitioner. She was interested in knowing about posting isolation signs outside resident rooms rather than a "Stop...see the Nurse before Entering" signs. Sue mentioned that she had recently attended a meeting and was advised that it was not a HIPAA violation to post the specific type of isolation poster outside the resident room…we simply cannot put up anything about the particular organism for which the isolation is in place.

There was also some discussion regarding bagging of isolation linen. Sue advised that at her facility they keep the laundry hampers immediately outside the door of the resident room. The last thing the CAN does before leaving the room is to call for another person to open the lid of the isolation cart so that the "contaminated" CAN can place the bag inside the hamper, then remove her isolation gear and wash her hands before leaving the room. Sue recommended checking the CDC website for isolation posters that show the graphic representation of what PPE should be used as well as written description to follow.

Sue reminded the group that with Natalie's departure, the Secretary position was now open again. She asked for folks to think about it and let her know if they are interested in taking the position.

With nothing further to discuss, the meeting was adjourned at 2:45 PM with a motion by Chris Orris and seconded by Beth Samuels.

Respectfully submitted,

Susan Dubb RN, AEMT
President, New Haven Chapter ICNC