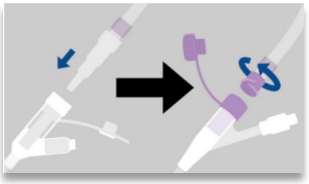
island health

May 2024

DID YOU KNOW...

In order to reduce misconnections between enteral and other delivery routes, Island Health has converted to ENFit enteral products. Visit the website for supply list, order numbers, learning resources and printable posters. There is also a Learning Hub module for nursing staff to complete for more information.



Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

In this Issue

Civility Matters

Jenny rolls her eyes at her colleague Steve as he enters the break room. She gets up and leaves, encouraging Shauna, another HCA to come with her. Behaviours like these can be challenging to address. While there is legal recourse for bullying and harassment in the workplace, acts of incivility as described in the scenario above may be harder to detect and act on.

We enter healthcare careers with a desire to help others and make the world a better place. We strive to make a difference and provide quality care. Many challenges such as working short staffed, high job demands, limited support and resources can lead to feelings of powerlessness and disillusionment. Individuals who feel this way may engage in incivility as a means of trying to regain or maintain power differentials, leading to submissive, passive aggressive behaviours in their workplace. Incivility, also known as micro-aggressions, are low-intensity, passive, indirect, deviant acts that violate workplace norms but don't rise to the same level as bullying or harassment.

So, what can we do to prevent or address incivility and improve our workplace culture? Safecare BC has developed an online toolkit for LTC front-line and leadership staff. The online toolkit provides resources and information to raise awareness about workplace incivility, practice-based scenarios, webinars and more. The toolkit is organized into sections for front-line and leadership staff, with resources tailored for both.

In addition, all team members are required to complete the Our Respectful Workplace Module in the Learning Hub upon hire. See the Respectful Workplace website for additional resources

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SafeCare BC

Clinical Documentation

High alert medications are medications with an increased risk to cause significant harm to the resident. The consequence of administration errors can be devasting. Independent double checks are a safety strategy used to minimize the risk of errors.

What is an Independent double Check?

A double check of high alert medications that must be done independently to be effective at reducing the risk of confirmation bias. If a colleague hands you a syringe and asks you "Can you check this is 3 units?" this is **not** an independent double check. The proper way to conduct an independent double check is to request a colleague review the high alert medication you have prepared.

See the following resources for more information:

- Independent Double check of High Alert Medications Procedure
- Independent Double Check of High Alert Medications - FAQ
- High-Alert Medications in Long-Term Care (LTC) Settings- Institute For Safe Medication Practices

Mentorship Quote:

"Everyone has a role to play in medication safety."

Kimberlee Araya RN, Medication Safety Consultant

PowerChart and CAPs documentation

Upon completion of quarterly and annual Resident Assessment Instruments (RAI), documentation of clinical decisions in addressing the Clinical Assessment Protocols (CAPs) is completed in the Clinical Notes section of PowerChart.

This will include a summary of the decision-making and rationale. A great resource to support you in addressing the triggered CAPs is the interRAI CAPs manual. The documentation includes new and triggered CAPS, outlining the name and type of CAP, the nature of the resident problem or strength, and a summary of key issues that contributed to the area of concern. Document the relevance and effectiveness of the interventions if applicable and the plan of care decisions.

If there is a new or modified CAP triggered, this will need to be addressed. For instance, if a resident is experiencing responsive behaviours and the behaviour CAP is triggered, the nurse will review and update the plan of care in collaboration with the team. Documentation of the steps taken will be entered as a Clinical Note. See the CernerWiki page for detailed instructions. For examples of the correct format of CAPs documentation there is a Job Aid available.

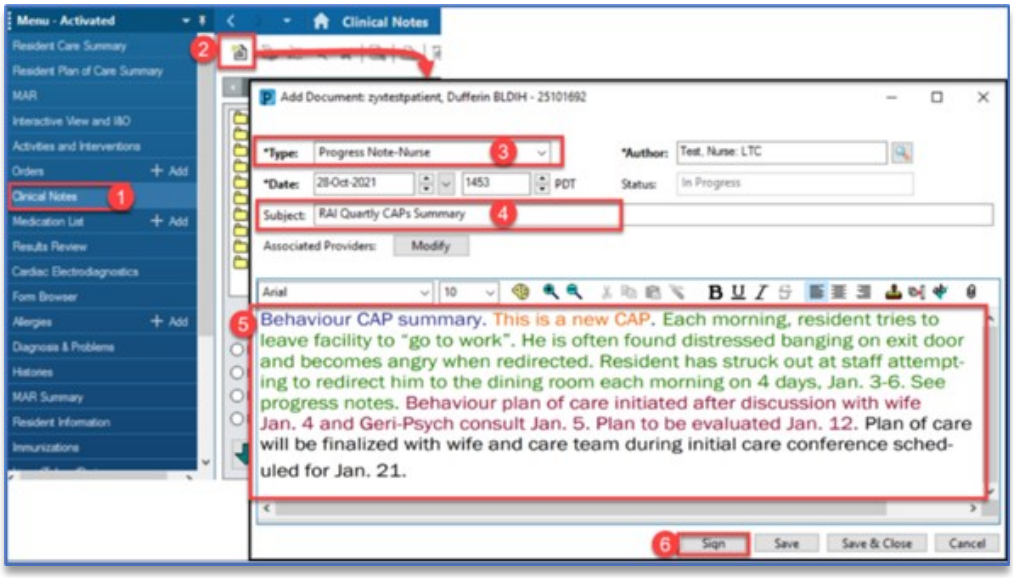


Image of a Clinical Note in PowerChart where CAPs charting is documented.

Test Your Knowledge

Match each term to the statement that best describes it then check your answers on page 7.

1.	The correct way to perform an independent double check is to request a colleague review the high alert medication you have prepared.	A. False B. Incivility C. strengths, needs and preferences D. True
2.	An accurate RAI helps clinicians determine the _____, _____ and _____ of each resident.	
3.	Surgical wounds are an example of a wound that requires PSLS reporting.	
4.	_____, also known as micro-aggressions, are low-intensity, passive, indirect, deviant acts that violate workplace norms.	

Putting the P.I.E.C.E.S.™ Together

Romulus moved into LTC six weeks ago after his vascular dementia progressed and his husband, Nino, was unable to care for him at home. Initially he settled in well, adjusting to the new routine. He started getting to know the staff and other residents, like his tablemate, Richard. Nino usually visits daily.

In the last week he is interacting less with staff and residents, choosing to stay in his room for all meals. He is declining invitations to activities he initially enjoyed, appears sad and states "what's the use?" Today an HCA noticed his pants and chair were soaked with urine as he had not gotten up to the bathroom all day. When she offered to help him get cleaned up, he screamed at her to "just leave me alone" and raised up his fists. Nino was not in today. The nurse called to update him, and he said "I told Rom yesterday I wouldn't be in for a few days because I have a cough. He seemed upset about it."

Q1 What are the priority concerns; is it a change for the Person?	Refusing care and meals; change in the last week Withdrawing from activities of interest; change in the last week Physical expressions – raised fists at HCA; new yesterday	
Q2 What are the RISKS and possible contributing factors? **Think PIECES**	**R**oaming: not identified **I**mminent Harm: **High Impact, Low Probability** **S**uicide Ideation: not identified **K**inship Relationship: **High impact, high probability** **S**elf-neglect: **High impact, high probability**	

- **Physical**: vascular dementia, possible delirium
- **Intellectual:** apathy -neglecting ADLs, withdrawal from activities, anosognosia, possible amnesia,
- **Emotional:** decrease in mood, recent loss of independence/connection with partner
- **Capabilities:** strong family support, possibly overwhelmed with offers of assistance
- **Environment:** recent adjustment to facility environment and new routines
- **Social:** building relationships with staff and tablemate, usually daily visits with Nino

Q3 What are the actions?
- Investigations
- Interactions
- Interventions

Investigations

- CAM negative and clinical assessment criteria to send urine specimen not met
- Complete the Cornell Scale for Depression –revealed a score of 17/36; DRS on admission RAI was 0/14
- BSO-DOS started and will gather data for 5 days
- Dietitian reviewed meals/preferences with kitchen. A food service worker reported that a week ago she overheard Romulus' tablemate Richard "Now that your fella put you here, maybe he can find a nice gal to marry." The RN and SW approached Richard about this comment, and he said, "I didn't mean to be rude, but in my day a real marriage was between a man and a woman."

Interactions

- Staff to report microaggressions from other residents/visitors regarding sexual orientation, and intervene

Interventions

- **RN & SW:** Arrange family meeting – Romulus shared that Richard's comment hurt him and Nino's absence made him question if Richard was right. Nino reassured him that their connection is strong and he is not going anywhere.
- **Care Team:** Arrange a new seat in the dining room
- **Activity Team:** Arrange daily Zoom calls between Rom and Nino until Nino is well enough to resume daily visits

Outcome: After implementing above actions, Rom has rejoined the dining room for meals; sharing a table with Mr. Green and they are getting along great! He is accepting care and invitations to activities again, but is sometimes wary if its an activity Richard also takes part in. If they both attend, staff seat them apart. So far Richard has not made any more inappropriate comments. Nino's cough resolved after a week, and he is back to daily visits. Their 20 year anniversary is coming up and they are planning an anniversary lunch with friends and family in the common room! On a repeated Cornell Scale for Depression Romulus' score was 0/36.

P. I. E. C. E. S. CORNER

The Antipsychotic Quality Indicator – A Brief Introduction

RAI 2.0

We all strive to deliver high quality of care to LTC residents. How do we measure this vital aspect?

One type of measure is looking at the Quality Indicators (QIs). There are many QIs measured in LTC. Below are the QIs that are currently of special focus within Island Health:

- Potential Inappropriate Use of Antipsychotics
- Worsening Pressure Ulcers
- Falls in the Last 30 Days
- Daily Physical Restraint Use
- Worsening Pain Rate

QIs are calculated from the data inputted ('coded') into the RAI assessment. The importance of completing the RAI assessment **ACCURATELY** can't be overstated. An accurate assessment help clinicians determine the *strengths, needs and preferences* of each resident. It also directs the health care team on areas to focus on when developing or updating a resident-centred plan of care.

One QI that's been receiving a lot of attention lately is the ***Potential Inappropriate Use of Antipsychotic Medications***.

Historically, many residents have received Antipsychotics to 'manage' their responsive behaviours. This is not best practice. However, for some residents, the use of Antipsychotics might be appropriate – for example, at end-of-life. In such cases, it's important to 'code' the RAI accurately to reflect that the resident is indeed receiving end-of-life, or hospice care. This would be indicated by checking off item P1ao in section P of the RAI, as seen in the screenshot below.

SECTION P: SPECIAL TREATMENTS AND PROCEDURES

P1a	SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS	*SPECIAL CARE—(Check treatments or programs received in LAST 14 DAYS.)*				
		TREATMENTS		PROGRAMS		
		a. Chemotherapy	a	m. Alcohol or drug treatment program	m	
		b. Renal Dialysis	b	n. Alzheimer's or dementia special care unit	n	
		c. IV medication	c	o. Hospice care	o	

Such a resident would then, correctly, not be included in the Antipsychotic QI calculation.

Stay tuned for more information on how to code the RAI assessment accurately to ensure the Antipsychotic QI is calculated correctly.

CODING CORNER

You Asked, We Answered

An HCA asks who in LTC is able to administer Naloxone (also known as Narcan) to residents?

A Clinical Nurse Educator Answers:

Within LTC, medication administration is limited to nursing staff. ***However, Naloxone is an exception to this rule.*** This means that anybody with training is able to give Naloxone, regardless of their discipline and scope. If non-nursing staff witness or suspect a drug poisoning (overdose) at work, they should call for nursing assistance. If after they have called for assistance a nurse is not available, staff at the scene should continue with Naloxone administration until additional assistance arrives. In addition, if staff who have completed Naloxone training are out in the community and witness a drug poisoning, they are able to administer naloxone at the scene. For more information on naloxone www.towardstheheart.com, is a resource created by the BCCDC. Please connect with a Special Population Unit CNE if you have any further questions.

To comment, contribute, suggest or ask a question, send an email to LTC.Newsletter@islandhealth.ca

When and Why to Submit a PSLS for Wounds

Wound Wise

Skin injuries and wounds are mostly preventable occurrences. Certain wounds need to be reported through the Patient Safety Learning System (PSLS) reporting system. Report all applicable wounds and skin injuries that are present at admission, transfer, or that occur after admission.

Which Wounds Should be Reported?

- **All** pressure injuries (stages 1/2/3/4, unstageable, deep tissue injury and medical device related)
- Incontinence-associated dermatitis
- Skin breakdown around an ostomy stoma or in a skin fold (intertrigo)
- Skin tears or burns

Why Should I report?

Reporting helps team leaders understand why wounds occur and what interventions need to be added to plans of care to prevent or minimize risk of injury. Reporting also helps in creating system-wide changes for wound prevention and skin integrity. If your care home lacks resources to prevent wound occurrences, reporting a PSLS demonstrates these needs to leadership.

What if I don't have time to report a PSLS?

Complete the report during your next shift or speak to your site leadership for support.

Where do I report a PSLS?

There's a link on the intranet home page! Select the category to report wound/skin injuries.

Examples of wounds that require PSLS reporting:

- A urethral wound caused by an indwelling catheter (considered a medical device-related pressure injury)
- A resident with skin breakdown from weeping edema
- A resident who spent the afternoon outside in the sun and experienced a sunburn
- A resident who transferred to acute care and returned to the care home with a reportable wound

Examples of wounds that don't require PSLS reporting:

- Cellulitis
- Cancer-related wounds
- Surgical wounds
- Wounds caused by an inflammatory or immune disorder (ie. bullous pemphigoid)
- Venous ulcers

By submitting a PSLS, you can be a part of creating change and improving the incidence of wounds in your care home!

Bactigras

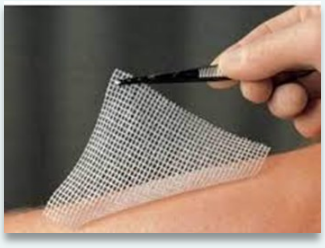
Bactigras is a non-adherent antimicrobial contact layer dressing. It is impregnated with paraffin for moisture and chlorhexidine to treat or prevent infection. It must be applied directly to the wound bed surface for the chlorhexidine to work against bacteria (this is true of all antimicrobial dressings!). It also needs a dressing on top, as the exudate will move through the holes in the dressing and be absorbed by the top dressing. Never use more than one layer, or fold the dressing over itself as this will occlude the holes in the dressing and cause the wound exudate to pool on the wound.

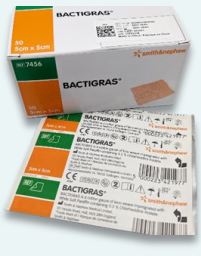
Use on: Shallow wounds with signs or symptoms of infection, or preventatively for wounds at high infection risk.

Do not use on: Wounds with depth, tunnels or undermining, as the edges could fray and leave dressing pieces in the wound, or on wounds that cover more than 10% body surface area.

Change Frequency: Can be left on for up to four days. Remember that if the wound has large or copious exudate it will wash away the antimicrobial in the dressing more quickly, if this is the case change more frequently.

Did you know? Bactigras is cheap!





PRODUCT CORNER

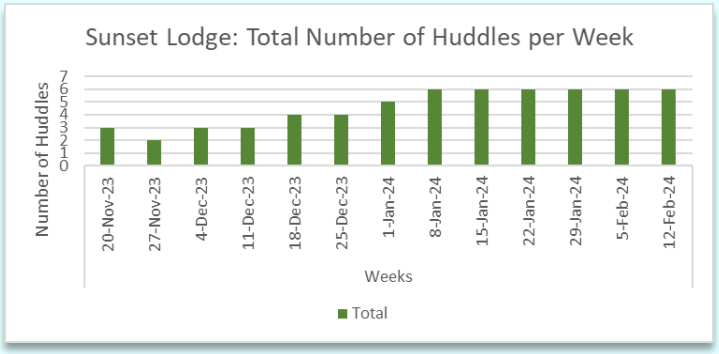
Care Coach Approach: Reducing Inappropriate Antipsychotic Use in LTC

In the Fall of 2023, Lindsay Dankwerth, Quality Team, Long -Term Care (LTC) Program had the opportunity to attend Quality Academy (QA) through Health Quality B.C.. This professional development program is led by expert instructors over a six-month period and equips learners to lead quality initiatives. As part of the program learners complete an organization sponsored project aimed to address five Dimensions of Quality from the B.C. Health Quality Matrix: Respect, Appropriateness, Effectiveness, Equity and Efficiency. Lindsay's Quality Academy project idea was inspired from the 2023 Island Health pilot project 'Reimagining Long-Term Care's Care Coach program' and was focused on one of the involved homes: "To Reduce Inappropriate Anti-Psychotic (AP) Use at Sunset Lodge LTC Home by 6% by September 1st, 2024."

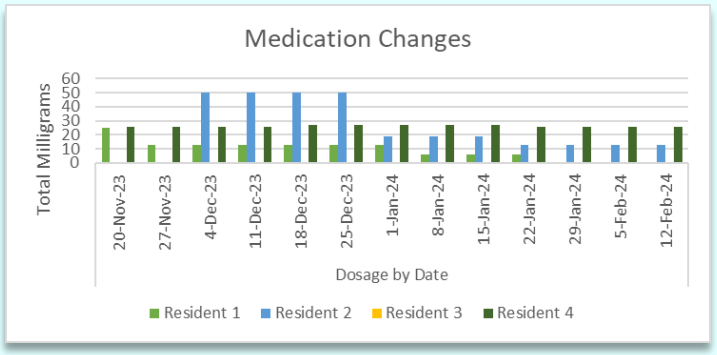
Initial steps were to connect with the site leaders and Care Coaches to gain an understanding of the current climate and get background information on challenges and successes. The culture of "If it's not broken, don't fix it," or the standard "this is the way we've always done it" is something that many health care professionals hear everyday. Engaging with site leaders and frontline staff from the initial stages can break down these ideas and result in cohesive teams with a common goal. Change is hard. But it doesn't have to be!

Then the Quality Team helped support site leadership and Care Coaches to develop structured days and times for care huddles, worked with frontline care teams to utilize Care Coach Tools including the P.I.E.C.E.S™ 3-Question Template, the Behavioural Supports Ontario–Dementia Observation System (BSO-DOS) and the U-First Wheel. During the first few weeks the site leader shared, "If we had this support and hands on at the beginning of the [Island Health] project… this is what we needed." Demonstrating that staff in the homes could be provided with training, but if they are not engaged in the means of the rationale barriers to change are created.

Additional techniques included upfront identification of residents without a antipsychotic-appropriate diagnosis, discussing the care of these residents at huddles and building care team confidence to utilize these tools with additional resident.



Initial huddles were occurring approximately once or twice a week prior to introducing a structured approach. The team increased the amount of huddles on all floors to twice a week with structured days and times, which contributed to maintaining sustainability (even during two outbreaks). The team used the 3 Question PIECES template to help facilitate a focused conversation and allowed time to discuss other residents that may have been experiencing challenges in between the scheduled days.



Through focused resident centered discussion downward titration of inappropriate AP medications resulted.

Key learnings through this journey are engagement from senior leadership is crucial! Engaging frontline staff for understanding supports buy-in and drives change, while evaluation of what is working or not is crucial. It's okay to Plan, Do, Study, Act (PDSA) multiples times and in fact teams do this every day!

Though Quality Academy ended February 29th, 2024, this project was developed with consideration to sustainability, and these learnings will continue to be applied.

Tribute to a True Leader

Dacia Reid, our exceptional leader of Long-term Care Program Practice & Education, is retiring on May 30th, 2024. This is a time of celebration of her contributions to Island Health. Dacia's work focused on inspiring those around her to be the best that they could be while striving to support each other in caring for residents and their families in LTC.

She took interest in our educator goals and empowered us to reach for the impossible by growing our talents, aspirations and inspiring us to embrace our learning goals to offer Person and Family Centred Care with appreciation, respect and honesty. She was for many of us, the first leader to ask us what we individually wanted to do in our role and then offered the support to accomplish this vision.

During her ten years as the program manager, Dacia was a model of leadership for all to emulate. This began with her understanding of the value of nurturing trusting and respectful relationships and by reaching out in collaboration with care and service areas to learn and advise for the common purpose. Her calmness in pivoting during stressful times to accommodate the asks and needs is monumental. We can all remember the recent pandemic and how the COVID-19 Coaches helped with the multiple new procedures and support to maintain the best in care.

Her other accomplishments to name a few, are the PIECES Care Coach, RAI Process Improvement in collaboration with the Quality Team to Reimagine LTC, beginning with the reduction of Inappropriate Use of Antipsychotic Medication. Let's not forget the wonderful work of the LTC LPN Scope Optimization and Skin Wellness Associate Nurses (SWAN) projects to invite, explore and support nurses in care. Another success is the support for the Health Care Support Worker (HCSW) program, and ensuring Orientation programs for care teams. To recognize her leadership accomplishments she was recently nominated by her peers for a Celebration of Excellence Award.

The greatest tribute to her leadership is our belief and understanding that Dacia did not seek recognition, rather she helped us gain appreciation of an exceptional leader amongst us.

Dacia is looking forward to spending more time with her granddaughter in her retirement!

Please Welcome our New Clinical Nurse Specialist!

Victoria Pickles started as the new Clinical Nurse Specialist in Long-Term Care on April 15th. She brings a wealth of clinical experience in critical care, nephrology and gerontology. As a younger nurse she worked as a critical care nurse in London, England and as a renal transplant nurse in Vancouver. Most recently, she has been working as a Quality Resource Leader with Island Health and comes to this role having worked as a manager and frontline nurse in affiliate care homes.

Long-term Care and gerontology is an area of love for her. Dementia care, person-centered care and understanding how care teams work is a passion and area of interest. This includes always striving for the best practice in a complex area.

Victoria is a student at the University of Calgary in the Doctor of Nursing program, serves on the provincial board for the Gerontological Nurses Association of BC and is a surveyor with Accreditation Canada. She has a blended family with four children and two dogs. Her other passion is horses.

Victoria feels so privileged to be working within the long-term care team and is looking forward to the work ahead!

Answers to Test Your Knowledge on page 2: (1) D, (2) C, (3) A, (4) B