Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

island health

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DID YOU KNOW...

Island Health has a dementia video series called "Sharing the Journey" that shares practical advice for family caregivers supporting their loved ones with dementia. You will likely find it helpful for your practice as well! The videos presents strategies to address a variety of challenges that can occur when caring for residents living with dementia.

In this Issue

Nutrition and Wound Healing

Pressure injuries are caused by sustained pressure, usually over a bony prominence, that impairs circulation and prevents oxygen and nutrients from reaching the skin. This results in tissue damage and skin breakdown.

Nutrients are required at all stages of the wound healing cascade and are vital to preserve skin integrity. Poor nutrition can contribute to wound chronicity and severity and can increase risk of infection. Dehydration can impact blood volume and circulation, resulting in reduced delivery of nutrients to the wound bed and elimination of wastes. Consuming enough calories, protein, and fluids is essential for wound healing.

As wound healing is an anabolic event (i.e. the building-up aspect of metabolism), calories from carbohydrates and fats are needed to "spare" protein, to allow protein to be used for wound healing and preserve skin integrity.

An increase in calories, protein, and fluid is needed to meet their daily requirements:

- 30 to 35 calories/kg of body weight (individualized for degree of underweight or obesity)
- 1.25 to 1.5 g protein per kg of body weight (with caution advised if renal or liver disease is present)
- 1 ml fluid per calorie (with caution advised if renal or cardiac disease is present)

The nutrition approach in wound healing is to ensure a balanced diet, include energy-dense foods, liberalize diet restrictions, and correct vitamin or mineral deficiencies

We want to thank Celia Carson, Dietitian, Dufferin Place, for this article.

Applying Clinical Documentation to Practice

It takes a collaborative team to put the P.I.E.C.E.S.™ together when it comes to solving the most challenging presentations of some of the residents.

The Priory is one of the first LTC sites to use the new Behavioural Supports Ontario—Dementia Observation System (BSO-DOS), a standardized tool for documenting patterns in behaviours of residents with dementia.

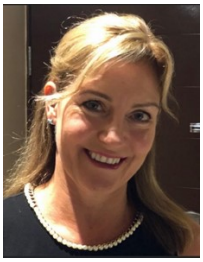
The original DOS Tool and the new BSO- DOS form both offer objective and measurable data to identify patterns and understand the meaning of behaviours.

What does the new BSO-DOS offer? The BSO-DOS is a user friendly two-page tool with a five day observation period. It allows the interprofessional team to compare behaviours that can be accommodated versus those that are potentially harmful.

The BSO-DOS allows analysis of hours spent exhibiting identified behaviours and allows care team to capture the context in which the behaviours occurred, if indicated. The enhanced BSO-DOS allows more efficient and effective care planning.

Mentorship Quote:

"By using the new and improved BSO-DOS we can capture all the details one can possibly imagine to support resident-specific plan of care and improve their quality of life."



Lisa Wiebe, HW CNL
The Priory

Quality Improvement – The 2nd Domain in Quality Systems Thinking

This is part one of a 4-part series on the second domain, quality improvement. When planning for whole system quality, the process for improvement lays the foundational work to operationalize the goals, strategies and priorities for quality.

How do we create a process for improvement? There are several methods but the most commonly used model has two parts. Based on the Institute for Healthcare Improvement's Model for Improvement, the first part is asking three fundamental questions in order and then using a Plan-Do-Study-Act (PDSA) cycle to test a change (see graphic).

Identifying an aim that is a SMART (Specific, Measurable, Achievable, Relevant and Timely) goal addresses the first part of this model. Coming up with a change idea to trial and test for improvement is the second part. In Long-term Care, the most relatable example of the process of improvement using this model is planning the care of a resident.

When a new resident comes in on admission, the plan of care evolves and looks very different from day 1 of admission to 30 days later and beyond. Care plan change ideas are discussed (Plan), documented (Do), monitored for improvement (Study) and adjusted as needed (Act).

Consider what problems could be explored to improve quality in day-to-day care of residents. Healthcare is a complex system but if making a small change that is an improvement within this system addresses a specific problem, it can lead to system level improvement through the process above. Stay tuned for part 2 on measurement. Measuring data is necessary to plan, do, study and act when working on improving a system, simple or complex.

Test Your Knowledge

Match each term to the statement that best describes it then check your answers on page 4.

1.	Poor nutrition can increase the risk of wound infection.	A. False
2.	The ___-___ is a standardized tool for documenting patterns in behaviours of residents with dementia.	B. Pressure Ulcer Risk Scale
3.	SMART goals are ones that are Special, Marvelous, Allowable, Reliable and Treatable.	C. BSO-DOS
4.	The _____ ____ _____ identifies residents at various levels of risk for developing a pressure ulcer.	D. True

P.I.E.C.E.S.™ on Nutrition

Sam Sharma is an 83-year old man newly admitted to a LTC home. He has been living with Parkinson's Disease and experiences dyskinesia and hypomimia. He has lived independently and enjoyed his hobbies until recently. He moved into care as he was no longer able to complete his Activities of Daily Living and Instrumental Activities of Daily Living (ADLs and IADLs) independently . Due to his dyskinesia, he has been struggling to feed himself. Care team members try to assist but he becomes easily frustrated, yelling "I'm not a baby, I can feed myself." Care team members are concerned as he is losing weight (61 kgs, height 178 cms). Using P.I.E.C.E.S™, they began to understand the underlying meaning of Sam's behaviours.

1. **What has changed?** verbally aggressive with care team members during meal times when they try to assist him with feeding; weight loss due to decreased intake

2 . What are the RISKS and possible causes?

Roaming— None identified
Imminent Physical Harm— Verbal aggression, care team concerned about escalating behaviours, VBACT assessed
Suicide Ideation— IS PATH WARM with some indicators present; ongoing monitoring required
Kinship Relationships, risk of harm— Care team hesitant to offer assistance with meals due to verbal aggression
Self-neglect— Intake inadequate due to challenges with inability to feed himself independently

Physical— Advancing Parkinson's Disease; dyskinesia and hypomimia
Intellectual—Cognitive Performance Scale = 2/6 (mild cognitive loss)
Emotional— Depression Rating Scale = 2/14; diminished facial expressions due to hypomimia; angry outbursts
Capabilities— Apraxia affecting ability to complete ADLs independently; declining assistance with meals
Environment— Challenges adjusting to eating in dining room with other residents
Social— Overstimulation when in dining room

3. What is the Action? A plan of care was developed to address Sam's nutrition and mood concerns.

Date	Focus	Desired outcomes S.M.A.R.T.	Intervention (Who, What, When) All care team members will:	Evaluation date	Initial
March 1/ 2022	Eating & Nutrition	Sam's daily intake will increase and he will regain weight to an ideal body weight range of 63-86 kilograms	• OT to provide adaptive eating aids to promote independence with eating • Care team members to set up meals • Dietitian ordered nutritional supplements and high calorie/protein diet, HCA to offer supplement, if meal not eaten • HCA to offer HS and between meals snacks ordered by the dietitian • Dietitian to assess weight monthly	March 14/2022	AF
March 1/ 2022	Mood/ Behaviour	Sam will have less incidences of verbal aggression during meals as demonstrated in the BSO-DOS	• Care team to complete a BSO-DOS monitoring to identify patterns and possible causes of verbal aggression • Allow Sam to direct assistance required	March 14/2022	AF

Outcome: The use of adaptive tools promoted Sam's independence with meals and staff are aware that he is able to direct the level of assistance he requires. So when assistance is needed, he is more accepting of it. Through these interventions, Sam's food intake increased. He is less frustrated and has regained three kilograms.

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

Pressure Ulcer Risk Scale (PURS)

RAI 2.0

The Pressure Ulcer Risk Scale (PURS) is one of 10 outcome scales, or outputs, generated from a completed RAI assessment. These outputs can be used by clinicians to help build a person-centred plan of care.

Specifically, **PURS** Scale identifies residents at various levels of risk for developing a pressure ulcer with the objective of targeting risk factors for prevention. The scale is calculated from the coding data provided in the following seven items of the RAI assessment:

- Bed Mobility Self-Performance (G1aA)
- Walk in Room Self-Performance (G1cA)
- Bowel Incontinence (H1a)
- Shortness of Breath (J1l)
- Daily Pain (J2a)
- Weight Loss (K3)
- History of Resolved Ulcer (M3); or Pressure Ulcer (M2a) for quarterly assessment

PURS scores can range from a low of 0 to a maximum of 8, with higher values indicating a higher relative risk of developing a new pressure ulcer.

The following chart can help clinicians interpret the scoring values.

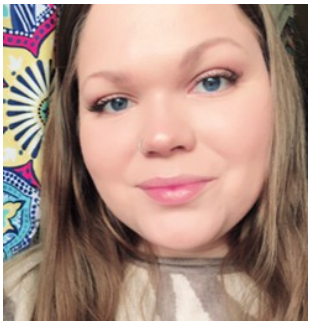
Descriptor	interRAI PURS Score
Very low	0
Low	1–2
Moderate	3
High	4–5
Very high	6–8

Unlike some of the other outcome scales, the **PURS** scale is not a summative scale meaning the values coded in the above 7 items can not be added together to obtain the score. Rather, Paris uses an algorithm to automatically calculate the score.

By focusing on those elements that contributed to a **PURS** score > 0, clinicians can target interventions to reduce the risk of developing a pressure ulcer. Upon completion of the next RAI assessment, the care team can revisit the **PURS** score to see if the interventions have been effective.

CODING CORNER

Introducing Our New Clinical Nurse Educator!



Please welcome Jessica Gergel as our new full-time regional CNE for the Specialized Populations Units at The Summit and Dufferin Place! Jessica graduated from Stenberg College with a diploma in psychiatric nursing in 2015. Prior to this, Jessica worked as an LPN for 5 years graduating from Vancouver Island University in 2010. She also holds a diploma in Mental Health Nursing for Practical Nurses through Douglas College.

Jessica started her nursing career working in Long term Care and various units of Cowichan District Hospital (CDH). She has spent the last 5 years working in several capacities as a Registered Psychiatric Nurse (RPN) including direct patient care. She has experience as a case manager with ACSS, as a COVID resource nurse at Cowichan Lodge, and most recently worked on the inpatient psychiatry unit of CDH. In addition, she worked casually doing intake and crisis response with Duncan Mental Health, as well as vaccinations within the COVID-19 vaccine clinics.

Jessica is passionate about person-centred, trauma informed quality care for seniors. Jessica believes strongly in a holistic approach that promotes trust and collaboration within the therapeutic relationship. She is passionate about harm reduction and reducing the stigma associated with mental health disorders.

Jessica lives in Duncan with her fiancé and dog. Jessica was born and raised on Vancouver Island. She is an avid runner and gardener, and is passionate about continuing education. Welcome Jessica!

To comment on an article, contribute a suggestion or experience, or ask a question send an email to: LTC.Newsletter@islandhealth.ca

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