Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

island health

March 2025

DID YOU KNOW...

The annual RAI competency test is due by May 31st for Island Health RAI assessors. Visit the LTC-Program support website for information and resources for completing your competency on Relias. If you have issues logging into your Relias account, reach out to your site CNE.

In this Issue

Post-Fall Management Procedure Updates!

Falls are a serious concern for older adults and are a leading cause of significant injury and death for those living in Long-term Care (LTC). Injury from a fall can significantly impact a person's quality of life. A comprehensive post-falls assessment can identify injury and support clinical and person-centered decision-making for a plan of care after an injury.

At the end of January 2025, LTC implemented an updated Post-Falls Management Procedure.

The updated procedure aims to clarify key areas including:
1. Requirements for post fall assessments
2. Expectations for nurses on when to contact a resident's MRP
3. Collaboration with the resident and/or temporary decision makers for care after a fall.

Major updates include steps for completing a first and second assessment after a fall, as well as a new algorithm to follow after a resident falls. The aim of the algorithm is to decrease discrepancies in practice and provide consistent guidance for care teams. The updated procedure also includes steps required for documentation and communication as well as a new section on Post-Fall Huddle.

While nursing has a key role in assessment of injury after a fall, inter-professional teamwork is also important to review potential reasons for a fall. A review should include looking at vital signs, medications and other fall risk factors. Reviewing and updating a person-centered plan of care, in collaboration with the team, resident and their decision maker, is also an important part of falls follow up. This procedure aims to support this process.

Clinical Documentation

There are several documentation requirements when a resident has a fall, differing if a site is PowerChart activated or not. Non-activated sites document findings and communication regarding the fall in the progress notes of the resident's health record. The 7-page care plan also needs to be reviewed and updated as needed.

Activated sites document fall details in the Post-Falls Evaluation Powerform and update the resident's Interdisciplinary Plan of Care (IPOC) as needed. See the Post-Fall Evaluation PowerForm Standard Operating Procedure for more details.

The Scott Falls Risk Screening Tool needs to be completed when a resident is newly admitted, has a change of status, has multiple falls and annually. This is completed in paper form for non-activated sites and in PowerChart for activated sites.

Finally, all sites need to complete a Patient Safety Learning System. (PSLS) incident report.

Mentorship Quote:

"The comprehensive guideline standardizes post-fall assessment and interventions. It outlines documentation and communication requirements, ultimately increasing resident safety."

Vicky Gao, CNL, Gorge Road Hospital

Introducing the LTC Behavioural Support Team (BeST)!

Is your team experiencing challenges care planning for residents living with complex behavioural presentations related to dementia, mental health, or substance use?
Do you feel like you've tried everything and don't know what to do next? You've connected with your site's Quality Resource Leader (QRL) and don't know who to turn to next?

Consult BeST for care planning support for:

- Mental Health and Substance Use and/or Addictions support, Trauma Informed Practice (TIP) and behaviour care management.
- Complex behaviours associated with acquired brain injury or mental health conditions such as personality disorders, major neurocognitive disease, or cognitive impairment.

Well, we have some good news for you!

Beginning in January 2025, sites will be able to connect with LTC behavioural consultant CNEs, Ashley Johnston-Lewis and Clare Fletcher, when requiring additional support with care planning for complex needs. Island Health's Virtual Care Services team has worked closely with the LTC Quality, Education and Research (QER) team and LTC homes throughout 2024 to set up and activate the BC Virtual Visit (BCVV) platform. Each of the 59 active homes are equipped with devices for use with BC Virtual Visit which are set up with a new virtual waiting room titled *LTC MHSU/Complex Behavioural Consults*. Residents, site leadership and/or care team members can be present for the consult. The meeting can include assistance with complex care planning, education, or information regarding available resources.

All initial consults will be conducted through this platform - if additional on-site support is required, this will be arranged with site leadership on a case by case basis.

Want to access this service?

Find the referral form and additional resources on the LTC Behavioural Support web page. Once the referral is reviewed, you will receive a response within 72 business hours to discuss next steps.

What's coming next?

We are also in the process of consulting with interested specialist physicians to add another tier of support for residents who may otherwise have barriers to accessing these services.

Test Your Knowledge

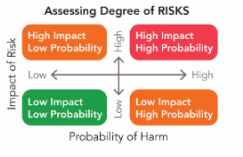
Match each term to the statement that best describes it then check your answers on page 7.

1.	The best predictor of future falls is a history of past falls.	A. False B. Dietitian care C. ostomy products D. True
2.	If _____ _____ aren't used properly, they can cause problems such as leaks, skin tears or irritation.	
3.	All RAI assessors are required to complete their Relias competency test by March 31st.	
4.	_____ ____ improves outcomes in residents by improving quality of life, nutrition status, and meal satisfaction.	

Putting the P.I.E.C.E.S.™ Together

Milo has been living in the LTC home for nearly a year after experiencing a stroke with left sided weakness. He has a history of depression and bilateral knee replacements. Milo was a writer and loves riddles and word games. Prior to his admission, he lived alone but regularly visited his older sister, Mya, who lives in a different LTC home. His nephew, Norton adopted his dog, Tock, when Milo was admitted to LTC. Milo has been having frequent falls over the last several weeks and upon review during the Falls huddle, it was noted that he has increased weakness and has stopped eating and drinking. The PIECES HCA Care Coach and practitioner have organized a PIECES huddle using the 3-Question Template:

Q1 What are the priority concerns; is it a change for the Person?	• Increased falls • Decreased intake
Q2 What are the RISKS and possible contributing factors? **Think PIECES**	• **R**oaming: not identified • **I**mminent: **frequent falls** • **S**uicide: not identified • **K**inship Relationship: **loss of connection to family** • **S**elf-neglect: **not eating or drinking**



- **Physical:** Increased overall weakness, bilateral knee replacements, stroke; CHESS: 3/5 (previous: 0/5)
- **Intellectual:** Cognitive Performance Scale (CPS): 0/6 (same as previous), enjoys word games and riddles
- **Emotional**: Depression Rating Scale (DRS): 5/14, (previous: 2/14), history of depression
- **Capabilities:** One person assist for ADLs, directs own care, capable of setting own goals
- **Environment:** Move to care home nearly a year ago
- **Social:** Loss of connection with Mya, loss of daily animal presence

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

Investigations

- HCAs to monitor intake; Dietitian to assess weight change (shows a decrease of 7% in the last two months); on further discussion Milo tells the Dietitian that he has no appetite and that it "doesn't seem worth it to eat".
- OT to assess mobility and transfers; during the assessment Milo tells the OT that "there's no point in even getting up since I have nothing to do."
- Activity aide to review activities of interest; Milo tells them that he had reading and word game books but he finished them all about a month ago. He is not interested in watching TV or most of the facility activities.
- Nursing team to complete Geriatric Depression Scale 5-15 (shows a score of 10/15, indicative of depression); on further discussion Milo tells the nurse he is coming up to one year in the LTC home. The upcoming anniversary has made him realize how much he misses Tock and having visits with his sister. When asked why Milo did not mention these feelings sooner, he says "no one asked."

Interactions

- HCSWs to spend 1:1 time with Milo daily; all care team staff to check in with him and how he is feeling

Interventions

- Activities team to arrange book delivery from the library, and source more word games
- Norton brings in Tock for regular visits, and assists with connecting Mya and Milo
- Dietitian to update food preferences and add dietary supplement
- Therapies to add Milo to the walking program and encourage him to attend exercise classes

Outcome: Norton has brought Tock in for visits twice a week. On Wednesday evenings, Norton brings takeout, and they have a virtual visit with Mya. Milo has lots of new word games and is looking forward to finding even more online, with help of the Activities team, when he gets his own tablet. He is eating and drinking again, has regained 2% of his weight back over only three weeks, and has had no further falls. His latest CHESS and DRS scores have returned to baseline, he has attended exercises classes regularly; his goal is to gain enough strength to walk Tock in the garden!

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

C O R N E R

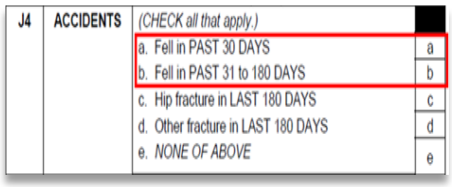
The Falls CAP Triggered – What Does It Mean?

RAI 2.0

A Clinical Assessment Protocol, or CAP, is a tool that helps clinicians focus on a resident's function and quality of life in specific areas. Clinicians can use CAPs to help create and/or update, a comprehensive, resident centred Plan of Care.

This is where the Falls CAP comes in! The Falls CAP is only 'triggered' for residents who have a HISTORY of falls. More specifically, if the fall has taken place within the past 30 days, the Falls CAP is always triggered.

In the current RAI-MDS assessment, a history of fall(s) is captured in items J4a (falls in past 30 days) and J4b (falls in past 31-180 days).



J4	ACCIDENTS	(CHECK all that apply.)	
		a. Fell in PAST 30 DAYS	a
		b. Fell in PAST 31 to 180 DAYS	b
		c. Hip fracture in LAST 180 DAYS	c
		d. Other fracture in LAST 180 DAYS	d
		e. NONE OF ABOVE	e

The Paris screenshot below shows a Falls CAP that has been triggered with a Medium Risk for future falls. The CAP was triggered because item J4a on the RAI was 'checked off', meaning there was at least one fall in the past 30 days; so J4a = 1.

10.	Falls Triggered into the medium risk of future falls group	☑	1	J4a =1, J4b = 0

A Triggered Falls CAP should always alert the clinician to ask questions. For example, most triggered Falls CAPs will likely have one or more risk factors, such as:

- Physical performance limitations – balance, gait, strength, muscle endurance
- Visual impairment – cataracts, glaucoma, myopia
- Cognitive impairment – dementia (Alzheimer's, Lewy-Body, vascular), stroke
- Medications – benzodiazepines, anti-hypertensives
- Postural hypotension
- An important question to ask might be "Did any of the above risk factors contribute to the fall?"

For a more comprehensive discussion about the Falls CAP, check out p. 93 of the CAPs manual. The manual is an excellent resource and an invaluable tool for clinicians in the care-planning process.

Do you know the BEST predictor of future falls is a history of PAST falls?

CODING CORNER

You Asked, We Answered

A Nurse asks: What concerns warrant a Dietitian consult?

A Dietitian answers: Most LTC residents are at risk for malnutrition and dehydration, which increases the risk of falls, infection, skin breakdown, poor wound healing, hospital admissions and overall morbidity and mortality. Quality of life is significantly impacted by mealtime experiences and nutrition status. Dietitian care improves outcomes in residents by improving quality of life, nutrition status, and meal satisfaction.

Consult the Registered Dietitian (RD) if you have questions/concerns about:

- Tube feeds
- Malnutrition OR risk of malnutrition (weight loss & reduced oral intake)
- Dysphagia (consult a dietitian post-stroke if resident fails swallow screen done by nursing).
- GI disease
- Increased nutrient needs (severe wounds, burns, certain cancers)

Diet preferences can be completed by nursing staff

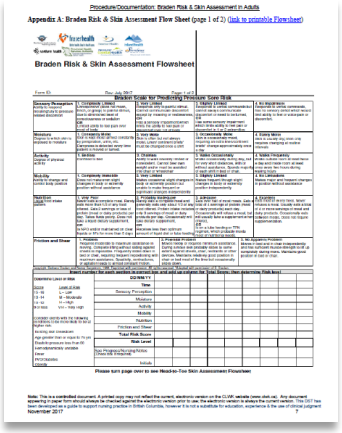
Dietitians are happy to help facilitate the best nutrition plan for residents.

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

Nutrition Screening for Skin, Bladder and Bowel Health

Wound Wise

Adequate fluid and nutritional intake are vital in preventing and healing wounds. Nutritional intake is a factor included in the Braden Risk and Skin Assessment. Fluid intake is also important for bowel and bladder health. Screening for adequate fluid intake can help identify barriers that may be impacting mentation, bowel and bladder health, wound healing – and much more!

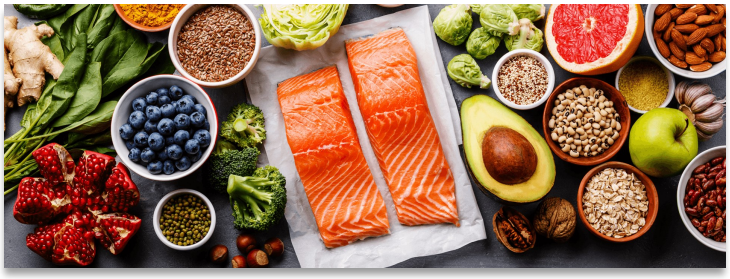

Procedure/Documentation: Braden Risk & Skin Assessment in Adults

Appendix A: Braden Risk & Skin Assessment Flow Sheet (page 1 of 2) (link to printable Flowsheet)

Braden Risk & Skin Assessment Flowsheet

Generally speaking, we should drink approximately 1,500-2,000 mL of fluids/day (unless contraindicated for cardiac/renal/liver concerns). This can come from cups of fluids, soups, jello etc. Some residents may restrict what they drink to avoid episodes of incontinence; however restricting fluids can lead to concentrated urine that irritates the bladder and actually causes urgency and/or frequency. Adequate fluid intake is also needed to help prevent Urinary Tract Infections (UTI), and constipation.

The Nutrition for Wound Prevention & Healing: Guideline for Nurses on the Connecting Learners With Knowledge (CLWK) website is a great resource, as is your Registered Dietitian and the SWAN/NSWOC team. Collaborating with these interdisciplinary team members is integral to maximize the resident's quality of life and health.



Product Corner: Ostomy products: Do we need those extras?

Barrier wipes (i.e. Skin Prep, Cavilon), barrier extenders, powders etc.— there are many 'extras' for ostomy appliances. However, if not used properly, can cause problems such as leaks, skin tears or irritation.

Best practice stoma care includes using a minimal number of products, preferably just the flange and the pouch. If the appliance is leaking, or not staying on as long as it should, connect with a SWAN or NSWOC for support.

Sometimes additional products are needed, and an in-depth assessment with the SWAN or NSWOC can help determine which products (if any) would be helpful. Regular use of additional ostomy products are not recommended without consultation with a SWAN or NSWOC.

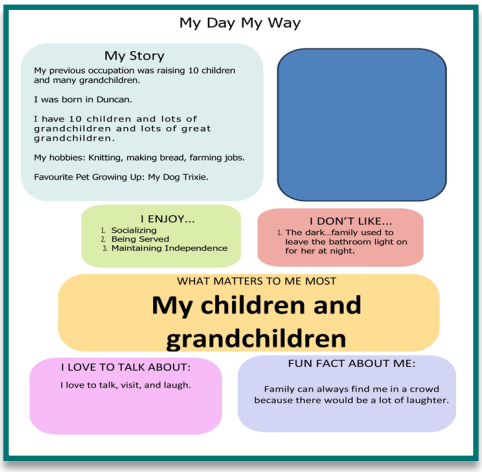
PRODUCT CORNER

"My Best Day, Every Day" Initiative

An exciting milestone has been met! All 61 LTC homes having now completed their annual Quality Site visits for 2024. The Quality Resource Team (QRT) has enjoyed engaging with the homes on their journeys with Quality Improvement Plans (QIPs), which includes testing out new change ideas. The QRT will be highlighting successes in hopes to inspire other homes across the island in meeting quality improvement goals.

Sidney Care Home launched an exciting initiative in 2024 called "My Best Day, Every Day," aimed at enhancing resident-centered care. This initiative was designed for the care team to build meaningful connections with residents and learn more about their life stories. Joan Smyth, Director of Care, shared how staff began by creating a "Guess Who" quiz for the team, which featured daily stories from a group of residents. Staff had to guess which resident the information described. The quiz quickly became a hit and was embraced by both the care team and residents.

The team then developed a questionnaire for residents and their families. This included life stories, preference, dislikes, and identifying what matters most to residents. The information was displayed on a poster with the resident's photo and showcased in their room. Feedback from residents and families was positive, with appreciation that staff were taking the time to learn more about residents. Resident and family quotes notably include: "Staff are exceptionally friendly and patient," "staff [do] their best to take care of my needs," "everybody seems to be empathetic and caring to all residents."



Initially, posters were created for 20% of residents, and after seeing the success, the initiative expanded to include posters for all residents, which will also be in place for all new admissions moving forward.

The initiative "My Best Day, Every Day" included an evaluation plan. A survey was provided to residents and families both before and after the project. Survey results showed significant improvements. Additionally, antipsychotic use has decreased at the home, and staff have reported feeling happier and more connected as part of the care team.

Survey Results		
Survey Questions	**Pre-Initiative**	**Post Initiative**
Some of the staff here know the story of my life	47.4%	80%
Staff ask how my needs can be met	47.4%	80%
Staff tried to understand what I'm feeling	68.4%	80%

Appropriate Use of Antipsychotics – Ongoing Improvement

- Before AUA: 26/59 (44%) homes below <26.1% (Q3 2022-23)
- Currently 32/57 (56.1%) homes are below 26.1% (Q2 2024-25)
- 12.1% improvement in homes who are meeting below the target rate.

Sign up for HQBC Action Series and HEC's Sparking Change in AUA

What's New on the LTC Program Support Website?

The Long-term Care Program Support Website, is growing! We are frequently adding new content:

Check out the newly published Falls in LTC Education & Resources page for:

- Learning resources to learn more about falls and injury prevention.
- Forms we use in LTC to screen for fall risk.
- Implementation Resources for the *New* Post-Falls Management Procedure that went live January 2025!

The Long-term Care Program Support Website is maintained by the LTC CNE Team. For questions, concerns or to suggest a topic send a message to our resource mailbox: LTCeducation@islandhealth.ca

Clinical Nurse Specialists Support LTC Homes with Quality and Best Practice

We are pleased to have Clinical Nurse Specialists (CNSs) on our team, dedicated to supporting Long-Term Care (LTC) homes across our region. CNS support is divided between the Central/North Island homes and the South Island homes in alignment with the Quality Resource Team. These positions are designed to enhance clinical practice and ensure the highest standards of care across both owned and operated as well as affiliated homes.

The CNSs play a pivotal role in overseeing and upholding regional policies and procedures, ensuring that updates and new documents are developed in alignment with best practice guidelines. They serve as subject matter experts for LTC and gerontology, collaborating with other program areas to advocate for the unique needs of residents. They work closely with the LTC Quality Team, as well as acute care teams, to address complex clinical care situations.

In addition, the CNSs actively participate in the LTC CARE Network and clinical governance to lead program-wide knowledge transfer, supporting practice-based evidence initiatives.

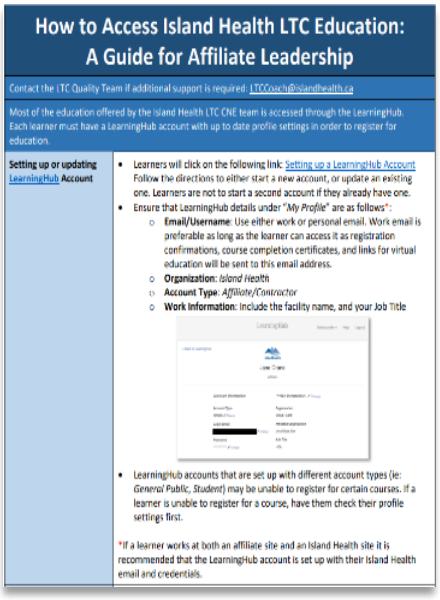
Behind the scenes, CNSs are responsible for analyzing regional data related to complex clinical issues, identifying trends, and providing recommendations to improve care. On an individual resident level, CNSs may complete complex case reviews upon request. The CNS role also encompasses leading and participating on working groups and other initiatives to support program development.

To encourage knowledge sharing, LTC CNSs connect with other CNSs within Island Health and the province.

To contact them, please email LTCPolicy@islandhealth.ca.

Check your Learning Hub Account Type!

As of June 2024, the LearningHub removed the option for *General Public* account types. As an employee at either an Island Health owned and operated site OR an affiliate site, this change will not impact you **if your account is set up correctly**. To check, log in to your LearningHub account and click on *My Profile*. From there you can view your account information and make updates if necessary.


How to Access Island Health LTC Education: A Guide for Affiliate Leadership

Contact the LTC Quality Team if additional support is required: LTCCoach@islandhealth.ca

Most of the education offered by the Island Health LTC CNE team is accessed through the LearningHub. Each learner must have a LearningHub account with up to date profile settings in order to register for education.

Setting up or updating LearningHub Account

- Learners will click on the following link: Setting up a LearningHub Account Follow the directions to either start a new account, or update an existing one. Learners are not to start a second account if they already have one.
- Ensure that LearningHub details under "*My Profile*" are as follows*:
  - **Email/Username**: Use either work or personal email. Work email is preferable as long as the learner can access it as registration confirmations, course completion certificates, and links for virtual education will be sent to this email address.
  - **Organization**: *Island Health*
  - **Account Type**: *Affiliate/Contractor*
  - **Work Information**: Include the facility name, and your Job Title

- LearningHub accounts that are set up with different account types (ie: *General Public, Student*) may be unable to register for certain courses. If a learner is unable to register for a course, have them check their profile settings first.

*If a learner works at both an affiliate site and an Island Health site it is recommended that the LearningHub account is set up with their Island Health email and credentials.

All employees of owned and operated Island Health LTC homes should have their account type as *Employee*, Health Organization as *Island Health*, and have their account verified with their employee number. Reach out to the Clinical Nurse Educator for your site, if you need help.

Employees at affiliate LTC homes should have their account type as *Affiliate/ Contractor*, Health Organization as *Island Health*, and should include their current *site* in the **affiliated organization field**.

Follow the instructions outlined in the *How to Access Island Health LTC Education* document for more details. Reach out to LTCCoach@islandhealth.ca if you need help.

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