island health

January 2025

DID YOU KNOW...

Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

We would love to hear your feedback about the Between the Lines Long-term Care (LTC) Program Newsletter!
Please complete this short survey (1-2 minutes) to let us know how we are doing:
LTC Between the Lines Newsletter feedback

In this Issue

Did You Know	1
New RAI Assessment	1
Clinical Documentation	1
HCSW Peer Mentorship	2
Test Your Knowledge	2
P.I.E.C.E.S.™ Corner	3
RAI Coding Corner	4
You Asked, We Answered	4
Wound Wise	5
Quality in LTC	6
Website Update	7
New Staff Bio	7

A New RAI Assessment is Coming to Long-Term Care

Beginning in the fall of 2025, Island Health will be introducing a new RAI assessment tool to LTC facilities across the island. The new tool will replace the current tool, known as the *RAI-MDS 2.0*.

The move to this new RAI tool is happening province- and country-wide. In fact, Saskatchewan and New Brunswick have already started using the new assessment tool.

Q1 - What's the name of the new RAI Tool?
The full name is: ***interRAI Long-Term Care Facilities Assessment Form***.
The abbreviated name is:
interRAI-LTCF

Q2 - What are the benefits of the new tool?
The new *interRAI-LTCF* has many similarities to the current tool and, therefore, won't look completely unfamiliar to many experienced assessors. But, of course, there will be some new and different things too!

The table below provides a 'Top 3 List' of benefits of the new RAI Assessment tool:

Benefits of the *interRAI-LTCF*

1. Fewer assessment items - 318 compared to 423
2. Shorter observation period - 3 days compared to 7 days
3. Full & Quarterly Assessments replaced with a new 'Routine Assessment'

As we move forward with this big change, we'll keep you informed in several ways:

- *interRAI-LTCF* ***Posters*** – keep an eye out for posters coming to LTC sites in January
- *interRAI-LTCF* ***Bulletin*** – we'll be introducing a short bulletin dedicated to all things *interRAI-LTCF*. Look out for the first edition coming February 2025!

Clinical Documentation

Are we required to document every bowel movement observed? Yes!
Documenting all bowel movements (BM), even BM that are less than half a cup need to be documented! The information captured is required for Island Health's BM documentation. This is important information that can indicate further nursing assessment and interventions. Multiple bowel movements that are less than half a cup can indicate that there could be clinical concerns such as a bowel obstruction, or infection. Other documented information such as frequency, consistency and size are all supporting information for whether further assessment is indicated. Any concerns should be ruled out by a thorough nursing assessment and MRP follow up if indicated.
If we fail to capture the less than half cup BM in our documentation, we do not have the full information about the resident's bowel pattern in order to make informed decisions to provide quality care for the residents.

Mentorship Quote:
"Monitoring daily bowel movements assists staff in quickly identifying irregularities, digestion problems, prevents constipation and even delirium in our residents. Healthy bowels improve quality of life!"

Jen Moore, LPN SWAN, Westhaven

Health Care Support Worker (HCSW) Peer Mentorship

The LTC program successfully enrolled ten new Peer Mentors who will be supporting Health Care Support Workers (HCSWs) during their non-clinical work experience. This new cohort of Peer Mentors, some who were HCSWs themselves, are supporting new HCSWs at multiple LTC facilities across south, central, and north island. Thank you for your continuous dedication to Island Health's Health Care Access Program (HCAP). Welcome to the LTC HCAP team!

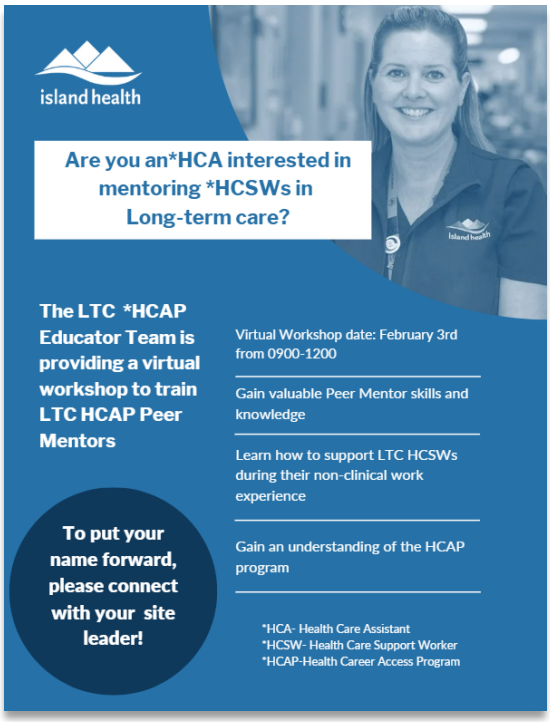
LTC Peer Mentors are essential in creating a supportive and positive environment. They serve as guides, offering both emotional and non-clinical practical support to new HCSWs. Through their personal and professional experiences, Peer Mentors help new HCSWs adjust to the complexities of LTC settings, making the transition into school a bit easier, and fostering strong relationships with the health care team.

For many Peer Mentors, the role brings a sense of fulfillment and pride in sharing their expertise and helping others succeed. Peer Mentors gain valuable leadership skills, while also building their professional network and confidence. Peer Mentors have voiced that this role has allowed them to grow personally and professionally, reinforcing the skills they have learned while giving back to the LTC team and residents.

For more information please email ltchcapeducator@islandhealth.ca and visit the Island Health HCAP Peer Mentor Website.

Do you know an HCA looking to enhance their role and work life?

The LTC HCAP team is always welcoming HCAs into the Peer Mentor role. If this is something that piques your interest, please connect with your site leadership team. The LTC HCAP Clinical Nurse Educators are offering a Peer Mentor Workshop on **February 3rd from 9-12**. Formal invitations have already been sent to site leadership and names must be submitted by January 27th.



Test Your Knowledge

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

1.	A new RAI assessment (the interRAI-LTCF) is coming in the Fall of 2025!	A. False B. cleanse C. Peer Mentors D. True
2.	____ _____ support new HCSWs as they grow in their role.	
3.	The Cognitive Performance Scale is a summative score, meaning that the numbers in each of the five items are added up to obtain the score.	
4.	Always _____ a wound before collecting a culture and sensitivity swab.	

Putting the P.I.E.C.E.S.™ Together

Teddy has been living in the LTC home for six months. He has moderate cognitive decline, congestive heart failure (CHF), and insomnia. He tends to keep to himself, spending much of his time in his recliner watching the news and enjoys chatting with his roommate, Ozzy, about world events. He has bilateral lower leg edema which has recently started weeping and gradually worsening over the last three months. In the last two weeks, Teddy has not been himself. He is even more withdrawn, will not get up to go to the toilet and sleeps through morning and evening care. When he does accept the offer to get up to his recliner, he promptly falls asleep. When he is awoken for meals, he seems confused and doesn't know where he is.

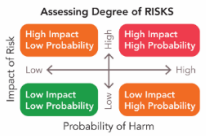
The PIECES HCA Care Coach and Practitioner have organized a PIECES huddle using the 3-Question Template:

Q1 What are the priority concerns; is it a change for the Person?

- Withdrawn
- Sleeping more than usual
- Neglecting ADLs

Q2 What are the RISKS and possible contributing factors? **Think PIECES**

- **R**oaming: not identified
- **I**mminent Harm: not identified
- **S**uicide Ideation: not identified
- **K**inship Relationship: **no longer engaging with Ozzy**
- **S**elf-neglect: **neglecting ADLs, sleeping through care**



- **Physical:** CHF, history of insomnia but now lethargic, worsening lower leg edema; on Lasix, and Seroquel
- **Intellectual:** Cognitive Performance Scale (CPS): 5/6 (previous: 3/6); Apraxia, Apathy, Altered Perception
- **Emotional:** Depression Rating Scale (DRS): 0/14, withdrawal from activities of interest
- **Capabilities:** Sets his own goals, close with roommate, keeps up to date with world events
- **Environment:** No recent changes; possible understimulation during day
- **Social:** Withdrawn from usual activities; supportive roommate

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

Investigations

- Confusion Assessment Method (CAM)- positive for possible delirium. Ozzy stated to the care team "one day he was fine, and the next day he was like this!"
- Screen for possible UTI - negative
- Vital signs and routine blood work all non contributory
- Medication review with clinical pharmacist revealed that his Lasix dose was increased two months ago. Seroquel PRN is used rarely but was given three nights in a row two weeks ago when Teddy complained his sore legs were keeping him awake.
- Abbey Pain Scale for three days – found scores ranging between 8-10 - Moderate

Interactions

- Provide calm and quiet area in room and gentle approach to care
- Gently re-orientate Teddy as needed by explaining where he is, who is he, and your role
- Provide stimulation: 1:1 time with HCSW, encourage Ozzy to continue visiting with him, have news on at a low volume

Interventions

- Provider decreased Lasix dose, discontinued Seroquel, and ordered analgesia for pain
- Nursing to administer CAM daily, monitor food and fluid intake, and assess for leg pain every shift
- Care team to encourage sitting up in recliner and assist with meals as needed; offer toilet every two hours, put lights on and open curtains during waking hours

Outcome: The pharmacist and provider correctly theorized that the combination of Seroquel and increased Lasix caused Teddy to experience a Hypoactive Delirium. One week after medication changes, Teddy's confusion has resolved, he is back to assisting with his own care, watching the news, and chatting with Ozzy. The care team has consulted the NSWOC to complete a lower limb assessment due to his on-going weeping edema. The new analgesia order has resolved his nighttime leg pain.

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

The Cognitive Performance Scale (CPS) – A Cerebral Outcome Scale!

RAI 2.0

The Cognitive Performance Scale (CPS) is one of ten 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.

The CPS score describes the ***cognitive status*** of a resident. As per the table below, the scores of this scale range from 0 - 6, with higher scores indicating more severe cognitive impairment. The table also shows how the CPS scores relate to the Mini-Mental State Examination (MMSE) scores (Note: a higher MMSE score indicates better cognition, which is the *opposite* of the CPS score).

CPS Score	Description	MMSE Equivalent Average
0	Intact	25
1	Borderline Intact	22
2	Mild Impairment	19
3	Moderate Impairment	15
4	Moderate/Severe Impairment	7
5	Severe Impairment	5
6	Very Severe Impairment	1

Remember, clinicians never have to calculate any of the Outcome Scale Scores. The Paris *software automatically does the calculation.*

The CPS score is calculated from the following 5 items on the RAI assessment:

	RAI-MDS 2.0 Items Used to Calculate the CPS
1	Comatose (B1)
2	Short-term memory (B2a)
3	★ Cognitive Skills for Daily Decision-Making (B4) ★
4	Making Self Understood (C4)
5	Eating (G1hA)

A key point to highlight is the third, red-starred item, *B4 - Cognitive Skills for Daily Decision-Making*. That's because the CPS score uses this item *twice* in its calculation. **Therefore, it's doubly important to ensure B4 is 'coded' accurately.** If the CPS score doesn't make sense, it's likely related to the coding of item B4.

Note: unlike the Depression Rating Scale (DRS) or Aggressive Behaviour Scale (ABS) scores, the CPS score is ***not*** a summative scale score, meaning one can't simply add the numbers in each of the five items to obtain the scale score.

Using the RAI manual when 'coding' an assessment is highly recommended. As always, the importance of ACCURATE CODING can not be overstated.

CODING CORNER

You Asked, We Answered

A Nurse asks: What tools do we use to assess resident cognition in LTC?

A CNE answers: Several cognition tools are commonly used in LTC to assess and support residents upon admission and for the duration of their care. The tools listed below help care teams identify cognitive changes, tailor plans of care, and enhance the quality of life for residents. RAI assessments, including outcome scales, are completed every 90 days, which calculates a Cognitive Performance Scale (CPS). Higher CPS scores indicate more severe cognitive impairment. Check out the RAI Coding Corner section for more CPS information. Visit the Seniors Health Standardized Assessment Tools webpage for more cognition assessment tools and resources.

Most commonly Used Tools in LTC:

- Mini-Mental State Examination (MMSE)
- Modified MMSE
- Montreal Cognitive Assessment (MoCA)
- Cognitive Performance Scale (CPS)

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

Wound Infection and Swabbing

Wound Wise

All wounds contain bacteria, but this does not mean that all wounds are infected. Wounds can be in bacterial balance or imbalance. When the wound is contaminated or colonized with bacteria, it remains in bacterial balance and can heal, allowing for other variables. As bacteria in a wound multiplies the bacterial balance is overwhelmed and the wound becomes infected.

When the infection is contained within the wound it is a local infection. These infections can be treated with topical antimicrobial dressings and cleansers. If the infection progresses beyond the wound border and invades the tissues surrounding the wound, this is called a spreading infection. These infections cannot be treated with antimicrobial dressings alone, they require systemic treatment with antibiotics.

Before antibiotics are initiated, we must first identify what bacteria is causing the spreading infection. This is what is accessed with a Culture and Sensitivity (C&S) swab. A C&S swab provides information on the type and number of microorganisms present in the wound and their susceptibility to specific antibiotics. C&S swabs are taken according to the Levine technique. To collect a swab, choose a one cm square, pink or red area and hold the swab at a 90-degree angle, rotating the tip of the swab for five seconds. Press down firmly enough to express fluid from the deeper tissues, as this is where the wound infection is occurring. To collect an effective sample, resident discomfort is common– address pain prior to completing.

Tips to remember before taking a C&S swab:

- A wound infection diagnosis comes from an assessment, not from a C&S swab
- An order is required
- Only swab a clean wound
- Push firmly to express fluid
- Do not culture wound exudate or eschar/slough

PRODUCT CORNER

Superabsorbent dressings are cover dressings used for wounds with large or copious amounts of exudate. We have two to choose from, Mesorb and Mextra Superabsorbent (Mextra) but what's the difference?

MESORB	MEXTRA
Three layer dressing with a layer of absorptive fluff	Four layer dressing with a layer of polyacrylate beads
Used for moderate to large exudate	Used for large to copious exudate
Very cost effective	Costs about four times more than Mesorb
Available in five sizes from stores	Available in seven sizes as special order (not in stores)
Cannot be cut	Cannot be cut
Can use barrier film to periwound	Cannot use barrier film to peri-wound (prevents transmission of exudate into dressing)

Mextra absorbs six times the amount of exudate that Mesorb does. Mextra will prevent periwound maceration more than Mesorb as the polyacrylate beads absorb and hold exudate away from the skin. The amount of exudate the wound is producing will guide the decision of which of these two dressings will be used.

Incorporating a Quality Council in Your Home

Incorporating a Quality Council supports monitoring and improving the overall quality of care for residents in Long-Term Care (LTC). The work of a quality council directly impacts the quality of life and desired health outcomes of residents by aligning the LTC vision of nurturing and inspiring hope, choice, and meaning for the residents we care for. Quality improvement (QI) is continuous and fluid through established regular meetings of a quality council to best support ongoing work.

A diverse quality council includes a multitude of team members, residents, and families who share their perspectives on high-quality, person-centered care. With the strength of a diverse group, it brings unique skill sets and experience fostering creativity and the opportunity for involvement and engagement.

A quality council should consist of:

- Team members including Activity Worker/HCA/LPN/RPN/RN/Support Service
- Medical Director/Coordinator
- Manager/Director of Care
- Care Leader/Provider
- Allied Health– i.e. Dietitian, Occupational Therapist, Pharmacist, Physiotherapist, Recreation Therapist, Social Worker
- One or more members from the Resident/Family Council

Quality Councils can use the Model for Improvement to support the homes QI work. First, they collaborate to conceptualize goals that are specific, measurable, attainable, relevant, and timely (SMART). Once goals are defined, the team plans change ideas to test on a small scale following the Plan-Do-Study-Act (PDSA) cycle model. Data is collected on each change idea and then studied or evaluated by the team. Using the learnings from the tested change ideas, the team will determine whether to adapt, adopt or abandon the change, ultimately promoting autonomy at the care home.

In addition to the myriad benefits to residents, the quality council also has a positive impact on participants by collaborating at regular check-ins to maintain a pulse on the QI initiatives the home is working on. Additionally, participation allows team members to champion the changes they help create and to receive recognition when the QI work is successful.

If you would like help to create a Quality Council in your home, please reach out to your Quality Resource Leader at LTCCoach@islandhealth.ca

Appropriate Use of Antipsychotics – Ongoing Improvement

- Before AUA: 26/59 (44%) homes below <26.1% (Q3 2022-23)
- Currently 29/57 (50.1%) homes are below 26.1% (Q1 2024-25)
- 6.1% improvement in homes who are meeting below the target rate.

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

Welcome to the Clinical Nurse Educator Team!

Please welcome Kirstine Carlson as the new temporary Clinical Nurse Educator (CNE) for Glengarry Hospital. Kirstine brings five years of LTC experience, including the past two years as a Clinical Nurse Leader (CNL) at two different facilities. She has a deep passion for ensuring high-quality care for residents and supporting families through the big life transition of coming into care. In the CNL role, she has been committed to facilitating interdisciplinary collaboration with the aim to support quality of life for residents, while supporting the skills and confidence of care teams.

Kirstine is passionate about education and fostering positive workplace culture to achieve quality care. In her new role, she looks forward to growing alongside the team and learning from the expertise and perspectives of its members. She aims to continue to support teams in maintaining their high standard of care and support them in making a meaningful difference in the lives of residents and their families.

What's New on the LTC Program Support Website?

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

Harm Reduction is an evidence-based approach focused on minimizing the negative consequences of certain behaviours, such as substance use, rather than attempting to eliminate them entirely. In the context of LTC (Long-Term Care), harm reduction strategies are essential for supporting residents' safety and well-being while respecting their autonomy.

Check out the newly published Harm Reduction in LTC Education & Resources page

Highlights include:

- Learning resources to explore harm reduction in general, the mitigation of exposures, naloxone, and trauma-informed practice.
- Additional resources on specific programs like iMAP, the 24/7 addiction medicine support line, harm reduction supplies, and more!

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

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