Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

island health

May 2022

DID YOU KNOW...

Accreditation is coming in November 2022!

Do you want to know more? Read the article on page 7.

ACCREDITED
ACCREDITATION AGRÉMENT CANADA

In this Issue

Functional Urinary Incontinence

Did you know that there are different types of urinary incontinence – and different management options for each?

Stress incontinence, urge incontinence, bladder obstruction incontinence– these are only some of the types of urinary incontinence that residents may experience. Functional urinary incontinence is caused by issues *not related to the urinary tract.* This could be cognition, or mobility.

If a resident has cognition-related urinary incontinence, a toileting program may be helpful, starting with a three day toileting trial.

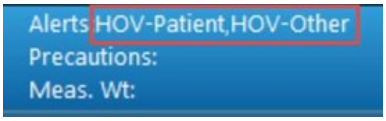
If a resident has mobility-related urinary incontinence, we may be able to change the environment (i.e. commode or urinal at bedside) and prevent incontinence episodes. These interventions have no side effects and can decrease the use of briefs (which can contribute to pressure injuries), decrease the risk of falls, and promote dignity.

How do you know what kind of urinary incontinence your client has?

Make a consult to our LTC Wound, Ostomy and Continence (LTCWOC) nurse! Erin Ballard will help you assess and create a plan of care for residents with urinary incontinence.

Make sure a toileting plan or bladder training program is in an individual's plan of care. This is also captured in section H3 of the RAI assessment.

Applying Clinical Documentation to Practice



All behaviour has meaning. Some may be unpleasant or even violent. To have a History of Violence alert in the PowerChart banner bar, a resident (HOV-Patient) or family/friend of resident (HOV-Other) must have had **at least one** incident:

- Assaulted or attempted to assault someone at Island Health
- Threatened to inflict harm to someone at Island Health
- A history of violence outside of healthcare- relevant to care setting

Examples:

Resident punched the face of HCA during care (physical assault- need to add HOV-Patient alert, if not already present).

Family member throwing a bowl at a caregiver (attempted physical assault- need to add HOV-Other alert, if not already present).

Resident's son-in-law arrested for assault (history of violence outside healthcare- need to add HOV-Other alert, if not already present).

Resident saying, "*You are the stupidest person!*" (unpleasant behaviour, but not violent by our criteria).

If a resident, or significant other, needs an HOV alert, how do you add one?

- Activated Sites- use the **History of Violence Alert** Powerform.
- Non-Activated (paper) sites- use the Violence Alert Activation Form

The Nursing Unit Assistant then processes the alert to include on the resident's banner bar. Remember to complete the Violent Behaviour Assessment Consideration Tool (VBACT) for every violent incident!

Mentorship Quote:

"Learning who has an HOV alert through the safety communication board or the banner bar will assist staff to know who is at risk for violence."

Erna Maghanoy, HCA, Code White Coach, The Summit

Speech-Language Pathology Services in Long-Term Care

Please welcome Dana Haydon as South Island's Speech-Language Pathologist (SLP) in Long Term Care (LTC).

Speech-Language Pathologists are health professionals who identify, diagnose and treat communication and swallowing disorders.

Dana's role covers the following South Island sites—Aberdeen Hospital, Gorge Road Hospital, The Summit, Saanich Peninsula LTC Units, The Priory, and Glengarry Hospital. Speech-Language Pathology offers services to residents with communication and swallowing challenges. The SLP's role is primarily related to assessing swallowing abilities and providing recommendations to promote safe eating and drinking. Additionally, the LTC SLP assesses and provides Alternative and Augmentative Communication (AAC) options for residents to maximize their communication abilities. **Augmentative** means to add to someone's speech. **Alternative** means to be used instead of speech. There are many different types of AAC options.

Dana Haydon and her pet goat Juanita

No-Tech and Low-Tech Options:

- gestures and facial expressions,
- writing,
- drawing,
- spelling words by pointing to letters, and pointing to photos, pictures, or written words.

High-Tech Options:

- using an app on an iPad or tablet to communicate and using a computer with a "voice", sometimes called a speech-generating device.

A person may use different types of AAC techniques because there are many ways that we all communicate. An AAC system includes all of the tools of this type that a person uses. A SLP can help find the right AAC system for each client. Not every tool works for every person, so it is important to find the right one for each individual. SLPs work with other professionals like occupational therapists and physiotherapists, if there are different physical skills that affect how one can access the AAC system.

Dana is passionate and committed to forming relationships with the teams she works with. She is keen to continue learning more about LTC and how she can best serve the residents and care teams to provide safe and quality care.

A referral to SLP Services can be made by care team members by emailing Dana at Dana.Haydon@islandhealth.ca.

If you see her in the halls of LTC please, don't be shy, stop by and say Hi!

Test Your Knowledge

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

1.	Secura Extra Protective Cream should be applied by rubbing in one direction only.	A. False
2.	_____ ___ _____ can help maximize a resident's communication abilities.	B. HOV-Other
3.	There are 5 types of measures that determine if a quality improvement initiative is working, needs adjusting or should be completely abandoned.	C. Alternative and Augmentative Communication
4.	If a family member threw a bowl at a caregiver, an ___-_____ alert needs to be initiated.	D. True

Putting the P.I.E.C.E.S.™ Together

Bob is a 87-year old man who has lived in the care home for two years to help manage his congestive heart failure. He was settled until he recently started taking a new diuretic medication. He has been in a constant rush trying to get to the wash-room during the day and cursing under his breath. He has had increased falls and incontinence episodes over the past week. When care team members offer assistance in changing briefs or cleansing, he is quick to curse them away.

Urinary incontinence is not a normal part of aging, however many older adults suffer from incontinence. Does Bob have functional, urge or stress incontinence? The team uses the P.I.E.C.E.S.™ 3-Question Template to avoid making assumptions. They discussed the changes observed and considered the RISKS involved. Using the P.I.E.C.E.S.™ approach, they began to understand the underlying causes of the behaviours.

1. What has changed? Increased falls, cursing at care team members, increased daytime urinary incontinence

2 . What are the RISKS and possible causes?

Roaming— No, not at this time
Imminent Physical Harm— Yes, increased falls
Suicide Ideation— No, not at this time
Kinship Relationships, risk of harm— Yes, staff avoidance if he continues to curse at them
Self-neglect— Yes, self neglect of ADLs

Physical— Urinary incontinence, increase in falls
Intellectual—Cognitive Performance Scale = 4/6 (mild/moderate cognitive loss)
Emotional— Depression Rating Scale = 5/14; potential problem with depression, cursing have increased
Capabilities— Requiring more help with ADLs
Environment— Rushing to find washroom
Social— Wife concerned with changes in mood, increased incontinence and falls

3. What is the Action? The care team determined that the cause of the behaviour was due to functional incontinence and developed a plan of care.

Date	Focus	Desired outcomes S.M.A.R.T.	Intervention (Who, What, When) All care team members will:	Evaluation date	Ini-tial
April 15/22	Elimination	Bob will have less urinary incontinent episodes during the day as demon-strated in his daily elimination record	• Toileting schedule adjusted for Q2 hourly toileting from 0800-1600 • Care team will provide toileting assistance as needed and ensure gait aide available for use • Trial using a mesh panty with male liner instead of tabbed brief to increase inde-pendence with toileting • PT/OT will assess Bob for appropriate mobility gait aide to assist with toileting	May 1/22	EB

Outcome: The scheduled toileting has resolved Bob's daytime incontinence episodes. He no longer has to rush to get to the bathroom, and is using the new gait aide to get there independently. Bob now requires only prompted toileting according to the schedule. The new containment product gives him more independence as he is able to doff and don his own undergarments. Bob has had no falls since initiating the new plan of care.

P. I. CORNER

RAI 2.0

The **May 31st** deadline for completing the annual RAI Competency Evaluation is nearly here! If you haven't started yet, why not begin now. Here's the link to the Relias login page to make things a little easier: https://vihaltc.training.relias.ca/. Remember, the preferred browser is **Google Chrome.**

Below are some tips to help you successfully complete and pass your competency:

- ⇒ You will need to use, and read, the RAI manual!
- ⇒ Pay attention to the look back period in each question – e.g. for section G1, the look back period is 7 days; for section H, it's 14 days; for section E1, it's 30 days
- ⇒ Read the last sentence a second time to ensure you understand which item you're being asked to code – e.g. is the question asking about G1A (resident ADL self-performance) or G1B (worker support provided)?
- ⇒ Use the Job Aids in the RAI manual (section 3 or 4) to assist you – in particular, look at the aids for questions on sections G1A and P1b (therapies)
- ⇒ Remember, you don't have to complete the evaluation in one sitting; you can save the questions you've completed and return at another time to continue

Relias will give you **three attempts** to obtain the passing grade of 80%. If you are unsuccessful after two attempts, it's recommended you get in touch with your site CNE before proceeding to submit for a third attempt.

Good luck!

CODING CORNER

Introducing Our New Clinical Practice Educator!

Please welcome Erin Ballard as our new full-time Clinical Practice Educator for Wound/Ostomy/ Continence! Erin began her nursing career in 2009 as an LPN on the Burn and Surgical unit at Royal Jubilee Hospital (RJH), caring for post-operative patients and patients with complex wounds. She completed her degree in nursing by distance through Athabasca University, and graduated in 2018. After working with surgical patients for ten years, she shifted to working in oncology and palliative care at RJH. Erin completed a nursing specialty in 2021 and is now a nurse specialized in wound, ostomy and continence (NSWOC). She is excited to join the long-term care team and contribute to the excellent gerontological care delivered by everyone in this program.

As an NSWOC educator, Erin will be providing monthly webinars on topics in wound care, ostomy care, GI tube care, and urinary and fecal continence. She also provides consultative services for residents with complex challenges in these areas through virtual appointments. Erin can help with creating evidence-informed plans of care that are uniquely tailored to the preferences and goals of care for residents. Care team members can refer to Erin using the referral form.

When she is not working, Erin can be found either dancing around her apartment with Prince on the stereo, or searching for the perfect cup of coffee.

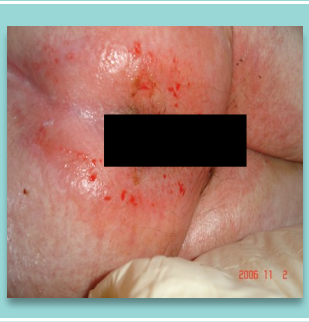
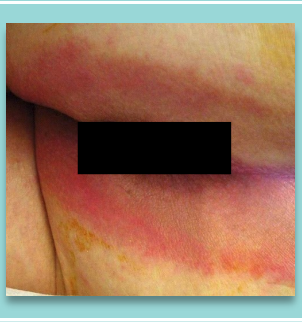
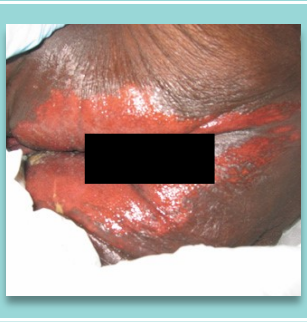
- Wound Referral
- Continence and Catheter Referral
- Ostomy Referral
- Gastrointestinal Tube Referral

Assessment and Treatment of Mild, Moderate and Severe IAD

Wound Wise

Incontinence-associated dermatitis (IAD) is a type of Moisture-Associated Skin Damage (MASD) found in the perineal area that can extend up the back and down the thighs. Skin exposed to moisture from urine and/or loose stool becomes reddened and broken down with prolonged exposure to the irritant.

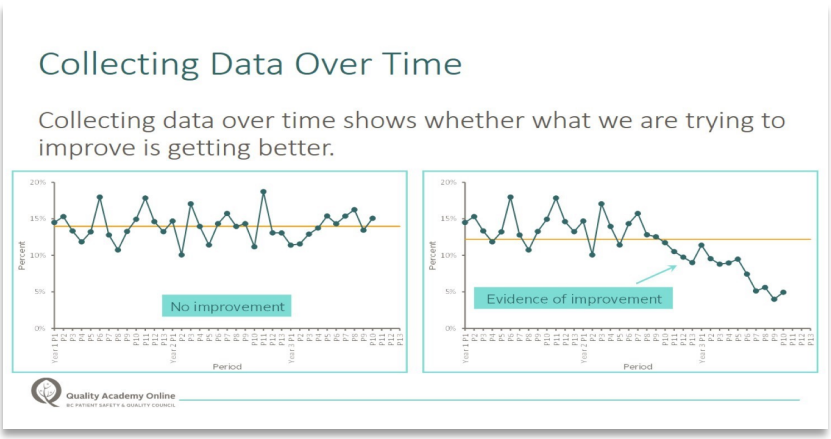
Prevention is the best medicine. Some of the good prevention strategies include minimizing incontinent episodes with prompted toileting, avoiding briefs when possible as they trap moisture and heat, and use of Remedy Hydraguard barrier cream on the perineal skin after every incontinent episode.

Mild IAD	Moderate IAD	Severe IAD
		
• Skin intact • Pink or red skin with irregular borders in white skin tones • Purple, white or yellow skin in non-white skin tones • May have burning, stinging pain	• Bright red skin in white skin tones • White, yellow or dark red skin in non-white skin tones • Areas of superficial skin loss • Will have pain, even if they cannot express it	• Large areas of skin loss • Large blisters • Moist, weepy skin • Bleeding • Bright red in white skin tones • Dark red or purple in non-white skin tones • Will have pain, even if they cannot express it
• Cleanse with no-rinse foam cleanser • Pat dry • Apply Remedy Hydraguard cream to area	• Manage pain • Avoid briefs • Cleanse with no-rinse cleanser and apply Remedy Hydraguard or Secura EPC zinc cream to area	• Manage pain • Avoid briefs • Refer to OT for pressure reducing surfaces • Cleanse with no-rinse cleanser • Zinc Secura EPC cream after every pericare episode

Secura Extra Protective Cream (EPC) is hard to clean off when I perform pericare, How do I remove it?

With every incontinent episode, take moistened disposable wipes or gauze with no-rinse foam cleanser on it, and place on top of the soiled skin. Wash away the soiled EPC cream on top – do not remove all of the EPC cream, only the soiled top layer. Pat dry and apply more EPC cream so that there is no skin showing through. Apply the cream in one direction only – do not rub it back and forth over the skin. It is good practice to remove all of the EPC cream every three days to do a skin reassessment. To do this, apply the no-rinse foam cleanser for 2-3 minute to soak the area until able to gently wipe away cream without rubbing. EPC should only be used for moderate or severe IAD – do not use on intact skin for prevention.

Data, Data and More Data!!!



This is part two of a four-part series on the second domain, quality improvement. In the last article, it is mentioned how data measurement is necessary in order to Plan, Do, Study and Act (PDSA) on improving a system. Measuring for improvement helps us understand the current baseline state; what a change over time looks like giving us a target to strive for and ways to change something in order to improve the process or situation.

In healthcare, we measure different aspects of care and processes to improve efficiency, reduce cost and to improve the client experience (patient, resident and staff). In Long-Term Care, there are several indicators that are measured to identify and work on areas for improvement e.g. potentially inappropriate use of anti-psychotics, worsening pressure ulcers etc...

There are three types of measures that determine if the improvement is working, needs adjusting or should be completely abandoned.

Outcome	Process	Balancing
• What is better for the client? • What is the result of the new process? • What will ultimately be better?	• Voice of the system • What is being done differently? • What is being done consistently?	• What unintended consequences occurred? • What do we need to be concerned about that we can address?
Example: • Did we meet our target goal to reduce potentially inappropriate use of anti-psychotic medications?	Example: • Percent decrease in usage of anti-psychotics over the trial period • Number of appropriate recreational activities over the trial period.	Example: • Percent rate of staff injury over the trial period due to behavioural and psychological symptoms of dementia. • Percent decrease of falls of residents over the trial period.

Data measurement is a science that requires understanding of what we need to measure, how we measure and for how long. If we keep our targets SMART (Specific, Measureable, Achievable, Relevant and Timely), this reduces the burden of feeling overwhelmed with measurement. Bear in mind with any system that involves humans, there is always variation in the data due to common or special causes within the system.

Shewhart's Theory of Variation:

Common causes: Those causes are inherent and can affect everyone working in the system. It also affects all outcomes of the system e.g. routine prescription of anti-psychotics for Behavioural and Psychological Symptoms of Dementia (BPSD).

Special causes: Those causes not part of the system all the time or do not affect everyone, but arise because of specific circumstances e.g. global pandemic.

We measure data all the time in the work that we do. Making it meaningful gives purpose in improving health outcomes and experiences for the resident and their families.

Think about areas of practice or processes that will foster improvement of outcomes as we journey along the path of quality improvement together.

Stay tuned for part three—Drivers and Process Mapping!

Long-Term Care Accreditation 101

Accreditation Surveys are coming!

Accreditation is one of the most effective ways for organizations to regularly and consistently examine and improve the quality of their services. The standards provide a tool for organizations to embed accreditation and quality improvement activities into their daily operations. The primary focus is to include the resident and family as true partners in care.

When is this happening?

Accreditation Canada has a new process which means our first half of surveys will be in November, 2022 followed by the second half in November, 2023. We should always be ready for an Accreditation Survey at any given moment. The areas we can "brush up on" between now and November will show us just how ready we are and help us to recognize opportunities for improvement.

Why is Accreditation so important?

Accreditation is one of the most effective ways for organizations to regularly and consistently examine and improve the quality of their services to enhance the lives of residents. Our Long-Term Care Philosophy of Care supports the inclusion of residents and families in the care provided. Accreditation Standards have People-Centred Care criteria weaved throughout, so care team members are empowered to give residents the tools and support they need to take charge of their own health.

How can I learn more about Accreditation?

Accreditation Canada's Long-Term Care Services standards are for organizations that provide high levels of care that are available 24-hours a day to residents. This also includes services such as accommodations, social and recreational activities, housekeeping, and meals. Each standard has criterion types: High priority criteria, Required Organizational Practices (ROPs), and performance measures, with relevant minor and major tests of compliance.

Visit Accreditation Canada's website to learn more.
At our Island Health website you can find:

- Updates
- Sequential Essentials
- Accreditation Toolkit
- Latest Standards
- Latest ROPs
- FAQs
- Current ROP Handbook (2021)

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