island health

July 2023

DID YOU KNOW...

Island Health has a Hot Weather Guideline to protect the health and safety of persons living in LTC.

This outlines how to identify heat related illnesses and emergencies and reviews key prevention strategies to keep residents and indoor spaces cool.

As the temperatures soar, make sure you are familiar with how to keep residents safe and comfortable!

Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

In this Issue

What's New on the LTC Program Support Website?

The Long-term Care Program Support Website, supports staff working in Long-term Care (LTC) to attain excellence in clinical practice through the implementation of best-practice and evidence-based guidelines. The ultimate goal is to ensure residents receive the highest standard of person-centred care, in terms of safety and quality, delivered in a caring and compassionate environment. The Education and Resources section of the website is growing! Our newest published pages are:

Quality in LTC	The Quality in LTC page outlines the Quality Assurance and Contract Management team's role in continuing quality improvements in LTC to improve resident quality of life. It also details the current program wide quality improvement project launched this year: *Appropriate Use of Antipsychotics (AUA).*
PIECES Care Coach	The AUA project includes implementation of the PIECES™ HCA Care Coach initiative aimed at increasing the valuable contributions of HCAs in LTC to the PIECES care planning process and peer coaching. Here you will find education for new Care Coaches and other resources.
Least Restraint	The Least Restraints in LTC page reviews the responsibilities of maintaining safety, dignity, and freedom of movement of those in our care. Find the Least Restraint Procedure for LTC, restraint alternatives, consent forms, the new monitoring form, and information for residents and families.

The Long-term Care Program Support Website is maintained by the LTC CNE Educator Team. For questions or to suggest a topic, email: LTCProgramSupportWebsite@islandhealth.ca.

Clinical Documentation

"My Story"provides person-centred information about a resident's life history. Here, their story is documented and the care team members can learn information such as the resident's personal strengths, family, friends and animals that are important to them, their hobbies and leisure interests and what they hope for at this time of their lives. It also includes their fears and things that make them upset.

This is documented on a paper form at non-activated sites and in PowerChart in the "Resident History and Preferences– My Story" Powerform at fully activated sites.

We often focus more on a resident's clinical issues, medical history, physical and psychological concerns. By taking the time to learn about the resident's history and preferences we can have a more holistic understanding of what matters to them.

Mentorship Quote:

"Understanding a resident's unique personal life story and journey helps the team provide person-centered care. 'My Story' is a great resource to document this story and share it with the team."

Victoria Pickles, RN
Quality Resource Leader
South Island

Continuity of Care with PowerChart

PowerChart connects us! It improves information access and encourages team collaboration- this is true within a site and between sites. When a resident discharges to another facility, there are places to document the discharge information such as last set of vital signs, skin and pain assessments, active allergies, MOST, and even when they left, who they left with.

If the receiving facility also has access to PowerChart, they will be able to view the discharge information and all other documentation. The receiving facility can access and copy the previous plans of care which provides the continuity of care and reduces relocation stress. Immunization records, falls history and allied health assessments are also transferable. The existing "My Story" is available and can be augmented as needed.

Some of the information on PowerChart crosses encounters. This is especially helpful during an admission to Long-term Care. They are referred to as 'controls' or histories. They are data elements about the resident that will cross encounters (medical history, allergies, age, MRN, procedure history, social history, MOST designation). This also includes medications, diagnoses and problems, other histories, allergies, immunizations and outpatient imaging, violence prevention documents, alerts and interdisciplinary notes. Most of them can be found in the Long-Term Care Summary Page, Clinical Notes, or in the Results Review sections. Once entered into the resident's electronic health record, they will carry forward into future encounters and can be leveraged by providers and clinicians for the current encounter documentation. Nurses are responsible for reviewing all controls at care transitions and throughout a person's hospital visits. Controls can be reviewed, modified, added and removed.

However, if the receiving facility is currently not documenting fully in PowerChart, the NUAs print off the required information and fax to the receiving facility. This allows them to also appreciate the rich information that supports smooth transfer in care.

Transfer of information through PowerChart does not replace the need to provide and receive verbal reports during any resident care transition.

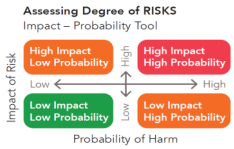
Test Your Knowledge

Match each term to the statement that best describes it then check your answers on page 6.

1.	The Hot Weather Guideline reviews key prevention strategies to keep residents and indoor spaces cool.	A. False B. Actisorb C. one D. True
2.	Reporting frequent preparation/administration of hazardous medication requires ___ e-form per month.	
3.	"My Story" includes clinical information about the resident.	
4.	_____ can provide effective odour control for non-healable wounds.	

Putting the P.I.E.C.E.S.™ Together

Ms. Jones is a 79 year old resident who moved into a LTC care home three months ago. This was after a hospital admission due to hypothermia when she was found sitting on the front steps of the police station in the middle of the night. She has frontal lobe dementia with severe cognitive impairment, depression, and end-stage lung cancer. She has limited ability to make herself understood but can make concrete requests regarding her basic needs (i.e. food, drink, sleep). Her only living family is a younger sister who lives in northern BC. They have not seen each other for three years. Since admission, Ms. Jones has been awake almost every night. She frequently gets up from bed and is often found rummaging around at the nursing station. Night shift staff are asking for help because she starts to cry if she is removed from the nursing station. The care team also noted that she sleeps through meals during the day and has lost 5% of her body weight in the last month. The care team has organized a PIECES huddle, with the HCA Care Coach, using the 3-Question Template.

Q1 What are the priority concerns; is it a change for the Person?	Mood/Behaviour— rummaging in the nursing station, crying if removed– since admission; possible change Nutrition— weight loss – change in the last month Sleep disturbance—awake at night, sleeping during the day – since admission; possible change
Q2 What are the RISKS and possible contributing factors? Think PIECES	**R**oaming: Yes, around the building but not exit-seeking **I**mminent Harm: No **S**uicide Ideation: No **K**inship Relationships: Yes, estrangement from family **S**elf-neglect: Yes, missing meals and losing weight
	
Physical: Lung cancer, frontal lobe dementia, depression, 5% weight loss **Intellectual:** Severe cognitive impairment; Cognitive Performance Scale (CPS) 5/6, Anosognosia, Amnesia, Aphasia **Emotional:** Depression Rating Scale (DRS) 10/14; crying when re-directed from nursing station, mood changes due to inadequate sleep **Capabilities:** 1 person assistance and task segmentation with ADLs; understands direct prompts and cues **Environment:** Has always lived alone; under stimulated or bored during the day; change in daily routine **Social:** No visitors; only sister lives in northern BC; limited participation in activities.	
Q3 What are the actions? • Investigations • Interactions • Interventions	**Investigations** **Nursing:** Screen for pain (cancer) using PAINAD x 3 days – revealed mild pain Initiate BSO-DOS x 5 days – revealed sleep disturbance around 11pm most nights Consult dietitian due to 5% weight loss **Activities & Social Work:** Complete social history including past roles, family, interests, & hobbies
Interactions	
Approach calmly from the front; speak clearly and slowly with direct eye contact; use short sentences; show rather than tell Front-load communication "I understand you're frustrated. How can I help?" Avoid starting sentences with “No” ,“Don’t” ,“You can’t”, “Stop”; avoid arguing Provide touch as appropriate	
Interventions	
Activity team to encourage both 1:1 (with HCSW), long walks in the gardens, and formal group activities for a busy day so she is tired enough to sleep at night; distract and redirect from wandering/searching with activities that meet interests, hobbies, and align with past roles. Reconnect with sister via Zoom **Dietitian and care team** to monitor weight, food intake, offer a variety of foods, provide extra snacks for night shift to offer, look for an appropriate tablemate for more incentive to go to meals and provide cueing and reminders to go to meals. **Care team** to monitor for pain and **nurse** to administer analgesics PRN or obtain scheduled order if warranted. **Physician** ordered a night time sedative PRN.	

Outcome: After the above actions were completed by the team, and in conversation with her sister, it was discovered that Ms. Jones was a long-time night shift 911-emergency dispatcher, loved long walks, gardening, and always had a pet cat. She was provided an inactive wireless head-set for when she wakes at night, providing a connection to her previous role. This decreased her rummaging in the nursing station which the care team now thinks she may have been interpreting as her former office. The Activities Team provided her a stuffed cat and pictures of her old cat and sister. She is kept busy during the day with gardening and walks. She settles to bed around 2230 and has not needed the PRN sedative. She enjoys eating lunch with her new tablemate, Lucy, who is a retired BC Tel office manager who loves to talk, even though Ms. Jones rarely replies. She has gained 2.5% of her weight back over the past 2 weeks.

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

A 'Small' Update for the RAI Observation Tool & A New Job Aid for Section G1

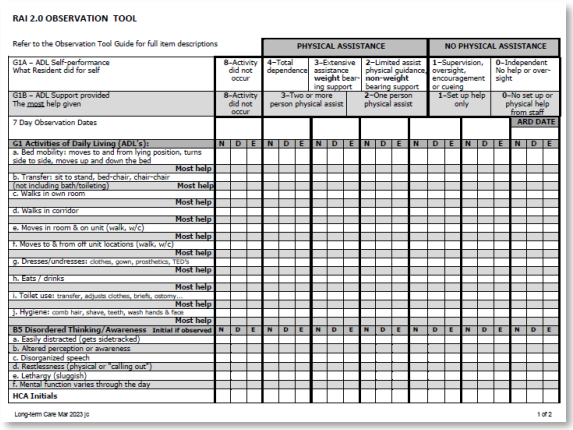
RAI 2.0

Yes, it's true – after many years, the RAI Observation Tool (Obs Tool) has been updated!

The good news is that the updates to the Obs Tool are truly 'Small'– some language changes to improve clarity, and two sections have switched pages to improve overall flow.

Below is a brief summary of the changes:

- Section G1A - ADL Self-performance – slight wording changes to better align with the RAI assessment
- Section J - Problem Conditions – this section has moved from page 1 to page 2
- Section B5 - Cognitive Patterns – this section has moved from page 2 to page 1, and been renamed **Disordered Thinking/Awareness** to better align with the naming found on the RAI assessment



RAI 2.0 OBSERVATION TOOL

Refer to the Observation Tool Guide for full item descriptions

		PHYSICAL ASSISTANCE			NO PHYSICAL ASSISTANCE	
G1A – ADL Self-performance What Resident did for self	8–Activity did not occur	4–Total dependence	3–Extensive assistance **weight bearing** support	2–Limited assist physical guidance, **non-weight bearing** support	1–Supervision, oversight, encouragement or cueing	0–Independent No help or over-sight
G1B – ADL Support provided The **most** help given	8–Activity did not occur	3–Two or more person physical assist		2–One person physical assist	1–Set up help only	0–No set up or physical help from staff
7 Day Observation Dates						ARD DATE

G1 Activities of Daily Living (ADL's):	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E
a. Bed mobility: moves to and from lying position, turns side to side, moves up and down the bed																					
Most help																					
b. Transfer: sit to stand, bed-chair, chair-chair (not including bath/toileting)																					
Most help																					
c. Walks in own room																					
Most help																					
d. Walks in corridor																					
Most help																					
e. Moves in room & on unit (walk, w/c)																					
Most help																					
f. Moves to & from off unit locations (walk, w/c)																					
Most help																					
g. Dresses/undresses: clothes, gown, prosthetics, TED's																					
Most help																					
h. Eats / drinks																					
Most help																					
i. Toilet use: transfer, adjusts clothes, briefs, ostomy																					
Most help																					
j. Hygiene: comb hair, shave, teeth, wash hands & face																					
Most help																					
B5 Disordered Thinking/Awareness Initial if observed	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E
a. Easily distracted (gets sidetracked)																					
b. Altered perception or awareness																					
c. Disorganized speech																					
d. Restlessness (physical or "calling out")																					
e. Lethargy (sluggish)																					
f. Mental function varies through the day																					
HCA Initials																					

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If you've been using the Obs Tool for some time, you might know that completing sections G1A (ADL-Self Performance - What the Resident Did for Self) and G1B (ADL Support Provided - The Most Help Given) can be challenging.

With that in mind, a new Job Aid has been created to help improve the 'coding' of these sections. The aid contains specific decision-support trees for G1A and G1B which, hopefully, will improve the accuracy and reliability of the information recorded in these sections.

The links to the Updated RAI Obs Tool and the New Job Aid can be found on the LTC website and are also available here:

- Updated RAI Obs Tool
- New G1A-G1B Job Aid

Effective July 2023, we'll be asking all LTC sites to start using the Updated RAI Obs Tool which will involve removing copies of the old Tool.

If you have questions about this change, feel free to connect with your site CNE.

CODING CORNER

You Asked, We Answered

***A Nurse Asks*:** How do I report the administration of hazardous medications?

***A Clinical Nurse Educator Answers*:** The Long-term Care Program Support website has all the necessary information, forms, links and resources available on their Hazardous Drugs webpage, including instructions for reporting the preparation/administration of hazardous medications. Reporting occasional preparation/administration of hazardous medication requires one e-form per drug/per day. Reporting frequent preparation/administration of hazardous medication requires one e-form per month that indicates the number of times medications have been prepared or administered on each day of the month. The BC Provincial Hazardous Drug List identifies the drugs that represent an occupational hazard to healthcare workers. The Hazardous Drug Exposure Control Matrix provides direction on handling the medication at each point of contact. It is your responsibility to understand how to remain safe in the workplace and identify unsafe encounters with hazardous drugs.

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

Welcome to our Island Health Long-term Care SWANs!

Wound Wise

Many long-term care sites on Vancouver Island will soon be welcoming SWAN™ graduates to their interdisciplinary teams.

A Skin Wellness Associate Nurse (SWAN™) has successfully completed additional, CNA accredited education in the areas of skin, wounds, ostomy and continence care. These nurses have an enhanced ability to provide optimal care for individuals with wound, ostomy, and continence issues as members of a collaborative Nurses Specialized in Wound, Ostomy and Continence (NSWOC) team across Canada.

A SWAN™ can provide insight into causes of concern for our residents, make suggestions for care, provide mentorship for their peers and act as liaison with the facility Nurse Specialized in Wound, Ostomy and Continence.

A SWAN™ works within their scope of practice and uses knowledge, skill, and judgment to apply an extended (beyond that of a generalist nurse) body of knowledge of integumentary, wound, ostomy and continence care to the practice of nursing. A SWAN™ brings best practice, evidence-based knowledge to the care team.

Island Health LTC leadership is generously supporting this education for a limited time.

INTERESTED?

Click on the following link, or connect with Shelly Barnes (shelly.barnes@islandhealth.ca).

Actisorb Silver 220

Actisorb Silver 220 is an activated charcoal dressing impregnated with silver for use on wounds that are malodourous.

How does it work? Charcoal traps odour-causing bacteria in the dressing, and then silver kills that bacteria.

Before you reach for this product to treat wound odour, ask yourself why the wound is so malodorous? An increasing malodour is one sign of wound infection, and if we use a product that will kill the odour, we are not addressing the cause.

Are we debriding a large amount of slough and eschar from a wound? This is going to cause an odour as that necrotic tissue softens and loosens from the wound. Actisorb may not be indicated here, as it's likely not compatible with the product we are using to debride.

However, Actisorb is the right dressing in some cases! For non-healable wounds, such as cancerous ulcers or end of life pressure injuries, Actisorb can provide effective odour control.

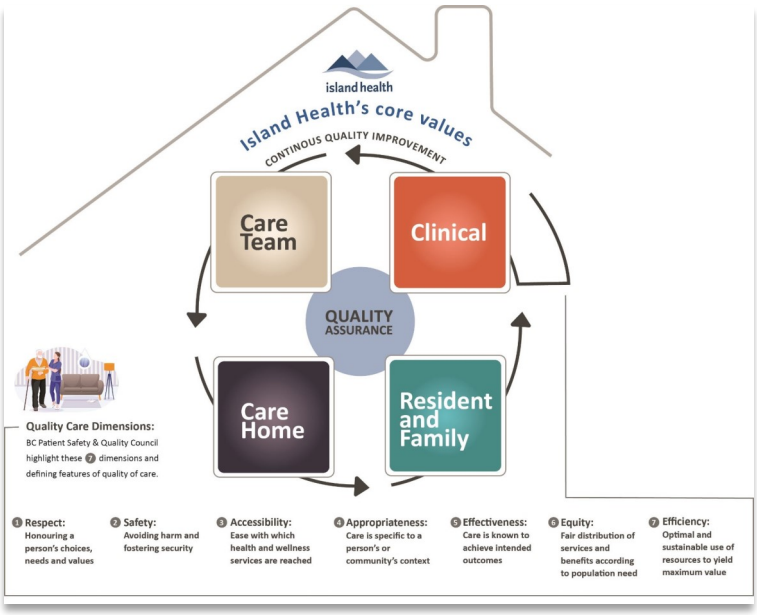
Tips for use:

- Do not cut the dressing
- Can stay in place for 7 days, but may need more frequent changes if large exudate
- If the dressing sticks to the wound you can put a non-adherent interface under the dressing to prevent this (ie. Mepitel)
- Can be used on wounds with scant to large exudate

For more information see the LTC Skin, Wound and Continence webpage.

PRODUCT CORNER

Let's Talk Quality in LTC!



Why is quality so important in healthcare? There are many answers to this question. This article will focus on assurance of and sustaining quality in Long-term Care (LTC).

The Long-term Care Quality Framework was created to define a process and accountability structure to focus on the quality of person-centred care. This is more than just complying with licensing regulations (which is a minimum requirement); it is about providing and supporting four major components that make up the delivery of the service.

With the recent release of two national standards for LTC Services and LTC Operations & Infection Prevention and Control, consider developing a person-centred plan of care based on these standards as it also aligns with the quality framework mentioned above. A third standard is in development based on a publication from 2021 to support the mental health and well-being of residents in LTC.

The Quality Resource Leaders (QRLs) joined the LTC Quality team in October 2022 and have been an integral part of the practical side of quality work. A major focus of their work has been completing annual quality site visits. They review the quality scorecard with site leaders to discuss goals and challenges of planning for quality improvement. The entire LTC Quality team is involved in the Appropriate Use of Antipsychotics (AUA) Initiative with Health Quality BC as part of the pan-Canadian Healthcare Excellence Canada's Re-Imagining LTC Initiative.

In addition to this, QRLs guide affiliate sites regarding relevant Island Health policies and procedures, act as a resource for all LTC homes (60 and counting) in quality improvement planning and provide on-site guidance as requested. They also provide support on trauma sensitive care, harm reduction or behavioural care planning. They collaborate with the teams to dive deeper in understanding resident needs by using available tools e.g. behaviour monitoring (BSO-DOS), resident story (My Story) and the P.I.E.C.E.S.™ approach. By providing this guidance, the care teams gain confidence and experience in developing person-centred plans of care.

The Quality Assurance and Contract Monitoring (QACM) Team is involved in various working groups to support and work on Island Health's strategic outcome goals that are specific to Long-term Care:

Long-term Care Wait Time

- Vacancy Management Pilot
- 7 Day Admission Pilot

Potentially Inappropriate Use of Antipsychotics

- Care Coach Program
- RAI Process Improvement Program
- Evenings and Weekends Activities Pilot

If you have any questions or want to learn more, please contact LTCCoach@islandhealth.ca.

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