Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

island health

March 2024

DID YOU KNOW...

Did you know there are free Wellness Workshops offered by Island Health's Wellness team happening throughout the year? Workshops change monthly and include topics like Workplace Conflict, Government Pensions and Benefits, Managing Finances and Healthy Living. To sign up, search course code 30764 on the Learning Hub.

Least Restraints

There are multiple considerations when restraints are used, such as following the Least Restraint Procedure, safety monitoring, obtaining consent and completing documentation.

Restraints include any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care's freedom of movement in a community care facility. A physical restraint includes anything attached or adjacent to the resident that restricts their movement or access to their own body. It is the effect the device has on the resident that classifies it into the category of restraint, not the name or label given to the device, not the purpose or intent of the device (RAI MDS 2.0 2012).

Seating, positioning and functional devices may be used to address related needs as per an Occupational Therapist (OT) or Physiotherapist (PT) assessment. The purpose and information of how to use the device needs to be clearly indicated. Examples may include seat cushions, and back supports. Proper positioning will reduce the need for restraints. These are not considered restraints but require training prior to use and ongoing monitoring.

To help answer the many questions about restraints, the new LTC Physical Restraint Types Quick Reference Guide has been developed! This document identifies common types of physical restraints used in LTC along with intended use, risks to use, and contraindications. Purchasing and suggested sourcing resource information is also included.

Always follow the least restraint principle, using any type of restraint only as a last resort when all other options have been tried. See the LTC Education and Resources Least Restraints webpage for links to policies, alternatives to restraints resources, FAQs, information for families, and related forms.

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Clinical Documentation

As more sites "go-live" with PowerChart many questions about clinical documentation come up along the way! The good news? There are multiple resources to support your learning needs (or to start preparing for your site's future activation!) The Wiki Cerner page provides detailed curriculums for different roles. This is what has been used for training in South Island and can be used to review or brush up on a specific area of PowerChart.

As well, many Standard Operating Procedures (SOPs) have been developed. The SOPs outline descriptions of the correct way to perform procedures or tasks in PowerChart.

Additionally, "Did you Know?" skills refreshers can be found on the LTC Program Support Website. These newsletters provide a brief review of practice areas that have required clarification. If you can't find the information you are looking for within these resources connect with your site leadership, CNE or PowerCoach (if at a site that has recently "activated.")

Mentorship Quote:

It's great to learn about all of the different resources available to support PowerChart learners. They will be helpful for refreshing our PowerChart skills"

Rhona White, LPN, Dufferin Place

PowerCoaches – Supporting Staff in PowerChart

When an Island Health Owned and Operated Long-term Care home activates with PowerChart, the care team members receive education on how to document and view information in the Electronic Health Record.

After the initial education, on-unit peer mentors and coaches provide elbow-to-elbow support to care team members while they continue to develop their new skills and knowledge. These peer mentors are called PowerCoaches and they are vital to helping our teams solidify their learning in a live PowerChart environment.

As PowerChart activations continue, more PowerCoaches will be needed at the care homes. Supernumerary PowerCoaches are able to devote their time completely to supporting and coaching their co-workers.

PowerCoaches are part of a team that is led by Naomi Sikora who works in consultation with Patti Linden, PowerChart Clinical Nurse Specialist and other site leaders. Naomi delivers specialized PowerChart training to the PowerCoaches to become more skilled in the functionality of PowerChart. This training is in addition to the basic education that all care team members receive. She also provides helpful tips on how to be successful in the role of coach. This extra training makes PowerCoaches a great resource to their colleagues.

Ruby Galanida and Min Wei
Nursing PowerCoaches, The Summit

They are also kept up-to-date with the current initiatives and changes in practice so they can pass this information on during their coaching sessions. Naomi meets regularly with the PowerCoach team members and continues to educate and support them in performing their valuable coaching role.

Some of our PowerCoaches are also now supporting the delivery of the PowerChart education for HCAs and Nurses.

Go, go PowerCoaches!

Test Your Knowledge

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

1.	HCAs may cut and trim uncomplicated toenails if there are no significant risk factors and when a plan of care is present.	A. False B. Nutrition C. Least Restraint Procedure D. True
2.	Always follow the _____ __________ __________, using any type of restraint only as a last resort when all other options have been tried.	
3.	The Undernutrition CAP would only calculate using the resident's weight (kg) value entered into section K2b	
4.	__________ plays a large role in the prevention and management of wounds.	

Putting the P.I.E.C.E.S.™ Together

Molly has Parkinson's Disease and experiences dyskinesia. Her adoring husband joins her for lunch and dinner daily, and her two daughters visit at least weekly. Molly usually walks independently in her room and to the dining room. In the last three weeks, an increase in falls has resulted in a decline in her transfers and walking, needing standby assistance. She often gets up on her own despite staff requesting she call for assistance and becomes frustrated with the frequent reminders. So far, Molly has not sustained any significant injury related to the recent falls. However, she fell and fractured her left hip two years ago resulting in her LTC admission. Her family are very concerned that she will have another fall that will result in serious injuries and are requesting that the team get an order for a wheelchair and waist restraint. The PIECES HCA Care Coach and Practitioner have organized a PIECES huddle using the 3-Question Template:

<table>
<tr><td>Q1 What are the priority concerns; is it a change for the Person?</td><td colspan="2">Increase in falls: 1-2 falls per shift, increased in the last 3 weeks.</td></tr>
<tr><td>Q2 What are the RISKS and possible contributing factors? Think PIECES</td><td>• Roaming: Not identified
• Imminent Harm: High Impact, High Probability
• Suicide Ideation: Not identified
• Kinship Relationship: Low Impact, Low Probability
• Self-neglect: Low Impact, High Probability</td><td>Assessing Degree of RISKS
High Impact Low Probability
High Impact High Probability
Low Impact Low Probability
Low Impact High Probability
Impact of Risk: Low / High
Probability of Harm: Low / High</td></tr>
<tr><td colspan="3">• Physical: Parkinson's with associated dyskinesia; mobility changes; takes levodopa/carbidopa; CHESS Score 3/5 (previous score 1/5)
• Intellectual: CPS 3/6 (previous score 1/6); anosognosia; apraxia; possible amnesia
• Emotional: DRS 0/14; frustration when offered assistance/reminders
• Capabilities: decreased independence; overwhelmed from offers of assistance
• Environment: room has effective lighting and is kept free of clutter; Molly spends much of her time reading in her favourite chair by the window in her room
• Social: very involved family who sees her daily</td></tr>
<tr><td rowspan="2">Q3 What are the actions?
• Investigations
• Interactions
• Interventions</td><td colspan="2">Investigations</td></tr>
<tr><td colspan="2">• OT, PT, Nursing, HCA: review falls to determine patterns (found that falls occur most frequently when getting up to get snacks in her drawer across the room, and going to the sink to refill water cup)
• OT: reassess Standardized Mini Mental State Exam (SMMSE) -showed decrease in score from baseline; assess room layout
• Pharmacy, Nursing, Physician Provider: review medications (i.e. for Parkinson's, etc).
• Dietitian: assess caloric intake; provide more snacks between meals</td></tr>
<tr><td colspan="3">Interactions</td></tr>
<tr><td colspan="3">• Ask (don't tell) Molly if she needs help; provide validation when she becomes frustrated
• Provide visual reminders (signs with pictures at bedside table, and within line of vision when sitting up in chair) to remind Molly to ring call bell for help before getting up</td></tr>
<tr><td colspan="3">Interventions</td></tr>
<tr><td colspan="3">• OT & Care team: Rearrange furniture to minimize distance to drawers and bathroom.
• OT & Nursing: Discuss cognitive changes with Molly and her family (family revealed that they have noticed signs of cognitive decline over time, but did not recognize them as such; Molly admitted she frequently forgets what the care team have told her)
• Care team, Dietitian & Nursing: Ensure Molly has finger food and fresh water within reach at all times</td></tr>
</table>

Outcome: Since the above investigations, interactions, and interventions were put in place, Molly had one fall while getting up to get a new book after she finished the one she was reading. The activities team now brings the library cart around to her room regularly to ensure she always has a new book to read. Molly's husband and children are pleased that the team was receptive to their concerns, and was able to address Molly's needs without the use of a restraint.

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

CORNER

Taking a Closer Look at the Undernutrition CAP

RAI 2.0

A Clinical Assessment Protocol, (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 them create and/or update, a comprehensive, RESIDENT-CENTRED Plan of Care.** There are a total of 19 CAPs which can be 'triggered' upon completion of a RAI-MDS 2.0 full, or quarterly, assessment.

The **Undernutrition CAP** focuses on the nutritional support of adults who are below their ideal body weight, as measured by a low Body Mass Index (BMI), BMI is the ratio of a person's weight to height.

K2	HEIGHT AND WEIGHT	a. (Record height in centimetres) a. HEIGHT (cm.)
		b. (Record weight in kilograms) b. WEIGHT (kg.)
		Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).

After the height (cm) and weight (kg) values are entered into sections K2a and K2b, respectively, of the RAI assessment, the Paris software automatically calculates the resident's BMI.

Question: How is the **Undernutrition CAP** 'triggered' in Paris?
Answer: This CAP can be triggered in two instances*:

- When the **BMI** is between **19-21**, the CAP is triggered at a **MEDIUM** risk
- When the **BMI** is **<19**, the CAP is triggered at a **HIGH** risk

(*Note – if item J5c (end-stage disease; 6 months or less to live) is checked off, the Undernutrition CAP will not be triggered)

When the **Undernutrition CAP** is 'triggered', it should prompt the clinician to find out more information. For example, most triggered persons will likely have one or more risk factors for undernutrition, such as:

- Chewing or Swallowing difficulties
- Dental Problems
- Cognitive and Communication deficits
- Medical Conditions
- Mood Disorders

Anytime the **Undernutrition CAP** is triggered, it's a great idea to consult with your Registered Dietitian. As an expert in nutrition, they can provide valuable information to the health care team. Inter-disciplinary collaboration is often key to creating and implementing a Resident-Centred Plan of Care that works for each resident.

For a more comprehensive discussion about the **Undernutrition CAP**, visit pages 121-125 of the CAPs Manual. The Manual is an excellent resource and an invaluable tool to have in the care-planning process.

*Overall goals of the **UNDERNUTRITION CAP**:*

- *Address underlying diseases, conditions or medications that contribute to undernutrition, or risk of it*
- *Implement a reasonable treatment plan to ensure adequate caloric intake and thus prevent further weight loss*
- *Increase Quality of Life by preventing the negative consequences of undernutrition*

CODING CORNER

You Asked, We Answered

An HCA Asks: Am I allowed to clip a resident's toe nails?

A Clinical Nurse Educator Answers: Upon admission the RN/RPN/LPN (Nurse) will complete an assessment of risk factors. This includes conditions such as diabetes, peripheral vascular disease, nail fungus, significant edema, or open areas. Following this assessment the plan of care will be initiated and if no significant risk factors are present HCAs may cut and trim uncomplicated toenails. It is the responsibility of the HCA to complete daily observations and hygiene care of the feet. Daily observation includes monitoring for open sores or cracks, reddened areas, swelling, nail condition, dry skin and skin discolouration. Any change are required to be reported to the Nurse before the end of the shift and prior to providing foot care or nail trimming. If a resident has diabetes then a nurse with additional foot care education is required. A resident may need to hire a qualified foot care nurse if none are employed by the care home. For additional information see the Foot Care Guideline for Long-term Care.

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

Nutrition and Wound Healing

Wound Wise

Nutrition plays a large role in the prevention and management of wounds. Nutritional deficiencies place the already fragile ageing skin at even greater risk of break-down due to pressure, friction and shear. Malnutrition also impairs wound healing, contributing to wound severity and chronicity.

Contributors to decreased intake include:

Poor appetite	Taste changes
Difficulty chewing	Shortness of breath
Pain	GI symptoms
Meal interruptions	Cognitive status
Medication side effects	

Carbohydrates provide glucose to support cell re-growth.

Protein contains nitrogen, which is essential for wound healing, and the binding material that helps maintain skin integrity.

Fat contains fat-soluble vitamins and provides insulation to protect bony prominences.

Fluids take vitamins to the cells and waste products from the cells and helps to maintain skin integrity.

There are no additional vitamin supplement therapies that have been proven to speed up wound healing, however vitamin deficiencies will delay or stop wound healing. If a diet is deficient in vitamins, then a daily multivitamin may be beneficial.

Existing large wounds with high volume exudate will deplete the resident's nutritional stores.
Protein and fluids are lost in wound exudate and need to be replaced above and beyond the resident's baseline nutritional requirements. Residents with existing wounds should be re-referred to a dietitian for reassessment of caloric and nutritional needs. High-protein and high-calorie snacks are a great way to increase a resident's nutrition in times of need.

Want to learn more? Check out the Skin and Wound: Nutrition and Wound Healing module in the Learning Hub!

PRODUCT CORNER

Atrac-tain

Atrac-tain is an advanced skin care moisturizer for very dry, scaly, cracked skin. It contains 10% urea and 4% alpha-hydroxy acid (AHA). The AHA removes the dead, dry skin, and the urea moisturizes and restores the barrier function of the skin. Those with diabetes or chronic kidney disease are prone to the development of dry, scaly skin build-up on their feet and legs. When this occurs, the resident is at higher risk of wound development, as fissures and cracks appear and progress to open wounds. Bacteria lives and thrives in dead skin and will quickly travel into a crack or fissure, often resulting in an infection.

When should I use it? When you notice the build-up of dry, scaly skin on a resident's feet or lower legs. Note that a resident specific order from Physician/NP/NSWOC/Wound Clinician is required.

When should I not use it? It should not be used as a general, everyday moisturizer or on broken skin. Do not use between toes.

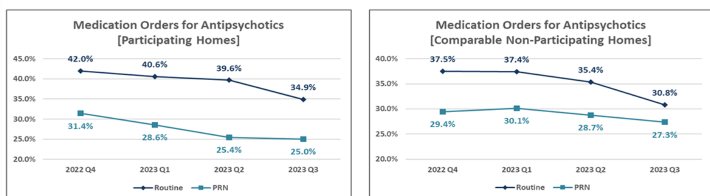
Frequency of application? Apply to area 2-3 times per day and anticipate results within two weeks. Once the dead skin has been removed, discontinue and use Remedy Moisturize to maintain healthy skin.

How to apply? Cleanse to remove any loosened dead skin. Pat dry to remove excess moisture but leave skin slightly damp. Spread/gently rub cream over skin until cream is absorbed.

Did you know? Atrac-tain can also be used on cracked, dry elbows and knees

Reimagining Person-Centred Care in LTC: A Quality Improvement Initiative

This hard work is worth celebrating! In 2023, 18 LTC homes took part in the Reimagining LTC initiative to focus on the Appropriate Use of Antipsychotics (AUA). LTC built two programs to support care teams and participating homes were chosen based on their high metrics for antipsychotics. They chose between the PIECES ™ Care Coach or the Resident Assessment Instrument (RAI) Process Improvement Program. As a result, there has been an increase in the confidence and competence of the care team, a marked decrease in medication orders for antipsychotics, and most especially an increased focus on providing person-centred care.



This has also been noted by the Canadian Institute of Health Information (CIHI) Quality Indicators.

In collaboration with a PIECES Practitioner, Health Care Aides (HCAs) Care Coaches learned the PIECES principles and integrated them at the bedside. They felt better prepared to care for a person experiencing Behavioural and Psychological Symptoms of Dementia (BPSD), learned how to apply person centered non-pharmacological approaches, provided peer to peer mentorship, and continued to enhance these through the Weekly Community of Practice. The care team, including allied health, have also utilized this resource to obtain their input and participation in care conferences and plan of care meetings. This has changed practice to a more team-based approach by allowing each member of the care team to take part in the resident's plan of care. Care Coaches expressed that they have felt more empowered to support and advocate through participation in the conversations about the residents.

The RAI Process Improvement initiative provided educational opportunities for clinicians and HCAs. HCAs received RAI Observation Tool refreshers to improve this process. Clinicians learned about the RAI outputs (Outcome Scales and Clinical Assessment Protocols) which are generated from the RAI assessments. By the end of the year, there was improved competence and confidence to understand the quality indicators.

This resulted in an enhanced collaborative process during the Weekly Plan of Care meetings through more meaningful discussions and improved person-centered plan of care outcomes.

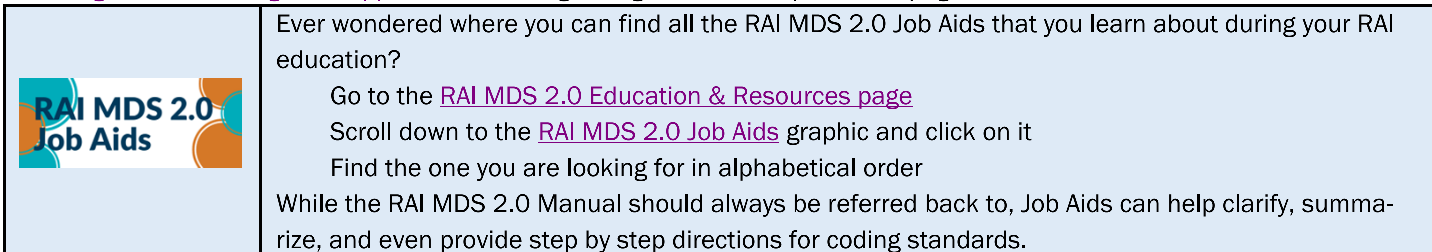
The successes and learnings from both programs will help plan the next steps for sustainability by integrating the person-centred culture and evidence based best practices in the daily care routines. Job satisfaction and improving staff experience has been one of the benefits, along with improved quality of life for residents.

Congratulations to all the participating homes for improving quality in LTC! For more information on this initiative, visit the LTC Program Support intranet page: Quality in LTC.

For the full article with images, visit the News page.

What's New on the LTC Program Support Website?

The Long-term Care Program Support Website, is growing! Our newest published pages are:



Ever wondered where you can find all the RAI MDS 2.0 Job Aids that you learn about during your RAI education?

- Go to the RAI MDS 2.0 Education & Resources page
- Scroll down to the RAI MDS 2.0 Job Aids graphic and click on it
- Find the one you are looking for in alphabetical order

While the RAI MDS 2.0 Manual should always be referred back to, Job Aids can help clarify, summarize, and even provide step by step directions for coding standards.

The Long-term Care Program Support Website is maintained by the LTC CNE Educator 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