Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

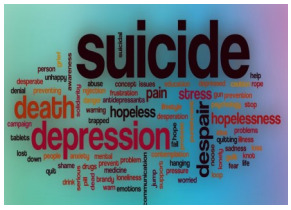
island health

September 2022

DID YOU KNOW...

Staff funding is available for the San'Yas Cultural Safety and Humility course. It is a facilitated online class that provides a foundation for reconciliation within our communities. San'yas Advanced Training—Bystander to Ally (BTA) is offered after the initial core training is completed. BCCNM recently initiated the Indigenous Cultural Safety, Cultural Humility, and Anti-racism standard to guide nursing practice in BC.

Suicide Awareness



Suicidal ideation (SI), often called suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide. A recent report shows that suicidal thoughts are higher since the pandemic began.

The mental and psychological impacts of COVID-19 have greatly affected the lives of those both young and old. Many people lost their social connections and feel more stressed, isolated and helpless which can lead to suicidal ideation. Warning signs of suicide vary from person-to-person. Some may verbalize their plan or thoughts of taking their life, while some may just withdraw from their families, friends and daily activities. Challenging emotions such as anxiety, depression, hopelessness or any significant mood changes can also contribute to suicidal ideations.

safeTALK is an in-person, half-day alertness training that prepares anyone to become a suicide-alert helper. Most people with thoughts of suicide don't truly want to die, but are struggling with the pain in their lives. safeTALK-trained helpers can recognize these invitations and take action by connecting them with life-saving intervention resources.

If you or someone you know is in crisis and need help, resources are available. You are not alone. Call Talk Suicide Canada Hotline: 1–888–456–4566. In case of an emergency, please call 911 for immediate help.

In this Issue

Applying Clinical Documentation to Practice

The Routine Vital Signs in Long-term Care guideline has recently been updated. Numerous physiological and pathological changes can occur with age and alter vital signs, particularly in frail older adults. There can be significant variability in blood pressure measurement when taken as a single, isolated reading. This may contribute to over-treatment of hypertension. Screening for possible orthostatic hypotension on admission helps to minimize the risks of falls and serious injuries. Post-prandial hypotension is common in geriatric residents and an important but under-recognized cause of syncope.

Routine vital signs must be taken:

- Upon admission, daily for 3 consecutive days
- Every 3 months, at a minimum in conjunction with the Resident Assessment Instrument (RAI).
- For acute clinical symptoms or medical conditions that require frequent monitoring
- At the clinical judgement of the LPN/RN/RPN or as ordered by the provider and is resident specific.

Read the guideline to review the steps to obtaining accurate vital signs.

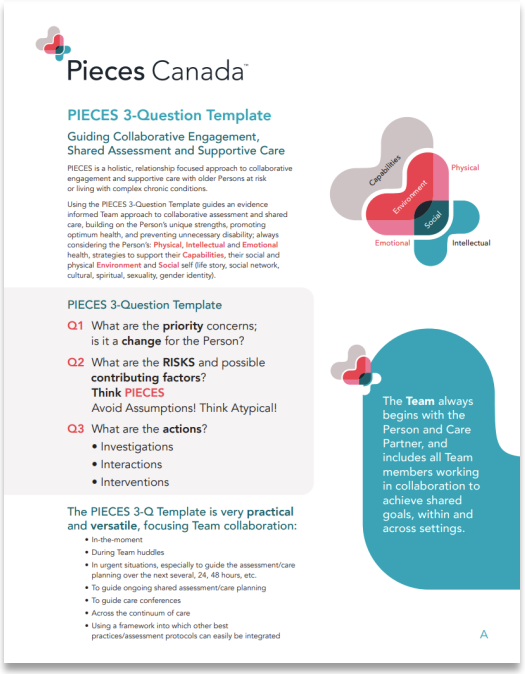
Mentorship Quote:

"Vital signs are an integral part of a resident's assessment. Measuring them is one of the first steps in identifying the cause of a multitude of possible issues."

Chris Grandmaison, LPN, Saanich Peninsula Hospital, ECU 1

P.I.E.C.E.S.™ Updated Curriculum

You may be familiar with the previous P.I.E.C.E.S.™ training or have seen it being applied on your unit. Maybe you have heard the phrase: "Every behaviour has meaning." P.I.E.C.E.S.™ is an approach used by health care professionals to determine the cause of the behaviour in older adults with complex mental and medical health issues. The updated P.I.E.C.E.S.™ curriculum has been designed "in shared support of older adults at risk or living with complex chronic conditions including neurocognitive disorders, mental health and substance use disorders, neurological conditions, physical health issues, and behavioural changes."



The P.I.E.C.E.S.™ 3-Question template provides holistic approaches including non-pharmacological options. Bringing the multidisciplinary team together and using this template can often assist in effective care planning and decreasing inappropriate use of anti-psychotic medications.

What has changed?

- To become a P.I.E.C.E.S.™ practitioner, the training is now 2 days instead of 2.5 days
- The updated BSO-DOS is introduced in the new P.I.E.C.E.S.™ curriculum for direct behaviour observation
- The 3-Question template has been simplified for a "quick 10 minute huddle" on the unit in order to make it easier to utilize in practice instead of requiring a formal meeting

P.I.E.C.E.S.™ training can help members of the team gain confidence in managing behaviours and contribute to the plan of care. It also familiarizes participants with other assessment tools that can be utilized to further assess the resident.

If you're interested in the P.I.E.C.E.S.™ training, let your leadership team know as they receive details about future sessions. They are available routinely via zoom. The LTC CNE Team has been facilitating these sessions for Island Health. Join us in becoming a P.I.E.C.E.S.™ practitioner!

Test Your Knowledge

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

1.	Arterial ulcers will not heal unless blood flow is surgically restored to the limb.	A. False
2.	The ____ ___ provides information to work on specific quality indicators in order to address overall quality of care and quality of life for residents.	B. SafeTALK
3.	To become a P.I.E.C.E.S.™ practitioner, the training is now 2.5 days.	C. heat map
4.	_____ is an in-person, half-day alertness training that prepares anyone to become a suicide-alert helper.	D. True

Exploring Depression Through P.I.E.C.E.S.™

Milly Gomez is an 87-year old resident with Alzheimer's disease who moved to the facility five months ago. She has recently started to feel sad and lonely. She wishes she could be with her husband who died a year ago. She misses her home and her past life with her husband. She recognizes that she feels lonely, but doesn't have the energy to meet new people. The care team notices she is napping for longer periods during the day and isn't participating in activities as much as she used to. The team uses the P.I.E.C.E.S™ 3 Question Template to guide their assessment.

1. What are the priority concerns? Is it a change? Milly is sad and lonely; withdrawing from her usual activities and interests. She doesn't want to meet new people, lacks energy and is napping more often. These mood indicators are all new in the last month.

2 . What are the RISKS and possible contributing factors (P.I.E.C.E.S.™)?

Roaming—No
Imminent Harm—No
Suicide Ideation—Possibly, stated wants to be with her deceased husband
Kinship Relationships, risk of harm—Yes, not interested in meeting new people
Self-neglect—Yes, sleeping more, less physical activity

Physical—Alzheimer's disease
Intellectual—Cognitive Performance Scale (CPS)= 2/6; mild impairment
Emotional—Depression Rating Scale (DRS) = 5/14; potential or actual problem with depression
Capabilities—Requires assistance and cueing with ADLs and daily routine
Environment—New to care home; living with people she doesn't know
Social—Index of Social Engagement Scale (ISE)= 1/6, not engaged with others or activities

3. What are the Actions? A plan of care was developed to address Milly's mood and psychosocial needs.

Date	Focus	Desired outcomes S.M.A.R.T.	Intervention (Who, What, When) All care team members will:	Evaluation date	Initial
Sept 15/ 22	Mood/ Behaviour	Milly's mood will improve as evidenced by decrease in her DRS to be less than 3/14 by next RAI in October	• Suicide Risk assessment completed using IS PATH WARM • The BSO-DOS was used for ongoing monitoring of her mood and behaviour • Care team to do Geriatric Depression Scale • Care team to follow Suicide Risk Assessment for Long-term Care guideline and recognize suicide warning signs • Review and identify Milly's positive key Protective Factors • Inform MRP of resident's mental health status	Oct 15/22	L.S.
Sept 15/ 22	Psychosocial	Milly will engage in life of the care home as evidenced by improved ISE by next RAI in October	• Social Worker to check in and provide counselling support to Milly • Rec Therapy to invite resident to participate in activities of interest • All team members to encourage Milly to form relationships with other residents	Oct 15/22	L.S.

Outcome: The team implemented the interventions of the plan of care. With the encouragement and support of the team, Milly has started to connect with more people in the care home. Her mood has been improving. She has more energy and is enjoying life more.

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

The RAI Observation Tool – Collaboration & Communication at Work!

RAI 2.0

WHAT: The RAI Observation Tool is a tool used by Health Care Professionals (HCPs) to gather information about a resident. Like the name suggests, the tool should be used to record what the HCP **observes**. The observations are recorded for each of the three shifts in a 24-hour day, for a 7-day period. The information on the tool is then used by clinicians to help them complete certain sections of a resident's RAI assessment, with each resident having such an assessment every 3 months.

WHO: Typically, it's often a combination of Health Care Aides and Rehab/Activity Aides that play a major role in observing resident function during the 7-day assessment period. However, by no means are they the only members of the care team who can contribute. In fact, it is hoped - and expected - that many HCPs, including clinicians, are involved in information gathering to ensure an accurate and complete Observation Tool.

WHY: It's important to remember the reason for using the RAI Observation Tool. Ultimately, the care team is gathering as much information as possible to enable the creation and development of a person-centred, individualized care plan to help HCPs deliver safe and quality care to each and every resident.

FINAL CHECK: The last row on page 2 of the Tool requires the nurse (RN/RPN/LPN) to place their initials in the box for that shift, signifying that s/he agrees the information on the Tool is accurate and correct.

HCA Initials														
RN/RPN/LPN Initials This indicates that both sides have been reviewed with IPT														

Collaboration & Communication with all members of the inter-professional team (IPT) is essential in order to complete an accurate RAI Observation Tool

CODING CORNER

You Asked, We Answered

An HCA asks: Are there HCA to LPN bridging programs available on Vancouver Island?

A Clinical Nurse Educator Answers: Yes, there are HCA to LPN bridging programs currently available. Entry requirements generally include Grade 12 graduation with select courses. Current registration as Health Care Assistant (HCA), Resident Care Attendant (RCA) or Home Support/Resident Care Attendant (HS/RCA) in BC is required. Applicants must have 600 hours of verified work experience in Long-term Care, Acute Care, Home Care or Hospice Care with multiple residents at once.

North Island College (Comox Valley) and Discovery Community College (Campbell River and Nanaimo) offer bridge programs that enters into Level 3 of the Practical Nursing Program. The next intakes are November 2022. Vancouver Island University (Nanaimo) is currently developing an HCA to LPN bridging program and are hoping to offer it in May 2023.

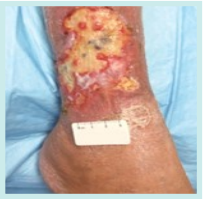
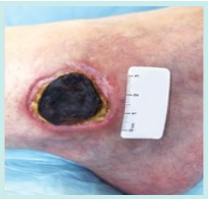
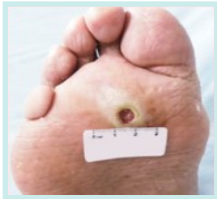
The provincial government is offering bursaries for close to 300 students that are enrolled in select Access to Practical Nursing programs. Students attending North Island College between November 2022 to May 2024 and Vancouver Island University between May 2023 to May 2024 are eligible for the bursary.

Lower Limb Wounds, an Overview– Part One

Wound Wise

Some of the most challenging wounds in Long-term Care are those that occur below the knee. There are several causes of lower limb wounds, and identifying the type of wound can be difficult. These wounds are often caused by pressure or minor trauma and are treated according to ulcer type: **arterial, venous, or neuropathic.** Lower limb wounds require specialized assessments and treatments due to their complexity, difficulty to heal, and risk of developing serious consequences such as osteomyelitis, sepsis and amputation.

Before we delve into how to determine wound type, (will be featured in the next newsletter), let's review the categories of lower leg wounds.

ULCER TYPE		
Venous	Arterial	Neuropathic
		

Arterial ulcers: These wounds are often caused by minor bumps or scrapes. The minor wound deteriorates due to inadequate blood flow caused by plaque build-up in the arteries. Healing is compromised because there is not enough oxygen getting to the wound (tissue ischemia). These wounds will not heal unless blood flow is surgically restored to the limb.

Venous ulcers: Occur when the venous wall and/or valves in the leg are not working effectively making it difficult for blood to be pumped from the legs to the heart. This results in pooling of venous blood in the extremities and edema. Ulcers usually start from minor trauma and **are hard to heal without compression**. Those with both arterial and venous disease may not be suitable for compression treatment. Tests must be done to determine level of arterial blood flow to the limb prior to starting compression.

Neuropathic (diabetic) ulcers: Loss of sensation, changes to the structure of the foot, and changes to blood flow put the resident with diabetes at high risk of developing a diabetic foot ulcer. Decreased sensation in the foot can result in a resident not recognizing: that ill-fitting footwear is rubbing and causing pressure; a pebble in their shoe is causing a wound; or that they need to move their legs in bed because their heel is sore. Again, these wounds are caused by pressure or minor trauma, and they **will not heal unless the wound is offloaded completely from any pressure source.**

Mixed ulcers: A lower limb wound may have more than one of the above factors contributing to it:

- ***Neuroischemic ulcers***- a mix of neuropathic disease (diabetes) and arterial compromise
- ***Arterial venous ulcers***– a mix of arterial and venous compromise

For the next issue, you will be introduced to the basic lower limb assessment form, and discuss why, how and when to use it. Stay tuned!

PRODUCT CORNER

Did you know we have four different Mepilex dressings to choose from?

Mepilex –a foam dressing that may be cut, with no tape border and a silicone non-adherent layer over the absorptive pad; best used as a primary dressing on painful or fragile wounds with moderate to large amounts of exudate; needs tape or cling gauze to hold in place

Mepilex Border Flex –a foam dressing with a silicone tape border and silicone non-adherent layer over the absorptive pad; cannot be cut; not to be used with skin prep; for use with painful or fragile wounds with small to large amounts of exudate

Mepilex Border Lite—similar dressing to Mepilex Border Flex but designed for wounds with scant to small exudate

Mepilex Lite –similar dressing to Mepilex, but designed for scant to small amounts of exudate

Sustainability of Improvement

This is part four of the 4-part series on Quality Improvement, sustainability of improvement.

Part 1—Process for improvement (PDSA)
Part 2— Measurement
Part 3— Drivers and process mapping

When a new change idea has been tried, tested and true, how do you make it stick?

A problem in the system was identified, worked on using the tools described in previous articles (links provided). Now, it is time to ensure those efforts are celebrated and valued to sustain the improvement! One way to do this is to think about spreading the improvement to another similar area or unit. This will help build confidence for others who have the same problems in their unit. For example, inappropriate use of anti-psychotics is a problem to address when one is looking at managing behavioural and psychological symptoms of dementia. The heat map provides information to work on specific quality indicators in order to address overall quality of care and quality of life for residents. But it doesn't always demonstrate the great work happening at site or resident level in real time.

If a LTC site has successfully sustained an improvement, spreading that improvement idea to another site will help build system level improvement in increments. This is scaling up the Plan-Do-Study-Act cycles! Imagine the power in spreading improvement that is sustained! This circles back to the quality planning domain in whole system quality. As noted in the January 2022 article on quality planning, to address a key priority, we will be launching a program wide initiative on Appropriate Use of Anti-psychotics (AUA) soon. Stay tuned on information through the LTC Quality Council and other forums for further announcements on this work! The form and function of this work will be similar to the AUA work at Alberta Health Services based on the Institute of Health Improvement's Learning Collaborative.

Here is an interesting resource when working on quality improvement changes in your area of work:

The NHS resource on spread and sustainability is based on 10 key factors below in the infographic.

The detailed resource provides rich information based on both systematic and non-systematic reviews.

The next issue will be about quality control—the third domain of whole system quality. It is the driver for sustaining improvements.

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