island health

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DID YOU KNOW...

There are plans to change Island Health employee email addresses from @viha.ca to @islandhealth.ca on September 28th. There will be a transition period where emails will still be received with your @viha.ca address. Following that period you will need to update your email address if you have subscribed to outside sites or newsletters.

Between the Lines

Long-Term Care Program Newsletter

Clinical Documentation and RAI updates to keep your practice current

In this Issue

HCAP –How is it Going?

I'm the Roving Reporter here at The Summit asking how the Health Care Access Program (HCAP) is going?

Reporter: *What do you like about being a Health Care Support Worker (HCSW) in the HCAP?*

HCSW: I love having time to chat with, sit by or listen to residents especially those who don't have friends or family who can visit. I like the variety of roles we can do within our scope. One of my favourite activities is connecting with the residents on the way to music concerts in the courtyard. As I alternate going to college and working at the Summit, our conversations with residents bring our course work to life!

Reporter: *What would you like to see more of within the program?*

HCSW: I would like more education on communicating with residents and to work the same shifts as our peer mentors.

Reporter: *As a CNL leading the site HCAP, how is it going?*

CNL: It's going great! There are over 200 HCSWs in owned and operated sites. There are more than 30 at The Summit. The students are appreciative of this career opportunity in healthcare. They are keen and find the work/study program is an excellent balance for them. Our goal is to make each resident's day special. We draw from social histories on PowerChart and our huddles to create meaningful conversations. Making these connections is what makes our work so rewarding!

Thank you to Janice Mangano, CNL, for this article and for supporting the success of the HCAP.

Applying Clinical Documentation to Practice

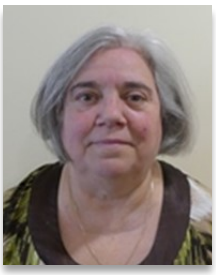
Suicide risk after age 65 is high with men aged 85 and older being at greatest risk. There are factors unique to older adults which put them at increased risk. These include loss of self-identity, loved ones and home as well as increased dependence on others, unmanaged pain, and alcohol or other substance use. Suicidal ideation and planning usually occur at length before attempts are made.

Warning signs need to be monitored closely. Significant behaviour or mood changes indicative of depression should be investigated. Common indicators include loss of interest in previously enjoyed activities, withdrawal from family and friends, changes in sleeping or eating habits and statements of hopelessness. Threatening to hurt or kill oneself or talking about a suicide plan needs to be treated as an emergency. It is important to be aware of the suicide screening tool IS PATH WARM. Refer to the Suicide Risk Assessment for Long-Term Care guideline for further information.

If care team members are concerned a resident may be at risk of suicide, this needs to be addressed immediately.

It is important to keep in mind that working with suicidal residents may be triggering for staff and self care should be encouraged.

Mentorship Quote:
"This is a difficult topic and it makes me want to investigate further on this subject of suicide assessments in the elderly."



Joanne Amberson
Activity Coordinator
Yucalta Lodge

Choosing a Depression Scale

Depression is a common diagnosis for older adults in LTC, but it is not a normal part of aging. Timely and accurate identification and assessment of symptoms related to depression is important in order to provide treatment and develop an appropriate plan of care.

The RAI-MDS 2.0 Depression Rating Scale Outcome Score (DRS) can be used as a clinical screen and a score of 3 or more may indicate a potential or actual problem with depression.
There are many secondary assessment scales and tools that can be used following initial screening. The DRS is validated against the Hamilton Depression Rating Scale, the Cornell Scale for Depression in Dementia, and the Calgary Depression Scale. The Beck Depression Inventory and the Geriatric Depression Scale are also available and appropriate for use with older adults.

But with so many options which one should you use?

In Island Health LTC, the most commonly used tools are the Cornell Scale for Depression in Dementia and the Geriatric Depression Scale. The Cognitive Performance Scale (CPS) will help you to determine which tool is appropriate.

The Cornell Scale for Depression in Dementia is approved for moderate to severe dementia (CPS 3-6) and it requires observations and subjective information in 19 domains from the older adult's caregiver which could be family or a staff member.

The Geriatric Depression Scale (Short Form) is appropriate for older adults experiencing mild or no cognitive impairment (CPS 0-2) and consists of 15 self-reported domains.

While these tools are designed to be carried out by a healthcare professional, they are not diagnostic. They are useful in establishing a baseline to compare mood and behaviour changes. They also provide a standardized common language when reporting concerns to a physician or psychiatrist for a formal diagnosis.

Test Your Knowledge

Match the answer to the statement that best describes it, then check your answers on page 4.

1.	The Geriatric Depression Scale is appropriate to screen for depression for a resident with a CPS score of 1.	A. False
2.	Forming _____ with residents is one of the highlights of the HCSW experience.	B. holistic approach
3.	Women over 85 are at a higher risk of suicide.	C. connections
4.	Whole system quality is a _____ _____ to quality activities based on three domains.	D. True

Putting the P.I.E.C.E.S.™ Together

Lucy is a 66-year-old resident at the Paradise Meadows Long-term care home. She requires care and support following a motor-vehicle accident (MVA) six months ago. She sustained a concussion and a spinal cord injury which resulted in paraplegia. She also lost her husband in the accident. She moved to LTC after a long hospital stay. She is dependent for her ADLs and can make decisions about her care. Recently, her mood has been low and she started on antidepressant medications one week ago. She stated to the care staff that she plans to drive her power mobility chair into traffic. She expressed that she has nothing left to live for and wants to join her husband. The Team, uses the P.I.E C.E. S.™ 3 Question Template to guide their assessment. They also completed a review of Lucy's Key Protective Factors to highlight positive aspects of her life that can be incorporated into her plan of care.

1. What has changed? Lucy has been expressing suicidal ideations with a plan, recently lost her husband, lost her independence, sustained a spinal cord injury and just moved into the Long-term care home.

2 . What are the RISKS and possible causes?

Roaming— No

Imminent Physical Harm— Yes, frailty post MVA; suicidal ideation with a plan

Suicide Ideation— Yes, expression with intent and a plan

Kinship Relationships, risk of harm— Yes, not connecting with other residents possibly due to age differences; withdrawal from family and friends

Self-neglect— Yes, due to depression; declining some meals and assistance with hygiene

Physical— Diagnosis of paraplegia requiring assistance with ADLs; incontinent of bowel and bladder

Intellectual—Cognitive Performance Scale (CPS) 2/6 (mild impairment); capable of daily decision making

Emotional—Depression Rating Scale (DRS)= 10/14; started on antidepressant medication one week ago; grieving loss of husband

Capabilities— Able to make decisions; can participate in some of her ADLs

Environment— Lack of privacy; missing her home and living independently

Social— No contact with family and friends; recent loss of husband; not participating in the life of the care home

3. What is the Action? The following strategies are discussed at the team huddle to consider for the plan of care.

Interventions:

- Suicide Risk assessment completed using IS PATH WARM
- Care team to do Geriatric Depression Scale
- Care team to follow Suicide Risk Assessment for Long-term Care guideline and recognize suicide warning signs
- Refer to Social Worker for grief counseling support
- Inform MRP of resident's mental health status

Interactions:

- Review and identify Lucy's positive Key Protective Factors
- Continue to encourage Lucy to form relationships with other residents
- Recreation department to invite Lucy to activities of interest
- MRN to contact family and provide education and support
- MRN to refer to Mental Health Services for expertise

Information:

- Social Worker to provide resident with information about support groups for people with spinal cord injuries
- Care team members to receive education on suicide risk assessment

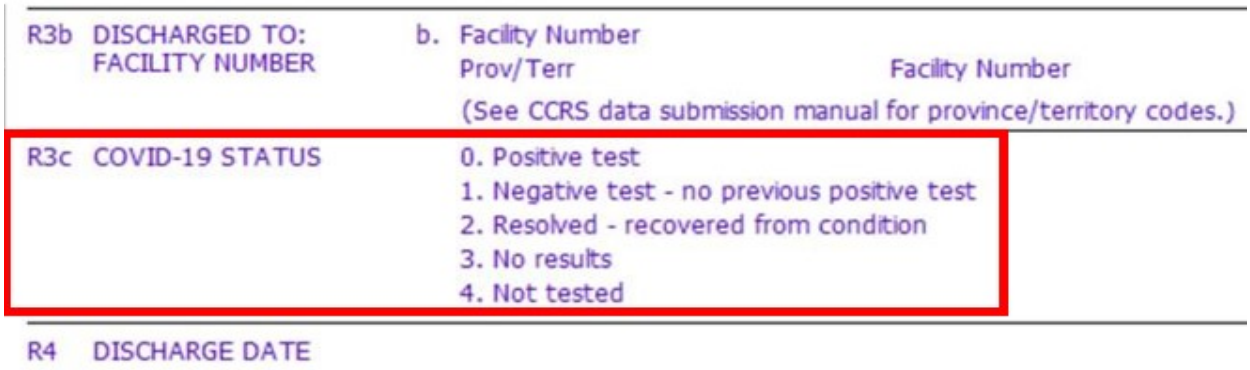
Outcome: After two weeks since antidepressants taking effect and mental health support provided, resident's mood and affect has improved. Care team continues with ongoing monitoring and support.

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

RAI Coding Corner

RAI 2.0

After the PARIS upgrade scheduled for this month, Nursing Unit Assistants (NUAs) will see a revised DISCHARGE FORM which will include one new data element – **R3c** (see image below). The purpose of this new field is to record every resident's COVID-19 status at discharge. The collection of this additional information has been mandated by CIHI.



In order to collect this information, NUAs will need the assistance of a clinician, most likely a member of the nursing team, to complete **R3c.** This means the clinician will need to go into PowerChart and see if the resident has had a **COVID-19 test within 92 days of their discharge date.**

For additional information about how to accurately answer the new R3c field, a CIHI FAQ document has been recently added to your facility RAI 2.0 user manuals. Should you have any further questions, please consult with your site CNL or CNE.

CODING CORNER

Introducing Our New Clinical Nurse Educator!

We welcome ***Nicole Biagioni***, our new interim Clinical Nurse Educator at Trillium and Eagle Park!
She graduated in 1995 from Thompson Rivers University in Kamloops and has background in Psychiatry, Crisis Intervention and Maternal/Child.

Nicole transitioned from Maternal/Child to LTC in 2013 in order to have work in the Oceanside area and keep up with her four sons. At work, she is focused on learning her new educator role and is committed to being part of the team to create safe resident care and quality living in LTC.

At home, she enjoys outdoor fun and time with family and friends. Her future goals include further education and leadership learning with Bloomberg Faculty of Nursing. Her current goals include overcoming the information technology gaps after being frontline for 27 years!

Welcome **Nicole**!

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

Quality – Systems Thinking

What does quality mean? When one thinks about quality, it is centred on how one feels from receiving or purchasing an item or service. We all want to feel valued, listened to, be comfortable, safe and have our needs met. For quality to be upheld and continuously monitored, we have to look at systems and how each component is related in effecting quality.

The Institute of Healthcare Improvement (IHI) published a white paper to rethink what quality means in healthcare. "Whole system quality is a holistic approach to quality activities based on three domains: quality planning, quality improvement and quality control/assurance (see Figure 1). It is about meeting the needs of the customer rather than just eliminating defects in the system. Customers are categorized into two groups. The primary customers are those who are most impacted by quality work i.e. patients, larger community that the health system serves and the workforce who engage in the quality activities. The secondary customers are payers, regulators, partners and other stakeholders who make it possible for delivering quality, continuously, reliably and sustainably."

Figure 1. Three domains of whole system quality, IHI

Our lives were turned upside down in early 2020 with the onset of the COVID-19 pandemic. The safety measures that needed to take place in Long-term care required mass coordination and participation from all of our care operators and partners. We can confidently say that the systems-wide engagement and collaboration that every person working in Long-term care participated in, helped keep the case numbers low. We learned so much from this experience and want to continue to learn and improve on various aspects of resident-centred quality for Long-term care.

As Director for Quality Assurance and Contract Monitoring, my role is to hear your feedback, ideas, strategies and input to make systems-wide quality practices in Long-term care that are continuous, reliable and sustainable as the Institute of Healthcare Improvement describes. We need your participation and collaboration to help the residents and families receive quality in the system. Together with all of you, we can grow, learn and innovate to provide excellence in resident care experiences. We all choose to work in healthcare because we care and we want to promote healing and health.

This quote speaks to each citizen's role in society to promote health for all:

"There is no wealth but life. Life, including all its powers of love, of joy, and of admiration. That country is the richest which nourishes the greatest numbers of noble and happy human beings; that man is richest, who, having perfected the functions of his own life to the utmost, has also the widest helpful influence, both personal, and by means of his possessions, over the lives of others." John Ruskin, English writer and philosopher

Contact our team to express your interest in getting involved or to give feedback and share ideas at LTCCoach@islandhealth.ca or directly to me at jaeyon.jones@islandhealth.ca and/or attend our Long-term Care Quality Council/Clinical Practice Council meetings.

Submitted by: Jae Yon Jones, Director, Quality Assurance and Contract Monitoring Long-term Care, Island Health