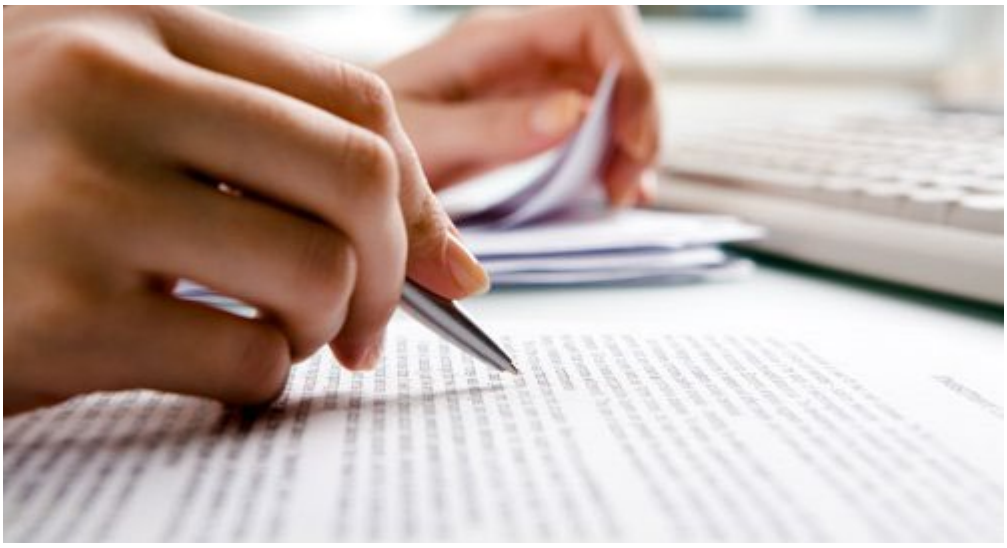
# CLINICAL RESOURCE MANUAL



# Long-term Care Services

Version 19: Nov 2024

*Please note this document is provided as a guide and is subject to change without notice. This document shall be updated bi-annually.*

*The Fraser Health Long-term Care Clinical Practice Advisory Group and the Regional Clinical Practice Team is acknowledged for the development of this document.*

**To suggest a revision to this document or to update your contact information send an email to:**

LTC.ClinicalServices@fraserhealth.ca

## Territory Acknowledgement

- **"We recognize that Fraser Health provides care on the traditional, ancestral and unceded lands of the Coast Salish and Nlaka'pamux Nations and is home to 32 First Nations within the Fraser Salish region."**

# Table of Contents

# Introduction and General Information

The purpose of this resource manual is to support you in your role as Clinical and to highlight the many resources available within Fraser Health to support clinical practice and quality assurance and improvement within your care community setting. While this manual gives you a great start, it is not meant to be comprehensive. To supplement this manual, other resources are available through the Fraser Health Long-term Care Contracts and Services Extranet SharePoint site, the Learning Hub and the Fraser Health website.

- Long-term Care Contracts and Services Extranet (Registration required for access – see page 5.)
- The Learning Hub
- Long-term care

In your role, you will connect with a variety of professionals and teams in Fraser Health including:

- Community, Access and Transitions Coordinators (CAT)
- The Long-term Care & Assisted Living Network Committee
- Local Community Networks
- Medical Directors
- The Long-term Care Clinical Practice Advisory Group
- Long-term Care Clinical Nurse Educators (CNE)
- InterRAI Educators
- Nurses Specialized in Wound, Ostomy and Continence Care (NSWOC)
- Long-term Care Clinical Nurse Specialists (CNS)
- Infection Prevention and Control Specialists (IPC)
- Director of Care (DOC) Groups
- Quality Partners (QP)

## A Culture of Caring in Fraser Health Long-term Care

**What is Culture?**

Culture is the way we think, our values, our attitudes, our perceptions and our beliefs. It's "the way we do things around here". We make decisions and behave in accordance with our culture. Shared values and beliefs shape our expectations of ourselves and of others and govern our actions. Over time, these actions become patterns which evolve into normal behaviour. [1]

**Why Does Culture Matter?**

Culture is the way we work together and interact with our residents, families and each other. By being aware of what values and beliefs are important to us in Long-term Care we can join together in creating a community of teamwork, safety and trust, with residents, families and staff as partners. A unified team working in alignment with a positive culture can more easily find solutions to problems, experience better outcomes for residents and feel "cared for" while at work. We can make decisions

based on our culture, knowing that if we have made a decision that aligns with our culture we have likely made the very best choice.

**How Can We Influence Culture?**
Leaders, both formal and informal greatly influence culture. What we choose to recognize becomes what is important to the organization. Finding ways to "fan the flame" of culture change in various ways at various times on an ongoing basis will, over time, help embed the culture you want to see grow.

[1] *BC Patient Safety & Quality Council (Oct. 2013) Culture Change Toolbox: Long-term Care*
"Walking the talk" will also have a major impact. Leaders who demonstrate their commitment to a resident-centred culture through actions or patterns of behaviour will see positive results. But what are the culture principles that will help advance resident-centred care?
Fraser Health has identified Respect, Caring and Trust as the three core values of our organization. To further shape a culture that reflects resident-centred care, Fraser Health Long-Term Services has expanded on these values by introducing six priority principles that we want our residents, families, staff and volunteers to experience.

**Caring Practice -** Every moment matters

**Physical Environment -** The place that helps me be all I can be

**Community -** It takes a village

**Leadership -** Together we can

**Trust -** Everything about me, with me

**Outcomes -** Driving innovative change

## About Long-term Care in Fraser Health

Long-term care services is for adults who meet Long-term care eligibility criteria and who can no longer live safely or independently in their own homes because of their complex health care needs. Fraser Health operates 16 sites and funds 66 additional long-term care communities (affiliated sites), which together accommodate more than 8400 adults throughout Fraser Health communities from Burnaby to Hope.

Some long-term care communities offer respite and convalescent care as well.

Other Fraser Health programs also offer short and/or long-term care including Hospice, Acquired Brain Injury (ABI), Group Homes and Mental Health.

## Fraser Health Long-Term Contracts and Services Extranet

The Fraser Health Extranet is a SharePoint site where Clinical Decision Support Tools and other clinical resources developed and/or promoted by Fraser Health are stored.

All Clinical and Operational Leaders should utilize the FH Extranet SharePoint site. Please contact the Fraser Health Long-term Services Administrative Assistant using the email address below and you will be provided with the appropriate registration forms to complete for access to the SharePoint site.

Email: LTC.ClinicalServices@fraserhealth.ca

## Guidelines for Using Fraser Health Documents

Fraser Health freely shares decision support tools (DSTs) in an effort to assist affiliated sites wherever possible to adopt best practices. Many DSTs are readily available on the Extranet. If the information you are looking for is not posted on the Extranet and there are no other sources available you may contact the CNE in your area to help you.

Permission to adapt or adopt a Fraser Health DST for use at your site is granted providing that:

(a) It is not used for commercial or for profit purposes
(b) The essence of the content remains the same
(c) The following statement appears as a footer at the bottom of each page

© [year] Fraser Health. Adapted with permission or © [year] Fraser Health. Reproduced with permission.

Note: Fraser Health preprinted physician orders (PPOs) must NOT to be amended due to the extreme risk associated with that practice.

## Performance Indicators

The Long-term Care & Assisted Living Network Committee oversees clinical quality and operational indicators for Fraser Health Long-term Care Services. The indicators are reviewed on an ongoing basis to identify opportunity for continuous improvement. The current Performance Indicators are listed in the chart below:

| No | Measure Name |
|---|---|
| 1 | % of Residents With Physically Abusive Behaviors |
| 2 | % of Residents Using 9+ Different Medications |
| 3 | % of Residents With Urinary Tract Infection |
| 4 | % of Residents On Antipsychotics Without a Diagnosis of Psychosis |
| 5 | % of Residents In Daily Physical Restraints |
| 6 | # of Unscheduled ED Transfers Per 100 Residents |
| 7 | % of Residents Who Had Stage 2-4 Pressure Ulcers |
| 8 | % of Residents Who Died in Long Term Care Facility |
| 9 | % of Residents Who Fell In The Last 30 Days |
| 10 | % of Residents With Pain |
| 11 | Average Vacant Bed Turnaround Time (In Days) |
| 12 | CIHI RAI Accepted Assessments Rate |

It is the responsibility of each care home to support and monitor clinical quality and take action to ensure residents receive high quality of care. Site based quarterly reports are sent by Fraser Health to

Administrators and Clinical and Operational Leader. If you are not receiving these regular reports you may need to update your contact information by sending an email to bindu.mohan@fraserhealth.ca

## The Long-term Care & Assisted Living Network Committee

The Long-term Care and Assisted Living (LTC-AL) Network Committee is a clinical quality committee that provides strategic clinical direction and monitoring for the network of Long-term Care and Assisted Living services. The Network team takes a regional perspective rather than an individual community view. The Network monitors and reports on clinical performance targets related to areas of focus determined by the Fraser Health Clinical Operations Committee.

LTC-AL Network Terms of Reference, meeting minutes and current LTC & AL Network goals can be accessed on the Long-term Care Contract & Services Extranet

## Local Community Networks

Most communities have developed or are developing local community networks to create a forum for communication and problem-solving. While community networks may vary slightly in composition, most have acute care, long-term care, home health and Division of Family Practice representatives. Their goal is to maintain a high standard of care and service to community residents by reviewing performance from a community perspective and responding to opportunities to improve.

## Teams Meeting

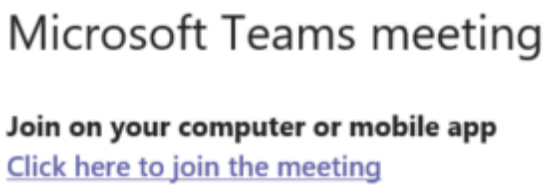
Fraser Health uses Teams for Business as a meeting and webinar platform. From time to time you will be invited to join a Teams for Business meeting or will want to register for a webinar that becomes available. Click on "Join now", embedded within the Outlook meeting invitation:

### Join from a mobile device

If you are using your mobile device for the first time, you will have to install the Teams app on your mobile device.

- On your **corporate device**, install Teams from the Fraser Health Catalogue app.
- On your **personal device**, download Teams from your mobile phone's app store.

1. Open the Calendar meeting or email invite.
2. Underneath the Microsoft Teams meeting heading, click **Click here to join the meeting**.
3. The Teams app will launch. Select whether to turn your camera and microphone on or off.
4. Click **Join now** to enter the meeting.




If you have any difficulty, accessing or opening Teams for Business please submit a request for assistance to LTC.ClinicalServices@fraserhealth.ca.

## Unifying Clinical Information (UCI)

To help support our contracted sites in ensuring continuity of care, Fraser Health has developed the Unifying Clinical Information (UCI) Network. This is a web application and clinical viewer which provides an integrated view of data pulled from our internal systems and is available to Fraser Health affiliated LTC and AL employees.

UCI provides you with quick access to your resident's health information and allows you to see:

- Acute care records, including emergency records, consults and discharge summaries
- Diagnostic imaging reports from all public facilities
- Community documents, including home health, mental health & substance use and public health
- Provincial lab results, including all public and private labs
- Medical orders for scope of treatment documents
- BC Cancer Agency documents
- BC Children's and Women's documents

The UCI Network can benefit you by:

- Increasing access to relevant resident information
- Decreasing time to access and review resident information
- Decreasing time to share resident information
- Decreasing duplication of clinical treatments and service provisions

For further information, please contact **UCI [FH] <UCI@fraserhealth.ca>**

To request access for UCI enrollment please reach out to:

LTC Care Communities: Site Administrator at uci.useraccess@fraserhealth.ca

AL Care Communities: Stephanie Costelo, Administrative Assistant at stephaniekith.costelo@fraserhealth.ca

## Medical Support

Long-term care in Fraser Health follows a dyad-leadership model consisting of the Director of Care (DOC) or Manager and Care Community Medical Director (CCMD) who are closely partnered in a shared and complementary decision-making relationship with common performance targets.

## Why Dyad Leadership?

The Dyad Model effectively brings together clinical and administrative information for efficient decision making and action. The principal goal of the dyad is to allow both leaders to make quick decisions in tandem and to problem solve together with clear responsibilities.

As a Clinical and/or Operational Leader, you need to know:

- Who your Care Community Medical Director (CCMD) is
- The roles and responsibilities of a CCMD
- The number of sessions allocated to your CCMD to support the care community so that the Clinical and/or Operational Leader and CCMD can work together to ensure organizational goals and objectives are met within the allocated sessions
- Who the Medical Leader is for your regional area (Fraser North, Fraser South and Fraser East)
- Who the Physician Leadership Team is and the practice areas covered

- Who the group of physicians/nurse practitioners (NP) are that are assigned to provide care at your care community
- Who your Geriatric Psychiatrist is, if applicable
- Who your Community Older Adult Mental Health team is, if applicable
- Who the local Division of Family Practice Long-Term Care Initiative (LTCI) Physician Lead is
- Who the local Division LTCI Administrative Lead and Executive Director is.
- What the priority education areas are for the local LTCI group
- What LTCI meetings or activities you might be engaged in to support quality of care

Each community has a Division of Family Practice. In 2015/16, the Family Practice Services Committee implemented the LTCI provincially which works through the Divisions to ensure all long-term care residents have a Most Responsible Practitioner (MRP).

The intention of the LTCI is for family physicians and nurse practitioners working in long-term care, via the Divisions of Family Practice, to collaborate with long-term care communities and regional health authorities to ensure quality care is being provided to residents while supporting practitioners in working together.

The LTCI has five best practice expectations for physicians that are the pillars in which medical support is provided in long-term care:

- 24/7 availability and on-site attendance when required
- Proactive visits to residents
- Meaningful medication reviews
- Completed documentation
- Attendance at case conferences
-

Refer to the Divisions of Family Practice and LTCI websites for more information

# Clinical Information and Resources

## Complex Care Definition

Long-term Care is a service for adults 19 years and over whose ongoing complex physical, psychological and social needs require 24-hour clinical RN/RPN/LPN supervision. Their unscheduled, unpredictable or high intensity care needs cannot be managed at home and they have exhausted all formal and informal caregiving support. Typically they have multiple long term, irreversible health conditions with physical or cognitive impairment causing life-limiting frailty and are deemed as living at an intolerable level of risk to self and others.

**Inclusions:**

Those who…

- Have cognitive impairment putting them at risk due to lack of safety awareness or insight that creates high potential to cause harm
- Have socially inappropriate behaviours that are responsive to care planning
- Require a secure environment to prevent self-harm related to exit seeking or wandering
- Have mild to moderate unprovoked physical/verbal responsive behaviour
- Are frail, with comorbidities that require 24-hour professional nursing care or supervision

- Require professional nursing to monitor and provide daily or frequent nursing interventions (refer to Appendix A for examples)
- Require assistance or total care with activities of daily living

**Exclusions:**

Those who…

- Are independently mobile (ambulation or wheelchair) with impaired impulsivity control whose behaviour may spontaneously escalate with unpredictable episodes of physically aggressive responsive behaviour
- Exhibit severe aggression presenting intolerable risk to self and others
- Primarily have a Mental Health diagnosis without a life-limiting physical or cognitive impairment
- Have reversible functional impairment or frailty caused by active substance misuse
- Are actively dying (new admissions) and are eligible for Palliative Care services

Complex Care Definition APPENDIX A

## Understanding Goals of Care

Many resources are available to assist you in supporting the goals of care for residents. These resources will also assist you in navigating complex situations, for example when a resident and family's goals of care are not consistent with clinical best practice.

Palliative Approach to Care (PA2Care) - This initiative, closely tied to Advance Care Planning, supports you in having serious illness conversations with residents to help establish their goals of care, early in their journey.

Advance Care Planning – MOST - Here you will find an overview of Advance Care Planning and resources for clients and staff. There is also contact information if you need any further assistance.

Moving Day Interview – This tool is designed to gain a clear understanding of a resident's preferences and basic care needs. It should be completed as close to the move in day as possible and should be used to help populate the RAI assessment.

Living at Risk - This guide allows us to support residents to live in ways they feel are important, even if this may put them at some risk.

## Quarterly Connections

Care Community Quarterly Connection- TOR - Copy

# The Long-term Care & Assisted Living Clinical Practice Advisory Group

## Clinical Practice Advisory Committee Purpose & Scope

- The Clinical Practice Advisory (CPA) focuses on creating, revising, and decommissioning all clinically related decision support tools, standards, operational documents, and guidelines for Long-term Care (LTC) and Assisted Living (AL) Services.
- CPA creates and revises clinically related decision support tools in aim to align with the LTC AL Network vision of Comfort, Caring, and Connection; and the LTC AL Strategic pillars.
- CPA involves the residents, families, and staff in the development and revision of decision tools that may impact resident and family outcomes and safe quality practices.

## Role & Responsibilities

In addition the Clinical Practice Advisory Committee, Integrated LTC-AL is responsible to:

- Indentify areas of work that prioritize resident and staff safety; and the LTC AL Network Strategy:
    - Resident and family experience
    - Staff and physician experience
    - Research innovation
    - Actively engaged communities
- CPA will seek approval and consultation regarding changes to practice, and challenges to the LTC AL Network; and help identify clinically related decision support tools that need creation, revision, or decommissioning.
- Support the organization of smaller shared working teams who will be accountable for creating, updating, or revising documents they have been tasked with in a timely manner, and report out regular meetings.
- Collaborate with partners (Owned and Operated and Affiliate Mangers and Clinicians, Clinical Nurse Educators, Physicians, Licensing, Quality Assurance Coordinators, The LTC AL Network, Resident Tenant & Family Councils, IPC, ACT, PH).

CPA TOR May 2024.docx

## Learning Hub

The Learning Hub offers an array of on-line learning opportunities as well as classroom sessions. It is a convenient way to review resources available, register for sessions and keep record of attendance.

Some of the more commonly accessed modules include:

| Topic | Search Terms (once logged in) |
|---|---|
| Provincial Code Red for Acute and Long-term Care | Code Red |
| Provincial Hand Hygiene Module for Health Care Staff and Volunteers | Hand Hygiene |
| Braden Scale for Assessing Resident Risk of Pressure Injury | Pressure Injury Prevention |
| Introduction to RAI Assessment Tool | Introduction to RAI |
| Skin & Wound: Pressure Ulcer Prevention Online | Skin & Wound |

## Clinical Practice Team

The Long-term Care Services Clinical Practice team supports Clinical and or Operational Leaders to provide quality resident care. The team consists of:

- Clinical Nurse Educators
- Wound Care Clinicians
- Clinical Nurse Specialists
- LPN HCAP Educators

### Long-term Care Clinical Nurse Educators (CNE)

There are eight Regional CNEs hired to support the advancement of skills and knowledge in Long-Term Care. Their primary role is to support region-wide LTC Network goals and regional initiatives and while also supporting care community-based requests, when those requests are to help staff learn uncommon skills required to manage residents with Complex Care needs. There is no cost for this service, however there is an expectation that site clinical leads will participate in the education being delivered, will support staff in making the necessary clinical practice changes to ensure sustainability and will evaluate the effectiveness of the education provided. The support provided by the CNE could include, but is not limited to:

- Consultation about clinical education needs
- Referral to existing educational resources (i.e. BCCNP, online learning, FH DSTs)
- Virtual Webinars/Education Sessions
- Face-to-face on site or regional education sessions
- Train–the-trainer sessions

To contact the CNE in your geographic area, please send a brief email to the appropriate CNE below and include the following information:

- Your name and contact details (email, phone and Care Community name)
- Educational need (i.e. what is the issue/concern?)

A CNE will respond to your request within 3 business days to gather additional information and to discuss an educational plan.

| CNE Name and Contact Information | Geographic Location (subject to change) |
|---|---|
| Michelle Sprangers<br>15521 Russell Avenue (PAH)<br>White Rock, BC V4B 2R4<br>Tel: 778-240-3630<br>Michelle.Sprangers@fraserhealth.ca | **Fraser South**<br>Brookside Lodge<br>Evergreen Hamlets<br>Guildford Seniors Village<br>Hilton Villa<br>Kinsmen Lodge<br>Laurel Place<br>Suncreek Village<br>Crescent Gardens<br>Clayton Heights<br>Zion Park Manor |
| Ann Jamieson-Wright<br>15521 Russell Avenue (PAH)<br>White Rock, BC V4B 2R4<br>Tel: 778-240-6643<br>Ann.Jamieson-wright@fraserhealth.cas | **Fraser South**<br>KinVillage<br>Morgan Place<br>Peace Portal Seniors Village<br>Suncrest Retirement Community<br>Residence at Morgan Heights<br>West Shore Laylum Care Centre<br>White Rock Seniors Village<br>Northcrest Care Centre<br>Good Samaritan Delta View |
| Krista Homfeld<br>33 Blackberry Drive ( Queens Park)<br>New Westminster, BC, V3L 5S9<br>Tel: 236-332-2824<br>Krista.homfeld@fraserhealth.ca | **Fraser South**<br>Fleetwood Place<br>Evergreen Baptist<br>Harrison at Elim Village |
| Jennifer Brett<br>504-3392 Production Way<br>Burnaby, BC V5A<br>Tel: 236-332-4606<br>Jennifer.Brett@fraserhealth.ca | **Fraser North**<br>Kiwanis Care Centre<br>Royal City Manor<br>Carlton Gardens<br>Cascade Gardens<br>Dania Home<br>Fair Haven Homes<br>George Derby<br>New Vista Care Centre<br>Normanna<br>St. Michael's Centre<br>Willingdon Care Centre |
| Marie Blair<br>504-3292 Production Way,<br>Burnaby, BC V5A 4R4<br>Tel: 236-558-5600<br>Marie.Blair@fraserhealth.ca | **Fraser North**<br>Buchanan Lodge<br>Lakeshore Care Centre<br>Belvedere Care Centre<br>Cartier House<br>Dufferin Care Centre<br>Foyer Maillard<br>Hawthorne Seniors<br>Nicola Lodge<br>The Madison Care Centre<br>Maple Ridge Seniors Village<br>Holyrood Manor |
| Mike Mutter<br>301-32463 Simon Avenue<br>Abbotsford, BC V2T5E3<br>Tel: 778-240-6649<br>Mike.Mutter@fraserhealth.ca | **Fraser East**<br>Bevan Village<br>Jackman Manor<br>Maplewood House<br>MSA Manor<br>Tabor Home<br>Valhaven Rest Home<br>**Fraser South**<br>Fort Langley Seniors<br>Langley Gardens<br>Langley Lodge |
| Kim Martin<br>301-32463 Simon Ave<br>Abbotsford, BC V2T 5E3<br>Tel: 236-332-8347<br>Kim.Martin@fraserhealth.ca | **Fraser East**<br>Agassiz Seniors Community<br>Eden Care Centre<br>Glenwood Seniors Community<br>Valleyhaven Retirement<br>Waverly Seniors Village<br>Menno Home<br>Menno Hospital<br>The Mayfair Seniors<br>The Oxford Care Centre |
| Stacey Rosen<br>301-32463 Simon Ave<br>Abbotsford, BC V2T 5E3<br>Tel: 236-332-6109<br>stacey.rosen@fraserhealth.ca | **Fraser East**<br>Cascade Lodge |

## RAI-MDS Education and Support

All Long-term Care sites use the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0) as the Long-term assessment system. The RAI-MDS is completed for all permanent residents on moving in and then quarterly, annually, when there is a significant change in the resident's clinical status, and on discharge.

RAI-MDS assessment data and outputs provide critical information about a person's clinical and functional status. Clinicians receive real-time reports on the person's health status, progress (improvement or deterioration) and risks. This allows direct care staff to develop person-centred care plans. It also provides information at an organizational and provincial level and is used to drive quality and inform decision-making. For more information, see the Fraser Health InterRAI Guide (2015).

RAI assessments are built into software for point-of-care capture and data submission. Some of the affiliated sites use Fraser Health GoldCare and receive support from Fraser Health for GoldCare education and support. These sites are referred to as "Option A". Other affiliated sites use an alternate platform such as Point Click Care, Momentum. These sites are referred to as "Option B" and are responsible to support staff in learning and using the software.

As the Clinical and or Operational Leader, it is your responsibility to support RAI assessors in their learning and in the timely and accurate completion of RAI assessments. However most importantly, it is to help staff understand the value of the assessment in care planning and monitoring.

| I am looking for: | Resource | |
|---|---|---|
| Information about RAI-MDS | Fraser Health InterRAI Guide (2015) | |
| All resources related to FH RAI-MDS | Extranet interRAI page | |
| Information about RAI education options, registration | Extranet interRAI page | |
| Information about RAI education on the Learning Hub:<br>• Registration curriculum and courses<br>• RAI education session dates<br>• Tracking education<br>• Certificates | **Option A Homes**<br>Learning Hub link for Option A Sites (that use FH GoldCare)<br>FH_GoldCare User Setup Request.pdf<br>RAI education registration process<br>***Note:*** *GoldCare User Setup Request form can be found on Extranet or by emailing interRAI@fraserhealth.ca if the link to the above document does not open.* | **Option B Homes**<br>Learning Hub link for Option B Sites (that use alternate software<br>RAI education registration process |

| I need support in relation to: | Contact | Contact information |
|---|---|---|

| | | |
|---|---|---|
| • RAI education options, sessions<br>• RAI education registration<br>• RAI resources<br>• RAI coding competency testing | FH Long-term RAI educator | RAIEducator-LTC@fraserhealth.ca<br><br>**Michelle Sprangers**<br>**Marie Blair** |
| • GoldCare access (option A sites that use FH GoldCare)<br>○ Initial access<br>○ Reinstating access<br>○ Access issues<br>○ *GoldCare technical support | The Fraser Health InterRAI team | interrai@fraserhealth.ca<br>**Phone 604-415-8705**<br>**Fax 604-415 – 8701** |
| • *GoldCare technical support<br>• Login issues<br>• GoldCare technical issues | Fraser Health Service Desk<br><br>***NOTE:** For GoldCare issues, please first contact FH Service Desk at servicedesk@hssbc.ca; if necessary, they will refer the issue to the FH interRAI technical support team. | servicedesk@hssbc.ca<br>**604-585-5544** |
| • Relias (formerly AIS) profile (User Accounts)<br>○ Setting up user accounts<br>○ Changing/updating accounts<br>○ Requesting reports<br>○ Requesting Supervisor access for Report managements for your site<br>• Coding Competency Evaluations:<br>○ Reports<br>○ Support related to coding questions | The Fraser Health InterRAI team<br><br>RAI Educator | interrai@fraserhealth.ca<br>**Phone 604-415-8705**<br>**Fax 604-415 – 8701**<br><br>RAIEducator-LTC@fraserhealth.ca |

## Wound Consults

Care community leadership has a responsibility for ensuring the skin care provided meets best practice. It is possible to avoid any new pressure injuries with good skin care practices. Fraser Health Long-term Care Services has three advanced practice Nurses Specialized in Wound, Ostomy and Continence Care (NSWOC) available to provide support to your care team and all residents living in a funded FH bed with complex wound issues. Each care community is assigned a primary NSWOC, however during vacation periods you may see an alternate NSWOC. To book a wound consult, please send a referral by Strata Pathways.

Your request will then be directed to the appropriate NSWOC and your care community will be contacted by the NSWOC with an assessment date.

| NSWOC Name and Contact Information | Geographic Location (Subject to Change) | |
|---|---|---|
| Vacant<br>Work Cell: 604-365-6748<br>Fax: 604-851-3041<br><br>**Kim Lemond is on leave.** | **Fraser North**<br>Belvedere Care Centre<br>Buchanan Lodge<br>Burquitlam Lions Care<br>Carlton Gardens<br>Cartier House<br>Dania Home<br>Dufferin Care Centre<br>Eagle Ridge Manor<br>Fair Haven<br>Fellburn Care Centre<br>Finnish Manor<br>Foyer Maillard<br>George Derby Centre<br>Harmony Court | <br>Hawthorne Care Centre<br>Holyrood Manor<br>Kiwanis Care Centre<br>Lakeshore Care Centre<br>Madison Care<br>Maple Ridge Seniors<br>New Vista Care Centre<br>Nicola Lodge<br>Normanna<br>Queen's Park<br>Royal City Manor<br>St. Michael's Centre<br>William Rudd House<br>Willingdon Care Centre |
| **Kristina Cantafio** RN, BScN, IIWCC, WOCN, AAPSYC.<br>Work Cell: 604-364-2970<br>Fax: 1(604) 851 3041<br>kristina.cantafio@fraserhealth.ca | **Fraser South**<br>Brookside Lodge<br>CareLife Fleetwood<br>Clayton Heights<br>Crescent Gardens<br>Czorny Alzheimer Centre<br>Mountainview Manor<br>Deltaview Life Enrichment<br>Elim Village<br>Evergreen Baptist<br>Evergreen Hamlets<br>Fleetwood Place<br>Guildford Seniors Village<br>Hilton Villa Care Centre<br>Kinsmen Place Lodge | KinVillage<br>Laurel Place<br>Morgan Heights<br>Morgan Place<br>Northcrest Care Centre<br>PAH- Foundation Lodge<br>PAH- Hogg Pavilion<br>PAH- Weatherby<br>Rosemary Heights<br>Suncreek Village<br>Suncrest Retirement<br>White Rock Seniors<br>Zion Park Manor |

| NSWOC Name and Contact Information | Geographic Location (Subject to Change) | |
|---|---|---|
| Kristen Avery-Girard BSN RN NSWOC CLT<br>Tel: 604-851-3038<br>Cell: 236-632-5748<br>Fax : 604-851-3041<br>Kristen.Avery-Girard@fraserhealth.ca | **Fraser East**<br>Agassiz Seniors<br>Bevan Lodge<br>Bradley Centre<br>Cascade Lodge<br>Cheam Village<br>Cottage Worthington<br>Eden Care<br>Fraser Hope Lodge<br>Glenwood Care Centre<br>Heritage Village<br>Jackman Manor | Maplewood House<br>Menno Home<br>Menno Hospital<br>MSA Manor<br>TRIM<br>The Mayfair<br>Tabor home<br>Valhaven<br>Valleyhaven<br>Waverly of Chilliwack |
| | **Fraser South**<br>Fort Langley Seniors<br>Langley Gardens<br>Langley Lodge<br>Langley Memorial Hospital | |

## When to refer NSWOC

Referring to a NSWOC early can improve wound outcomes for our residents. Consider a referral to the NSWOC in the following circumstances:

- Stage 3, 4 or Unstageable Pressure Injury or deep tissue injury (DTI).
- Residents with a Braden Score of 12 or less and with open skin or recent wound development.
- Wounds that require advanced therapies such as Negative Pressure Wound Therapy (NPWT), compression therapy, or Conservative Sharp Wound Debridement.
- Wounds that fail to progress towards healing (ex: wounds that demonstrate little to no healing in 3 to 4 weeks).
- Wounds that demonstrate rapid or progressive deterioration.
- Wounds where wound diagnosis is unclear.
- Residents who transition from health care settings such as acute care, ED, community, or other care communities with a wound present.
- Wounds with exposed tendon, bone, ligaments, or exposed hardware (ex: pins, screws, plates).

If you feel involvement of a NSWOC is urgent, ensure a Strata Pathways referral is in place as well as a phone call or email to your area NSWOC.

## How to refer to NSWOC

### Strata Pathways

Please see below info for the new Strata Pathways online Clinical Nurse Specialist and Nurses specialized in Wound, Ostomy and Continence. Referral process beginning April 14, 2022, in your region.

Dashboard: https://fha.stratahealth.com/ad

Here are the new links:

FHA - How to Start a Wound Care Referral -
https://training.stratahealth.com/fha/FHA_How_to_Start_a_Referral_Quiz/index.html

FHA - How to Complete a Wound Care Referral -
https://training.stratahealth.com/fha/FHA_Complete_a_Referral_Quiz_FINAL/index.html

FHA – Wound Care Dashboard Management -
https://training.stratahealth.com/fha/FHA_Dashboard_Management_Quiz_FINAL_V2/index.html

FHA – How to Receive a Wound Care Referral -
https://training.stratahealth.com/fha/FHA_How_to_Receive_a_Referral_in_Pathways_Quiz_FINAL/index.html

FHA Wound Care -
Quick Reference Gui

## Wound Care Education

Wound Care Education is delivered in classroom sessions throughout the year excluding July, August & December. Nursing and allied Health staff can either self – register or be registered by their supervisor through Learning Hub. Courses available include:

**Skin and Wound Module 1: Basic Prevention & Management of Skin Breakdown (for Long-Term Care)**
**Skin and Wound Module 2: Lower Leg Wounds, Non-Healing Wounds and Stomas**

There are a number of online learning courses in wound care on the Learning Hub. To find them, sign in to your Learning Hub account and search using "Wound Management for Nurses – Provincial Curriculum" This will come up under Vancouver Coastal Health but is available province wide. Courses noted in Chapter 1 are pre-requisites for all classroom Wound Modules. Examples include "How Wounds Heal" and "Wound Assessment".

## Connecting Learners with Knowledge Skin and Wound Community of Practice

The Skin and Wound Community of Practice is overseen by the British Columbia Provincial Nursing Skin and Wound Care Committee with the goal of enabling healthcare professionals to quickly access important skin and wound resources. The committee is composed of Skin and Wound Care Clinicians from across BC and from all sectors of health care delivery.

CLWK – Connecting learners with knowledge has links to Decision Support Tools, Product Information Sheets and documentations

Resources and e-Learning Modules. The site is maintained by the BC Patient Safety & Quality Council.

## Negative Pressure Wound Therapy

Contracted sites may be requested to admit a resident who requires Negative Pressure Wound Therapy most commonly referred to as VAC Therapy. While this is an advanced nursing skill, it can be safely supported in a Long-term Care home with a partnership between Home Health, the Long-term Care home and the Long-term Care NSWOC.

Prior to acceptance, Home Health must agree to provide the dressing changes and a funding request must be submitted and approved for Supportive Funding to cover the cost associated with this therapy. In addition, the Long-term Care NSWOC must be available to provide "just in time" VAC maintenance and troubleshooting education to the care home staff.

When requests for NPWT/VAC Therapy occur, please ensure the Long-term Care NSWOC is involved and the ACT Team has approved of the Supportive Funding request to ensure safe and appropriate transitions of care.

## Clinical Nurse Specialists (CNS) in LTC and AL

### *What is the role of a Clinical Nurse Specialist (CNS) in Long-Term Care and Assisted Living?*

- Providing clinical consultation for residents with complex health issues i.e. residents with palliative care needs or with behaviours
- Collaborating with FH Palliative care CNS and clinicians for resident with palliative care needs
- Identifying system issues and addressing system wide strategies to enhance the resident/ families and care providers experience
- Working in partnership with care communities and others on ensuring teams are engaged which results in proactive responsive care teams, and optimize quality care and services to residents and families
- Informing and monitoring key performance indicators and quality improvement initiatives to align with Fraser Health's strategic priorities
- Collaborating with leadership, LTC and AL Clinical Nurse Educators (CNEs) and Quality Partners to create and support the uptake of knowledge and best practices

| Name | Geographic Location |
|---|---|
| **Gita Rafiee**  | Care homes located in: Port Moody, Port Coquitlam, Coquitlam, New Westminster, Maple Ridge and Burnaby<br><br>**604-614-6129** |
| **Andrea Pomeroy**  | Care Homes located in: Langley, Alder grove, Abbotsford, Chilliwack, Agassiz, Mission and Hope<br><br>**236-332-9259** |
| **Anita Wahl**  | Care homes located in: Surrey, White Rock/South Surrey, North and South Delta<br><br>**604-614-8752** |

**What are the qualifications of a CNS?** CNSs are advanced practice registered nurses or registered psychiatric nurses with a Master's degree in Nursing with a specialized body of knowledge and expertise in their area of practice.

**How do I initiate a CNS consultation & what is required?** Please complete the CNS consultation form in pathways


CNS Role and Coverage-Oct 12 20

## Infection Prevention and Control

LTC IPC Manual

Viral RI Outbreak Protocol and Toolkit

Viral GI Outbreak Toolkit

Learning Hub Courses:

IPC New employee orientation module

Viral Respiratory and Gastrointestinal Illness (RI/GI) Outbreaks in Long term Care

IPC Coverage:

IPC email address for general inquires askIPCCommunity@fraserhealth.ca

Coverage for IPC practitioner is according to geographic areas. See below. ss


Copy of IPC Community LTC Assi


Community IPC Practitioner Geogra

## Community, Access & Transitions (CAT) Team

The Community, Access and Transition team is primarily responsible for access to flow to Long Term Care, Assisted Living, Convalescent Care and Hospice and supporting the transitions to these care locations including those with specific resident needs such as: supportive funding requests, financial incapability assessments and relocation requests. You may contact the main office at 604-519-8500 for assistance.

## Long term Care Contracts Department - Financial Administrator Team

In your Clinical and or Operational Leader role you may be asked to respond to resident-related financial issues such as resident rates or you may have questions about your HPRD audit. You should contact your facility's assigned point of contact Fraser Health Financial Administrator for answers to these questions. If you do not know your assigned Financial Administrator, you may email Shannon Uppal, Lead Financial Administrator at Shannon.Uppal@fraserhealth.ca

The Fraser Health Financial Administrator team is responsible for:

- The yearly rate setting process for all Long term Care clients
- Review and follow up of client financial concerns (e.g. clients or families with concerns about the rate setting)
- Client rate verifications, consents and Temporary Rate Reduction (TRRs)

- For facility care homes specifically, the quarterly HPRD audit, staffing plans and Care Model compliance related to HPRDs, and as per Ministry of Health and contract guidelines.
- Release of information Requests for Contracted LTC Sites.

You may also email your questions to richard.simson@fraserhealth.ca or melecio.estoque@fraserhealth.ca (Jay Estoque)

## Quality Partners

### Quality Partner description

Supporting Partners in Compassion and Quality

What we do…

- Quality Assurance Reviews, annually at each care community - collaborate with your home to complete an annual quality assurance review that examines quality indicator outcomes in an effort to identify exceptional quality and quality improvement opportunities
- Review reportable incident reports for funded residents - We have a dedicated quality partner who reviews Reportable Incident Forms (RIF's) and if required participates in clinical reviews and/or investigations lead by licensing. The outcome of a clinical review or an investigation may help identify quality improvement opportunities. **Should a high risk or urgent clinical incident/situation occur we ask that you contact your Quality Partner directly and as soon as possible.** You can do this by sending an email to QP@fraserhealth.ca
- Report skin injuries on behalf of Care Communities to the FH PSLS System
- Encourage Quality Assurance functions
- Promote Quality Improvement plans and opportunities
- Provide assistance with focused quality improvement projects, through discussion and collaboration, and may recommend additional supports.
- Support to new LTC/AL Leaders
- Set up and attend Quarterly Connections with care communities and regional teams. Quarterly Connections are designed to bring together key stakeholders in a structured manner to work in partnership between Care Communities and Fraser Health (FH) Long Term Care Assisted Living (LTCAL) Services.

| FH North<br>Burnaby - Coquitlam | FH East<br>Langley - Hope | FH South<br>South Langley, Surey, White Rock, Delta | Reportable incident review and investigation |
|---|---|---|---|
| •Amrit Dhaliwal<br>•Tara Hartshorne<br>•Aljonita Montinola | •Ashley Fulton<br>•Keith Williams<br>•Mohinder Mann | •Cathy Smith<br>•Prabhjot Singh<br>•Ranjit Parmar | • Glen Ang |

## LTC and AL Leadership Coaching Services:

This service is available for all leaders within the owned & operated and affiliated network. By filling in the information requested in the link below, you will be contacted for coaching support from Alisha Wood, Consultant, Organization Development.

Leadership Challenges may include:

- Interpersonal Conflict
- Change Management
- Managing uncertainty, stress, overwhelm
- Team Dynamics
- Personal Leadership challenge
- Other

**IMPORTANT NOTE ON CONFIDENTIALITY: All consultations are completely confidential between you and the coach. No information will be shared with your supervisor or with anyone within the Fraser Health Authority.**
Qualtrics Survey | Qualtrics Experience Management

## Community Care and Facilities Licensing

Community care facilities licensing supports the delivery of care and services in licensed residential care facilities by ensuring the Community Care and Assisted Living Act and Residential Care Regulation requirements are met. Please review the legislation below:

Community Care and Assisted Living Act
Residential Care Regulation

It is within Licensing's mandate to conduct unannounced inspections, however on occasion Licensing Officers will schedule follow-up or complaint inspections, depending on the circumstances.

Reportable incidents are to be completed and submitted as required by Licencing. Online reportable incident login and instructions can be found here:

https://healthspace.ca/Clients/FHA/FHA_Website.nsf/Login.xsp

Additional resources can be found here:

http://www.gov.bc.ca/residentialcarefacility

## Director of Care Groups in Fraser Health

DOC groups generally meet monthly in each of three geographic locations in Fraser Health. These professional resource groups provide a forum for networking and information sharing. Contact the Chair or Co-Chair in your geographic area to be added to the distribution list.

| Long-Term Care DOCs List of Chairs | | |
|---|---|---|
| **Facility** | **Chair** | **Co-Chair** |
| East | Smitha Varghese, Menno hospital<br>Smitha.Varghese@mennoplace.ca | Kim Scott, Menno Home<br>kim.scott@MennoPlace.ca |
| | | |

| | | |
|---|---|---|
| South | Michelle Whitehouse<br>mwhitehouse@zionparkmanor.com<br><br>Secretary: Dee Stewart, Northcrest Care Center dee.stewart@ppsl.com | Lisa Samms-Maxwell<br>lsamms@langleylodge.org |
| | | |
| North | Traci Skaalrud<br>tskaalrud@ppsl.com | Ramon Castillo<br>ramon.castillo@normanna.ca |

# Key Fraser Health Clinical Programs You Need to Know About

## CommuniCare

CommuniCare is a Fraser Health program aimed at improving health care transitions between Long-term Care and Assisted Living (LTC&AL) and the hospital. Care transitions at handover points are a high risk activity for miscommunication and a fertile ground for adverse events. The LTC&AL population thrives when cared for in an environment suited to their unique needs. When a transfer to hospital occurs, gaps in communication can result in adverse events and longer than necessary acute care lengths of stay.

CommuniCare addresses some of the issues associated with care transitions by:

1) Identifying this special population with a coloured wrist band when transferred to hospital (pink for Long-term Care and blue for Assisted Living)
2) Using standardized communication tools and processes

Key clinical information is shared when residents and tenants are transferred to and from hospital using the Long-term Care to ED Transfer form.

Regular, verbal communication occurs during a hospital stay to actively plan for discharge, allowing LTC&AL operators the opportunity to make any needed special arrangements for residents/clients returning to their care homes.

For more information check out the resources found on the CommuniCARE - All Documents (fraserhealth.ca).

## P.I.E.C.E.S. ™

Pieces is a holistic, relationship focused approach to collaborative engagement and supportive care with older Persons at risk or living with complex chronic conditions. Further information related to P.I.E.C.E.S. can be found https://fhextranet.fraserhealth.ca/sites/ResidentialContractsServices/PIECES/Forms/AllItems.aspx

PIECES Education is offered monthly January- May and Sept-November. Education consists of two full days of online education. Staff can register for the courses on the Learning Hub:

1. PIECES (2 Day) Program for Fraser Health Long-Term Care only Day 1- **13060**
2. PIECES (2 Day) Program for Fraser Health Long-Term Care only- Day 2- course number **28884**

## Polypharmacy Reduction

Information related to the Polypharmacy Reduction initiative can be found Decision support tool

## LTC COPD Services (formerly known as BreatheWell)

LTC COPD goal of this project is to prevent and manage COPD Flare Ups and improve resident's quality of life.

LTC COPD tools and resources are available on the Extranet:

- COPD Flare Up in Long-Term Care Home - Pre-Printed Order: The goal of this PPO is to provide quick intervention if a flare-up occurs; improve the quality of life for residents with COPD.
- COPD Initiation SBAR - Long-Term Care - Form
- COPD Follow Up SBAR - Long-Term Care – Form
- Resident and family education: Living with Chronic Obstructive Pulmonary Disease in Long-Term Care (Fraser Health) – Brochure
- Community Respiratory Services (CRS) Staff Education Request Form for Residential Care Services
- On line education (Learning Hub): Caring for Residents with COPD (Online) - Learning Module
- In addition to the above, you will find education resources (i.e. PowerPoint, Handouts etc.)

## THE PREVIEW-ED© TOOL in Fraser Health

Seniors living in Long-term Care are at high risk of being transferred to an Emergency Department (ED). Some of these ED visits are avoidable if signs of health decline are identified early by staff and managed within the long term care home. PREVIEW-ED

The PREVIEW-ED© is an innovative tool, developed by Marilyn ElBestawi through the Canadian Foundation for Healthcare Improvement's (CFHI) Executive Training Program: EXTRA. The tool was designed specifically for Health Care Assistants (HCA) working in Long-term Care. Whereas many tools used to identify decline of patients focus on the nurse's assessment, this tool uses simple language and an accessible format to increase ease of use. Completed daily, the tool leverages the observational skills and familiarity of direct care staff with the residents for whom they provide care. In addition the tool assists HCAs to identify the subtle changes in resident conditions that may lead to health decline. PREVIEW-ED© focuses on four of the main reasons why residents are transferred to the ED: UTI, Dehydration, CHF and Pneumonia.

It is standard practice for all Fraser Health homes, both contracted and owned and operated to use the PREVIEW-ED© in Long-term Care. More information on the tool and educational material can be found on the **Extranet**.

For more information and to obtain a password/ user name for the website contact

| Name | Email | Role |
|---|---|---|
| Mike Mutter | Mike.Mutter@fraserhealth.ca | CNE Fraser Health |

## Medical Assistance in Dying

Resources for Medical Assistance in Dying can be found on the Fraser Health Extranet:

https://fhextranet.fraserhealth.ca/sites/ResidentialContractsServices/MAID/Forms/AllItems.aspx