Ontario Long Term Care Clinicians

Friday, October 21, 2023

MANDATORY TRAINING & NEW IN PRACTICE – CORE TOPICS

FRED MATHER , MD CCFP FCFP

CARRIE HEER, RN(EC), BScN, MN, NP-PHC

8:45 – 10:15	Part one
10:15 – 10:30	Break
10:30 – 12:00	Part two

Ontario Long Term Care Clinicians

AGENDA

1. Welcome and introductions. 20 minutes. 8:45 AM
   - Session is interactive and will include five case discussions. Attendees are welcome to bring their own cases for discussion.
   - Flip chart for “parking lot”, i.e. questions and concerns to discuss at the conclusion of the session.

2. Case discussion 1: 20 minutes 9:05
   - 88 woman admitted to LTC three weeks before. She develops an apparent delirium. The RPN calls you for an antibiotic because she likely has a UTI. This is what they always did when she became agitated in the alternative level of care (ALC) unit. How do you respond.
   - After discussion, introduce relevant resources such as CWC, dobugsneeddrugs, etc.

3. Antibiotic stewardship following the case study. Introduce the *MyPractice LTC application.* 10 minutes 9:25

4. Fixing LTC Term Care Act (10 minutes) 9:35
   - Background.
   - Relevant sections for physicians and nurse practitioners.
   - Palliative philosophy of care.

5. Mandatory training 9:45
   - Training requirements for all staff, FLTCA 82 (2)
   - Additional training direct care staff. FLTCA 82(7), O Reg 246/22 s.261

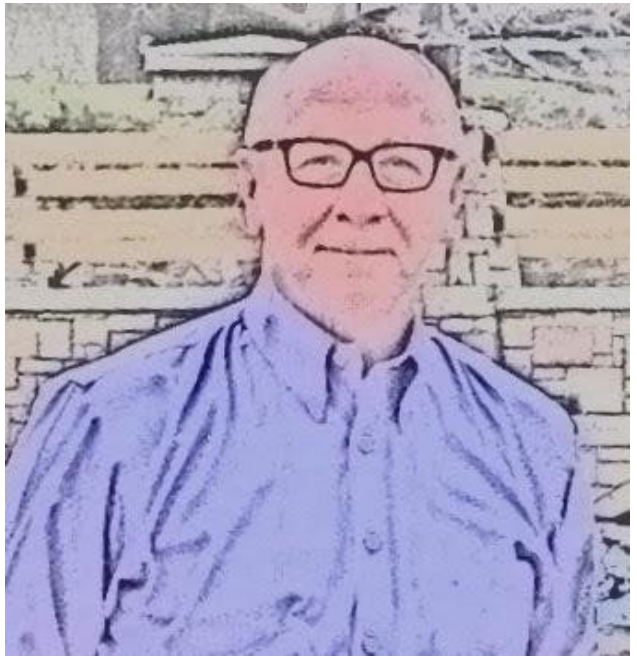
6. Summary of session so far, 15 minute break. 10:15

Ontario Long Term Care Clinicians

AGENDA

7. Mandatory training continued 10:30
8. Case discussion 2: Abuse recognition and prevention 10:45
9. Case discussion 3: Restraint use and reduction. 11:00
10. Case discussion 4: Antipsychotic deprescribing. 11:15
11. Case discussion 5: Consent and capacity in LTC. 11:30
12. Parking lot and LTC resources. 11:45
13. Adjournment for lunch 12:00

Carrie Heer obtained her Bachelor of Science in Nursing from University of Windsor & Master of Nursing & Advanced Graduate Diploma: Advanced Nursing Practice from Athabasca University. Carrie currently holds the position of Nurse Practitioner, Brant Community Healthcare Systems, Emergency Department/Nurse Led Outreach Team (NLOT) where she works collaboratively with LTC homes to reduce unnecessary ED transfers. Carrie has held roles that included acute care, education, public health and advanced nursing practice.



Dr. Fred Mather served both as president of OLTCC and the prior Ontario Long Term Care Physicians. He is the Medical Director of Sunnyside Home, the municipal home for the Region of Waterloo, and attending physician for two Extendicare homes. He presently serves as Vice Chair for the Ontario Association of Resident Councils.

Faculty/Presenter Disclosure

Faculty: Carrie Heer

Relationships with financial sponsors:

- **Grants/Research Support:**
- CIHR Operating Grant
- Government of Canada's Employment and Social Development Canada Program: Foundation for Advancing Family Medicine-Workplace Integrated Demonstration Project Grant-Invitational Call.
- **Speakers Bureau/Honoraria:** OLTCC
  - **Consulting Fees:** Toronto Metropolitan University: ESDC Project Grant
  - **Other:** Employee of Brant Community Health Care System, Adjunct Faculty Bloomberg Faculty of Nursing, Affiliate Investigator, Bruyere Research Institute

CFPC CoI Templates: Slide 2 and 3

Disclosure of Financial Support

None

Potential for conflict(s) of interest:

- Carrie Heer honoraria from OLTCC for presenting

Mitigating Potential Bias

NO BIAS IN ANY PRESENTATIONS

CFPC CoI Templates: Slide 1 – used in Faculty presentation only.

Faculty/Presenter Disclosure

Faculty: Fred Mather

Relationships with financial sponsors:

Grants/Research Support:

- **No**

Speakers Bureau/Honoraria: OLTCC

- **No**

CFPC CoI Templates: Slide 2 and 3

Disclosure of Financial Support

None

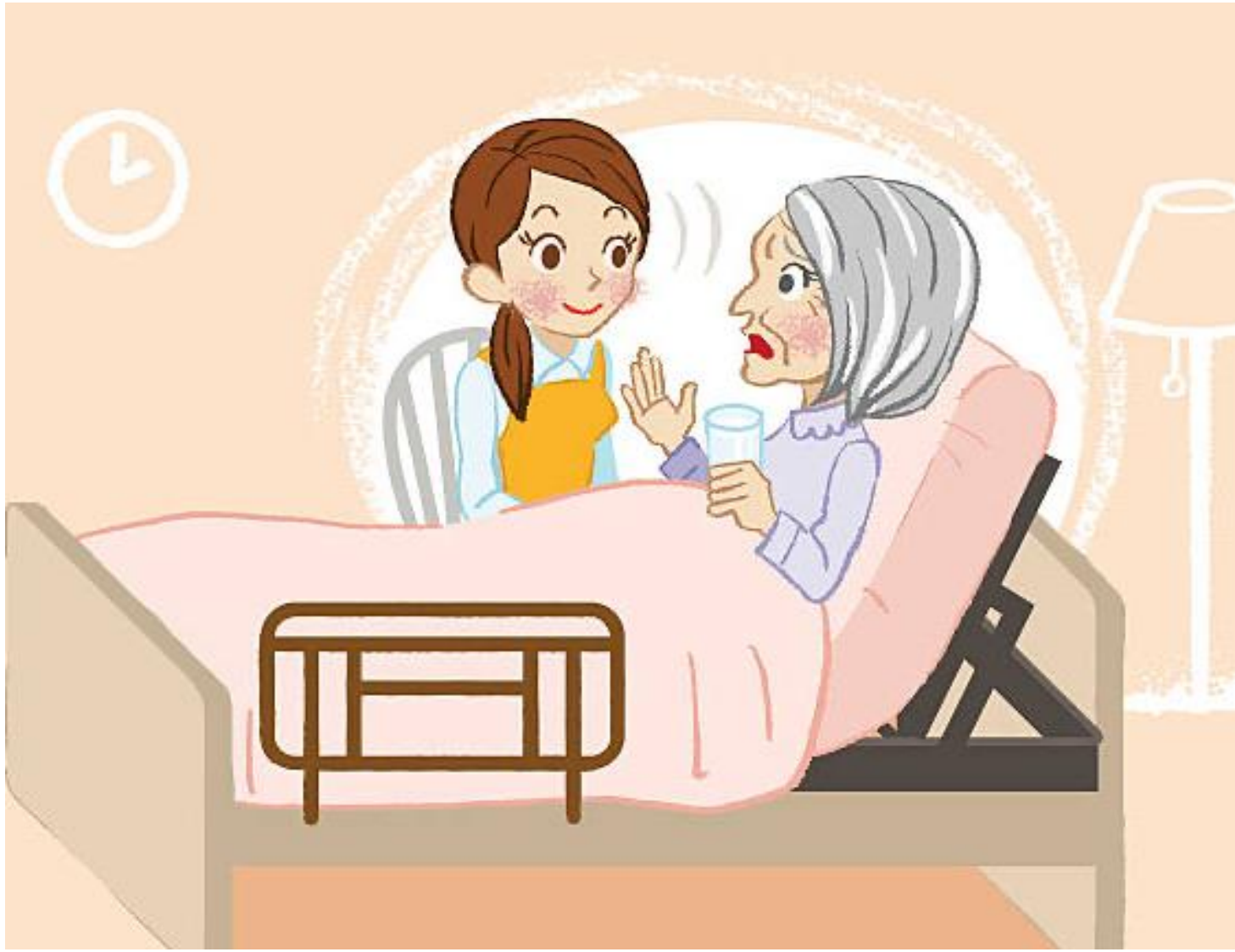
<u>Potential for conflict(s) of interest</u>:

- **Fred Mather** receives honoraria from OLTCC for presenting

Mitigating Potential Bias

NO BIAS IN ANY PRESENTATIONS

88 woman was admitted to LTC three weeks before. She develops an apparent delirium. The RPN calls you for an antibiotic because she likely has a UTI. Her daughter states that this is what they always did when she became agitated in the alternative level of care (ALC) unit. How do you respond?



Antimicrobial Stewardship Essentials

PRIMER

Antimicrobial Stewardship Essentials in Long-Term Care: Antimicrobial Stewardship as Quality Improvement

A primer meant to guide directors of care, medical directors, prescribers, quality improvement specialists and antimicrobial stewardship champions in planning or expanding an ASP in LTC.

1.4 MB | Updated 2 Oct 2018

CHECKLIST

Antimicrobial Stewardship Essentials Checklist in Long-Term Care

A checklist that supports the implementation or expansion of an antimicrobial stewardship program (ASP) in a long-term care (LTC) setting and provides some examples of resources and practical tools.

1.5 MB | Updated 2 Oct 2018

INFOGRAPHIC

Antibiotic Overuse in Ontario's Long-term Care Homes

Infographic of literature examining antibiotic use in Ontario long-term care homes and recommendations on how to reduce harm to residents.

1 MB | Updated 27 Jan 2017

Shorter is Smarter: Reducing Duration of Antibiotic Therapy

EVIDENCE BRIEF

Duration of Antibiotic Treatment for Uncomplicated Cellulitis in Long-Term Care Residents

A summary of literature pertaining to treatment duration for uncomplicated cellulitis, particularly as it relates to residents of LTC homes.

1.2 MB | Updated 2 Oct 2018

EVIDENCE BRIEF

Duration of Antibiotic Treatment for Pneumonia in Long-Term Care Residents

A summary of the literature pertaining to treatment duration for pneumonia with a focus on its implications to residents of LTC homes.

1.2 MB | Updated 2 Oct 2018

EVIDENCE BRIEF

Duration of Antibiotic Treatment for Uncomplicated Urinary Tract Infection in Long-Term Care Residents

A summary of the literature pertaining to treatment of uncomplicated lower UTI in LTC residents, with a focus on optimal duration of therapy.

1.3 MB | Updated 2 Oct 2018

FACT SHEET

Shorter is Smarter - Reducing Duration of Antibiotic Treatment for Common Infections in Long-Term Care

A fact sheet that outlines shorter courses of antibiotics for common infections in long-term care.

226 KB | Updated 2 Oct 2018

INFOGRAPHIC

Shorter is Smarter: Reducing Duration of Antibiotic Therapy in Long Term Care

An infographic that outlines the benefits of reducing duration of antibiotic therapy in long-term care.

164 KB | Updated 2 Oct 2018

Public Health Ontario
PARTNERS FOR HEALTH

Santé publique Ontario
PARTENAIRES POUR LA SANTÉ

Antibiotic overuse

in Ontario's long-term care homes

What is the problem?

50%
of antibiotic courses are unnecessary[1]

78%
of residents receive at least one antibiotic course each year[2]

How are antibiotics overused?

There is variability in prescribing:

10x

Homes with the highest use are using 10x more antibiotics than homes with the lowest use

Prescriber preference is the key reason for differences - not resident characteristics[2]

Duration of therapy is often longer than necessary[2]

Why is this important?

Residents in homes with higher antibiotic use experience more harm:

24% increased risk of *Clostridium difficile* infection, diarrhea, allergic reactions and antibiotic-resistant organisms[3]

What can you do?

Practice antibiotic stewardship:

- reduce unnecessary antibiotic prescriptions
- re-assess the need for antibiotics regularly
- use the shortest effective duration possible

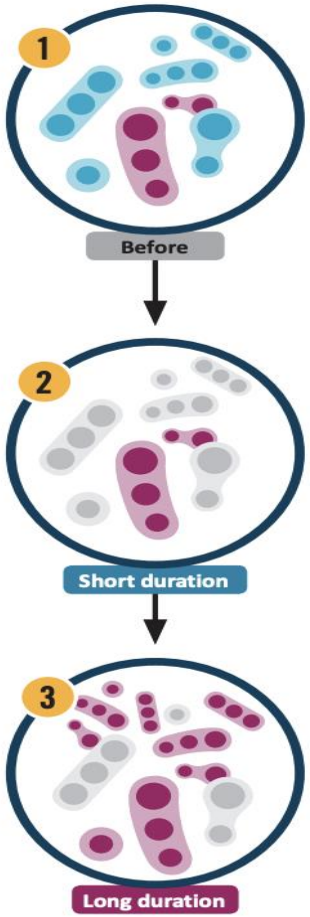
SHORTER IS SMARTER

Public Health Ontario | Santé publique Ontario

Prescribers/Clinicians:
Reducing duration of antibiotic therapy in long-term care

Antibiotic use drives selective pressure

Selective pressure kills **susceptible bacteria** and allows **resistant organisms** to thrive and multiply.



Shorter courses are as effective as longer courses

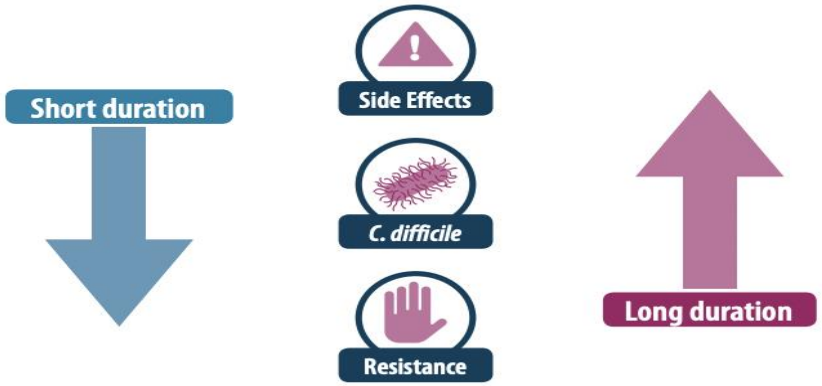
Uncomplicated cystitis	
Short **3-6 days**	Long **7-14 days**

Pneumonia	
Short **5 days**	Long **7-10 days**

Cellulitis	
Short **5 days**	Long **10 days**

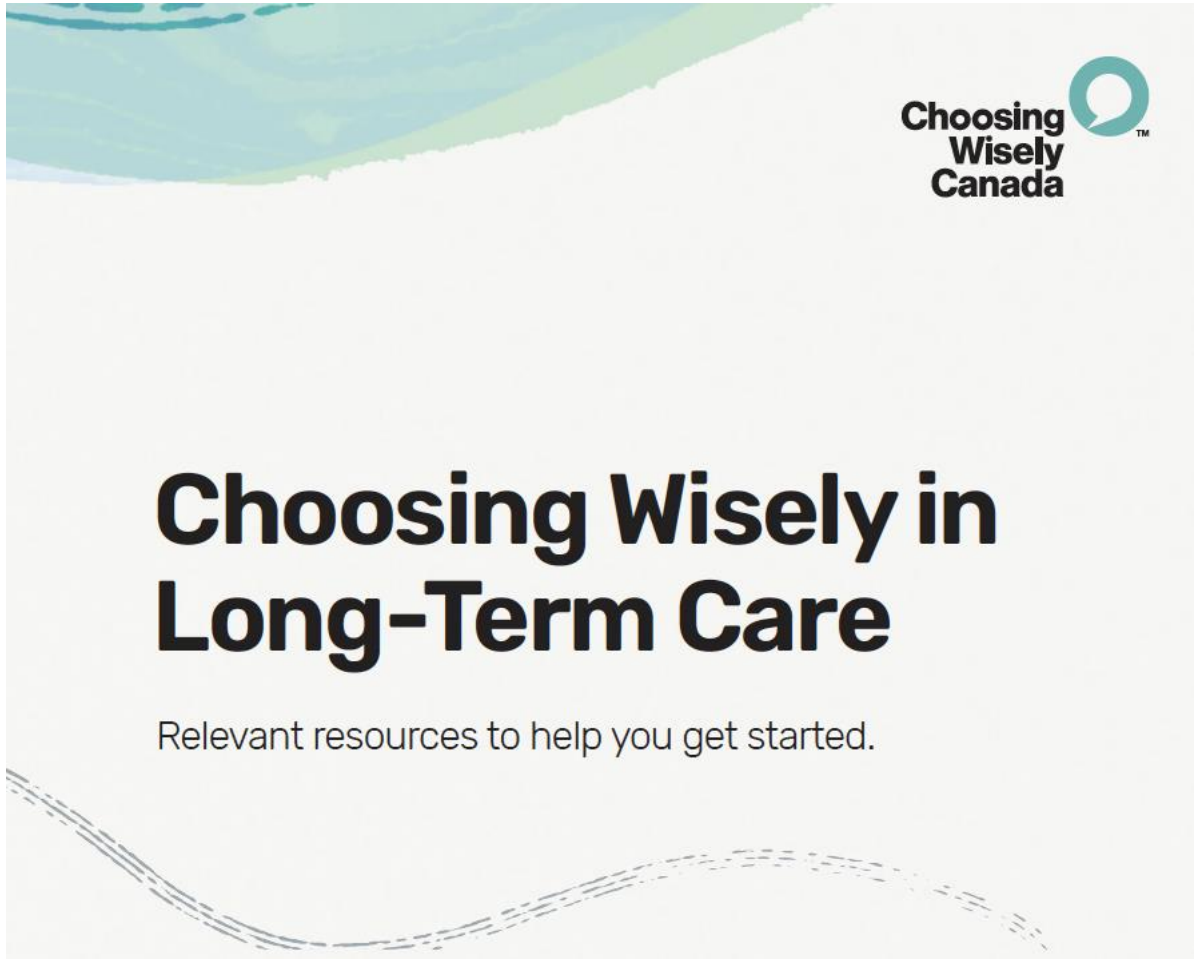
Based on studies in hospitalized and ambulatory patients for common infections seen in long-term care.

Shorter courses have a lower risk of harm



Choosing Wisely Canada™

- Using Antibiotics Wisely
- Time To Talk



Nursing Home Acquired Pneumonia Checklist

Resident Label

Measure and record vital signs

Record all values, even if normal. Record additional information in chart.

_____Respiratory rate (measure for 60 sec)
_____Temperature
_____Blood pressure
_____Pulse
_____Oxygenation

Chest auscultation & exam _____
_____
Level of consciousness _____
_____
Hemodynamically stable (relative to baseline) ☐Yes ☐No
Hydration <1L/day ☐Yes ☐No

Initials Date Time

THEN

Assess for symptoms of NHAP (1)

Indications (check all that apply):

☐ [redacted] bpm or increased over baseline)
AND 1 or more of the following:
☐ New or increased cough
☐ New or increased sputum production
☐ [redacted]C or increase of [redacted]C over baseline
☐ Pleuritic chest pain
☐ New or increased abnormal findings on chest examination
☐ New delirium or decreased level of consciousness
☐ Dyspnea
☐ Tachycardia
☐ New or worsening hypoxemia

Initials Date Time

NO → **Consider other diagnosis (2)**

YES

Goals of Care Designation

☐ Further treatment is aligned with Goals of Care Designation

Initials Date Time

NO → **Discuss options with resident or alternate decision maker**

YES

Chest X-Ray *Obtain if possible but do not delay treatment* (3)

☐ Chest x-ray obtained

Initials Date Time

YES

Additional clinical information

Drug allergies _____
☐ No drug allergies
Underlying pulmonary disease ☐ Yes ☐ No

Initials Date Time

IF NOT ALREADY DONE, FAX/COMMUNICATE ALL OF THE ABOVE INFORMATION TO THE PRESCRIBER. INDICATE URGENT ON FAX AND CALL.

Antimicrobial therapy

Antibiotic _____ Dose _____ Frequency _____ Duration _____
☐ Check here if antibiotic not ordered

Initials Date Time Date and time therapy initiated

Assess for transfer to acute care

☐ Goals of Care are consistent with transfer to acute care
AND resident meets one or more of the following criteria (check all that apply)
☐ Hydration < 1L/day (4)
☐ O_2Sat <92% with available supplemental oxygen
☐ O_2Sat <90% with available supplemental oxygen & COPD
☐ Respiratory rate >40 bpm or significantly increased over baseline
☐ Systolic blood pressure <90 mmHg or decreased 20mmHg under baseline
☐ Hemodynamically unstable or deteriorating rapidly

Initials Date Time

YES → **Transfer to acute care**

Initials Date Time

NO → **Reassess diagnosis and/or treatment if no improvement in 24-[redacted] hours**

Reassess for possible transfer to acute care

(1) PRACTICE POINT

☐ [redacted] bpm is highly specific and sensitive for NHAP
☐ [redacted] bpm may be an indication for transfer to hospital
☐ If resident has problems swallowing, consider aspiration pneumonia

(2) PRACTICE POINT

☐ If cough and fever are present, consider viral respiratory tract infection, especially influenza during November to April. Refer to Public Health Guidelines for case definitions.
☐ If chest pain and elevated temperature are absent, consider another diagnosis (for example CHF).

[redacted]

Transfer to acute care for chest x-ray alone is not required.

(4) PRACTICE POINT

Consider clysis if oral intake is less than 1L/day

Prescriber Information

Initiate antibiotic therapy within 4-8 hrs of symptom onset

First line
[redacted]
Alternative
Amoxicillin-[redacted]
or
Levofloxacin [redacted]
days

Consider adding one of the following if underlying pulmonary disease:

Doxycycline 200mg PO once, then 100mg [redacted]
or
Azithromycin [redacted]
or
Clarithromycin [redacted]

If unable to administer PO, consider transfer to acute care for IV therapy

If aspiration pneumonia is suspected, consult Bugs & Drugs or pharmacist for choice of antibiotic

bugs drugs | Alberta Health Services

[redacted]

THIS FORM CANNOT BE USED TO ORDER LABORATORY TESTS OR MEDICATIONS

Urinary Tract Infections in LTCF Checklist

Resident Label

Typical Symptoms (1) (No indwelling catheter)

Indications (check all that apply):

☐ Acute dysuria
OR
☐ Temp >38°C or 1.1° above baseline on 2 consecutive occasions (4-6 hr apart)
Temp 1 _____ Temp 2 _____
PLUS one or more of the following:
☐ New or increased urinary frequency, urgency, incontinence
☐ New flank or suprapubic pain or tenderness
☐ Hematuria

Initials Date Time

Typical Symptoms (1) (Indwelling catheter)

Indications (check all that apply):

☐ No other identifiable cause of infection
AND one or more of the following:
☐ Temp >38°C or 1.1° above baseline on 2 consecutive occasions (4-6 hr apart)
Temp 1 _____ Temp 2 _____
☐ New flank or suprapubic pain or tenderness
☐ Rigors
☐ New onset delirium

Initials Date Time

Medical status deteriorating rapidly

☐Yes ☐ No

Initials Date Time

NO → **Push Fluids (2)**
☐ Fluids pushed for 24 hours

Initials Date Time

YES

Typical symptoms continue

☐ Yes ☐ No

Initials Date Time

NO → **Consider other diagnosis**

YES

Goals of Care Designation

☐ Further treatment aligned with Goals of Care Designation

IF NOT ALREADY DONE, FAX/COMMUNICATE ALL OF THE ABOVE INFORMATION TO THE PRESCRIBER. INDICATE URGENT ON FAX AND CALL.

Urine C&S (3)

☐ Order for C & S received
☐ Specimen collected

Initials Date Time

C&S Results (4)

☐ Significant
☐ Not significant
☐ Contamination likely

Initials Date Time

NOT SIGNIFICANT
☐ Antibiotic not initiated
☐ Antibiotic stopped if already initiated

Initials Date Time

SIGNIFICANT

Additional clinical information

Drug allergies _____
☐ No drug allergies
CrCl _____

Initials Date Time

FAX / COMMUNICATE ALL INFOR MATION ON THIS FORM and C&S REPORT to PRESCRIBER. INDICATE URGENT on FAX and CALL.

Antimicrobial therapy

Antibiotic _____ Dose _____ Frequency _____ Duration _____
☐ Check here if antibiotic not ordered

Initials Date Time Date and time therapy initiated

Review and discuss with pharmacist and health care team as needed

☐ Antibiotic is consistent with recommendations in guideline / Bugs & Drugs
☐ All organisms are susceptible to the prescribed antibiotic
☐ Therapy appropriate for renal function

Initials Date Time

Continue to monitor. Document clinical findings.
If no improvement after 24 hrs consider transfer to acute care.

(1) PRACTICE POINT

- **Diagnosis of UTI is based on clinical assessment *not* laboratory testing**

(2) PRACTICE POINT

- Unless on fluid restriction
- Consider clysis or IV fluids if oral intake is less than 1 L/day
- Consider alerting prescriber regarding symptoms and potential need for C&S

(3) PRACTICE POINT

- **The role of urine C&S is to guide selection of antibiotic therapy**
- Refer to laboratory protocol for urine collection and labeling
- Complete all fields on laboratory requisition including signs and symptoms and current or recent antibiotic use

(4) PRACTICE POINT

- **The presence of bacteria in the urine alone without signs of infection (asymptomatic bacteriuria) does not indicate a UTI**
- The frequency of asymptomatic bacteriuria increases with age and is common among LTC residents
- ***ONLY*** if signs and symptoms of a UTI are present, a bacterial count $\geq 10^6$ cfu/L is significant; use sensitivity results to guide antibiotic selection
- More than 3 organisms usually indicates contamination and the need for new specimen

Prescriber Information

Antibiotic therapy should not be initiated prior to receipt of C&S results (unless medical status is deteriorating rapidly).

If needed, selection of an antibiotic before C&S results are available should be based on local resistance patterns and resident tolerance.

Local resistance patterns can be accessed here: www.dobugsneeddrugs.org/health-care-professionals/antibiogram

Repeat C&S after antibiotic therapy is **NOT** necessary unless typical UTI signs and symptoms persist.

bugs drugs | Alberta Health Services

December 2014

THIS FORM CANNOT BE USED TO ORDER LABORATORY TESTS OR MEDICATIONS

MyPractice reports enable physicians working in long-term care to confidentially see their prescribing patterns (antipsychotics, benzodiazepines and antibiotics) in relation to peers across the province. The report also provides data on resident characteristics like the aggressive behavior scale, clinical indications, and percentage of new residents.

MyPractice
Long-Term Care

A tailored report for quality care

Overview

Reporting period: Oct 1, 2021 – Dec 31, 2021

ANTIBIOTIC PRESCRIBING

11 %

of my residents were prescribed an antibiotic

Lower than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

ANTIBIOTIC PROLONGED TREATMENT

16 %

of my antibiotic prescriptions were longer than seven days

Similar to many of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

ANTIPSYCHOTIC PRESCRIBING

15 %

of my residents with dementia without psychosis were prescribed an antipsychotic

Lower than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

BENZODIAZEPINE PRESCRIBING

9 %

of my residents were prescribed a benzodiazepine

Similar to many of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

CNS-ACTIVE MEDICATIONS

12 %

of my residents were prescribed three or more specified CNS-active medications

Similar to many of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

Fixing Long-Term Care Act, 2021 – Palliative Care

Residents' Bill of Rights

25. Every resident has the right to be provided with care and services based on a palliative care philosophy.

Plan to cover all aspects of care

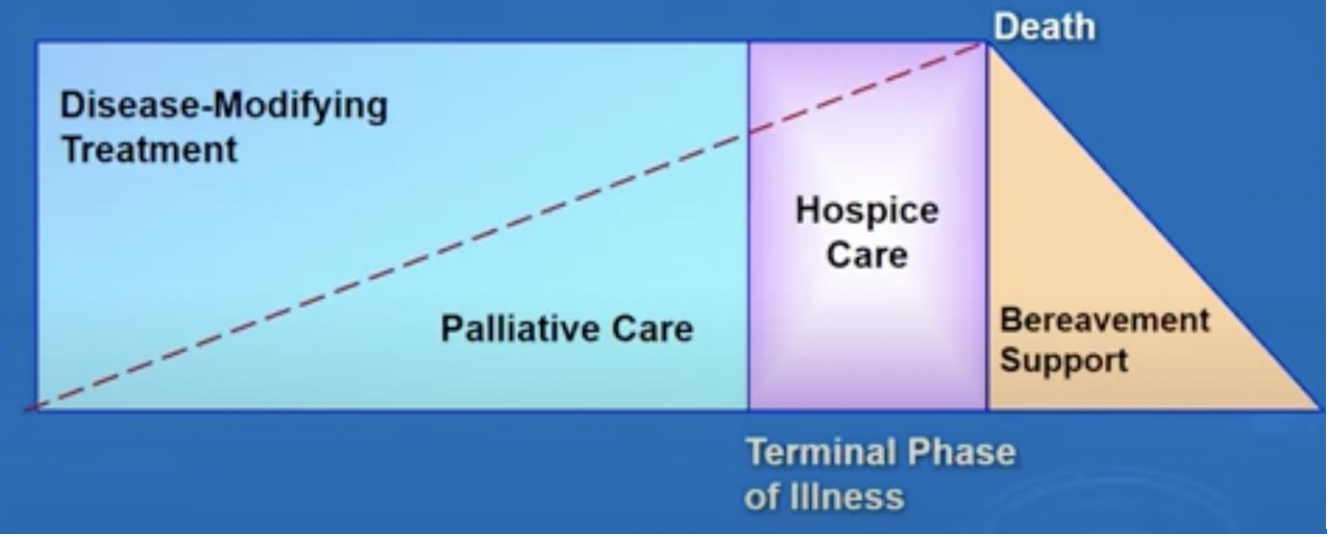
6(3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, mental health, nutritional, dietary, recreational, social, palliative, restorative, religious and spiritual care.

Palliative Care

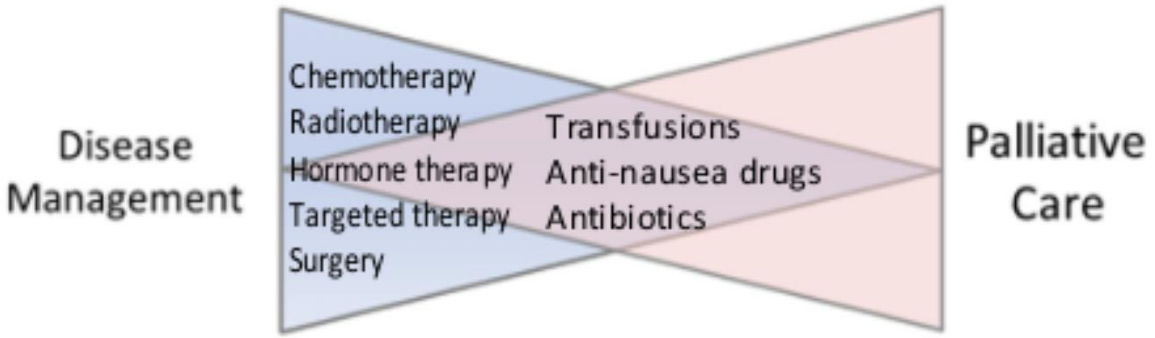
12 (1) Every licensee of a long-term care home shall ensure that, subject to section 7, residents are provided with care or services that integrate a palliative care philosophy.

Matters in regulations

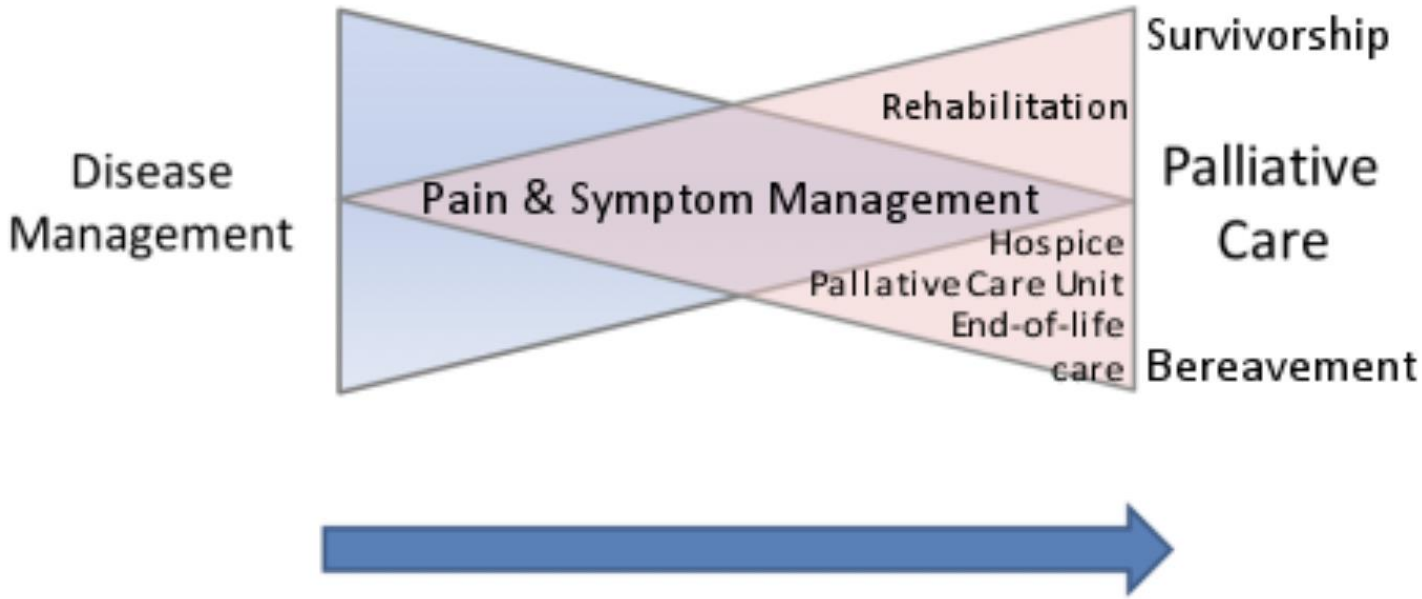
(2) Without restricting the generality of subsection (1), every licensee shall comply with the regulations respecting palliative care and the palliative care philosophy.



Disease Management-Enhanced Model



Palliative Care-Enhanced Model



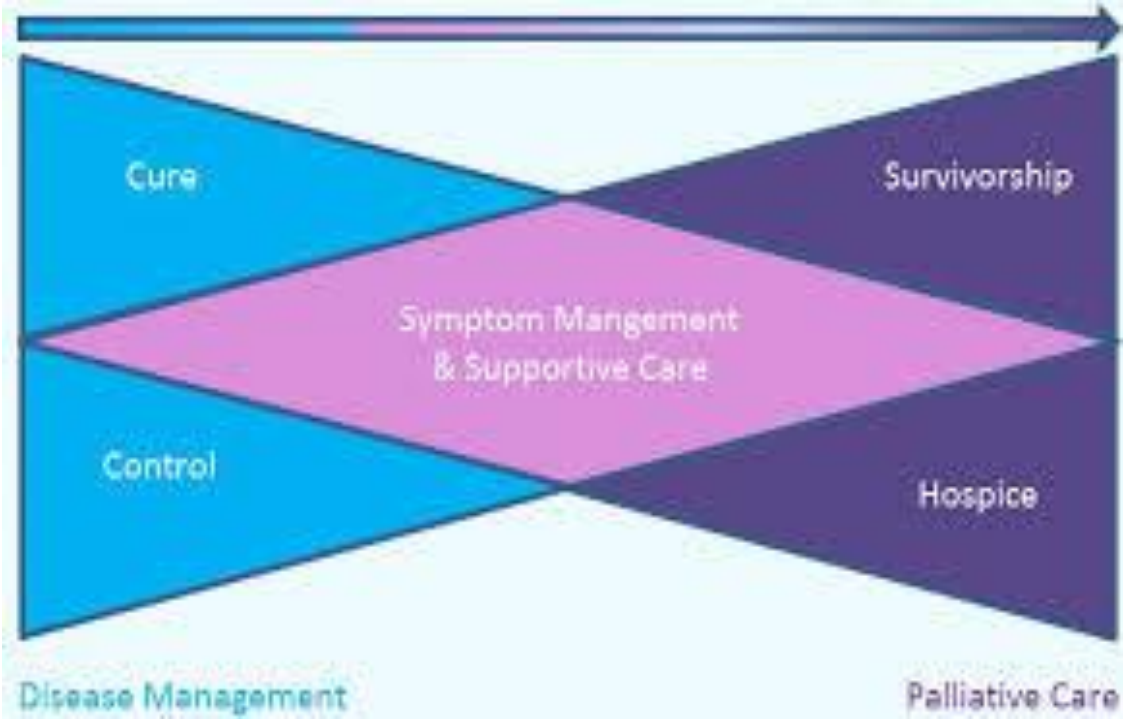
Fixing Long-Term Care Act, 2021 – Palliative Care

Regulation 61 – Palliative care

- Every licensee of a long-term care home shall ensure that the resident, the resident's substitute decision-maker, if any, and any other person or persons designated by the resident or their substitute decision-maker, are given an explanation of **palliative care options** that may be integrated into the care that is arranged, carried out or provided to a resident **including, but not limited to, end-of-life care.**

- Every licensee of a long-term care home shall ensure the assessment that palliative care covered by a resident's plan of care is based on includes a **holistic and comprehensive assessment of a resident's needs.**

- Where required to meet a resident's assessed needs, every licensee shall also ensure that the care and services provided under subsection (2) include, at a minimum,
  a) quality of life improvements;
  b) symptom management;
  c) psychosocial supports; and
  d) end-of-life care.



A palliative philosophy, or approach, to care

Quality of Life

- A process that begins on admission or before.
- Affirming the palliative approach assures better quality of life.

PALLIATIVE CARE DEFINITION

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

Ontario Long Term Care Clinicians

A definition for the PALLIATIVE PHILOSOPHY OF CARE

Response to Phase 1 draft regulation of FLTCA

A palliative philosophy supports individual quality of life through a continuum of care delivered alongside curative measures and throughout chronic illness.

- A palliative philosophy acknowledges and responds to all aspects of humanity not just medical considerations but also physical, psychosocial, cultural, emotional, and spiritual needs.
- A palliative philosophy is based on conversations with individuals to understand personal goals of care based on their values, culture and preferences.
- The palliative approach understands the uniqueness of each individual, their personal history, experiences, spiritual identity, cultural norms, and the vital interpersonal relationships that bring meaning to the whole person.

Ontario Long Term Care Clinicians

A definition for the PALLIATIVE PHILOSOPHY OF CARE

Response to Phase 1 draft regulation of FLTCA

The palliative approach to care aims to maximize quality of life by mitigating all aspects of suffering by identification and anticipation of problems including but not limited to natural aging, disease progression, pain, loneliness, interruption of familiar patterns of living and loss of identity that accompany moving into a long term care home.

Ontario Long Term Care Clinicians

A definition for the PALLIATIVE PHILOSOPHY OF CARE

Response to Phase 1 draft regulation of FLTCA

The palliative approach to care requires the understanding of everyone involved in caring for long term care residents. The conversation ideally begins before admission. The palliative philosophy influences every opportunity for individuals to experience quality of life during their long term care journey. When end of life approaches, the palliative approach assures individually appropriate, compassionate, and dignified end of life care.

END-OF-LIFE CARE

End-of-life is the final period of the individual's illness trajectory when it becomes medically obvious that death is imminent, often measured in hours, days or weeks. As the systems of the body begin to shut down common symptoms include drowsiness, confusion, progressive weakness, and decreased level of consciousness. There is a loss of thirst and appetite and a reduced need for food and fluids. Late signs include mottling and cooling of the extremities and a change in the breathing pattern. Goals of care are for pain and symptom management rather than any life-sustaining treatments.

Training Requirements for all staff in the home

FLTCA 82(2)

1. The Residents' Bill of Rights.
2. Mission statement.
3. Policy to promote zero tolerance of abuse and neglect of residents.
4. The duty to make mandatory reports.
5. Whistle blower protections
6. Policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Additional Training, Direct Care Staff

FLTCA 82(7), O Reg 246/22 s.261

FLTCA 82(7)

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. Restraints.
5. Palliative care.
6. **Any other areas provided for in the regulations.**

O REG 246.22 S.261

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. Restraints
6. PASD

O Reg 261 (2) Training, Direct Care Staff

261(2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:

1. ..the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.
   - Abuse, mental health, restraint, dementia, palliative care, and areas in regulations

2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on their assessed needs.

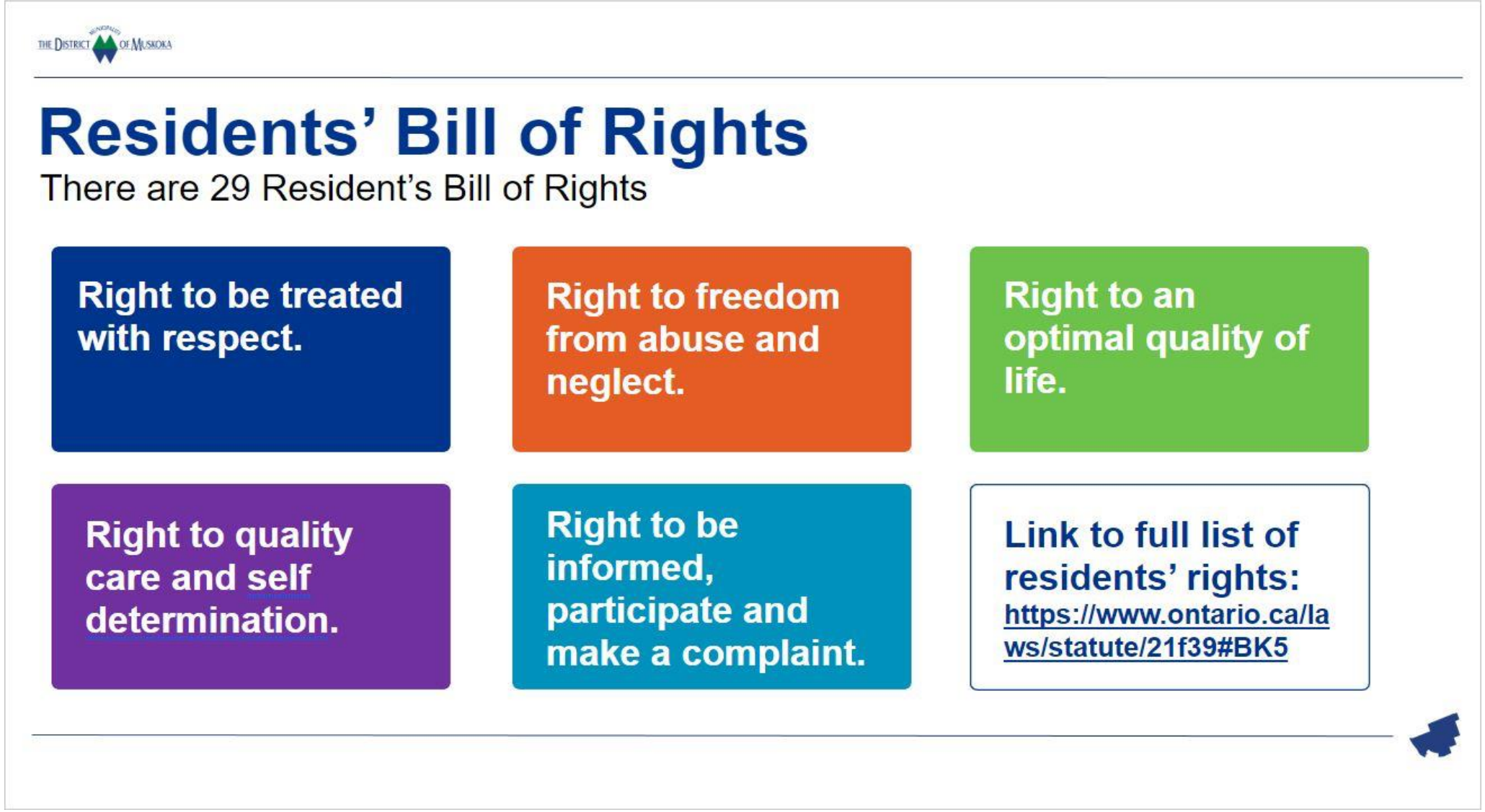
Staff as defined by FLTCA Section 2(1)

"staff", in relation to a long-term care home, means persons who work at the home,

(a) as employees of the licensee,

(b) pursuant to a contract or agreement with the licensee, or

(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel")



MDs and NPs may use the Bill of Rights to advocate for their residents

Fire Prevention and Safety

FIRE SAFETY PLAN

IN THE EVENT OF A FIRE

REACT

Remove persons from immediate danger if possible (evacuate)

Ensure doors and windows are closed to confine fire and smoke

Activate the fire alarm system/ use nearest pull station

Call the Fire Department - Dial **9-1-1**

Try to contain (contain/extinguish) fire or concentrate on further evacuation

WHEN USING A FIRE EXTINGUISHER

PASS

Pull the locking pin

Aim the nozzle at the base of the fire

Squeeze the discharge lever

Sweep the nozzle side to side at the base of the fire to ensure it is completely out

If the fire is not extinguished after the PASS, back away from the fire, contain the fire by closing the door and continue to evacuate.

Extendicare

Donning and Doffing PPE

You are going in to examine a resident on contact/droplet precautions. The RN is doing the mandatory audits for a home in outbreak and you are being observed.

Donning: Place the following in the correct order

Put on eye protection

Put on gown, tied at neck and back

Perform hand hygiene

Put on gloves

Put on mask/respirator

Doffing PPE -place the following in the correct order

- Remove the gown
- Perform hand hygiene
- Remove gloves
- Remove eye protection
- Perform hand hygiene
- Remove mask

Codes	Description
Black	A Bomb Threat Emergency is present or that a Bomb Threat Drill is being exercised.
White	An aggressive/violent/threatening situation is in progress or that code white is being exercised.
Red	A Fire Emergency is present or a Fire Drill is being exercised.
Yellow	A client is wandering and missing; or that code yellow is being exercised.
Green	An evacuation is imminent, usually occurring with lead time. This may be caused by, lack of heat in the hospital, fumes from an internal toxic spill, or other events.
Blue	A Cardiac Arrest/Medical Emergency is in progress.
Grey	An external airborne toxic spill has occurred and that external air must be excluded from the building
Purple	A hostage situation is taking place.
Orange external	A disaster outside the hospital where the Emergency Operations Centre for the city of Thunder Bay, require our facility as a back up institution for their evacuees.
Orange internal	A need for extra personnel to care for clients and possible evacuation of them due to a disaster within the facility. (i.e. loss of electricity)
Lockdown	The perimeter of the building in physically secured and locked. Persons are asked to remain in the building until the emergency is cleared. Visitors are asked not to attend to the building during this time.
Silver	A person with a weapon is present within the building. If you hear this emergency declared secure within a room or space for your safety. Remain there until directed otherwise.

Pain Identification and Management

Comprehensive Approach to Managing Pain

- ✓Comprehensive triggers to pain assessments, including admission/ readmission, new pain or new diagnosis of painful disease or pain not managed on current treatment plan

- ✓Assessments can include a Pain Assessment in Advanced Dementia (PAINAD), used for non-verbal and cognitively-impaired residents and a DN4 for Neuropathic Pain

- ✓The use of non-pharmacological methods will also be explored and added to the resident's plan of care, as appropriate, based on the individualized assessment

OLTCC Community of Practice, May 20, 2023

World Falls Guidelines for Prevention and Management

Manuel Montero-Odasso MD, PhD, FRCPC, AGSF, FGSA

https://worldfallsguidelines.com/

JAMA Network | Open

Original Investigation | Geriatrics

Evaluation of Clinical Practice Guidelines on Fall Prevention and Management for Older Adults

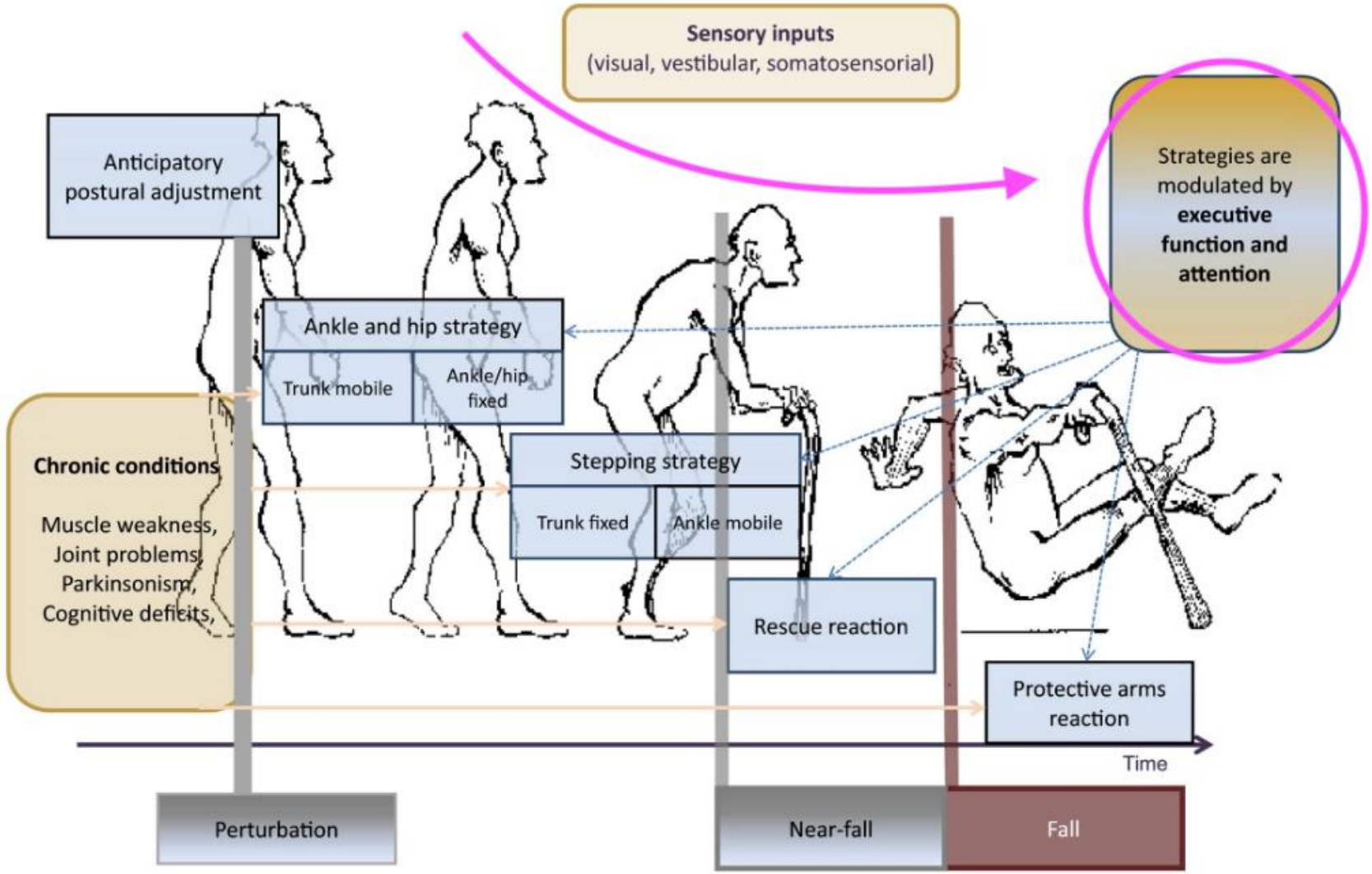
A Systematic Review

Manuel M. Montero-Odasso, MD, PhD; Nellie Kamkar, MSc; Frederico Pieruccini-Faria, PhD; Abdelhady Osman, MSc; Yanina Sarquis-Adamson, PhD; Jacqueline Close, MBBS, MD; David B. Hogan, MD; Susan Winifred Hunter, PT, PhD; Rose Anne Kenny, MBBS, PhD; Lewis A. Lipsitz, MD; Stephen R. Lord, PhD; Kenneth M. Madden, MD, MSc; Mirko Petrovic, MD, PhD; Jesper Ryg, MD, PhD; Mark Speechley, PhD; Munira Sultana, PhD; Maw Pin Tan, BMBS, MD; N. van der Velde, MD, PhD; Joe Verghese, MBBS, MS; Tahir Masud, MBBS, MSc; for the Task Force on Global Guidelines for Falls in Older Adults

- 15 high quality (AGREE II scores>75%) CPGs:
  USA, UK, Canada, France, Korea, Australia, and Ireland.
- Risk stratification based on falls history and gait/balance problems
- Majority recommend strongly
  - physical exercises
  - medication review
  - modification of environmental hazards
  - addressing cardiovascular causes
- Recommendations were inconsistent on:
  - Vitamin D
  - Hip protectors
  - Cognitive management
  - Wearable and digital technology
  - Education to prevent falls

Key messages

1. The world's population is ageing. Falls and related injuries are increasingly common, making their prevention and management a critical global challenge.
2. Many falls can be prevented. Fall and injury prevention needs multidisciplinary management.
3. Engaging older adults is essential for prevention of falls and injuries: understanding their beliefs, attitudes and priorities about falls and their management is crucial to successfully intervening.
4. Managing many of the risk factors for falls (e.g. gait and balance problems) have wider benefits beyond falls prevention such as improved intrinsic capacities (physical and mental health), functioning and quality of life.
5. Estimates of risk of future falls can be done by trained clinicians with simple resources.
6. Multidomain interventions (i.e., a combination of interventions tailored to the individual), when delivered, are effective for reducing the rate of falls in high-risk community-dwelling older adults.
7. **In care homes and hospital settings all older adults should be considered as high risk and a standard comprehensive assessment followed by multidomain interventions should be considered.**
8. Vitamin D supplementation to prevent falls should be reserved for those at risk of vitamin D deficiency.
9. Modification to the approaches for assessment and interventions may be needed for older adults with certain medical conditions associated with an increased likelihood of falling.
10. Application of some of these recommendations may need modification to meet the needs of older adults in settings and locations with limited resources.


Sensory inputs
(visual, vestibular, somatosensorial)
Anticipatory postural adjustment
Strategies are modulated by executive function and attention
Ankle and hip strategy
Trunk mobile
Ankle/hip fixed
Chronic conditions
Muscle weakness,
Joint problems,
Parkinsonism,
Cognitive deficits,
Stepping strategy
Trunk fixed
Ankle mobile
Rescue reaction
Protective arms reaction
Time
Perturbation
Near-fall
Fall

PREVENTION OF ABUSE

Mr. Stanley is 79 year old retired miner who has emphysema and needs supplemental oxygen. On a weekly visit, you ask him how he is and he states he cannot sleep, then suddenly gets tearful. Mr. Stanley shares with you that a night staff person is very mean to him and this is causing him great distress and trouble sleeping. He has refused to name the person, but states that she scolds and belittles him if he asks for help to get to the washroom at night. He is afraid to go to the bathroom alone for fear of falling as he needs manage his oxygen tubing as well.

You ask if he has made a formal complaint about this caregiver. He says he has not because he knows this person is a single mother and needs the job to support her children. He says that the caregiver used to be very friendly but that things have changed. He is afraid that if he says something, she will lose her job. He is also afraid that if she doesn't lose her job things might get worse for him.

Prevention of Abuse and Neglect

Duty to protect

24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

If absent from the home

(2) The duties in subsection (1) do not apply where the resident is absent from the home, unless the resident continues to receive care or services from the licensee, staff or volunteers of the home.

Offence

(3) Every licensee who contravenes subsection (1) is guilty of an offence.

Policy to promote zero tolerance

25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

Contents

(2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated;

(b) shall clearly set out what constitutes abuse and neglect;

(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;

(d) shall contain an explanation of the duty under section 28 to make mandatory reports;

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

(f) shall set out the consequences for those who abuse or neglect residents;

(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and

(h) shall deal with any additional matters as may be provided for in the regulations.

Communication of policy

(3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers.

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The Journal of Post-Acute and Long-Term Care Medicine
amda

REVIEW ARTICLE | VOLUME 22, ISSUE 8, P1678-1691.E6, AUGUST 01, 2021

Resident-to-Resident Elder Mistreatment in Residential Aged Care Services: A Systematic Review of Event Frequency, Type, Resident Characteristics, and History

Marta H. Woolford, BHSc (Honors) • Susan J. Stacpoole, BAppSc (Pod), PhD, FAAQHC • Lisa Clinnick, RN, BN, GrdDpGrntN, MCIN, MBA, DN, FACN

Published: March 13, 2021 • DOI: https://doi.org/10.1016/j.jamda.2021.02.009 •

In general,

- 80 – 90% of residents have cognitive impairment.
- Broader structural conditions in LTC that foster aggression are
  - confinement,
  - lack of privacy,
  - carer workload,
  - inconsistencies in staffing
  - fewer behavioural, recreational, and social care providers,
  - reduced staff for basic physical tasks such as bathing.

policy for NOTIFYING police

Region of Waterloo / SUNNYSIDE Seniors' Services		Manual **Master**	Policy # **5-134**
Seniors' Services		Section: Quality Improvement and Risk Management	
		Revised/Approved: May 26, 2021	Original: June 15, 2016
Title:	**NOTIFYING POLICE**		
Applies to:	Employees		

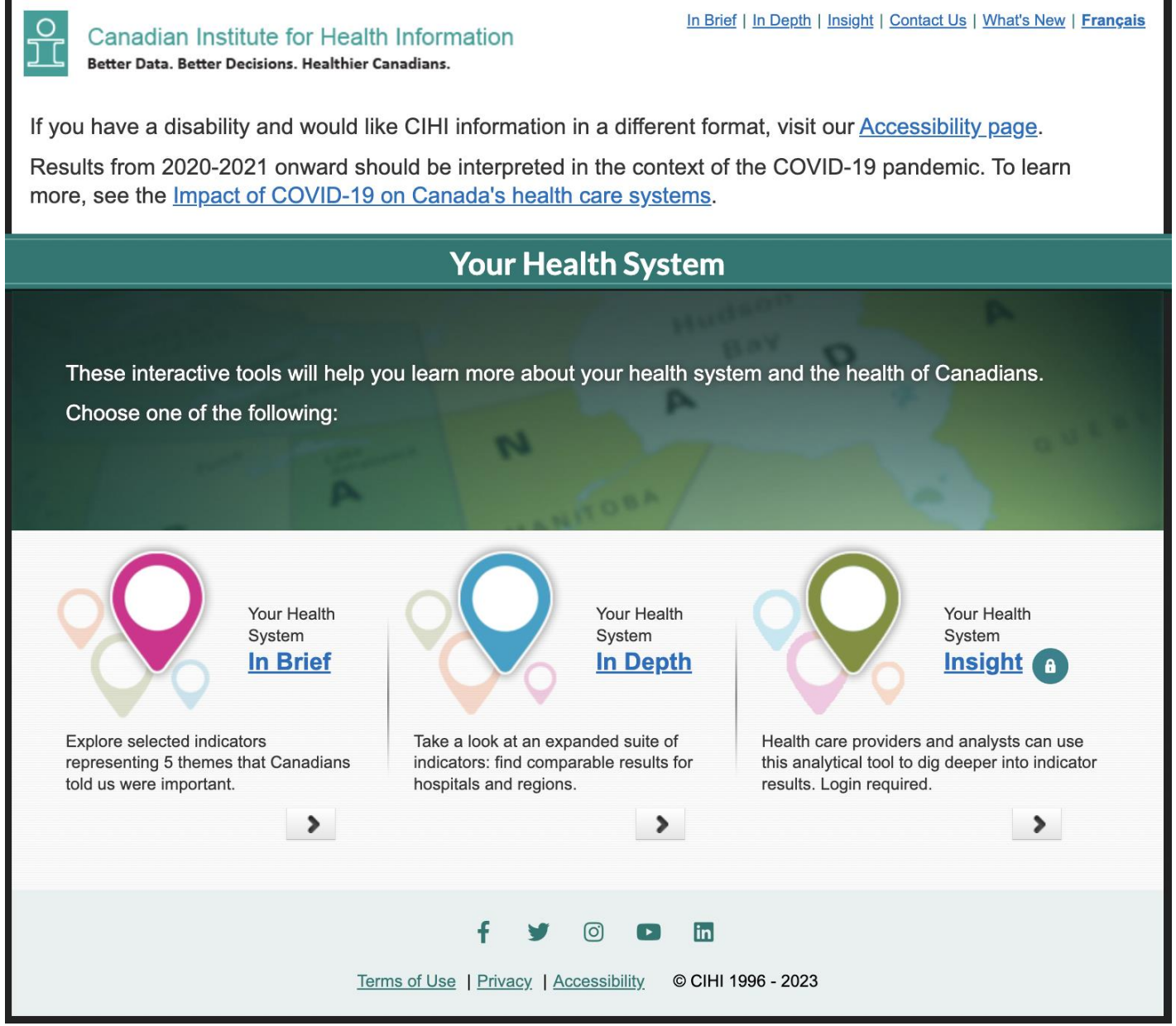
The intention of this policy is to identify the circumstances in which the Police will be notified, who is responsible for contacting the Police and who should be notified if the Police are called. The policy also identifies when the police should be notified through the Seniors Support Team (SST, formerly referred to as the EART team).

Without Exception, Police will be called when:

- When an incident is a mandatory report by law (use the MLTC decision trees)
  - **Any suspected or witnessed incident of abuse or neglect** that may constitute a criminal offence through notification of Seniors' Support Team (SST). For emergencies, notify Waterloo Region Police directly.
  - Any suspected or witnessed incident of **domestic abuse** that may constitute a criminal offense through notification to the Waterloo Region Police (not SST).
- If the incident is in progress and requires immediate intervention (e.g., when there is imminent physical threat for safety)
- Level 4 incidents in the Code of Conduct policy
- Other circumstances under which Management / Standby Manager deems it necessary to contact the police

RESTRAINTS

At the Professional Advisory Committee meeting the Administrator informs the home the restraint use, as reported on the Canadian Institute for Health Information (CIHI), is much higher that homes in your area and the province. Restraints are 7%. More that half of the comparative homes have restraint use of 0%. She asks how the professional staff can address this discrepancy.



https://yourhealthsystem.cihi.ca/

RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

iaBPG INTERNATIONAL AFFAIRS & BEST PRACTICE GUIDELINES

LTC LONG-TERM CARE BEST PRACTICES PROGRAM

RNAO Best Practices: Evidence Booster

Alternatives to the use of restraints: Long-Term Care Home experience

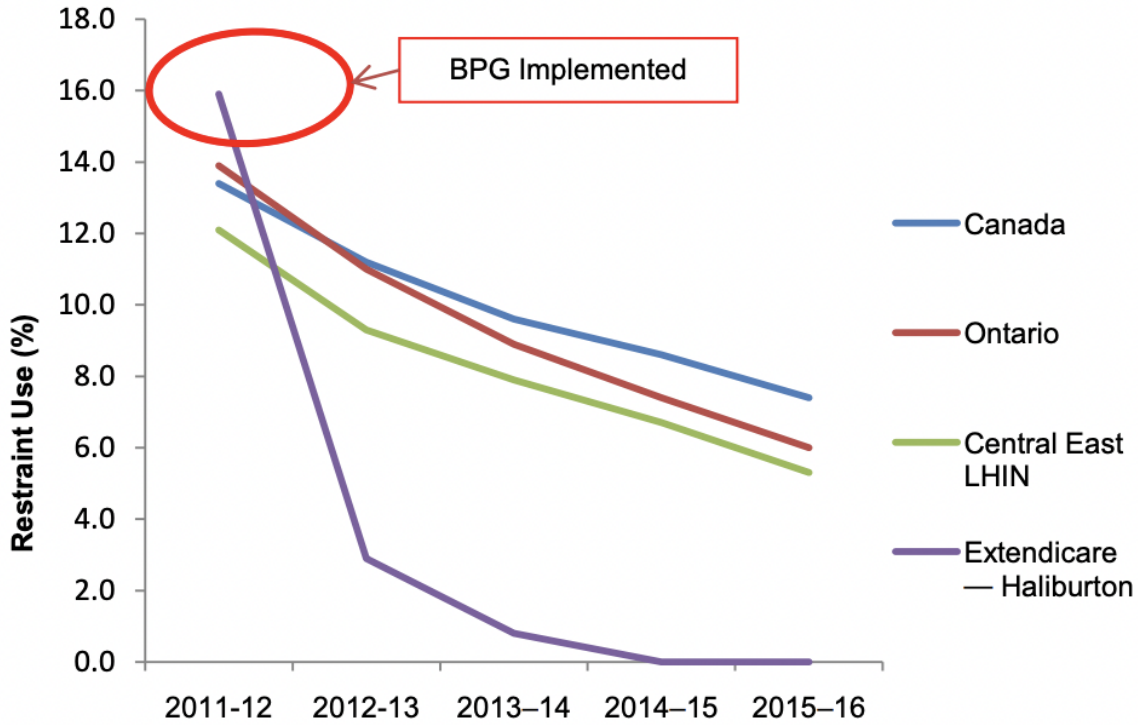
Background

When Jane Rosenberg was a nursing student, using restraints was common practice. "Although I wasn't comfortable using restraints, I followed orders," she recalls. In those days, it was frowned upon for nursing students to rock the boat. But she knew restraints threatened the dignity of her residents, so she made a quiet commitment to pursue a change.

While working as a charge nurse in long-term care (LTC), Rosenberg participated in the *Walk a Day in my Shoes Program*, which allows health-care providers to simulate life as a LTC resident. She was placed in a wheelchair and secured at the waist by a wide black belt tied securely at the back of her chair. A white plastic tray was placed in front of her and limited her movement. The chair was positioned off to the side of the classroom, brakes were locked and she was left to sit there feeling isolated, forgotten, and powerless.

Rosenberg recalls the experience like it

Figure 1: Restraint Use in Long-Term Care



Source: Your Health System Trend Over Time, CIHI 2016

Impact: Restraint use was decreased from 15.9% to zero by implementing the RNAO BPG, *Promoting Safety: Alternative Approaches to the Use of Restraints (2012).*

Antipsychotics

Medication	Reason
Alendronate 70mg once weekly Vitamin D 1000 IU daily	Osteoporosis
Ramipril 10mg daily Bisoprolol 2.5mg daily Atorvastatin 40mg daily ASA 81mg daily	Secondary Prevention of CVD
Levothyroxine 50mcg daily	Hypothyroidism
Tiotropium 18mcg daily Salbutamol prn	COPD
Vitamin B12 1200mcg daily	B12 Deficiency
~~Omeprazole 20mg daily~~	~~No Specific Indication~~
Olanzapine 10mg twice daily	BPSD

Carole

SEVERE MENTAL ILLNESS:

- Schizophrenia
- Bipolar disorder
- Major depression
  - With or without psychosis

Dementia more common among older adults with SMI.

20-30% of older adults with schizophrenia had dementia.

5-20% of old adults with BD have dementia.

Doses of antipsychotic medication used for SMI are much higher than is indicated for BPSD.

deprescribing.org

Potentially inappropriate use of antipsychotic:

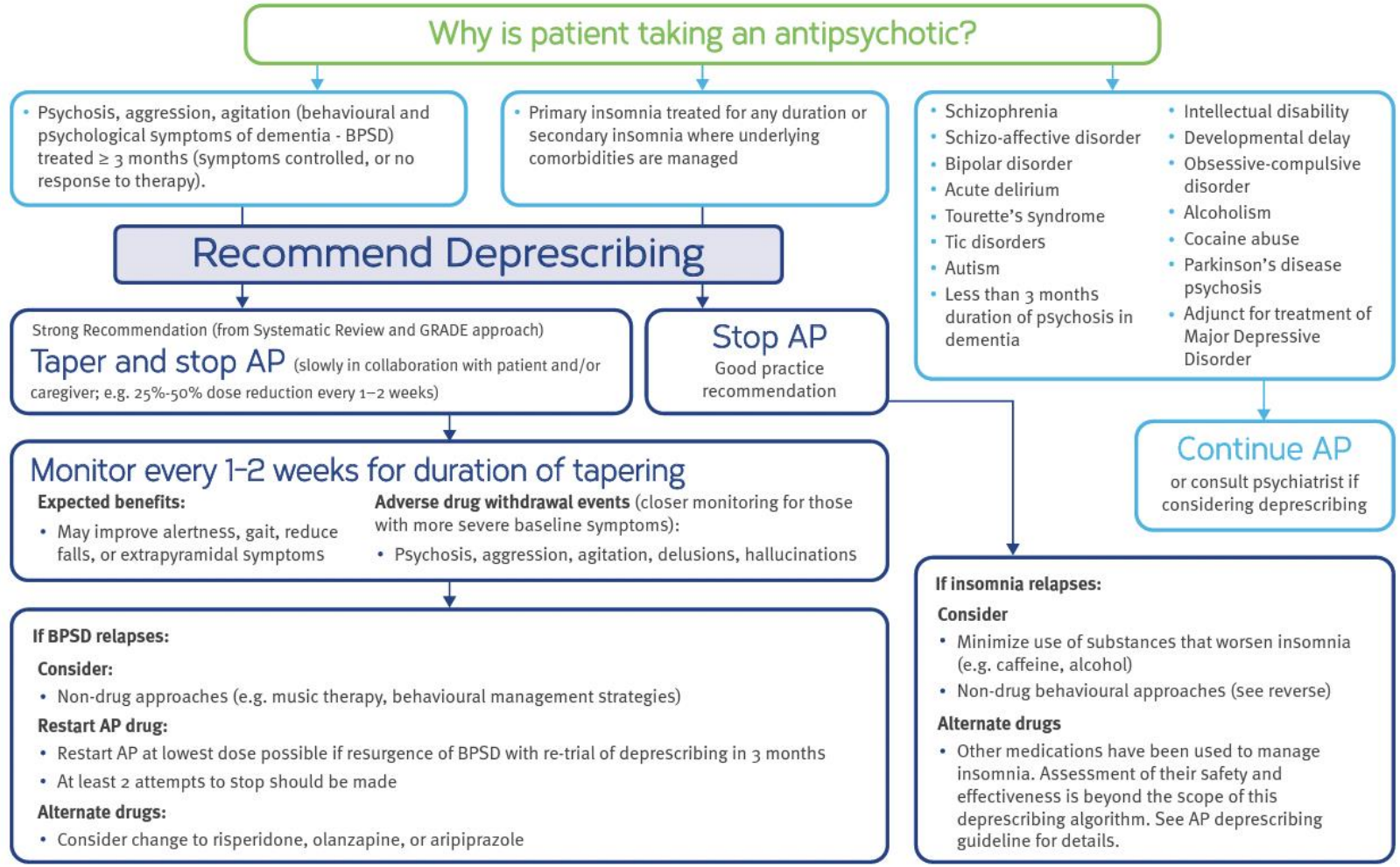
CIHI exclusion data:

- **Schizophrenia**
- **Huntington's disease**
- **Hallucinations**
- **Delusions**
- End-of-life

- Schizophrenia
- Schizo-affective disorder
- Bipolar disorder
- Acute delirium
- Tourette's syndrome
- Tic disorders
- Autism
- Less than 3 months duration of psychosis in dementia
- Intellectual disability
- Developmental delay
- Obsessive-compulsive disorder
- Alcoholism
- Cocaine abuse
- Parkinson's disease psychosis
- Adjunct for treatment of Major Depressive Disorder

deprescribing.org | Antipsychotic (AP) Deprescribing Algorithm

August 2018



Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, et al. Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia: Evidence-based clinical practice guideline. Can Fam Physician 2018;64:17-27 (Eng), e1-e12 (Fr).

deprescribing.org | Institut de recherche Bruyère Research Institute | open Ontario Pharmacy Evidence Network

- Psychosis, aggression, agitation (behavioural and psychological symptoms of dementia - BPSD) treated ≥ 3 months (symptoms controlled, or no response to therapy).

- Primary insomnia treated for any duration or secondary insomnia where underlying comorbidities are managed

Recommend Deprescribing

Strong Recommendation (from Systematic Review and GRADE approach)

Taper and stop AP (slowly in collaboration with patient and/or caregiver; e.g. 25%-50% dose reduction every 1–2 weeks)

Stop AP

Good practice recommendation

Monitor every 1-2 weeks for duration of tapering

Expected benefits:

- May improve alertness, gait, reduce falls, or extrapyramidal symptoms

Adverse drug withdrawal events (closer monitoring for those with more severe baseline symptoms):

- Psychosis, aggression, agitation, delusions, hallucinations

If BPSD relapses:

Consider:

- Non-drug approaches (e.g. music therapy, behavioural management strategies)

Restart AP drug:

- Restart AP at lowest dose possible if resurgence of BPSD with re-trial of deprescribing in 3 months
- At least 2 attempts to stop should be made

Alternate drugs:

- Consider change to risperidone, olanzapine, or aripiprazole

CAPACITY AND CONSENT

John is a 71-year-old gentleman admitted one month earlier. He has progressive amyotrophic lateral sclerosis (ALS). Weakness is increasing and respirations have become more of an effort.

In hospital, he had an initial assessment for MAID. He wants to get another assessment. The nurse points out to you that he cannot consent to MAID because his cognitive performance scale (CPS) is three.

Category	Score
MDS Scores Type: Q	ARD: 10/26/2020
RUG	IB1
CMI	0.95
CPS	3
DRS	0
COMM	1
PAIN	1
ISE	4
ADL Short	2
ADL Long	9
ADL Self	1
CHESS	2
ABS	0
PSI	1
PURS	1
FRS	4

Capacity is time and decision-specific

Time Specific

- A person may be capable of decision-making at one time but incapable of that same decision at another time.

Examples:

1. Sundowning in people with dementia. They may be capable of providing consent for a swallowing study in the morning when they are lucid but not during the evening.
2. A person with delirium secondary to an infection may not be capable of consenting to have a drain inserted to clear the infection, but once the delirium has resolved, they are once again capable.

Decision Specific

- A person may be mentally capable of making one decision and not another decision.

Examples:

1. A person may be *capable* to consent to starting antibiotics for an infection, but *incapable* of making a more complex decision about whether or not to have surgery.
2. A person may be *incapable* to consent to decisions regarding moving into long term care but *capable* of making decisions about receiving the flu vaccine.

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Cognitive Performance Scale

≠

Capacity, consent

Every resident has the right to have their participation in decision-making respected.

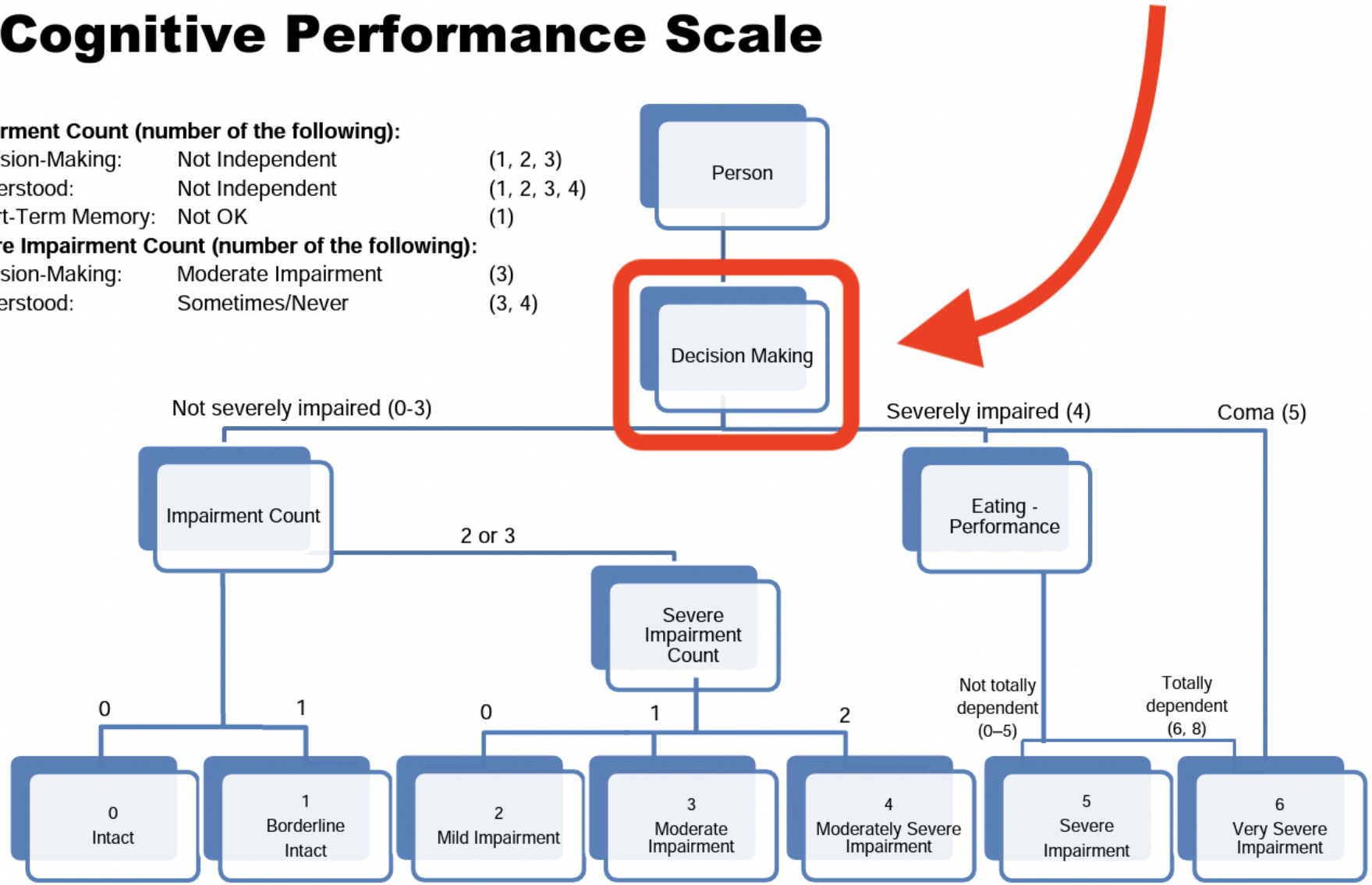
Cognitive Performance Scale

Impairment Count (number of the following):

- Decision-Making:	Not Independent	(1, 2, 3)
- Understood:	Not Independent	(1, 2, 3, 4)
- Short-Term Memory:	Not OK	(1)

Severe Impairment Count (number of the following):

- Decision-Making:	Moderate Impairment	(3)
- Understood:	Sometimes/Never	(3, 4)

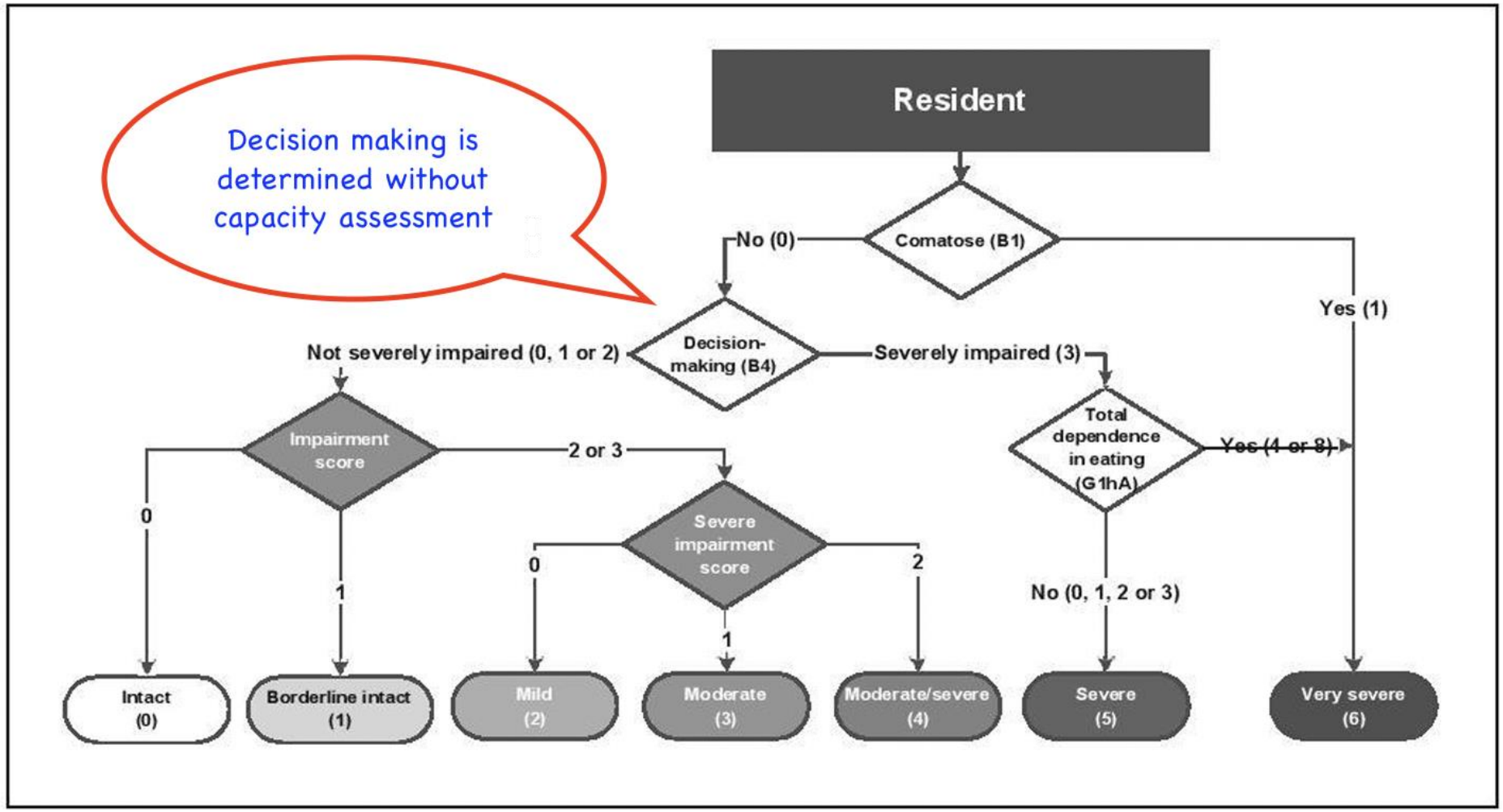


Source: Morris JN, Fries BE, Mehr DR, Hawes C, Philips C, Mor V, Lipsitz L. 1994. MDS Cognitive Performance Scale. *Journal of Gerontology: Medical Sciences* 49(4): M174–M182.

Cognitive Performance Scale & MMSE

CPS score	Description	MMSE equivalent average
0	Intact	26
1	Borderline Intact	22
2	Mild Impairment	19
3	Moderate impairment	15
4	Moderate/severe impairment	7
5	Severe impairment	5
6	Very severe impairment	1

The following decision tree illustrates how the CPS score is determined:



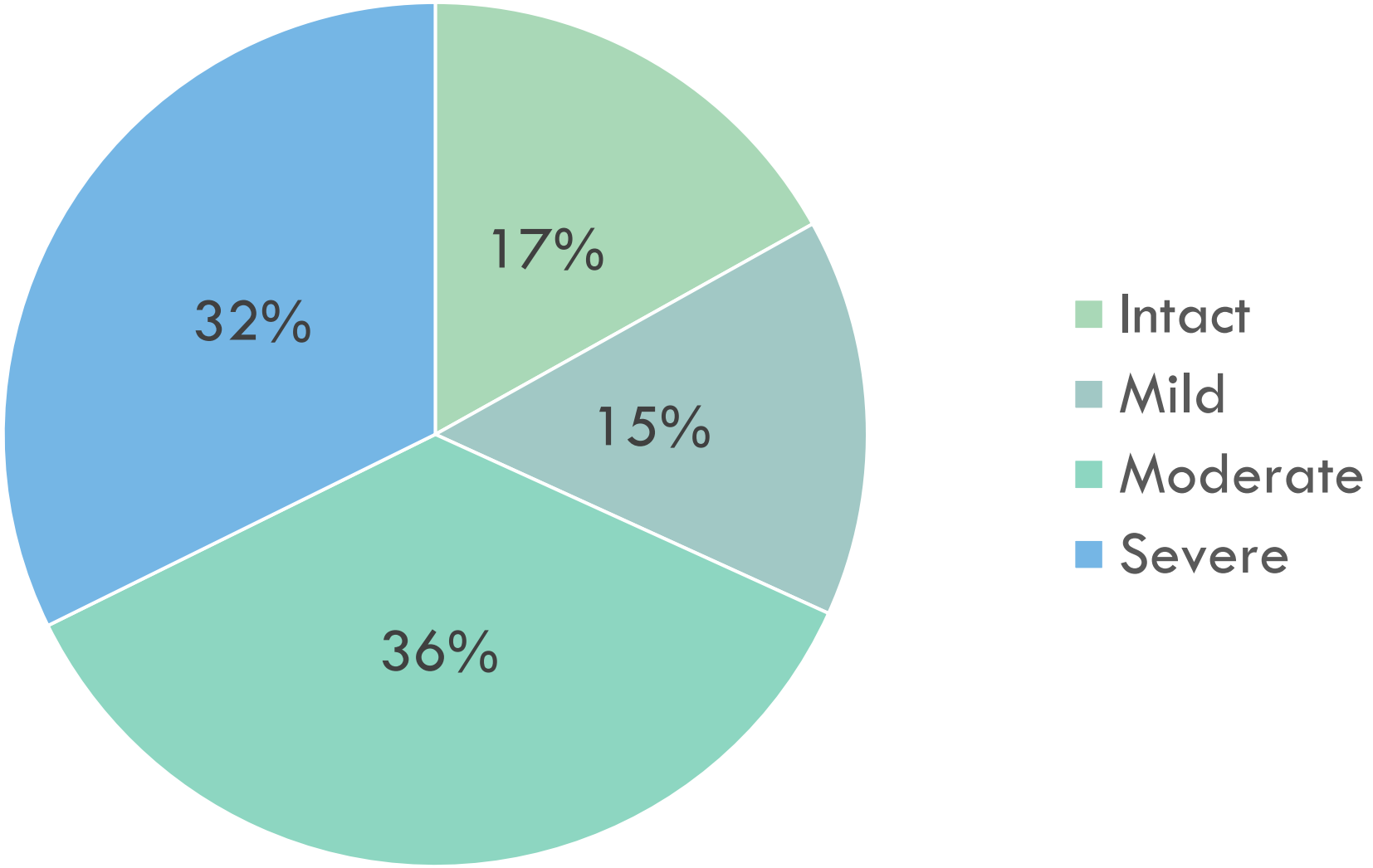
Source

Morris JN, Fries BE, Mehr DR, Hawes C, Philips C, Mor V, Lipsitz L. MDS Cognitive Performance Scale. *J Gerontol: Med Sci.* 1994;49(4):M174-M182.

CPS	Ontario	SSH	FHLTC
Relatively intact, 0-1/6	16.9%	16.3%	14.9%
Mild impairment 2/6	14.9%	9.7%	27% *
Moderate impairment 3/6	35.9%	42.8%	38% *
Severe impairment 4-6/6	32.3%	31.1%	20%

* Estimate based on relative provincial percentages

CPS Scores



68% of residents have moderate or severe impairment

Continuing professional development should be:

- Needs based
- Relative to practice

Ideally, it should also be:

- Interactive
- Reflective
- Accredited