For electronic distribution

Redeployment Orientation Resources - NURSING

In this package you will find introductory information for working in Long Term Care. It is the expectation that a new worker will receive this package, as well as an orientation to the area using the checklist provided. This package does not take the place of in-person guidance and established protocols.

In this package:

1. Introduction to Long Term Care Overview
2. Orientation checklist for redeployed Nurses
3. Skills Self-Assessment
4. Client Identification
5. Quick Tips for Working with People with Dementia
6. Falls Information
7. Restraints
8. Advance Care Planning
9. Medi-system Frequently Asked Questions
10. Feeding and swallowing
11. LTC PPE requirements
12. Links to PPE resources
13. Essentials of working in geriatrics – links and topics
14. Additional Resources for working in geriatrics – links and topics

Introduction to Long Term Care

Please take a moment to read this Practice Expectation Spotlight **Registered Nurse Responsibilities in New Practice Environments** from the College of Registered Nurses of Manitoba.

The Long Term Care Model

Personal Care Homes do not operate using a medical model. They usually function in a social model with use of an Interdisciplinary team with large involvement of family and/or substitute decision maker. It is important to remember that you are **working in someone's home**. The residents live here with their belongings placed where they need them and routines that reflect their personal choice and preferences.

Staffing and Personal Care Homes

Staffing ratios at PCH look very different from acute care areas. This is because the job role of a nurse in PCH looks different, usually with fewer acute changes happening on a day to day basis. Examples: Days: 1 nurse to 20 residents, Evenings: 1 nurse to 40 residents, Nights 1 nurse to 80 residents

HCA ratios may also differ from PCH to PCH.

The Resident's Bill of Rights:

PCH resident care is based on the foundations detailed in the Resident Bill of Rights. Each PCH has a Resident Bill of Rights that is posted prominently in the PCH. Every person entering into the PCH is guided by these rights. Manitoba PCH's must also adhere to the Manitoba Health Standards of Practice in every aspect of their operation and provision of care.

Documentation:

Documentation at PCH will vary from site to site. Some homes use electronic health records, others use paper charts. Each PCH will have a resident care plan with individualized interventions to address the specific needs of each resident. The health record will include the IPN which are usually narrative, SOAP, or DARP format, physician orders and flow sheets to track day to day care tasks. In each resident room, usually facing the wall in a bathroom, there will be an ADL sheet that communicates some of the basic care/assistance needs for the resident.

Safe Resident Transfers:

A transfer logo located in the room will help identify how much assistance and assistive devices are needed to mobilize the resident. **In PCH 2 staff are required to safely use a mechanical lift.**

Violence Prevention Plan (VPP):

The C.A.R.E. Use Caution and Respect Every Day Provincial Violence Prevention Program is in use in PCH's. Each PCH will have a system in place to identify residents who have been deemed at risk for behaviours and will have specialized care plans in place to communicate approach or care interventions that should be used with that specific resident. Please confirm the PCH specific implementation systems in place for C.A.R.E. VPP.

Orientation and Handoff Checklist for Redeployed Nurses

This is a list of minimum expectation for in person orientation of staff attending to a PCH for emergency redeployment. Each of these shall be discussed, and time provided for the new nurse to review the materials provided in this package.

Documentation:

- ☐ Care plans, Kardex, ADL sheets and flow sheets
- ☐ MARS and odd time meds for assigned shift
- ☐ Charting practices
- ☐ Computer systems as applicable
- ☐ Unit Calendar
- ☐ RL6 Reports
- ☐ VPP protocols

Medications:

- ☐ Med cart/med room and med systems overview
- ☐ Access to manuals/policies re medications
- ☐ Pharmacist contact information
- ☐ Narcotic counts and processes

Tour:

- ☐ General tour of site
- ☐ Wander guards
- ☐ Supplies
- ☐ Kitchen and provisions for snacks etc.
- ☐ Exit alarms
- ☐ Fire alarms, fire extinguishers
- ☐ Door codes
- ☐ Water for drinking

Contacts:

- ☐ CRN/Nursing Coordinator and/or other contact numbers
- ☐ Physician/NP access
- ☐ Telephone system

Emergency and other protocols and procedures:

- ☐ Emergency equipment
- ☐ Emergency plan
- ☐ Emergency codes
- ☐ Facility Policy Manual
- ☐ Calling 911
- ☐ Post fall protocols
- ☐ Death protocols
- ☐ Restraint Observation Sheet, Restraint Policy & procedures

Orientation and Handoff Checklist for Redeployed Nurses

Change of shift report

- ☐ Patient hand off – status reports and relevant information about each person that would be helpful to know and personal routines

COVID practices /PPE Review:

- ☐ Donning & Doffing
- ☐ Breaks vs Lunch protocols – Physical distancing and sharing of food
- ☐ Extended use protocols
- ☐ When to change gloves
- ☐ Never sanitize gloves
- ☐ Point of Care Risk Assessment (PCRA)
- ☐ N95 mask use and AGMP's
- ☐ Green/orange/red zone
- ☐ Where to find COVID protocols and resources

Competency Checklist for Long Term Care Nurses (RN, RPN, LPN)

- Please review this list and self identify areas where you feel that you would need additional education
- Skills required will vary by unit/facility/department.
- Contact area designate to fill gaps in learning resources and utilize clinical skills,use Nursing Skills Online and other resources as provided. Designated resource person: _____

Skill/Procedure	**Self Identify** Competency Level		
	C= competent	NR= needs review	Date Training Completed
1. Urinary Catheter • Removal/replacement			
2. Pain Assessment and Management			
3. Sepsis Management			
4. Suprapubic Catheter * • Removal/Replacement			
5. Ostomy Care & Appliance Change • Colostomy • Ileostomy • Urostomy*			
6. Enteral Feeding			
7. Nasopharyngeal Swabs			
8. Suture/Staple Removal			
9. Venous Thromboembolism (VTE) Management			
10. Glucose Monitoring			
11. Protected Code Blue • CPR*			
12. Restraints-Long Term Care			
13. Medication management • Medication reconciliation • Medication administration • Narcotic control-doc/count • High alert medications • Hazardous Drugs non-chemo administration & precautions • Immunizations • Chemotherapy Drugs-Oral for cancer and non-cancer administration & precautions • Subcut • Intramuscular			

Skill/Procedure	Self Identify Competency Level		
	C= competent	NR= needs review	Date Training Completed
14. Palliative Care • Hypodermoclysis*			
15. Anaphylaxis intervention (assessment & initial)			
16. Tracheostomy Tube Care* • Suctioning			
17. Suction			
18. Non-invasive positive pressure ventilation- chronic established CPAP/BIPAP			
19. Cough Assist*			
20. Oxygen Therapy • High flow* • Portable oxygen cylinders-safe handling • Concentrators			
21. Skin and Wound care • Basic Skin Care • Basic Wound care • Pressure injuries-care of, Braden Scale • Wound irrigation and Packing • Compression –care of • Compression bandaging-application • NPWT-application/care of (VAC/PICO)*			
22. PPE • Donning and doffing • Continuous and extended PPE guidelines			

***May be site specific requirement**

Client Identification

Why do we need client identification?

We must always make sure that we a re providing care for the right person. We do this by checking TWO identifiers all of the time. This helps us to avoid:

- Privacy breaches
- Allergic reactions
- Unsafe Discharge (discharge of client to the wrong location)
- Medication errors
- Procedures on the wrong person

Working with residents and families, we use at least ***two*** client specific identifiers to confirm that residents receive the right care. This includes meals. We must make sure that each person receives the right diet and food consistency. This is important to prevent choking and allergic reactions.

What are client specific identifiers?

These may used as client identifiers:

- Client's full name (Ask, "What is your full name?" **Don't ask**: "Is your name 'Bill Smith'?")
- Date of birth (ask client "What is your birthdate?" **Don't ask**: "Is your birthday June 12?")
- An up to date photograph
- Recognizing a person who you already know
- Medication identification bands/wristbands
- Health records
- Personal identification number (ie: PHIN or equivalent, medical record number, etc.)
- Identification bracelets (WRHA/affiliate health care facility)

***Two identifiers may be taken from the same source**

***When using photographs:**

- Photo must be current, dated and re-taken annually and as necessary
- Photos are useful in binders for recreation and food service, for medication administration (medication administration record and/or pouch porter), placed on the client's room door, and as a tag on their wheelchair. ***A client's room or bed number unconfirmed by Client or family member shall not be used as a Client-Specific Identifier.***

When would I use Client Identification?

Client Identification will occur at the following points of care:

- Before to providing any care
- Before giving medications
- Before to providing meals
- If a resident is moving from one care area to another

Working with Persons Living with Dementia

Dementia is not just “memory problems”.

People with dementia have changes to the brain that make it hard for them to think, to do things that used to be simple, and to communicate. The last part of the brain to be affected is often the amygdala. This is the part of the brain that is focused on survival, needs and safety. The survival instinct is their strongest part of their brain.

With the “thinking” parts of the brain damaged, people with dementia can sometimes become afraid and defensive about things that we do not think are scary.

Here are some important tips to remember:

- Their reactions to things are not personal, even if it feels like it is.
- If a person with dementia is acting defensive or scared it is because they feel threatened in some way. ***Every behaviour has meaning.***
- Sometimes we can figure out what is scaring them and change it. Sometimes we can’t – but there is something.
- They may remember something tomorrow that they couldn’t remember today. That’s not on purpose. That’s the brain changes and brain chemicals changing from day to day.
- Never argue with someone with dementia. No one wins.
- Live in the moment with the person – even if they seem to be living in another time and place. Correcting them will not help.
- Do not talk to them in “baby-talk” tones.
- Your tone of voice and body language are your most important tools. – Sound and look like you respect them, and they are important.
- Their ability to express themselves may be gone before they lose the ability to understand what’s being said to them.
- Their ability to “read” your body language and tone of voice remains even when they don’t understand your words.
- ***They cannot easily change their response, so we must change our approach***

How to Approach Residents: (seated resident)

- Approach from the front
- Smile and gently wave to get their attention
- Walk slowly
- Greet by name and make eye contact
- Go to the side
- Crouch to eye level
- Speak slowly and clearly in short simple phrases and allow time to process and respond

There are many excellent videos that can be found online to learn about caring for someone with dementia. If you search: “**Teepa Snow**” and/or “**Caregiver training videos - UCLA Alzheimer’s and Dementia**”, you will find many excellent videos.

CNS Chat

With Kristine Schellenberg & Luana Whitbread

Clinical Nurse Specialists, WRHA Long Term Care Program

FALLS Part 1: Assessment of Falls Risk

Did you know?

In Manitoba, falls among older adults are:

- The leading cause of death due to injury
- The leading cause of injury hospitalization
- Responsible for $164 million annually

In Winnipeg, falls among older adults result in:

- 2000 hospitalizations each year
- An average length of stay per hospitalization of 33 days
- 90% of all hip fractures

What is the definition of a Fall?

FALL: Unintentionally coming to rest on the ground, floor, or other lower level with or without an injury

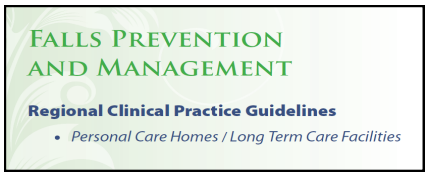
The majority of falls are un-witnessed— a person is found on the floor and neither the person nor anyone else knows how he or she got there

The 'typical' fall is often not caused by one single thing; however, these falls:

- Often occur in bedrooms, hallways, and bathrooms
- Are common in late afternoon and evening
- Happen when moving about, transferring, walking, or toileting

Falls Prevention and Management

- Preventing and managing falls requires the assistance of all team members
- Incorporates a multi-factorial approach using standard falls prevention interventions
- Should be routine care for all residents of personal care homes



http://www.wrha.mb.ca/extranet/eipt/files/EIPT-007-003.pdf

Routine Practice for Falls: Use the acronym FALLS

Just as we use routine practices for infection control, we also use the concept of routine practices for falls. This means, at minimum, the following would be done for everyone living in LTC.

FAMILY &/or resident will communicate falls risk & history of falls prior to or at admission

ASSESS – pain, elimination needs, hunger, thirst, ability to use call bell, etc

LOOK at environment & reduce hazards

LYING & sitting/standing BP

SHOW surroundings – orient resident to environment

Assessment of Falls Risk

A Falls Risk Assessment Tool (FRAT) or an equivalent tool is completed within 24-48 hours of admission to identify resident-specific areas of risk. This allows a specific care plan to be developed based on the findings.

The MOST IMPORTANT component of the assessment is not the number generated but rather the information that is obtained (i.e. risk factors) that can be used to formulate the plan of care.

NOTE: Focus **LESS** on the 'score' (number generated from the risk assessment) and **MORE** on the individual risk factors!!

It is important to regularly re-evaluate the risk of falls, particularly whether interventions are effective in preventing falls and/or reducing risk for harm if someone falls.

See policy: For more info refer to Falls management in Personal Care Homes-Assessment of Risk-Routine Practice for Falls #110.130.100

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FALLS Part 2: Interventions

Did you know?

- The WRHA Fall Prevention and Management Clinical Practice Guideline has interventions specific for PCH and Long Term Care facilities.
- The CPG is accessible on any computer with internet access http://www.wrha.mb.ca/extranet/eipt/files/EIPT-007-003.pdf (not just an MDS computer)

Risk assessment is done...now what?

After completing the risk assessment (i.e. FRAT) and identifying risk factors specific to each resident, then a care plan needs to be created. Interventions should take into consideration that risk factors are both modifiable (things we can change) and non-modifiable (things we cannot change but try to reduce risk if possible).

There are multiple risk factors, but we are going to discuss interventions for six common risk factors.

All intervention should be specific to the needs of the individual resident

Risk factor: *Balance and mobility limitations*

- Assess use of mobility aides, wheelchairs etc.
- Ensure mobility aides are correct height for resident and in good working order
- Ensure correct transfer logo is in place and visible to all staff
- Ensure slings used are appropriate size and in good working order

Risk factor: *Continence*

- Consider use of commode at bedside, assist resident to bathroom at set times (e.g. q1-2 hours)
- Keep lights/nightlights on in bathroom, clear path to the bathroom

Risk factor: *Vision*

- Provide adequate lighting and visual cues (e.g nightlights)
- As appropriate, ensure glasses fit well and are clean

Risk factor: *Environment*

- Consider resident's preferred arrangements for belongings and furniture
- Provide easy access to items (e.g. phone, call bell)
- Ensure bed is in locked position and at the lowest height appropriate for safety of resident (i.e resident can sit and touch floor with legs at 90 degrees). Not every resident needs a bed that lowers to the floor
- Consider fall mats, as appropriate

Risk factor: *Footwear*

- Safe footwear includes shoes with thinner, firmer soles, low square heel
- Discourage use of slippery slippers or socks

Risk factor: *Medications*

- Review medications (especially antipsychotics/ anti depressants) on admission, after a fall or change in dosage (either ↑ or ↓)
- Risk of falls ↑ within 3 days of any change in psychotropic medication

Those are some examples of possible interventions. Depending on the resident, some other risk factors that may need interventions include: **cognitive impairment; orthostatic hypotension; observation and monitoring; restraints; nutrition; and osteoporosis.**

Communication & Evaluation

⇒ Ensure that you communicate the interventions to all of the members of the team who need the information - this includes the resident and family, HCA's, housekeeping.

⇒ Remember to evaluate your plan within a few days of resident's admission to the PCH, with any change in resident condition, after a resident fall, and quarterly.

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Did you know?

Manitoba Health Standards Review for PCHs in the WRHA will begin January 2018 (Don't panic!).

Standard 9: Use of Restraints is an area where questions and clarification points continue to arise. We want to highlight some common areas that are sometimes overlooked.

It is important to follow the process of assessment, documentation, and reassessment to provide the resident with the best care if a restraint is to be considered. It is not only about meeting MB Health Standards.

Assessment

* IDT assessment prior to application of restraint is a ***bolded*** measure (except for emergency and interim restraints)
* Ongoing reassessment is required
* Reassessment needs at least 2 members from different disciplines to discuss (e.g. nurse and HCA, but not 2 nurses only)
* All relevant alternatives should be tried, exhausted, and documented

Consent

* Consent is required for all restraints (except for an emergency restraint)
* If verbal consent obtained, then 2 staff signatures must be documented (1 staff member must be a nurse)
* Written consent is still required after obtaining verbal consent (ideally within 2 weeks of obtaining verbal consent)

Benefits and Burdens

* Restraints are not benign safety devices --- they create additional hazards for residents
* Individual assessment and documentation of actual and potential benefits and burdens to the resident is crucial
* Consider the possibility of death as a burden for all restraints
* Consider ethical considerations (e.g. family request vs. other alternatives or interventions)

The actual order for restraint:

* Remember to date, sign, and put your professional designation on the order
* For chemical restraints, there must be a **discontinuation date**, not just a reassessment date.

Care Plan must indicate:

* Frequency of checks while the restraint is in use
* Length of time restraint is to be used for each application
* When regular removal of restraint is to occur

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Feel free to send us topics to discuss.

Next Chat: May 2017

Topic: TBD

CNS Chat

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Clinical Nurse Specialists, WRHA Long Term Care Program

Advance Care Planning

Did you know?

- April 16th is national Advance Care Planning Day
- Advance care planning (ACP) is a process, not just a document. It involves conversations with family or substitute decision makers (SDM) about personal values and beliefs as well as medical procedures that the resident wants at the end of life
- The process occurs at any time when future or potential life threatening illness treatment options and Goals of Care are being considered or revisited

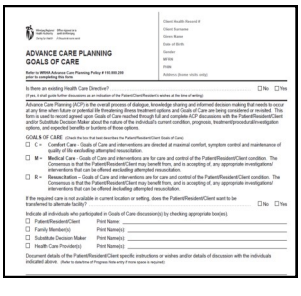
What is the difference between a Health Care Directive and the WRHA Advance Care Planning form?

Health Care Directive (HCD)

- Legal document that allows a person to express their wishes about the amount and type of health care and treatment they want to receive should they become unable to speak or communicate
- **Enacted only when the resident is unable to make decisions for themselves**
- It also gives another person (Health Care Proxy) the power to make medical decisions should the person be unable to themselves

WRHA Advance Care Planning—Goals of Care Form

- The form is to be completed as part of policy to help inform healthcare providers of person's expectations of care in order to respond to clinical changes.
- If a HCD exists, it takes precedent.
- The form should NEVER be handed to resident or family to complete without some discussion. The goal of care selected is the outcome of this discussion.
- The Advance Care Plan policy emphasizes that the process is based on consensus between the resident/ substitute decision maker and the health care team.



ADVANCE CARE PLANNING
GOALS OF CARE

3 Goals of Care

R = Resuscitation – Goals of Care and interventions are for care and control of the Resident condition ***including*** attempted resuscitation

M = Medical Care

Goals of Care and interventions are for care and control of the Resident's condition ***excluding*** attempted resuscitation.

C = Comfort Care

Goals of Care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life ***excluding*** attempted resuscitation.

Comfort care **does not** mean:

- Resident is never transferred to hospital
- Conversations stop with resident/SDM/family
- Resident never gets out of bed
- Resident is not regularly assessed
- All meds are stopped or only pain meds given
- Resident is imminently dying

Regardless of the goal of care chosen by the resident (or substitute decision maker), it is important to remember that a conversation should take place about the person's expectations of the type of care they wish to receive with each clinical change. It requires ongoing discussion as a person's situation may change over time.

Tips:

- ♦ Start conversations early (don't wait for a crisis) - that means in your personal life too!
- ♦ Communicate honestly and sincerely - you may be uncomfortable approaching the topic, but people will remember if you were respectful regardless if you felt awkward.
- ♦ Please don't refer to the person as 'C', 'M', or "R'

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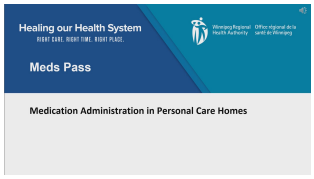
Please view: Orientation for Pharmacy Services in Long Term Care and Medpass Medication Administration in Personal Care Homes Videos **(Images linked to videos on YouTube)**



COMMONLY ASKED QUESTIONS

Q: How does the strip packaging differ from the bubble pack system?

A: The medications are in individually sealed plastic packages that are resident, date, pass time and medication specific. The packages are connected together in chronological order for a 7-day supply.

Q: How are narcotics, controlled and targeted substances packaged?

A: The scheduled narcotics, targeted and controlled medications are packaged in the strip packaging. Non-scheduled narcotics and controlled medications (PRN, wardstock and statbox/emergency supply) are packaged in unit dosed blister cards. Urgent narcotics required between scheduled fills will be provided in unit dose blister cards.

Q: Which narcotics, controlled and targeted substances require counting?

A: Narcotics, controlled and targeted substances supplied in the WEEKLY medication strip packaging DO NOT require counting. Interim doses supplied in bubble packs PRN, wardstock, patches, injectables, liquids, and emergency/stat box, DO require counting.

Q: How can I be re-assured the strip packaging contains the correct medication?

A: MediSystem uses automated visual inspection machines (PacVision™ technology) This technology uses an advanced pill recognition system that verifies every pouch for pill quantity, color, size and shape.

Q: Is nursing staff responsible for re-ordering the resident strip packages?

A: No. The reordering is done automatically on a weekly basis for packaged medications

Q: Which medications require re-ordering by nursing staff?

A: Medications such as creams, solid dosage forms that cannot be packaged in the strip, inhalers, cytotoxic, non-cytotoxic medications, wardstock, emergency/stat box and PRN medications must be reordered as needed by nursing staff

Q: What happens with discontinued medications?

A: Medication must be removed by nursing staff if the medication needs to be discontinued prior to the start of the new weekly medication strip. Medications are to be destroyed on-site in the Daniels container. Narcotics, controlled and targeted medications will require a double nurse signature prior to destruction. MediSystem will not be accepting medication returns.

COMMONLY ASKED QUESTIONS

Q: What happens if a pill is dropped or contaminated from the strip package?

A: Obtain the replacement medication from the stat box/emergency drug supply. If the medication is not available from the stat box/emergency supply, take the last pouch from the end of the strip with the same medication and time. Notify the pharmacy via fax a replacement pouch is required for the specific time and date.

Q: What is considered an urgent medication, and when will the urgent medication be delivered?

A: Urgent medication are those that are assessed by a prescriber as essential in the prompt treatment of acute and unforeseen adverse changes in a resident's condition that are an immediate threat to his/her life or have a clinically significant impact on well-being (refer to MediSystem Urgent Medication List). Urgent medications will be filled for next business day delivery.

Q: What if a medication is not considered urgent, how soon will the medication be delivered?

A: All non-urgent medication changes will commence with the NEW weekly strip

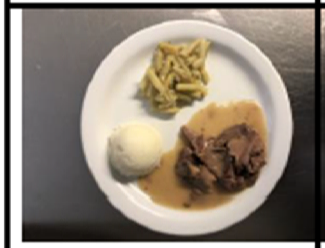
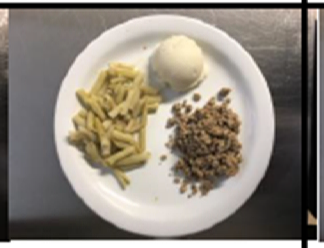
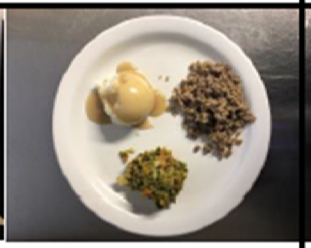
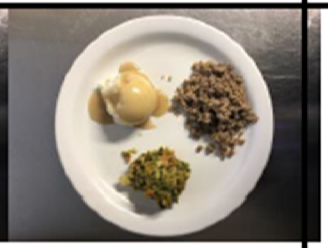
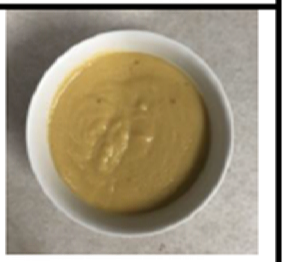
Q: What happens if a medication is not covered by Manitoba Health?

A: If a medication is not covered, MediSystem will fax a payment approval form indicating the need to apply for part 3 exceptional drug status (EDS) or obtain approval for payment from the resident or their designate. Medication will not be supplied by MediSystem until payment has been approved.

Q: What is an EDS medication?

A: EDS stands for Exceptional Drug Status. Certain medications require specific criteria in order to be covered by Manitoba Health. If the resident meets the specified criteria, the prescriber or nurse can apply for EDS by completing the EDS request form and faxing it to Manitoba Health. Once approval is granted, it is the responsibility of the long term care facility to notify MediSystem that the medication has been granted EDS status.

Diet Textures

SOFT	SOFT/MINCED	MINCED	TOTAL MINCED	PUREED	BLENDED
					
Soft to chew foods No crumbly, chewy, sticky or gummy foods. **Meat** – Regular; **Starch** – Regular **Vegetable** – Regular; no hard/crunchy vegetables such as dill pickles & cucumber with skin **Sandwich**- Regular **Soup**- Regular **Salad**- Soft - no nuts or dried fruits **Dessert**- Regular no nuts, no seeds, sticky or gummy. No hard fresh fruit (apples) or firm canned fruit (pineapple)	Soft diet with minced meat. Regular starch and vegetables. **Meat** – Minced; can have all types of eggs **Starch** – Regular **Vegetable** – Regular; no hard/crunchy vegetables such as dill pickles & cucumber with skin **Sandwich**- Regular **Soup**- Regular with soft or minced meat **Salad**- Minced salad **Dessert**- soft moist cakes, pies, squares, cookies/bars, puddings, custards, ice cream, gelatin, mousse, yogurt	Meat, vegetables and starch are **minced**. Can have bread and baked products. **Meat** – Minced; can have all types of eggs **Starch** – Minced **Vegetable** – Minced **Sandwich**- Minced fillings or cheese **Soup**- Regular with soft or minced meat **Salad**- Minced salad **Dessert**- Soft, moist cakes, squares, cookies/bars; pudding/custard like pies; pudding; custard; ice cream; gelatin; mousse; yogurt	Meat, starch, vegetables and fruits should all be minced. No bread products allowed. **Meat** – Minced; scrambled or pureed eggs **Starch** – Minced **Vegetable** – Minced **Sandwich**- NO **Soup**- Pureed soup **Salad**- Minced salad **Dessert**- Puddings, custards, ice cream, gelatin, mousse, yogurt	All foods must be pureed. **Meat** – Pureed; pureed eggs **Starch** – Pureed **Vegetable** – Pureed **Sandwich**- NO **Soup**- Pureed soup **Salad**- NO **Dessert** - Smooth puddings, custards, sherbet, ice cream, gelatin, mousse, plain yogurt	The meat, starch, vegetable and soup is blended together into a drinkable form. **Entrée** – Blended **Breakfast** – Cream of wheat **Lunch/Supper** – blended entrée **Sandwich**- NO **Soup**- Included in Entrée **Salad**-NO **Dessert** – pureed

*If a resident is on a thickened fluid diet, they cannot be served ice cream, sherbet or jell-o

Diet Textures

Mildly Thick (2)

Old name: Nectar thick
New name Mildly thick (2) PINK
fluids runs freely off the spoon but leaves a milk coating on the spoon.
e.g. regular yogurt, magic cup, cream soup.

Moderately Thick (3)

Old name: Honey thick
New name: Moderately thick (3) YELLOW.
Fluid slowly drips in dollops off the end of the spoon.
e.g. thick sauce or greek yogurt.

*If a resident is on a thickened fluid diet, they cannot be served ice cream, sherbet or jell-o

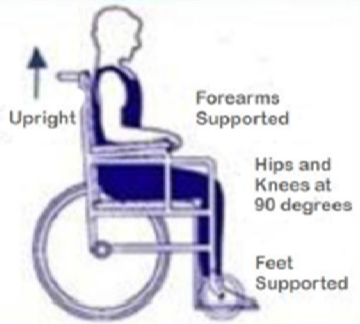
Standard
Feeding Procedures

#1 Care plan

A. Check diet order

B. Check for safe swallowing and feeding guidelines

#2 Mealtime position



#3 Diet order

Does food/liquid on tray match diet order?

#4 Feeding position

Sit beside and at eye level with resident

View from above

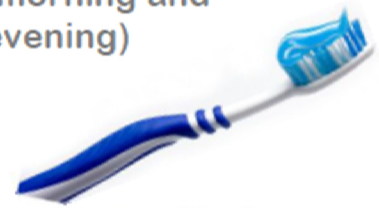
#5 Safe feeding

A. Use general and/or resident-specific safe swallowing and feeding strategies

B. Know what to watch for

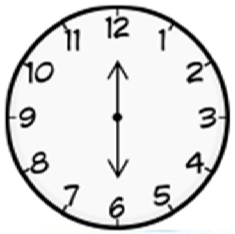
#6 Clean mouth

Clean mouth at least twice per day (morning and evening)



#7 30 minutes

Stay upright for at least 30 minutes after meals



#8 Report problems

Report problems to nurse

adapted from: Riverview Health Centre Dysphagia Team

Long-Term Care

COVID-19 Definitions

Green Zone - COVID-19 Non-Suspect patients, residents or clients are those who do not meet the criteria for testing and/or those deemed “recovered” by Public Health (if not admitted) or by Infection Prevention and Control (if admitted).

Orange Zone - COVID-19 Suspect patients, residents or clients are those who have been tested based on symptoms or contact/travel status and the result is pending OR a person who, based on clinical symptoms or exposure history, needs to be tested for COVID-19, regardless of vaccination status.

Red Zone - COVID-19 Positive patients, residents or clients are those who have been tested and have a positive test result and who have not been deemed “recovered” by Public Health (if not admitted) or by Infection Prevention and Control (if admitted).

PPE – Long-Term Care

Areas Included	Activity	Type of PPE for COVID-19 Non-Suspect	Type of PPE for COVID-19 Positive and COVID-19 Suspect
Personal Care Homes **Supportive Housing** **Residential Care** **Group Homes** **Health Centres**	Direct Resident Care Includes care and support that requires close resident encounter (e.g.,, dietary, OT, PT) For supportive housing environments, includes providing direct support to the resident where social distancing (6 feet/2 metres) is not possible	Procedure mask Eye protection Gloves as per Routine Practices Gowns as per Routine Practices Extended use of ***same procedure mask*** for repeated interactions with multiple residents. ***Change mask if*** it becomes wet, damaged, or soiled and/or at breaks. **Eye protection** to be used throughout the shift with appropriate cleaning and disinfecting protocols. Remove and clean/disinfect at breaks and at end of shift. For direct patient care, use of a full face shield is recommended. Wherever possible, retain lenses and/or frames and disinfect eye protection at the end of the shift. ***Gowns*** are to be used as per Routine Practices (e.g., MRSA, scabies, blood or body fluid contact or excessive soiling) AND in situations requiring Additional Precautions. ***Gloves*** are not required for every resident interaction however meticulous attention to hand hygiene is required. Gloves should only be applied as per Routine Practices and Additional Precautions (e.g., MRSA, scabies, blood or body fluid contact or excessive soiling).	Extended use of ***same N95 respirator OR procedure mask, eye protection*** for repeated interactions with multiple residents; discard and replace mask following breaks. ***Change respirator or mask*** if it becomes wet, damaged, soiled and/or at breaks. **Eye protection** to be used throughout the shift with appropriate cleaning and disinfecting protocols. Remove and clean/disinfect at breaks and at end of shift. For direct resident care, use of a full face shield is recommended. Wherever possible, retain lenses and/or frames and disinfect eye protection at the end of the shift. With **COVID-19 Positive residents**, extend use of **gowns** except in situations when Gowns should be used as per Routine Practices (e.g.,, MRSA, scabies, blood or body fluid contact or excessive soiling) AND in situations requiring Additional Precautions. Remove gown prior to leaving the **COVID-19 Positive** unit. With **COVID-19 Suspect residents**, **gowns** are to be used as per Routine Practices and Additional Precautions (e.g., MRSA, scabies, blood or body fluid contact or excessive soiling). With **COVID-19 Positive** AND **Suspect** residents, **gloves** must be applied and changed per Routine Practices and Additional Precautions (e.g., MRSA, scabies, blood or body fluid contact or excessive soiling). Hand Hygiene before/after donning/doffing gloves or contact with resident or patient environment without gloves.

PPE – Long-Term Care – AGMPs

Areas Included	Activity	Type of PPE for COVID-19 Non-Suspect and Green Zone > 14 Days LOS
Personal Care Homes **Supportive Housing** **Residential Care** **Group Homes** **Health Centres**	Aerosol-generating medical procedures	The following recommendations are in addition to the recommendations already made for direct resident care. N95 respirator Eye protection Gloves Gown Extended use of ***same N95 respirator*** for repeated interactions with multiple residents (excluding post intubation). ***Eye protection*** to be used throughout the shift with appropriate cleaning and disinfecting protocols. Remove and clean/disinfect at breaks and at end of shift. For direct resident care, use of a full face shield is recommended. Wherever possible, retain lenses and/or frames and disinfect eye protection at the end of the shift. ***Gowns*** are to be used as per Routine Practices (e.g.,, MRSA, scabies, blood or body fluid contact or excessive soiling) AND in situations requiring Additional Precautions ***Gloves*** are not required for every resident interaction however meticulous attention to hand hygiene is required. Gloves should only be applied as per Routine Practices and Additional Precautions (e.g.,, MRSA, scabies, blood or body fluid contact or excessive soiling)

PPE – Long-Term Care – AGMPs

Areas Included	Activity	Types of PPE for COVID-19 Positive and COVID-19 Suspect and Green Zone < 14 Days LOS
Personal Care Homes **Supportive Housing** **Residential Care** **Group Homes** **Health Centres**	Aerosol-generating medical procedures	The following recommendations are in addition to the recommendations already made for direct resident care: Extended use of same N95 respirator***, eye protection*** for repeated interactions with multiple residents. ***Change respirator*** if it becomes wet, damaged, soiled and/or at breaks and/or post intubation. **Eye protection** to be used throughout the shift with appropriate cleaning and disinfecting protocols. Remove and clean/disinfect at breaks and at end of shift. For direct resident care, use of a full face shield is recommended. Wherever possible, retain lenses and/or frames and disinfect eye protection at the end of the shift. With **COVID-19 Positive and** residents, extend use of **gowns** except in situations when gowns should be used as per Routine Practices (e.g., MRSA, scabies, blood or body fluid contact or excessive soiling) AND in situations requiring Additional Precautions. Remove gown prior to leaving the **COVID-19 Positive** unit. With **COVID-19 Suspect** residents, **gowns** are to be used as per Routine Practices and Additional Precautions (e.g.,, MRSA, scabies, blood or body fluid contact or excessive soiling). With **COVID-19 Positive** AND **Suspect** residents, **gloves** must be applied and changed per Routine Practices and Additional Precautions (e.g., MRSA, scabies, blood or body fluid contact or excessive soiling). Hand Hygiene before/after donning/doffing gloves or contact with patient or patient environment without gloves Change N95 respirator, gloves, gown following intubation **In accordance with Shared Health Recommendations for AGMPs and Long Term Care** an N95 respirator is required for all AGMPs in Long Term Care: With **COVID-19 Positive** and/or **Suspect** patients extend use of same N95 respirator**,** for repeated interactions with multiple patients. ***Change respirator*** if it becomes wet, damaged, soiled and/or at breaks and/or post intubation.

PPE links for Long Term Care

These resources provide links to quick references for many frequently asked questions about PPE use.

Video: How to properly don PPE

Video: How to properly doff PPE

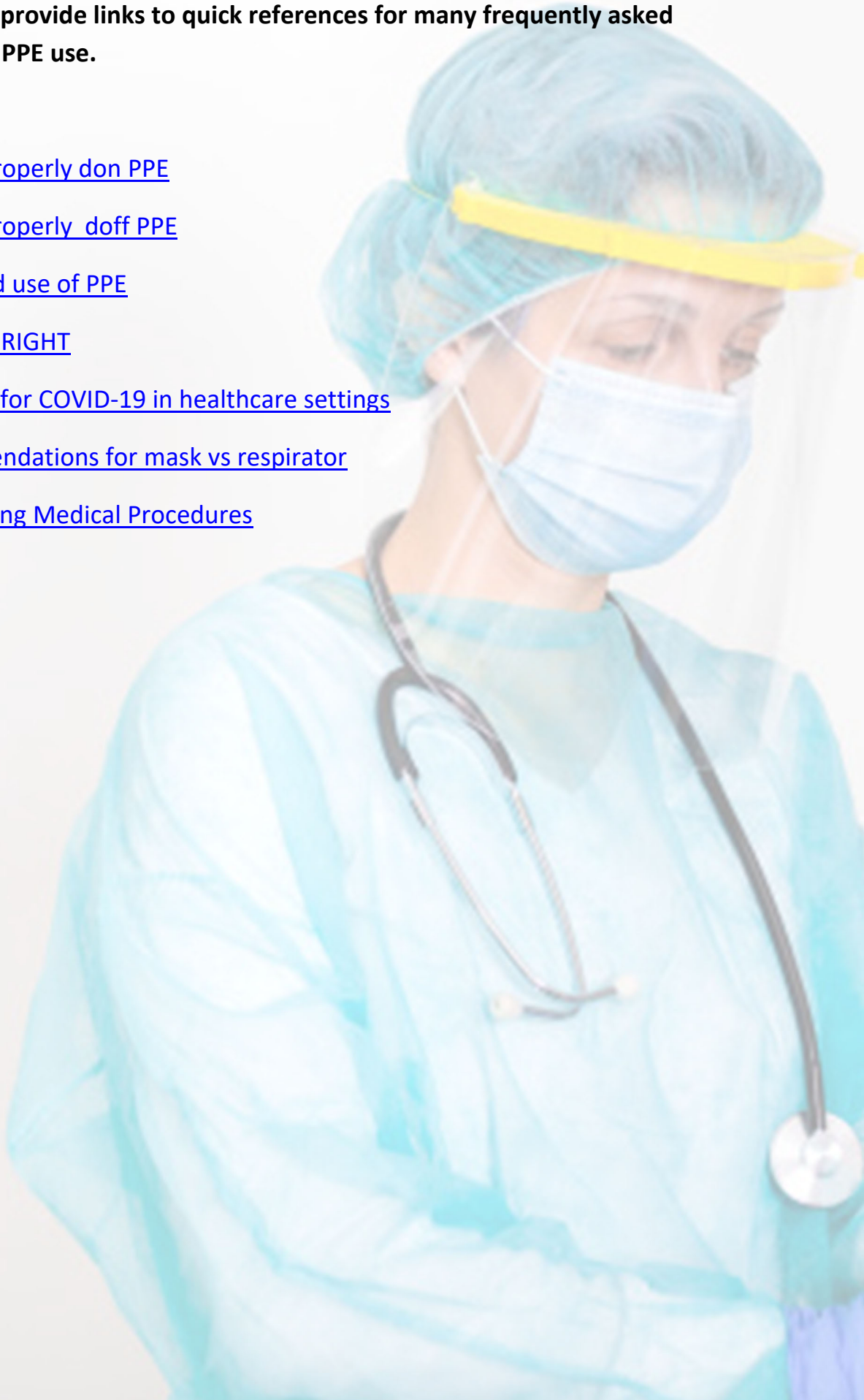
Tips for extended use of PPE

PPE – Wearing it RIGHT

Appropriate PPE for COVID-19 in healthcare settings

Clinical recommendations for mask vs respirator

Aerosol Generating Medical Procedures



Introduction to Long Term Care - Nursing

Welcome to Long Term Care and the field of geriatrics. There are many factors unique to care of the older adult. This self-directed tool highlights resources that will introduce you to the essentials of the area. These links have been chosen because they are concise and provide a good introduction for you.

Introduction to Geriatrics

Choosing Wisely

- Geriatrics
- Long Term Care

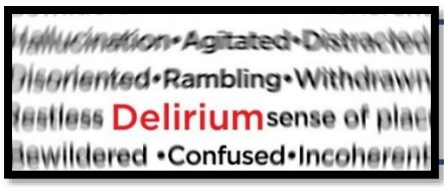
COVID19 Presentation in Frail Older Adults
Typical versus Atypical Presentation of Illness in Older Adults
Treating Asymptomatic Bacteriuria: All harm, No Benefit

Dementia

Person Centred language Guidelines
10 Tips When Talking with Someone with Dementia
What is Dementia
Meanings and Solutions for behaviours in Dementia
Video: How to support residents living with dementia
Dementia and Covid19 Isolation Precautions

Pain

Pain and Dementia
PAINAD



Delirium

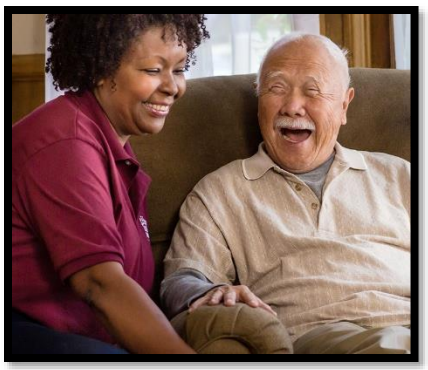
WRHA Delirium CPG

PPE and COVID protocols

Infection prevention and control guidance for personal care homes

Additional Learning Opportunities for Working in Long Term Care - Nursing

These resources build upon many of the concepts in the orientation reading list and are an option for people who would like to build their skills and knowledge.



Introduction to Geriatrics

- Geriatric Syndromes and their Implications for Nursing
- Geriatric Principles Video
- Safer Prescribing in Elderly patients
- BEERS Criteria
- Elderly Patients with an Atypical Presentation of Illness in the Emergency Department

Asymptomatic Bacteriuria versus UTI

- ASB Video

Pain

- Assessment and management of pain in the Elderly

Delirium

- Video: Delirium

Dementia and Approach to Care

- Video: Therapeutic Use of Self

igericare https://igericare.healthhq.ca/

Intended for public education this site provides easy access to simple lessons and helpful resources that allow you to learn about dementia at your own pace. The ten lessons are: 1. What is dementia 2. What is mild cognitive impairment 3. How to promote brain health 4. The different types of dementia 5. How is dementia Treated 6. Safety and dementia 7. Caring for the person with dementia at home 8. Apathy, depression and anxiety in dementia 9. Managing Behavioural issues in dementia and 10. caregiver wellness.

Additional helpful videos: (titles are linked)

- What is dementia? (part 1) with Teepa Snow of Positive Approach to Care
- How to approach residents with behaviours
- 10 ways to de-escalate a crisis w Teepa Snow
- Bathing and dementia – with Teepa Snow of Positive Approach to Care (PAC)
- Using hand-under-hand to Assist with Getting Dressed – Shirts and Coats
- Communicate with patient with dementia/Alzheimer's
- Phrases to learn for caregivers
- How dementia affects language skills (especially 15:25 min to 18:15 min)