Residential Care

Spring 2014 Edition

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Contacts:

Northeast:
Fort St. John: 250-263-6000
Dawson Creek: 250-719-6500

Northern Interior:
Prince George: 250-565-2150

Northwest:
Terrace: 250-631-4222
Smithers: 250-565-2150

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A Message from the Regional Manager, Community Care Licensing

I hope you've all made it through another Northern winter and are looking forward to the promising warmth of summer. Before I point out some of the highlights of this 2014 Spring Newsletter, I want to draw your attention to some changes taking place.

We have recently revised the Exemption Request package. The changes were made to assist you with submitting all of the required information at the outset and reduce the need for your Licensing Officer to request additional documents. We will not be putting the package on our website at this time - instead, your Licensing Officer will send you the new package on request. Please note that the old exemption forms will no longer be accepted.

In this issue, you will also find the following topics:

- *Fact Sheet: Smoking in Residential Care* will provide you with helpful information to support you in the development of appropriate guidelines or policies for your facility.
- Changes that took place late last year regarding *Incident Reporting and Criminal Record Checks* are highlighted and explained.
- Finally, we offer some updated information on *Recommended Vaccines in Adults and Food Safe Refresher Courses*. In addition, we've inserted a one page information sheet on *Elder Abuse* that you can use for staff, resident and family education.

We hope you enjoy this latest edition of the newsletter; if you have any comments or suggestions for future articles, we would welcome your ideas.

Valerie Waymark
Regional Manager, Community Care Licensing

FACT SHEET: SMOKING IN RESIDENTIAL CARE

Did you know?

World NO Tobacco Day is May 31, 2014

Section 23 of the Residential Regulation requires that licensees ensure that:

- No one other than a person in care smokes while on the premises of a facility
- Employees do not smoke while supervising persons in care, and
- If necessary for his/her safety, a person in care who is smoking is supervised.

Are persons in care allowed to smoke at a residential care facility?
Persons living in care facilities that are licensed under the Community Care and Assisted Living Act can smoke in designated smoking rooms if one is provided. However, municipalities, health authorities and facilities may have stringent restrictions on where people can smoke and, if so, those restrictions apply. For example, Northern Health facilities have a Smoke Free Grounds Policy – smoking will not be allowed in and/or on Northern Health owned and operated facilities. This includes all buildings, grounds and parking lots.

Are facility staff allowed to smoke at a residential care facility?
Staff may not smoke at a care facility at any time, even if they are accompanying a resident to ensure his or her safety in a designated smoking area. Staff are not permitted to smoke while they are providing care and supervision for persons in care while away from the care facility.

How can a person in care be adequately supervised while smoking without placing staff at risk of the effects of second-hand smoke?
Each situation of ensuring the safety of a person in care is different depending on the needs and abilities of the person in care, the layout of the facility, and other factors. Staff exposure to second-hand smoke may be avoided by supervising residents from a distance. For example, staff could observe a resident through a window or by electronic means. Family members could be asked to accompany and supervise the person in care while smoking.

INTERESTED IN QUITTING SMOKING, RESOURCES, PUBLICATION AND INFORMATION, PLEASE CHECK THE FOLLOWING WEBSITES:

- BC Smoking Cessation Program -- www.health.gov.bc.ca/pharmacare/stop-smoking/ (or call 8-1-1)
- QuitNow Online -- www.quitnow.ca (or call 8-1-1)
- BC Lung Association -- www.bc.lung.ca/smoking_and_tobacco
- Northern Health Tobacco Reduction Strategies -- http://www.northernhealth.ca/YourHealth/HealthyLivingCommunities/TobaccoReduction.aspx
- Health Canada – Tobacco -- http://hc-sc.gc.ca/hc-ps/tobac-tabac/index-eng.php

INCIDENT REPORTING - Changes effective December 1, 2013

Criminal Record Re-Checks must be done every five (5) years. For inspection purposes please process before clearance check expires.

1. Reporting Aggression between Persons in Care

The Director of Licensing Standard of Practice for reporting Serious Incidents outlined the addition of reporting aggression between residents in care to the Serious Incident Reporting criteria. This is defined as aggressive behaviour by a person in care towards another person in care that causes injury that requires first aid, emergency care by a medical practitioner or nurse or transfer to a hospital.

The standard further outlines policy explaining aggressive/unusual behaviour by a person in care towards another person in care where theirs' harm (physically or emotionally), requires an incident report submitted to Licensing. The incident must be immediately reported to:

- the representative of the person in care, or the contact person, and
- the medical practitioner or nurse practitioner responsible for the person in care, and
- the medical health officer (Community Care Licensing Program), and
- the funding program (if the facility receives funding)

- *Reminder:* if a person in care witnesses a reportable incident, their name(s) is also reportable under section 77 of legislation.

2. Definition of reporting "choking" has been changed:

This amendment requires facilities to report incidents of chocking where first aid practices were administered (such as the Heimlich maneuver). The previous threshold for reporting was limited to incidents where a higher level of care was sought – such as with transport to hospital emergency department.

WHY ARE THESE AMENDMENTS BEING MADE?

- The new reportable incident "aggression between persons in care" is based on recognition of the increasing complexity of persons being cared for in residential care facilities. Appropriate reporting of these incidents will better enable care providers to develop care plans and strategies to prevent their occurrence.
- The definition of "choking" has been amended in response to recent coroner's recommendations. After a choking occurrence, there may be an increased risk of respiratory difficulty. Fluid or air may have entered the lungs or the Heimlich maneuver (if administered) may have caused ribs to break or harmed internal organs that can cause bleeding or infection.

http://www.northernhealth.ca/YourHealth/CommunityCareLicensing/ResidentialCareProviders.aspx

http://www.health.gov.bc.ca/ccf/adult_care.html

BC Criminal Records Review Act (CRRA) Amendments

The Criminal Records Review Program (CRRP) implemented changes to the CRRA effective November 30, 2013. Key changes include:

1. A more efficient and secure online process has been developed. All organizations currently under the CCRA can sign up for this new service and obtain a link to direct all their employees to. Applicants will go through electronic identification verification by providing their consent information.
2. Employees covered under the CCRA will be able to share, for free, the results of their clear criminal record checks with other organizations registered with the CRRP.
3. The CRRP has enhanced the protection of children and vulnerable adults by requiring fingerprints for those who share a date of birth and gender with a pardoned sex offender. The prints will be at the applicant's expense.
4. Organizations that have volunteers that work with children or vulnerable adults may register as a volunteer organization under the CCRA and will be provided with free checks. In additionally for free, volunteers may share the results of their clear checks with other organizations through the online service.
5. Volunteer agencies that opt in and register with the CRRP to conduct their volunteer checks will also be subject to the same risk assessment provided currently to employers.
6. As a result of these program enhancements, the fee for processing criminal record checks went from $20 to $28, which works out to an increase of $1.60 per year for each check.

For further information regarding the volunteer initiatives and to view updated forms, policies and education material, please check the Ministry of Justice – Criminal Record Review Program's website at http:/www.pssg.gov.bc.ca/criminal-records-review/ or call 1-855-587-0185.

WHAT VACCINES ARE RECOMMENDED FOR ADULTS?

The vaccines you need as an adult depend not only on your age, lifestyle, overall health, pregnancy status, and travel plans but also on who you are in close contact with and what vaccines you had as a child.

Talk to your doctor about which vaccines you need. Common adult vaccines include:

- Flu;
- Human Papilloma Virus (HPV);
- Pneumococcal;
- Shingles;
- Tetanus, diphtheria, and pertussis.

DID YOU KNOW!

*In adults who have completed a primary series in childhood, a booster dose of tetanus toxoid is recommended every 10 years to maintain protection against tetanus

Although adults aged 60 years or older are recommended to get the shingles vaccine, only 20% of them have received it. Among the estimated 1 million cases of shingles in the United States each year, about half occur in adults aged 60 years or older. This age group is also the most likely to experience severe post herpetic neuralgia with prolonged pain from shingles that can last for many months. And only 60% of adults aged 65 years or older, all of whom are recommended to get pneumococcal vaccine, received it. There were approximately 32,000 cases of invasive pneumococcal disease in 2012 and about 3000 of those resulted in death.

A 2012 national consumer survey indicates that adults believe that immunization is important, but most adults are not aware that they need vaccines throughout their lives to protect against diseases such as shingles, pertussis, and hepatitis. For more info on adult immunizations, see the BCCDC website http://www.bccdc.ca/imm-vac/AboutImmunization/default.htm

FOODSAFE Level 1 Certificates good for 5 years; Refresher course available

Section 44 of the Residential Regulation states the licensees must ensure that employees responsible for preparation and delivery of food have the experience, competence and *training necessary to ensure that food is safely prepared and handled* and meets the nutritional needs of person in care.

FOODSAFE courses meet the intent of this section of the Regulation; and, for those facilities that are required to obtain a food premises permit under the B.C. Health Act/Food Premise Regulation it is a requirement that at least one employee on duty has completed FOODSAFE Level 1 training and holds a valid FOODSAFE certificate.

FOODSAFE courses were originally developed in 1986 as a voluntary course, with no expiry dates on the certificates; however, this has changed: FOODSAFE Level 1 certificates are now issued with a five year expiry dated starting July 29, 2013. ***FOODSAFE certificates issued prior to this date will expire on July 29, 2018***.

To learn more about FOODSAFE Level 1 expiry dates and refresher courses, please check the following websites:

- www.health.gov.bc.ca/protect/food-safety-courses.html
- www.foodsafe.ca
- www.northernhealth.ca/YourHealth/EnvironmentalHealth.aspx

The Do Bugs Need Drugs? Program team has assembled a collection of evidence based resources for the Management of UTI and RTI in Long Term Care.
http://www.bccdc.ca/prevention/AntibioticResistance/DBND/Resources/default.htm

QUALITY CARE TIPS

Director of Licensing Standards of Practice – includes the newest standard, Incident Reporting of Aggressive or Unusual Behavior - http://www.health.gov.bc.ca/ccf/adult_care.html

PICnet (Provincial Infection Control Network) Practice Guidelines - includes Residential Care Infection Control Manual - http://www.picnetbc.ca/practice-guidelines

http://www.palliativealliance.ca/project

http://www.palliativealliance.ca/assets/files/Alliance_Reources/Education/Palliative_Approach_Facilitators_Guide.pdf

Submissions by:
Kelli Sumner,RN
Sandra Faulkner
Barb Mahon
Shirley Gray

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What are the Risk Factors for Elder Abuse?

There are a number of factors that put older adults at risk for abuse. Those factors that may leave some older adults at risk for abuse and neglect include (University of Toronto, 2008):

Cognitive impairment (confusion):

- Alzheimer's disease and other dementias can lead to patients/residents behaving in ways that frontline staff may not understand. Without understanding the cognitive disorder, staff members may believe that the patient/resident is doing the behaviour "on purpose" or maliciously, and sometimes the staff member "retaliates."

Physical conditions and dependency on others for care:

- Difficulty with many activities of daily living, including bathing, dressing and toileting, necessitates dependence on others for assistance.

Inability to express wishes:

- Cognitive status or communication difficulties (aphasia and other expressive difficulties, hearing problems, language barriers)

Isolation

- Social isolation — having few if any contacts with people inside or outside the facility, being "alone in a crowd"
- Geographic isolation — where the facility or community is located, or as a result of a patient/resident being transferred, "uprooted" or required to take the first available space regardless of location

Lack of choice

- People who need care and support may be forced by government policies or the availability of services to go where space is available, which may not be the place best suited to them. This in turn increases isolation.

Economic vulnerability

- A patient/resident with limited financial resources may have far fewer choices. He or she may be unable to move elsewhere if the care and assistance being provided is not adequate.

In a landmark study in the United States exploring elder abuse in long-term care settings: 36% of staff in long-term care settings reported having witnessed at least one incident of physical abuse of a resident in the previous year; 10% admitted having committed at least one act of physical abuse themselves; 81% had observed psychological abuse; and 40% indicated that they have psychologically abused residents in their care (Pillemer & Moore, 1990).

Reference: http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/en/elderabusefacts.pdf

What is a Community Response Network, or CRN?

A CRN is a diverse group of concerned community members who come together to create a coordinated community response to adult abuse, neglect and self-neglect.

The British Columbia Association of Community Response Networks (BC CRN) grew out of the need to create an on-going, permanent provincial funding and support structure for the benefit of local CRNs and adults in their communities experiencing abuse, neglect and self-neglect. The Association provides small project funding, materials, training, support people and maintains a website to assist Community Response Networks in their work. As well, provincial teleconferences are held on a monthly basis with all CRN members and interested parties invited to join the conversation.

* More information to come in the Summer addition of the newsletter

JUNE 15TH

WORLD ELDER ABUSE AWARENESS DAY