2021 PCH Self Learn Information & Questions

PACKAGE #2

For:

NURSES + HCAs

This package contains the **information and the questions** needed to complete the answer sheet.

This Information and Question Package is to be shared and each individual must complete their own **Answer Sheet**.

PLEASE DO NOT WRITE ON THIS PACKAGE

FIRE SAFETY *Information*

PCH Standards 24.20, Workplace Safety & Health

Fire Prevention

Fire requires oxygen, fuel and a heat source to start and continue. If one of these elements is missing, the fire will not continue. Our goal is to PREVENT FIRES FROM STARTING and if they do start, PREVENT FIRES FROM SPREADING.

Know your role...

- What to do if you hear "Code Red" being paged?
- Where are the pull stations in your work area?
- The location and function of fire doors, fire zones?
- Is there a sprinkler system at your site and if so, where?
- Where are the fire extinguishers and exits?
- Where are the fire annunciator panels and what do they do?
    - It is the responsibility of all staff to check the fire panel (annunciator) for the location of the fire.
- Review your PCH's task sheets.

It is every employee's responsibility to review the above facts at least yearly.

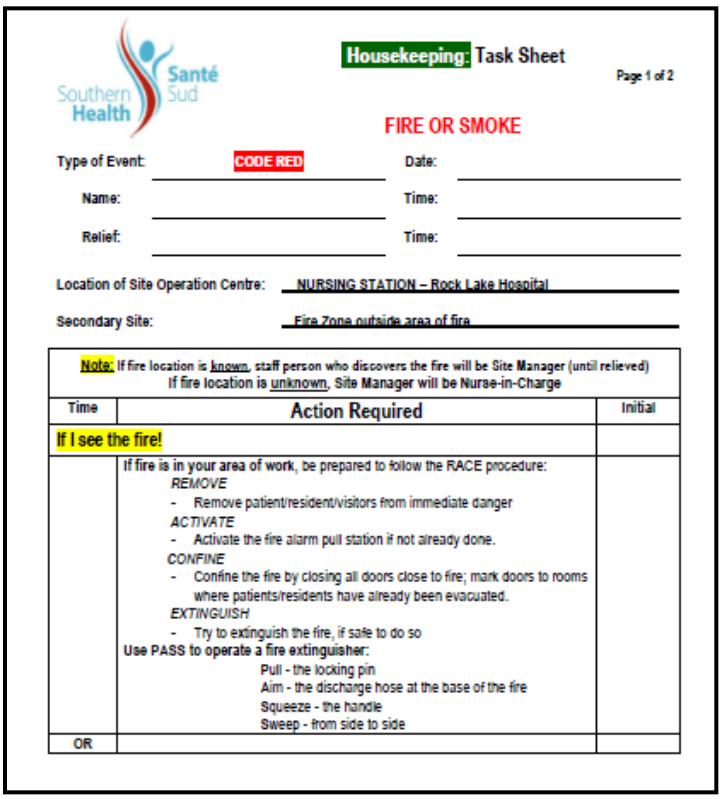
A quick way to remember each code in an emergency is to check the back of your name tag and/or the Quick Reference Guide.

Code White ……. Violence	Code Pink …….. Infant/Child Abduction
Code Purple …… Hostage Situation	Code Brown …….. Chemical Spill
Code Red …… Fire	Code Grey ……. External Air Exclusion
Code Green ……. Evacuation	Code Orange ……. Major Emergency/Disaster
Code Yellow …….. Missing Client	Code Black …… Bomb Threat

Fire Prevention Guidelines

- Enforce/follow the "NO SMOKING" policy.
- Dispose of aerosol cans in designated containers.
- Ensure flammable containers like paint cans or cooking spray cans are stored safely in metal storage lockers or boxes, and away from any heat source.
- Keep hallways clean and free from obstruction.

- Report all broken electrical cords or faulty outlets to maintenance for repair or replacement.
- Be familiar with the fire guidelines in your work area – including your departments "TASK SHEETS" that will tell you what to do if a fire alarm is heard in your area.
- Do not use door wedges on fire doors.
- Do not use candles or sparklers.
- Report potential fire hazards to maintenance or your department manager.



Housekeeping: Task Sheet

Page 1 of 2

FIRE OR SMOKE

Type of Event: CODE RED Date:

Name: Time:

Relief: Time:

Location of Site Operation Centre: NURSING STATION – Rock Lake Hospital

Secondary Site: Fire Zone outside area of fire

Note: If fire location is known, staff person who discovers the fire will be Site Manager (until relieved)
If fire location is unknown, Site Manager will be Nurse-in-Charge

Time	Action Required	Initial
If I see the fire!		
	If fire is in your area of work, be prepared to follow the RACE procedure: *REMOVE* - Remove patient/resident/visitors from immediate danger *ACTIVATE* - Activate the fire alarm pull station if not already done. *CONFINE* - Confine the fire by closing all doors close to fire; mark doors to rooms where patients/residents have already been evacuated. *EXTINGUISH* - Try to extinguish the fire, if safe to do so Use PASS to operate a fire extinguisher: Pull - the locking pin Aim - the discharge hose at the base of the fire Squeeze - the handle Sweep - from side to side	
OR		

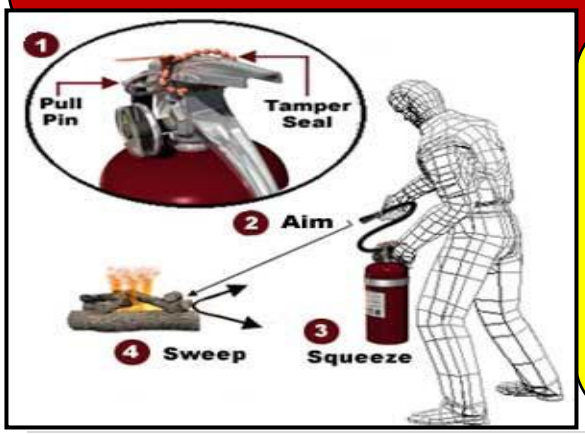
What To Do in a Code Red Emergency

R – **Remove** residents/visitors from immediate danger, move beyond fire doors.

A – **Activate** the fire alarm pull station if not done already.

C – **Confine** the fire by closing all doors near the fire; mark doors to rooms where residents have already been evacuated; if smoke is coming from base of door, place a wet towel at base of door.

E – **Extinguish** the fire, if safe to do so.



Use PASS to operate an extinguisher

Pull the pin

Aim the discharge hose at the base of the fire

Squeeze the handle

Sweep from side to side always aiming at the base of the fire and moving in slowly if safe to do so

It is important to remember that when there is a fire alarm in a PCH, all magnetic doors open. This safety mechanism can become a danger as residents with dementia who are at risk for exiting may leave the PCH while staff are busy and the doors are unlocked. It is important that staff are assigned to watch these doors and make sure residents stay safely in the designated area.

Evacuate in the following order:

- Room that has fire in it, if safe to do so
- Room sharing bathroom
- Room adjacent to the fire but without shared bathroom
- Room across the hall
- Never use elevators during a fire or potential fire
- Close doors of searched and evacuated rooms: Use your PCH's tools to identify that a room has been evacuated – this will be site specific (examples include fire flip flag, orange magnetic dot, etc.)

If you have the slightest doubt about your ability to fight a fire... EVACUATE IMMEDIATELY!

Note: Always enter the zone of the fire with a partner and always evacuate out of the fire zone. Do not cross the fire.

Fire Classification

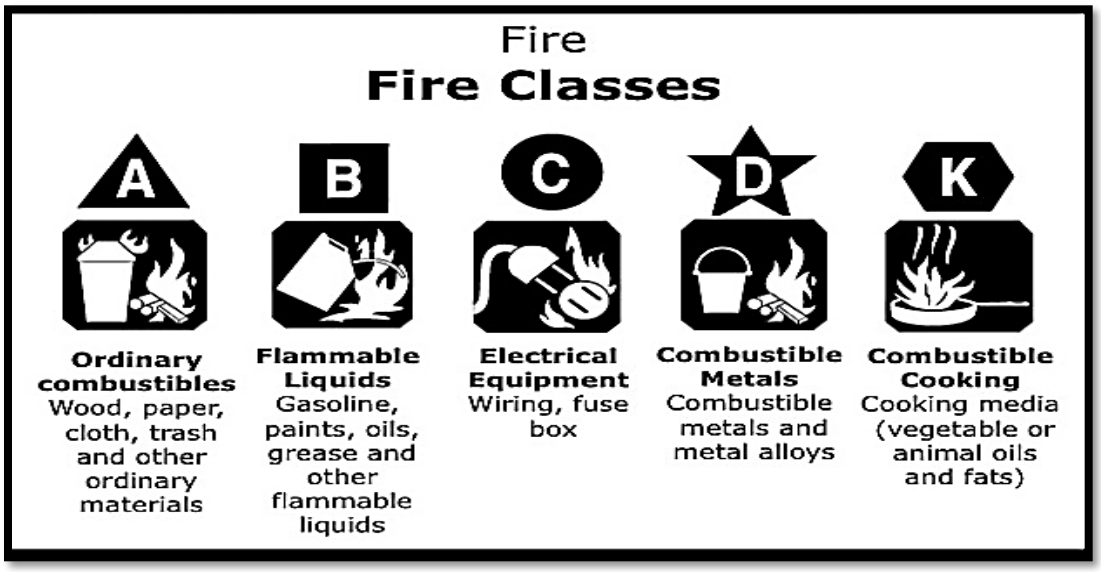
Fires are classified according to the type of fuel that is burning.

- If you use the wrong type of extinguisher on the wrong type of fire, you could make matters worse.
- Most extinguishers will have a pictograph label that will indicate what type of fire it will put out.
- The most common extinguisher found at our sites is an ABC extinguisher.

Five main types of fire:

1. **Class A - Ordinary Combustibles** (Wood, paper, cloth, ordinary trash)
2. **Class B - Flammable Liquids and Gases** (Gasoline, oils, paints, propane)
3. **Class C - Fires involving electrical equipment** (these could be any of the other type of fires, but electrical equipment is involved)
4. **Class D fires - Combustible Metals and Metal Alloys** *(not very common)*

5. **Class K fires - Fires involving cooking materials** (Cooking oils, animal or vegetable fats, grease)



Do not fight a fire if:

- **You don't have adequate or appropriate equipment.** If you don't have the correct type or a large enough extinguisher, do not attempt to extinguish.
- **You might inhale toxic smoke.** When synthetic materials such as the nylon in carpeting or foam padding in a sofa burn, they can produce hydrogen cyanide, acrolein, ammonia and carbon monoxide. These gases can be fatal in very small amounts.
- **Your instincts tell you not to.** If you are uncomfortable with the situation for any reason, just let the fire department do its job.

The final rule is to always position yourself with an exit or means of escape at your back before you attempt to use an extinguisher to put out a fire.

FIRE SAFETY *Questions*

PCH Standards 24.20, Workplace Safety & Health

REMINDER: DO NOT ANSWER ON THIS PACKAGE. USE ANSWER SHEET.

Scenario: You are walking down the hall in your PCH and you smell smoke. As you keep walking, you see smoke coming out from underneath a resident's closed door. The alarm is not ringing and there is no one else around. You can hear someone coughing behind the door.

1. What is your first step when thinking RACE?

   a. Pull the alarm.
   b. Wait for the alarm to ring.
   c. Put your hand on the door to see if the door is hot before entering the room and rescuing the resident.

When you check the door, it is cool to touch, so you open the door cautiously to rescue the resident. Once you get into the hallway with the resident, you **Activate** the alarm.

2. What do you need to do next?

   a. Leave the door open so you can see the fire.
   b. Close the door so you can contain the smoke and fire.

3. It is safe to walk past the room with the fire.

   a. True
   b. False

4. You put the flames out, but unfortunately, the base of the fire was still so hot that it re-ignited and quickly became out of control. There is no one in the room but you remember that there are oxygen tanks stored in the room next door. You grab a cart for the oxygen and evacuate it past the fire doors or out of the building to allow more time to evacuate the residents in the nearby rooms. If the oxygen is around a fire, the canisters can explode.

   a. True
   b. False

WHMIS 2015 Safety Data Sheet	
Section 1: Identification	Section 8: Exposure Controls/Personal Protection
Section 2: Hazard Identification	Section 9: Physical and Chemical Properties
Section 3: Composition / Ingredients	Section 10: Stability and Reactivity
Section 4: First-aid measures	Section 11: Toxicological information
Section 5: Fire-fighting measures	Section 12: Ecological Information
Section 6: Accident Release Measures	Section 13: Disposal Considerations
Section 7: Handling and Storage	Section 14: Transport Information
Section 8: Exposure Controls/Personal Protection	Section 15: Regulatory Information

Section 1: Identification – Product identifier, recommended use and restrictions on use, supplier contact information, emergency phone number

Section 2: Hazard Identification – classification (hazard class and category), label elements (including pictogram, signal work, hazard statement and precautionary statements and other hazards

Section 3: Composition/Ingredients – chemical name, synonyms, CAS No., hazardous ingredients that contribute to the classification of a hazardous material and associated health hazards

Section 4: First Aid Measures – provides the first-aid measures by route of exposure as well as most important symptoms/effects

Section 5: Fire-Fighting measures – provides information to assist with fire, explosion, procedures in the event of emergency. Includes suitable (and unsuitable) extinguishing media, specific hazards, special equipment and precautions for fire fighters

Section 6: Accident Release Measures – provides information on handling accident spills and leaks. Includes information on protective equipment, emergency procedures, methods and materials for spill containment and clean up

Section 7: Handling & Storage – provides information on precautions for safe handling and conditions for storage including safe storage of the hazardous material

Section 8: Exposure Controls/Personal Protection – provides information on measures to prevent workers from being overexposed; including exposure limits, engineering controls, personal protective equipment

Section 9: Physical & Chemical Properties – provides a physical description of the hazardous material that is useful for identification and to understand how the hazardous material responds to changes in the physical environment

Section 10: Stability & Reactivity – provides information on the stability of the hazardous material and its likelihood of dangerous reaction with other chemicals. These include chemical stability, conditions of instability, incompatible substances, reactivity, and hazardous decomposition products

Section 11: Toxicological Information – provides information on how the material is likely to enter the body (known as routes of entry). There is also information on the short term, long term and multiple health effects that are possible in the event of worker over-exposure. Included are the effects of short term and long term (acute and chronic) exposure, carcinogenicity, reproductive effects, and respiratory sensitization

Section 12: Ecological Information – provides information on how the hazardous material is likely to affect the environment. Included are aquatic and terrestrial toxicity (if available), persistence and degradability, bio- accumulative potential, and mobility in soil

Section 13: Disposal Considerations – provides information on how to safely dispose of the hazardous material. Included are methods for safe handling of waste and disposal method (including contaminated packaging instructions)

Section 14: Transport Information – provides information needed for the transportation of dangerous goods. Included are UN number, proper shipping, name, hazard classes and packing group

Section 15: Regulatory Information – contains information on safety, health and environmental regulations specific to the product

Section 16: Other Information – including the date of the latest revision of SDS

Source: WHIMS PowerPoint (July 2019) from Regional Orientation, slide 30 and notes.

WHMIS *Questions*

We have a problem! We were using Oxivir wipes to disinfect surfaces, but because of strict COVID-19 related precautions, stock is running low. We will be using use Oxivir plus disinfectant cleaner concentrate as an alternative to the wipes. Where would I find the information on the Safety Data Sheet (SDS) for this product?

Use the previous pages to answer the following questions:

1. Where would I find information on personal protective equipment to be worn when using the diluted or the concentrated Oxivir Plus solution?
    a. Section 6 Accident Release Measures
    b. Section 8 Exposure Controls/Personal Protection

2) Where would I find the symbols on the SDS?
    a. Section 2 Hazard Identification
    b. Section 3 Composition/Ingredients

3) Where would I find information on what should be done if this product gets on your skin?
    a. Section 4 First Aid Measure
    b. Section 6 Accident Release Measures

PROTECTION FOR PERSONS IN CARE OFFICE (PPCO) *Information*

PCH Standards 24.21

What is the *Protection for Persons in Care Act*?

Proclaimed on May 1, 2001, this legislation created a formal process for reporting, investigating, and resolving allegations of abuse and neglect in designated facilities such as hospitals, personal care homes, and the Selkirk Mental Health Centre.

The purpose of the Act was to protect all adults from abuse in "designated health care facilities".

The Protection for Persons in Care Office (PPCO) administers *The Protection for Persons in Care Act (PPCA)*. The objective of the PPCO is to manage the reporting and investigation of alleged patient abuse and neglect in designated health care facilities under the legislative requirements of the *PPCA.*

What is abuse?

According to *The Protection for Persons in Care Act,* abuse is defined as an act or omission that is mistreatment, whether **physical, sexual, mental, emotional, financial or a combination of any of them**, and causes or is reasonably likely to cause the death of a resident, serious physical or psychological harm to a resident or significant loss to a resident's property.

What is neglect?

Neglect is defined as an act or omission that is mistreatment that deprives a resident of adequate care, adequate medical attention or other necessaries of life, or a combination of any of them, and causes or is reasonably likely to cause the death of a resident, or serious physical or psychological harm to a resident.

There are two elements to a finding of abuse and neglect:

1. The action must be defined as mistreatment.
2. The mistreatment must have caused serious harm or have been reasonably likely to have caused serious harm.

What is mistreatment?

Mistreatment is defined as treating someone badly, cruelly or unfairly.

What is serious harm?

The PPCO defines serious harm as something which interferes in a significant or substantial way with an individual's well-being.

Because the PPCO's definitions of abuse and neglect include the term "reasonably likely", this means that abuse or neglect can be either potential or actual.

Examples of neglect:

- Improper lift (not following applicable SCHIPP logos, doing a one-person transfer when the resident requires a two-person transfer)
- Misuse of medication (with-holding necessary or pain medication, over-medicating)
- Not following the care plan (no oral/dental care, inadequate restraint checks, not doing required skin observation checks or prescribed wound care)
- Failure to maintain a care plan
- Failure to follow standards of care (keeping residents hydrated, turning off a call light and taking no action on the resident's request, not offering enough help at mealtimes)
- Staff sleeping during work time

What are staff members' responsibilities?

- Take reasonable steps to protect residents from abuse and neglect
- Provide immediate safety, security, and well being of all residents who may be at risk of abuse or neglect

Are staff required to report abuse or suspected abuse?

In Manitoba, it is mandatory to report suspected abuse and neglect in designated health facilities promptly. This means that anyone who has a reasonable basis to believe abuse or neglect has occurred, or is likely to occur, must report these concerns as soon as possible.

When suspected abuse or neglect is reported in good faith, the Act prohibits:

- Any interruption in the care and services provided to patients and residents; and
- Any action or proceedings against any person, including health facility employees, for reporting suspected abuse or neglect.

The Act also protects caregivers and others who work with persons in care against malicious reporting.

How do you report abuse?

The PPCO now requires facilities to report allegations of abuse or neglect in writing only. The PPCO will continue to accept reports from the public in any format.

What is the Adult Abuse Registry?

The Adult Abuse Registry (AAR) is a database which records the identity of individuals who have been found to have abused or neglected a vulnerable adult. The purpose of the AAR is to allow employers to screen potential employees and volunteers who want to work directly with vulnerable people. The AAR came into effect on March 15/2013.

PROTECTION FOR PERSONS IN CARE OFFICE (PPCO) *Questions*

1. Mistreating a resident is hard to define and therefore it is not defined as abuse.
    a. True
    b. False

2. Serious harm is something that interferes with a resident's well-being in a significant way.
    a. True
    b. False

3. It is mandatory that any staff report suspected abuse or neglect promptly.
    a. True
    b. False

RESIDENT BILL OF RIGHTS *Information*

The Resident Bill of Rights is a document that was initiated by Manitoba Health and is developed by residents and their families. It informs them about the type of care they can expect from the personal care home leadership and staff. Upon moving into a personal care home (PCH), residents and their families are given a copy of the Resident Bill of Rights. The Bill of Rights is also posted in the care home. As staff, we are expected to be familiar with these rights and to provide care that meets or exceeds these expectations.

Where is the Resident Bill of Rights located in your Personal Care Home?

This past year has been interesting in regards to the Resident Bill of Rights in light of COVID-19. We have had to examine our own practices and see how we can maintain the spirit of the Resident Bill of Rights while ensuring the safety of residents, staff and their families.

What is person centered care?

Person centered care focuses on the individual rather than their conditions as well as on the person's strengths and abilities rather than what the person cannot do. We want to look at the whole person, not as a room number where staff have to complete a number of tasks. Person centered care approach recognizes that individuals have unique values, personal history and personality along with an equal right to dignity, respect, and to participate fully in their care and environment. That can be challenging when we know that some of their choices are not always in what we believe to be, their best interests.

Person centered care values the individual, regardless of age or cognitive ability. We want to provide care that is best for that particular resident, recognizing their uniqueness and trying to understand the world from the resident's perspective. We also want to provide a social environment that meets the psychological needs of the resident.

Right to Refuse

One area that seems to come up frequently is the resident's right to refuse consent for treatment and care. Some examples that come up often: the resident needs to have their underwear changed however they refuse to allow this to happen. The resident needs to take their prescribed medication at a certain time but they refuse.

A resident eats food that is not within the diet recommended by the dietician. A resident refuses to have a nasopharyngeal swab taken to check what kind of virus is causing their illness. What do we do?

Let's look at the situation from staff and then the resident's perspective with this example. John is participating in Sing Along time and enjoying singing. It's time to do his blood sugar check. The nurse appears and says, "John, it's time to do your blood sugar check." John refuses to leave the area. The nurses insists that he needs to have this procedure done now because other work is waiting for them to do.

John is having fun! Does the blood sugar check have to happen right now or can it wait until the fun activity is completed? Sometimes as staff, we impose care on residents because it fits our schedule or we think it should be done a certain way. But maybe we need to look at ourselves for reasons why the resident refuses. Are we rushing the resident in providing care? This approach can cause greater confusion because the resident doesn't understand what the rush is about. Maybe we are talking and the resident doesn't understand us – because of hearing loss, or not paying attention while we were talking, or our tone of voice. Slow down, take a deep breath, and focus on the resident. They will notice and will feel like they are valued. Often they are then willing to work with you.

Here's another example: eating foods that might not be considered healthy. Let's take a look at the person's history – why do they eat the way they do? Culture. Lifestyle habits. Enjoyment of food. These are values that don't change easily. Even when we are consciously trying to do the right thing, this is hard. We might need to involve a dietitian, family members, or Seniors Mental Health to provide us with some different ideas on managing food. We might need to look at changing the environment by not having food readily accessible. We might have to have them participate in activities to move their focus away from food. As a team, you can work with the resident to provide some ideas to help them to focus on things other than food.

RESIDENT BILL OF RIGHTS *Questions*

1. Mrs. Jones has a birthday today. Her family brings in her favourite cake to celebrate. Mrs. Jones is on a diabetic diet but she would like to have a piece of cake. The best response would be for staff to quickly intervene stating that the resident is not allowed to have cake as she is diabetic.

a. True
b. False

2. Mr. Jones does not like to be interrupted when he is in his room. He is frequently in his room in the morning when housekeeping staff are in his area for cleaning rooms. How could staff accommodate Mr. Jones?

a. If he is in his room, ask him to leave so that you can clean the room.
b. Modify your cleaning routine to help accommodate Mr. Jones wishes, and communicate those changes to the other staff.

INFECTION PREVENTION & CONTROL *Information*

PCH Standards 21.11 & 21.12

Hand Hygiene

In Canada, one in nine patients acquire **Healthcare-Associated** Infections (HAIs) during their hospital stay. HAIs may result in higher healthcare costs, disability and death. By increasing hand hygiene by 10%, HAIs can be reduced by 40%. Proper hand hygiene and glove use helps to reduce HAIs. Wearing gloves when not recommended can be a large risk factor for poor hand hygiene compliance and spreading germs.

Hand hygiene is a general term referring to any action of hand cleansing. Hand hygiene includes the use of alcohol-based hand rub (ABHR) or soap and water.

ABHR is preferred to soap and water because it:

- Is faster
- Is more effective, gets rid of most germs
- Is gentler on your skin than soap and water
- Is usually available at point of care

Wash your hands with soap and water when your hands look dirty, whenever ABHR is not available, and when providing care to residents with C. difficile.

Bare Your Wrists

Proper hand hygiene technique is just as important as knowing when to wash your hands. In addition to keeping fingernails short, do not wear artificial nails or chipped nail polish. Do not wear a wrist watch or jewelry that will get in the way of hand hygiene. Plain rings/bands may be worn.

Point of Care Risk Assessment

Prior to each resident interaction, staff must complete a Point of Care Risk Assessment (PCRA) to assess the risks posted by the resident, situation or procedure to themselves, other care providers or other residents or visitors.

Conducting a PCRA involves asking a series of questions before every resident interaction to determine the risk of being exposed to a potential hazard, such as COVID-19.

The Point of Care Risk Assessment tool is included on the following 2 pages.

COVID-19 Point of Care Risk Assessment Tool

Prior to each client interaction, staff must complete a Point of Care Risk Assessment (PCRA) to assess the risks posed by a patient/client/resident, situation or procedure to themselves, other care providers, other patients/clients/residents and visitors.

Conducting a PCRA involves asking a series questions before every client interaction to determine the risk of being exposed to a potential hazard, such as COVID-19:

1. **Is the hazard present in the situation?**
   - Close contact (within two meters) with a person with symptoms of COVID-19?
   - Close contact with surfaces or items contaminated with body fluids?
   - Likelihood of splashes or sprays of blood or body fluids?
2. **What is the health status of the person receiving care?**

   Examples of situations in which there might be a greater risk of exposure to patient/resident/client droplets include:
   - Providing assistance with care needs and hand hygiene
   - Persons with copious respiratory secretions
   - Persons with frequent coughing or sneezing
   - Persons with poor compliance to respiratory hygiene, hand hygiene and physical distancing
   - Persons who are immunocompromised (potential prolonged viral shedding)
3. **What type of task am I doing (from a specific interaction)?**
   - Direct care tasks requiring close contact involve a greater risk of exposure (e.g., wound care, feeding, assisting with bathing, dressing, transporting clients)?
   - Indirect care tasks not requiring close contact (e.g., housekeeping, delivering or removing trays or equipment from an empty room)?

     Note: Always try to maintain a physical distance of six feet/two meters for tasks that do not require close contact.
4. **Where am I doing my task?**

   Some examples of situations in which there might be a greater risk of exposure include:
   - Prolonged and frequent contact to an infected source
   - Inadequate patient/client/resident placement or cohorting

- Shared rooms or washrooms
- Shared patient/client/resident care equipment without cleaning between episodes of patient/client/resident care
- Inadequate spatial separation (at least six feet/two meters) between the person receiving care and caregiver
- Inadequate ventilation
- Infrequent housekeeping
- Non-compliance with cleaning and disinfection standards of environment and/or equipment

5. **What action do I need to take?**

Choose appropriate actions, control measures and/or PPE needed to minimize the risk of clients, care providers and other staff being exposed to COVID-19.

Appropriate actions can include:

- Hand hygiene
- Respiratory hygiene
- Source control and physical distancing
- Environmental and equipment cleaning
- Accommodation selection
- Client ambulation or transfer
- Use of PPE and additional precautions as required

Resources

https://sharedhealthmb.ca/files/IPC-acute-care-manual-winnipeg.pdf

https://sharedhealthmb.ca/files/COVID-19-highlights-winnipeg.pdf

https://sharedhealthmb.ca/files/IPC-acute-care-manual-provincial.pdf

https://sharedhealthmb.ca/files/COVID-19-highlights-provincial.pdf

https://sharedhealthmb.ca/files/covid-19-highlights-ltc.pdf

https://sharedhealthmb.ca/files/covid-19-physical-distancing-and-restoring-services.pdf

https://sharedhealthmb.ca/files/covid-19-provincial-ppe-framework-guidance.pdf

Glove Use

Gloves protect you against germs. However, once used, gloves can become a means of spreading germs to yourself, other residents, or environmental surfaces. Therefore, the way you use gloves can spread germs. The decision to wear gloves is based on routine practices Point of Care Risk Assessment Gloves are one type of PPE.

Gloves are not required for routine resident care activities when contact is limited to healthy skin unless the resident is on additional precautions. Gloves do not provide complete protection against germs, as germs can go through the gloves through tiny holes and tears in gloves, or by touching the hands during glove removal. Every time gloves are removed, wash your hands.

Inappropriate Glove Use

- Using gloves when they are not needed is a waste of resources and does not help the spread of germs.
- Using gloves wrong results in missed chances for hand hygiene
- The use of dirty gloves caused by wrong storage (for example, in pockets) and when not needed may spread germs.
- Putting on and taking off gloves may also spread germs.

<table>
<tr><th>Do</th><th>Don’t</th></tr>
<tr><td>Perform hand hygiene before donning and after doffing gloves</td><td>Don’t use gloves to access clean supplies</td></tr>
<tr><td>Select gloves that fit properly</td><td>Don’t touch common items with dirty gloves (for eg. light switches, phones, charts)</td></tr>
<tr><td>Work from clean to dirty</td><td>Don’t wash gloves</td></tr>
<tr><td rowspan="5">Change gloves:
• between residents
• between procedures on the same resident
• after completing tasks, but prior to touching the environment</td><td>Don’t reuse gloves</td></tr>
<tr><td>Don’t double glove</td></tr>
<tr><td>Don’t wear fake nails, long fingernails, or jewelry that may snag, tear or puncture gloves</td></tr>
<tr><td>Don’t use gloves instead of washing your hands</td></tr>
<tr><td>Don’t store gloves in your pockets</td></tr>
</table>

• before leaving resident environment unless handling very dirty equipment • when holes or tears are seen	Don't wear gloves in hallways unless you are handling very dirty equipment or linens
Discard after use and immediately perform hand hygiene	

Gloves work in protecting healthcare workers' hands, and helping slow the spread of germs through correct glove use and proper hand hygiene before donning, after doffing gloves, and the 4 moments for hand hygiene.

Should I Stay or Should I Go? When to Stay Home From Work

Calling in sick can be a source of anxiety for workers who wonder if they should call in sick. If you have a fever, sore throat, cough, runny nose (not related to allergies), body aches, diarrhea, or vomiting you should stay home. These are some of the symptoms of having germs that can be spread easily. If you begin to feel sick at work, report to your manager and leave as soon as possible. Working while you are sick spreads your germs to residents, staff and everybody you come into contact with. Plan to get your annual flu vaccine!

INFECTION PREVENTION & CONTROL *Questions*

1. A HCA should wear gloves to get clean linen from the linen cart.
   a. True
   b. False

2. Gloves do not provide complete protection against hand contamination, as germs can penetrate the gloves through small defects in gloves or by contamination of the hands during glove removal.
   a. True
   b. False

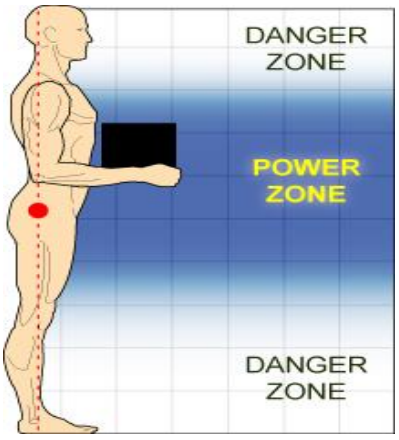
3. Doing a Point of Care Risk Assessment (PCRA) is only applicable in the COVID-19 pandemic situation.
   a. True
   b. False

SCHIPP REVIEW *Information*

SAFE MOVING HABITS

- PLAN before you move an object
    - How heavy is the object?
    - Do you need help (equipment and/or person)?
- PUSH before you PULL before you LIFT
- Perform all movements in a CONTROLLED manner
    - No jerky or rapid movements!
- FOCUS on the TASK and use proper techniques EVERY TIME

WHEN MOVING AND LIFTING, KEEP IN MIND YOUR POWER ZONE!



- Load/arms close to body
- Hands between hips and shoulders: Elbows in
- Weight shift with Legs
- Move your feet to avoid twisting your back
- Move smoothly – avoid sudden movements

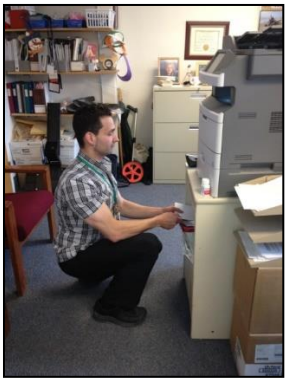
1. Keep the load close to your body, elbows in and thumbs up. If your arms wing out, you are offloading forces onto your neck and shoulders, if your arms come forward, you are offloading forces to your lower back
2. Squat when you are lifting or getting down to an appropriate work height and ensure that you hinge at your hips keeping your spine neutral. Other alternatives to bending include half kneeling, sitting, or a golfer's lift.

**Your leg muscles are stronger and bigger than your back muscles so we want to use them for lifting. The muscles in the back are intended as stabilizers not movers!

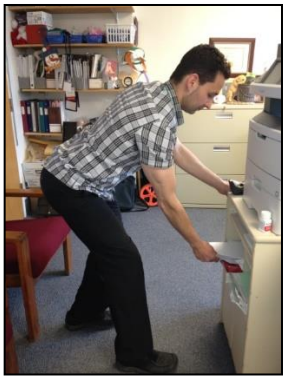
3. Weight shifting with your legs and using a staggered stance and wide base of support allows you to avoid bending and twisting your back. The more muscles you engage the less strain you put on one part of your body. If you are only lifting with your arms this puts additional strain on that one part of your body
4. Move your feet to avoid twisting your back. Twisting is a high risk activity for the back. Bending and twisting tends to aggravate the back the most. Once you twist while lifting you increase your risk of injury by 25%.
5. Move smoothly. Lifting in a slow controlled manner puts less stress through your joints and soft tissues, helping to keep your body safe.

Poor posture when picking up paperwork or items below waist-height can lead to overuse injuries. Although not always possible, trying to keep your back straight when possible does reduce your risk of injury.

✗ Rounded back



✓ Straight back

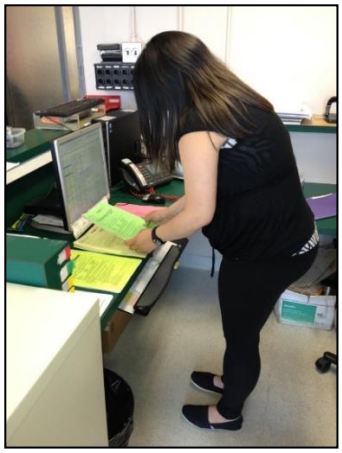


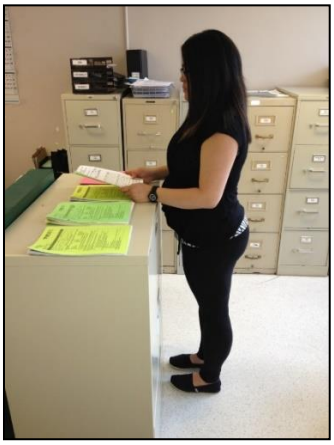
✓ Option if bending knees is a challenge

WHEN LIFTING OR PICKING UP AN ITEM FROM A LOW LEVEL, ALWAYS REMEMBER:

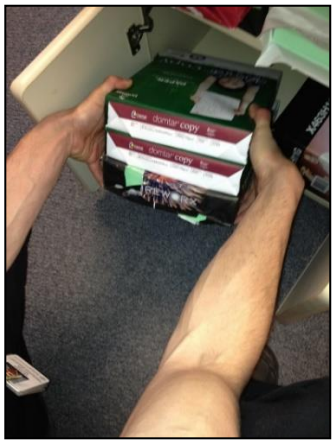
- Keep the load close
- Bend at your hips and knees and keep your back straight
- Tighten your abdominals
- Keep your head up
- Ensure a good grip

CONSIDER YOUR POWER ZONE AND KEEP IN MIND YOUR WORK HEIGHT





WHEN RETRIEVING AND GRASPING, DON'T BITE OFF MORE THAN YOUR HANDS CAN CHEW!



KEEP THE LOAD CLOSE TO YOUR BODY

Maintaining proper body mechanics and ensuring minimal exertion during patient transfer and positioning tasks are important to reduce the risk of work related injuries. The tools we use can go a long way to ensuring the avoidance of overexertion in awkward postures. Below are tips on two common tasks that can be challenging without the right tools.

Assisting a patient to get their legs into bed.
If a patient requires assist with legs into bed, raise the head of the bed and bed rail if present. Patient lowers upper body onto bed surface.

Option 1:
HCW is in a low position facing the patient's feet with back straight. Wrap sheet or alternative (eg. transfer belt) around patient's lower leg(s) and hold ends to reduce low position.
Alternatively HCW places hands around patient's lower leg(s).




Option 2:
HCW places a slider on the edge of the bed, tucking it under the thigh. HCW places hands onto the upper shin of the patient and pushes leg(s) across slider onto the bed. Remove slider.


Option 3:
Wrap a slider or alternative (eg. sheet) around lower limbs. Hold ends while standing at the foot of the bed with one foot in front of the other, keeping elbows close to body. HCW shifts weight from front leg to back leg and walks backwards as required while pulling legs onto bed.
Alternatively, stand in a low half kneel/couch position at foot of bed. Shift weight up and forward to lift patient's leg(s) onto the edge of the bed.
Note: where possible, lift one leg at a time.


If the above methods continue to be excessively challenging due to the weight of the client's legs or their inability to help, it may be time to switch to the use of a mechanical lift.

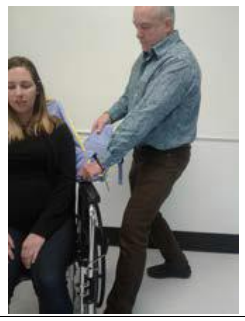
Lifting a heavy leg while crouched down in front of a wheelchair to insert or remove a sling from beneath a patient's legs can be a challenging task. Good teamwork and the use of a slider can make this task far less physically demanding, while minimizing sheer on the patient's thighs. **No lifting required!**

Two Person Seated Sling Insertion/Removal from Beneath Legs in a Chair

1. Facing the patient, HCW #1 pushes folded edge of slider under thigh toward buttocks


2. Insert leg strap under slider from outside to inside of leg. HCW #2 stands on opposite side of patient and pulls leg strap through. Remove slider and repeat for opposite leg.


3. Remove sling by tucking leg strap under itself to prevent shearing and pull towards outside of chair. Repeat with opposite side.
   Continue tucking and peeling sling away from thigh and work towards the hip and up the back.

Note: The use of a slider between the patient's thigh and the sling will minimize shearing and avoid having to lift the patient's leg.

When choosing which method is best in a specific circumstance, you may need to consider the weight of the client's legs, as well as how much the client can assist. An additional option that can be considered is to use a limb sling to lift a client's leg for sling insertion/removal.

SCHIPP REVIEW *Questions*

1. Safe moving habits include:
   a. Planning the move ahead
   b. Pushing or pulling rather than lifting where possible
   c. Avoiding rapid or jerky movements
   d. Focusing on good body mechanics EVERY time
   e. All of the above

2. Working in the power zone includes
   a. Reaching outside my base of support
   b. Maintaining a narrow stance so I can lean over properly
   c. Weight shifting with my legs to help avoid bending, twisting and over reaching
   d. Moving very quickly

3. Which of the following is <u>NOT</u> proper body mechanics when bending/lifting:
   a. Keeping the load close to my body
   b. A rounded back
   c. Tightening my abdominals
   d. Bending my knees

4. Good body mechanics only needs to be considered when lifting heavy loads.
   a. True
   b. False

REPETITIVE CALLING OUT *Information*
(DEMENTIA CARE)

'Repetitive Vocalization' is the term used to describe a person making excessively loud and/or repetitive vocalizations, such as single words or phrases, nonsensical sounds, screaming, moaning, or constant requests for attention. ("Help me! Help me!...Nurse! Nurse!")

These behaviours can be difficult to manage, and can lead to significant stress for staff, visitors and other residents.

Repetitive actions and repetitive questioning, as with any behaviour, have a cause. Sometimes, it is the result of changes in the brain. In dementia, damage to the front area of the brain can lead to perseveration. With verbal perseveration, the same thing is repeated over and over again, like a music CD that skips. The person with dementia likely has no insight or control over this behaviour.

Repetitive vocalizations may provide a form of self-stimulation or self-soothing and are not malicious. This behaviour often does not respond to medication. Behavioural approaches and changes to the environment tend to show the greatest benefit.

Possible causes of repetitive behaviour to consider:

- Pain
- Sadness, depression, distress, loneliness
- Side effects of medication – sometimes the cause of repetitive behaviours, such as a tongue going in and out repeatedly, is a side effect of medication.
- Memory loss – the person may not remember having asked the same question or having done the same activity.
- Stress and anxiety – this could be due to the person being unable to interpret sights and sounds. They may be unable to remember what has just happened or where a loved one has gone.
- Inability to express a need or emotion – hunger might be expressed by repeatedly asking, "What's for lunch?" Being too warm could be expressed by pulling on one's shirt. The person may be feeling fearful or confused.

- Frustration – perhaps the person is trying to communicate but is not being listened to or is unable to get the message across.
- Inability to understand what is happening – even the simplest, everyday routine may become unfamiliar to the person, causing them to repeatedly question what is happening.
- Boredom - the resident may be under-stimulated and is using repetitive behaviours to alleviate their restlessness.
- Changes in the brain caused by dementia - as the disease progresses, people with dementia lose the ability to remember what they have just said or done. By repeating themselves, they are trying to gain a bit of control over their lives.

HOW DO I RESPOND?

Approach

- Use a calm tone of voice. Do not take the behaviour personally. The person with dementia is quite possibly unaware that they are repeating themselves. Remember that these vocalizations are not malicious nor intentional. They occur as a symptom of the person's condition and may also express unmet needs.
- Address the feeling, not the question. Repetitive questioning is often not a need for information but rather a need for reassurance. A hug or gentle touch on the arm or shoulder may help calm the person.
- If the repetition is a question, avoid reminding them that they have already asked the question. Instead, try: giving a different response; turning the question into a discussion; understanding why they may be repeating the question, and responding to any underlying feelings.

Redirect

- If vocalizations appear to serve as self-stimulation, or as a way to communicate boredom, under-stimulation, isolation, or withdrawal: try redirection to personally meaningful activities, music, distraction, or other sensory stimulation activities, giving them something to occupy their hands and attention, such as a simple puzzle or a stress ball.
- If the vocalizations appear to be related to overstimulation, try relaxation, environmental control, or redirection to a less stimulating activity or area.

Keep it simple
Respond as briefly and simply as possible. Avoid telling the person that they have repeated themselves as this may only serve to upset them. If changes in routine tend to upset the person, try telling them about your plans only shortly before the event. Sometimes simply ignoring the behaviour works in time.

Responsibilities of Nurses and HCAs

- Ensure a proper medical workup has been completed, especially if the behaviour is a sudden change for the person.
- Assessing pain is important. Pain should be ruled out before attempting any other technique. Discuss pain management options with the person's physician when appropriate. If changes to pain management happen, track whether the vocalizations change with the use of pain management.
- Document the behaviour and the situation (e.g., physical environment, staff presence, the presence of other people or family members, activity level, noise level, time of day, etc.) Initiate a DOS to identify patterns and potential triggers.
- Document any approaches that seem to have a beneficial effect. This can help identify useful strategies for management and recognizing potential triggers.

References: Alzheimer Society of British Columbia, Repetitive Behaviour, 2017
Saskatoon Health Region, Long Term Care, Behavioural Resource Sheet: Repetitive Vocalizations

REPETITIVE CALLING OUT *Questions*

1. Repetitive vocalizations are often a result of damage to the frontal part of the brain. They may serve as self-stimulation for boredom or self-soothing with overstimulating environments for residents.
   a. True
   b. False

2. Giving an anti-psychotic medication is one of the only effective means of responding to this behaviour.
   a. True
   b. False

3. If you are working around a resident who is calling out, it is helpful to remind them to be quiet as they are bothering other residents and staff.
   a. True
   b. False

USE OF RESTRAINTS *Information*

PCH Standards 24.23

There are four types of restraints:

1. Physical- Restraining limbs to provide care; moving a person to another location against their will.
2. Environmental- barricades; removing a walker needed for mobility to prevent wandering
3. Mechanical- a seat belt that cannot be opened by the resident (back opening or front opening); a Broda chair; full bed side-rails
4. Chemical

Chemical restraints are medications given to control behaviors and actions and/or restrict the freedom of movement- and not to treat a specific medical condition; can be regularly scheduled or prn. They are medications that are given to reduce or stop wandering, pacing, restlessness, agitation, aggression or uncooperative behavior and not required to treat the resident's medical or psychiatric symptoms. When a psychotropic is used without a diagnosis of a mental illness, it is a chemical restraint. This includes sleeping pills, hypnotics, anti-psychotics, antidepressants or anti-anxiety medications.

Residents who have chemical restraints have increased fall risk due to the effects of sedation, impaired balance, coordination, or orthostatic hypotension. Medication side effects can cause discomforts and general loss of function causing poor quality of life. Sedatives such as benzodiazepines increase the risk of falls, pneumonia and death.

Sometimes we do not recognize medications as a restraint. **It is everybody's responsibility** to help in fall prevention. The following are examples of chemical restraints:

1. Antipsychotics prescribed for responsive behaviors in dementia, or to "calm" or "settle" the resident and not for a mental health condition.
2. Antipsychotics prescribed for delirium. Antipsychotics are not a treatment for delirium, may worsen delirium and increase risk of mortality.
3. HS sedation given after midnight. There is no long term benefit for sleeping pills of any kind. Residents are more likely to fall, be confused, sleep all day and awake all night.
4. Anticholinergics for sedation. Medications such as dimenhydrinate (Gravol) and diphenhydramine (Benadryl) create brain fog with these medications.

Dementia is not an adequate diagnosis for use of chemical restraints. Chemical restraints may be necessary in an emergency, but they may still cause side effects. When there is no mental health issues, antipsychotics can increase nervousness, restlessness, calling out and difficulty sleeping. Antipsychotics can worsen responsive behaviors by adding confusion and restlessness.

Side effects of antipsychotics increases distress in residents. Some of the side effects of antipsychotics are:

- Confusion
- Agitation, restlessness
- Sleep problems
- Muscle stiffness, weakness, tremors, shuffling gait
- Difficulty peeing
- Nausea
- Drooling (increases risk of aspiration pneumonia)
- Falls
- Blurred vision
- Lip-smacking and tongue thrusting of tardive dyskinesia (may be permanent)

When medications are used to restrain a resident, the resident assessed and closely monitored to ensure their safety.

Before considering a chemical restraint, all other non-pharmaceutical, non-restraints alternatives must be tried for an adequate time prior to considering a chemical restraint. This includes diagnoses issues such as insomnia and anxiety. Giving a resident a diagnosis for the purpose of ordering a chemical restraint without the appropriate assessment and trial of alternatives is unethical.

There must be clear evidence in the restraint assessment that the medication being prescribed is being used as a last resort. The benefits of the restraint, to the resident, outweighs the burdens of the restraint, to the resident.

References:

Koch, S., Haesler, E., Tiziani, A., & Wilson, J. (2005). Effectiveness of sleep management strategies for residents of aged care facilities: findings of a systematic review. *Journal of Clinical Nursing* 15(10), pp 1267-1275.

Manitoba Health, Healthy Living and Seniors Continuing Care Branch-Personal Care Home Standards Team

Restraints in Personal Care Homes, SH-SS policy CLI.6410.PL.004

Westbury, J.L., et al. "RedUSe: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities," Medical Journal of Australia, May 14, 2018, https://www.mja.com.au/journal/2018/208/9/reduse-reducing-antipsychotic-and-benzodiazepine-prescribing-residential-aged, (accessed July 17, 2020).

RESTRAINTS *Questions*

1. Resident is diagnosed with dementia and is prescribed an antipsychotic for calling out. Is this a restraint?
   a. Yes
   b. No

2. Residents who have chemical restraints are an increased fall risk.
   a. True
   b. False

3. Whose responsibility is restraint safety?
   a. Nursing and recreation
   b. Dietary and Maintenance
   c. Housekeeping and Laundry
   d. All of the above

FALL PREVENTION *Information*

There are a variety of factors that contribute to the risk of falls for residents in PCH.

Falls are a safety concern

- 1 in 3 Canadians aged 65 years or older experience a fall
- Falls are the #1 cause of broken hips and head injuries
- About one quarter of people aged 50 and over who have a broken hip will die within 12 months

Resident's risk of falls is higher if they:

- Have had recent falls
- Have difficulty balancing or walking
- Have general weakness
- Have had changes to your memory
- Have sudden urges to use the washroom
- Take certain types of medications
- Take many medications
- Have problems with seeing or hearing
- Have recently moved to a personal care home

Decrease residents' risk of falling:

- Encourage resident to call for help before getting up if needing assistance, or feel weak, dizzy or unwell
- Encourage safe, well-fitting footwear
- Encourage sitting up in bed for a minute before standing
- If cane or walker is needed, encourage use at all times
- Ensure resident has their balance before attempting to walk
- Don't use bed rails

How we can help residents:

- We will assess their risk for falling
- We may recommend that they do certain things or buy items to help keep them safe, such as: shoes, non-slip socks, hip protectors, special monitors

Resident Wellness:

- Not all falls can be prevented
- If a resident does fall, we want to minimize the injury that happens
- The resident is an important part of planning their care to prevent falls

- Our goal is to help maintain residents' muscle strength, independence and overall well-being
- We will encourage residents to be active in their own care and to participate as much as they are able with personal care and other activities

Reference: Falls Prevention-A Guide for Residents CLI.6410.PL.014.SD.03

Fall Prevention and Fall Injury Prevention in PCH
SAFE FALLS!

Safe Environment

- Bottom bed rails down, unless assessed otherwise
- Pathways clear of clutter and tripping hazards
- Bed brakes are "on"
- Chair brakes are "on" for transfers
- Lights are working and "on" as required

Assist with Mobility

- Mobilize at least twice a day
- Safe and regular toileting
- Transfer/mobility assist documented
- Glasses, hearing and mobility aides within the resident's reach

Fall Risk Reduction

- Call bell within resident's reach
- Bed height adjusted to ensure safe mobility
- Personal items within resident's reach
- Proper footwear available and in use

Engage Resident and Family

- Discuss risk factors with resident and family
- Mutual falls prevention plan developed

To help prevent a resident from falling, ask these three questions before leaving their room:

1. Do you need to use the toilet?
2. Do you have any pain or discomfort?
3. Do you need anything before I leave?

Reference: Fall Prevention and Fall Injury Prevention in PCH - SAFE Falls Handout CLI.6410.PL.014.SD.01 Nov 20 2017 Page 1 of 1

As reviewed in the Restraint section, chemical restraints can increase the risk of the resident falling.

Use of restraints has not been shown to decrease falls or injuries. In fact, nearly all people fall at one time or another. In some cases, restraint use may actually increase the risk of injury in the event of a fall.
Restraints may increase agitation in some people. If physically restrained, the resident may become frustrated and agitated at not being able to move freely and at will.
A chemical restraint may cause drowsiness and result in an unsteady gait, increasing the risk for a fall. When given a choice, a resident may choose to risk falling in order to maintain their independence, comfort and dignity **'least restraint'**

Before staff can assist a fallen resident, a nurse must complete neurological and musculoskeletal assessments of the resident and determine if it is safe to move them.

Reference: Restraints in Personal Care Home-Client Teaching Handout CLI.6410.PL.004SD.01

Are you using this Falls Log in your PCH?

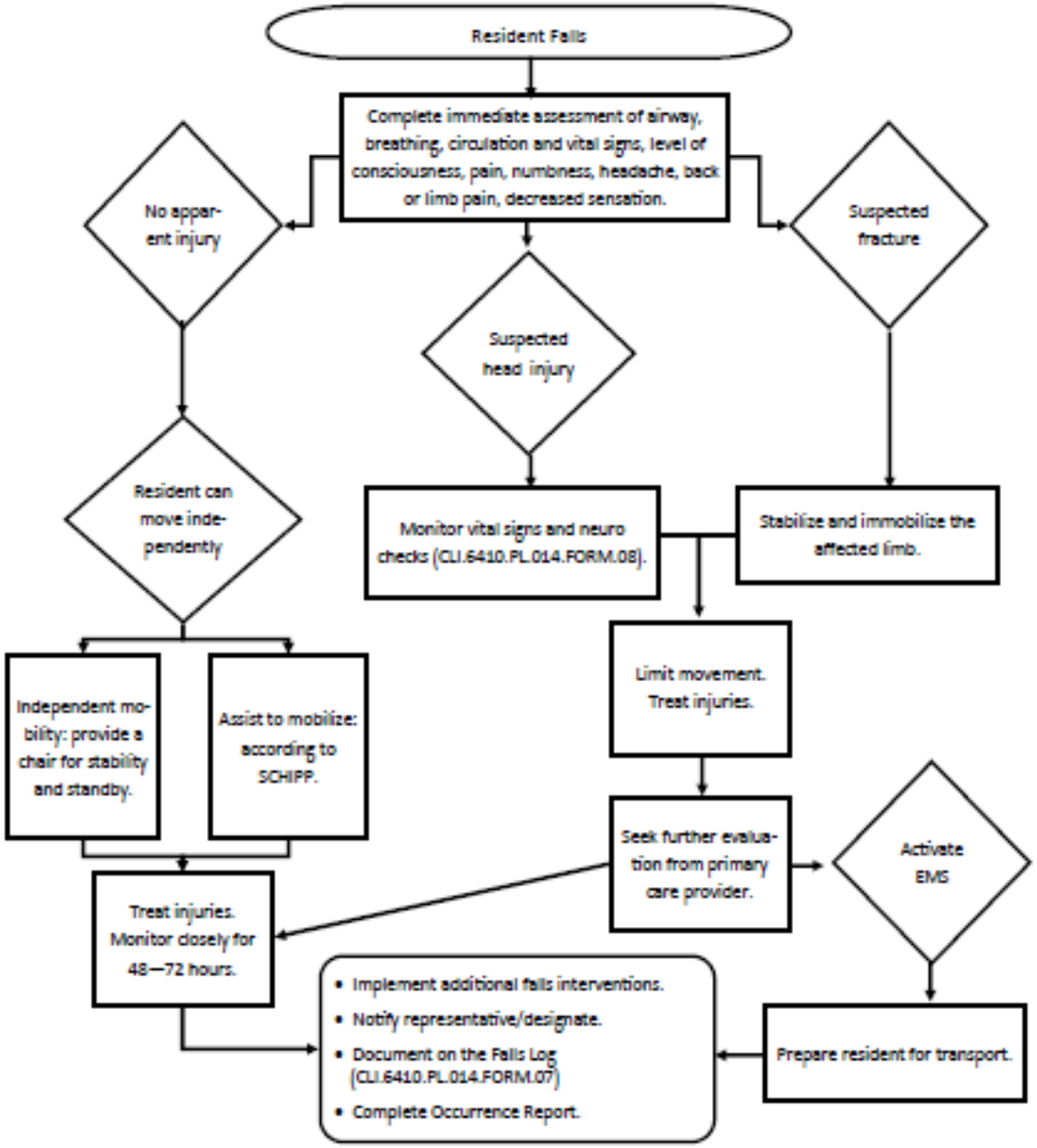
ADDRESSOGRAPH/LABEL

Fall Prevention and Management in Personal Care Homes
Falls Log

Event #	Date:	Time:
What? Where? (describe the fall) Who? (Who was present?) Why? (What may have caused the fall?)		Client Assessment & Initial Interventions
Signature/Designation:		Change to Care Plan: ☐ Yes ☐ No

Fall Prevention and Management in Personal Care Home

Post Fall Management Process Map



Fall Prevention and Management in PCH Post Fall Management Process Map CLI.6410.PL.014.SD.02 Nov 20 2017

FALL PREVENTION *Questions*

Use: 1) Post Fall Management Process Map & 2) Falls Log found on previous pages.

Mrs. D is a resident in your PCH. She is active and in good physical condition with advancing Dementia. Nursing staff have noticed that she has been more agitated and restless in the last month. She wanders in and out of other resident's rooms and becomes physical when staff try to redirect her. Staff have done a PIECES evaluation and consulted Seniors Mental Health who advised a trial period of an antipsychotic. She started on Risperidone 1mg PO BID last week and staff have noticed that Mrs. D is less agitated and easier to redirect when wandering. Staff also note that Mrs. D is not as steady on her feet and has lost her balance on occasion with a couple of near miss falls. You are doing your round at 0200 AM and find Mrs. D on the floor beside her bed, moaning in pain.

1. After the resident falls, the nurse needs to perform a thorough check of the resident's airway, breathing, circulation, etc.
   a. True
   b. False

2. There is a suspected fracture in Mrs. D's right arm. The next step is:
   a. Activate EMS.
   b. Stabilize and immobilize the affected limb.

3. The primary care provider (physician on-call) asks you to send the resident to the local ER. You activate EMS and prepare Mrs. D for transport. You fill out the Falls Log and read the question: What may have caused the fall? Using the information from the scenario you document the following:
   a. Dementia
   b. Antipsychotic medication
   c. Impaired balance
   d. All of the above

4. Under Client Assessment & Initial Interventions you decide to:
   a. Wait and see if Mrs. D has another fall.
   b. Put the resident on physician's rounds list to review the use of the antipsychotic.

SUICIDE RISK ASSESSMENT *Information*

Suicide Risk Assessment in Personal Care Homes

Last year staff started to do assessments about the mental health of residents in long term care, and especially looking at if a resident would be at risk for suicide. We want to prevent suicide and injuries from suicide from happening in our facilities. If a resident is thinking about suicide, we want to help the resident figure out what would help them feel better about themselves while living in long term care.

Depression is the main diagnosis in suicide attempts. There are different reasons that could lead to depression, like a person not being as healthy as they once were so they are no longer able to look after themselves. Once someone can't look after themselves, they lose their independence. Suicidal behaviour has many different aspects to it. Even with staff providing great care and mental health professionals providing their knowledge, some residents will still die by suicide. Some older adults may refuse to eat food or take their medications which could result in death. These deaths are usually not seen as suicide.

The assessment helps staff identify a resident's risk for suicide. This assessment includes information about the resident's past history, their current situation and how these might lead a resident to think about suicide. Initial screening of the individual should occur within 48 hours of moving into a facility and the resident is then screened every 3 months using the Geriatric Depression Scale if they have no cognitive impairment or the SIG E CAPS-Screening for Depression if someone has moderate to severe dementia. If a resident's score suggests depression, the nurse would then complete the Risk Assessment for Suicide Tool (RAST) to see what we should do to help. It is everyone's responsibility to observe residents for depression. Support workers should notify nursing staff if a resident starts to talk about ending their life or they don't seem as happy as they used to be.

SUICIDE RISK ASSESSMENT *Questions*

1. Screening only needs to happen on admission because there aren't opportunities for residents to harm themselves once they move in.
    a. True
    b. False

2. Depression is the main diagnosis in suicide attempts.
    a. True
    b. False

3. Two months ago, Mrs. Jones moved into Happy Care Nursing Home. The Suicide Risk Assessment did not identify any suicide concerns. Following their visit today, a family member tells you that her mother doesn't seem to be as happy now as when she first moved in. As a support worker, what is your next step?

    a. Complete the RAST

    b. Talk with other HCAs about how Mrs. Jones used to be happy when she first came to the care home.

    c. Tell the nurse in charge what the family member has told you.

    d. Don't do anything. She's just settling in. She was probably like this before she came to the care home but nobody knew because she lived alone.

PERSONAL HEALTH INFORMATION ACT *Information*

What is personal health information?
All information recorded or exchanged verbally about an identifiable person that relates to:

- The person's name, health or health care history, including genetic information about the person or their family;
- What is learned or observed about the person, including conduct or behaviour, which may be a result of illness or the effect of treatment;
- The provision of health care to the person. May include co-workers or families of co-workers when they are residents of a personal care home in Southern Health-Santé Sud
- Payment for health care provided to the person and includes:
    - The personal health identification number (PHIN) and any other identifying number, symbol or particular assigned to that person, and
    - Any identifying information about the person that is collected in the course of, and is incidental to, the provision of health care or payment for health care;
- The resident's personal information, including financial position, family difficulties or any other private matters relating to the resident which have been disclosed to staff or persons associated with Southern Health-Santé Sud.

Examples of Personal Health Information *Identifiers:*

IDENTIFIER: Age

Resident is 82 years

IDENTIFIER: Health

The resident first started experiencing pain after a fall.

IDENTIFIER: Type of Care Provided

Resident was sent for an x-ray of his left hip.

REMEMBER: Our residents depend on us to maintain their privacy and keep their Personal Health Information confidential.

What is PHIA?

The Personal Health Information Act, or PHIA as it is commonly known, is an Act that incorporates the common law right of an individual in Manitoba to examine and receive a copy of his or her Personal Health Information (PHI). It also limits and controls the manner in which Personal Health Information is collected, used, disclosed, stored and destroyed.

The Personal Health Information Act is a Manitoba Government Act, making it law with corresponding rules that must be obeyed. **PHIA policies** have been developed by Southern Health-Santé Sud to ensure we comply with this legislation. These policies are found in the **Administration Manua**l located in your personal care home. The policies are also accessible from the HPS home page.

As healthcare providers, we collect Personal Health Information in order to do our work. We become the trustees of this information and are required to protect its privacy and confidentiality. This includes how the Personal Health Information is obtained, handled, heard or viewed in the course of our work or association with the Southern Health-Santé Sud as well as how it is used, disclosed, stored and finally destroyed.

Each personal care home assigns staff to serve as *privacy officers*. Their role is to provide guidance and direction when unanticipated issues around privacy and confidentiality come up. The *privacy officers* are acquainted with the regional PHIA policies and have access to regional experts if unsure how to proceed on PHIA matters.

While performing your duties in personal care homes here in Southern Health-Santé Sud, you must adhere to the following:

- Keep all resident Personal Health Information confidential and private. <u>Do not discuss any resident information with anyone who does not need to know this information to do his or her job in Southern Health-Santé Sud</u>
- Do not share resident personal health or any other information provided to you:
    - if the person does not need to know it to do their job or is not legitimately entitled to the information

    - in the presence of anyone who might overhear and does not need to know this information (e.g., cafeteria, hallway, off premises)
- Exercise great caution when providing Personal Health Information over the phone and only share when you have established that the caller is entitled to a resident's PHI
- Avoid use of any social media such as 'Facebook' to post confidential information, (including pictures), about the residents or the Personal Care Home where you work
- Guard your password and never share it if your job includes accessing electronic health records
- Avoid 'snooping' in electronic health records of residents whom you are not caring for. (Be aware that regular electronic audits are conducted to ensure staff compliance with PHIA.)
- Take steps to secure all Personal Health Information properly to protect its confidentiality and ensure its safety from accidental loss or destruction
- Authorized personnel who need to transport Personal Health Information outside the Southern Health-Santé Sud's premises are required to store laptops, charts, or files in the trunk of their vehicle during transportation and must never leave this information in the trunk of a vehicle in an area of high risk of theft
- All confidential material must be disposed of by an approved method (most often shredding)

➢ Take precautions when sending Personal Health Information by fax. Use the **Record of Release of Personal Health Information** and ensure that the fax number is being used is correct

➢ If you are not sure what is the appropriate thing to do in a specific situation, discuss it with your supervisor, manager, or the Privacy Officer in your PCH or the regional privacy officer at (204) 822-2655 or (204) 326-6411, ext. 2195

A breach of confidentiality is when you:

➢ Access or request Personal Health Information **NOT NEEDED** by you to do your job

➢ Provide information **NOT NEEDED** by the other person to do their job

➢ Provide information to an individual who has no right to have the information under PHIA

- Where consent is required and consent has not been obtained from the resident or a person permitted to exercise the rights of the resident

If a breach of confidentiality is confirmed, discipline may include:

- Oral or written warning
- Suspension
- Termination of employment

(If convicted of an offence under PHIA, the courts may fine you up to $50,000.00. A confirmed breach of confidentiality may be reported to the staff person's professional regulatory body.)
Report all suspected breaches of confidentiality to your supervisor, manager, Privacy Officer or Regional Director and complete an occurrence report

PERSONAL HEALTH INFORMATION ACT *Questions*

1. Mrs. Jones moved into Happy Care Nursing Home on 8 June 2020 and did not show any signs of depression. In fact, she seemed happy to be in her new home. You were Mrs. Jones's neighbor for 20 years and she was part of a circle of friends who would get together for coffee once a week. At the next coffee group, the group asks you about how Mrs. Jones is adjusting.

    a. Tell the group how much she misses her friends and that you haven't seen any of them visiting her.
    b. Invite the group to visit her and let the group know that you cannot talk about how Mrs. Jones is adjusting to her new home.
    c. Show them pictures of her that you have placed on Facebook.

2. You are also a friend of Mrs. Jones but you work as a dietary aide. You happen to be in Mrs. Jones' neighborhood one day and speak with Mrs. Jones about how she is adjusting to her new home. She tells you that she is very lonely. She looks like she has lost weight. She says that the food doesn't taste good and she doesn't have much of an appetite. She says that she has kind of given up hope that her life doesn't matter anymore.

    a. Check her chart to make sure that she has been screened for depression.
    b. Talk with a friend of yours who is a health care aide for Mrs. Jones
    c. Talk with the nurse in charge about your concerns.
    d. Tell Mrs. Jones that you will let her friends know.

Ethical Decision Making *Information*

Assisting with Meals

A question that has been brought forward in our region is what is the most appropriate action for staff to take when a resident has choked and has now gone unresponsive after all interventions performed were unsuccessful in removing the object. The resident has a Do Not Resuscitate status listed on their Advance Care Plan or a ("ACP-C" or Comfort) on their Advance Care Plan. Is it appropriate to intervene? This raises an ethical dilemma.

Our region has easily accessible resources to staff members, and in this instance guidance tools to facilitate ethical decision making including the Ethical Decision Making Framework which is included on the next page. It can help a team or community work together by introducing a shared systematic process, facilitating effective communication, developing a shared language and building a common understanding of how to approach difficult ethical dilemmas. Regional core values, principles, vision and mission help us determine the most ethically justifiable option.

The Ethical Decision Making Framework is comprised of four steps and incorporates five conditions identified as important in the accountability for reasonableness framework developed by Daniels and Sabin (2002) and adapted by Gibson, Martin, and Singer (2005).

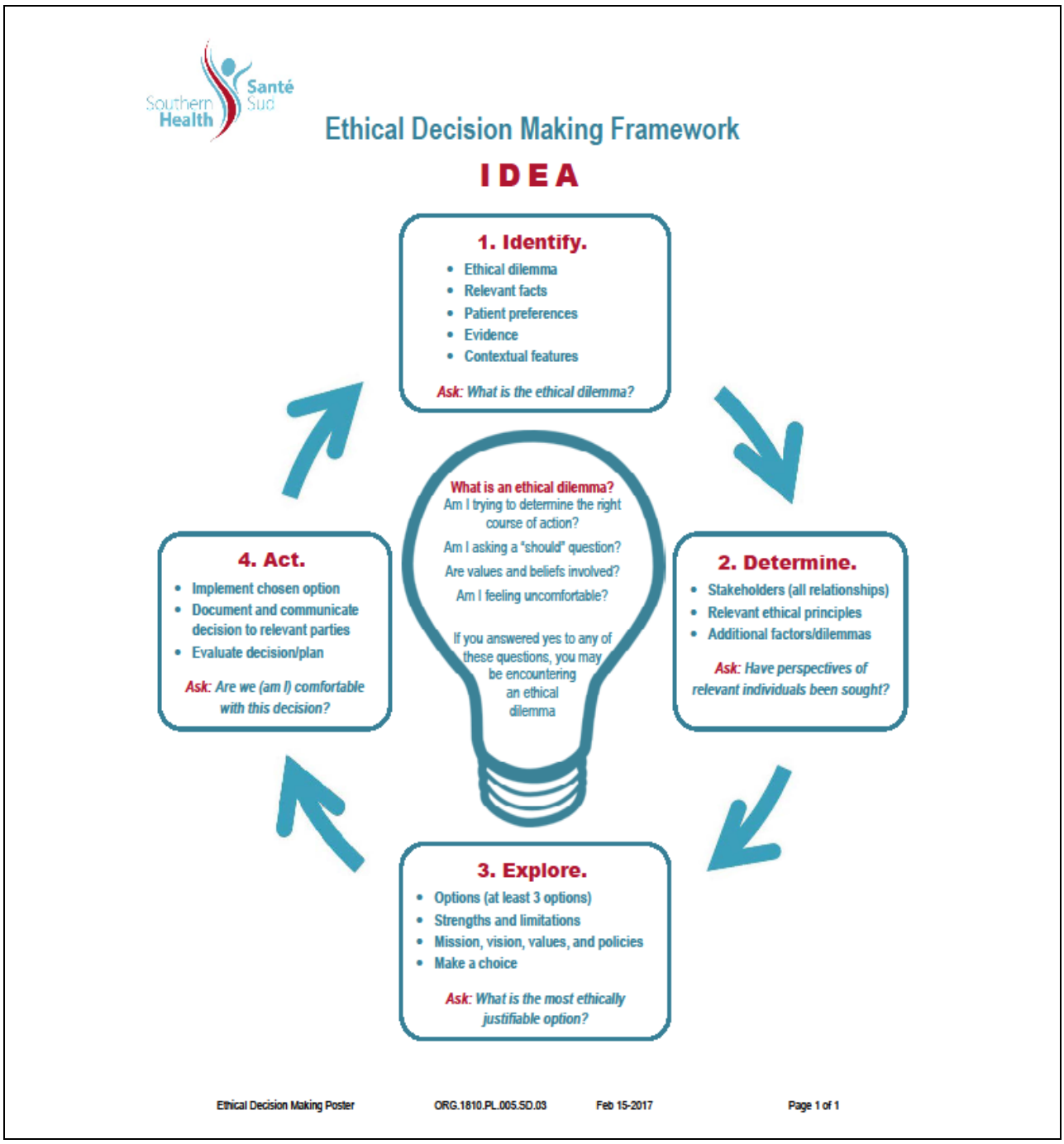
The first letter of each step in this framework forms the acronym "**IDEA**". In the centre of the framework there is a light bulb (a further reference to the framework's acronym, IDEA). The light bulb contains a set of questions to assist healthcare providers/administrators in the identification of ethical dilemmas to which the framework can be applied. The framework is depicted as circular, suggesting that decisions need to be revisited as new facts emerge.

The Ethical Decision Making Tool is to be applied when clinical and/or organizational dilemmas arise to address what we should do and why. Common ethical issues may include situations when:

- Client goals conflict with the health care team goals
- Family goals conflict with the health care team goals
- Staff member goals conflict with the physician's goals
- Co-workers' actions conflict with your beliefs

- Competing demands for human, financial, and/or physical resources

In the resident choking scenario mentioned in the first paragraph, initial discussions using the Ethical Framework have begun within the Staff Development/Infection Prevention & Control Team. Further discussions will be held regionally to determine the most ethically justifiable option of action in this situation.



Ethical Decision Making *Questions*

A resident is choking at the dining room table and has now become unresponsive as the airway is unable to be cleared. The resident has a health care directive that indicates no resuscitation. Do staff intervene? Do we stop all action and call 9-1-1? Do we continue with attempting to relieve the obstruction?

1. This is an ethical situation for staff.
    a. True
    b. False

2. Staff should proceed with the action they deem is appropriate based on their own personal values.
    a. True
    b. False

3. The regional Ethical Decision Making Framework & Worksheet are tools that can be used to guide team discussion around the ethical dilemma and determine the most ethically justifiable option.
    a. True
    b. False

ORAL CARE *Information*

The new Policy developed in 2020 Policy Purpose:

- To ensure a resident's oral hygiene needs are met according to their individual and clinical needs.
- To keep the structures and tissues of the mouth clean, functional, comfortable, and free from infection by effectively removing plaque and soft debris using safe and appropriate products.

Fact: Aspiration pneumonia in hospital adds substantial preventable cost to a patient's care, adding days to a patient's acute care admission and additional interventions at the cost of thousands of dollars per case (in the USA, $10,000-$13,000 per case).

When the mouth feels unclean, the person feels unclean, and is less likely to eat and drink well. "Dirty" mouths contribute to impaired taste, and impaired sensation of food or beverages in the mouth. For people who are compromised, for example, because of a stroke, this can lead to adverse outcomes. Good oral hygiene is the starting point for overall health. There are some linkages to show that poor oral hygiene or oral health status can make diseases such as diabetes, heart disease and respiratory disease worse. This link is poorly understood, but believed to have some bacterial origin. Getting rid of mouth bacteria regularly is important to help someone achieve their highest level of function and wellness.

Reference: Power Point on Oral Hygiene Developed by: Heidi Wiebe, Maria Krentz, Anne-Marie Heard 2019

Tips for all levels of oral hygiene:

- Complete with resident sitting upright when possible; alternatively, put the head of the bed at a 30-45 degree angle.
- Complete with a toothbrush at all times; clean the tongue, teeth, cheeks and palate.
- Dentures must be removed during care and brushed. Use a toothbrush and warm water or toothpaste.

Important Points to Consider:

- Sponge swabs (toothettes) are not to be used to provide oral hygiene. Sponge swabs are ineffective at removing plaque and soft debris in the oral cavity. Furthermore, sponge swabs may not retain their integrity and pose a risk of choking.
- Residents in PCH are required to provide their own oral hygiene products (toothbrush, toothpaste, denture care products, etc.). Patients in AC and TCC are strongly encouraged to provide their own oral hygiene products.
- There is a regional standard nursing reference text available in all AC units, TCC and PCHs.
- The reference text provides information about oral health assessment and interventions, and describes how to properly provide oral hygiene.
- The skill of providing oral hygiene as described in this reference text establishes the expected standard of care in Southern Health-Santé Sud.
- Referral to disciplines such as Dentistry, Speech-Language Pathology and Clinical Dietitians can be an important part of the oral assessment and treatment plan.
- Referral to Speech-Language Pathology is important when swallowing concerns are identified.

PROCEDURE:

Assessment

1. Assess each resident's or patient's oral health status on admission to PCH using the Oral Health Assessment and Care Plan Guide (CLI.4110.PL.018.FORM.01).

Care planning

2. Develop an oral hygiene care plan using the Oral Health Assessment and Care Plan Guide. Refer to the "Algorithm for Determining Level of Oral Hygiene Assistance Required" on p. 2 of the Oral Health Assessment and Care Plan Guide to help develop an oral hygiene care plan as needed.

3. Transfer any actions identified in Table A to the Integrated Care Plan (CLI.6410.PL.002.FORM.01).

4. Refer to the Oral Hygiene: Levels of Care Procedures (CLI.4110.PL.018.SD.01) document to develop an oral hygiene care plan. Transfer any interventions to the Integrated Care Plan.

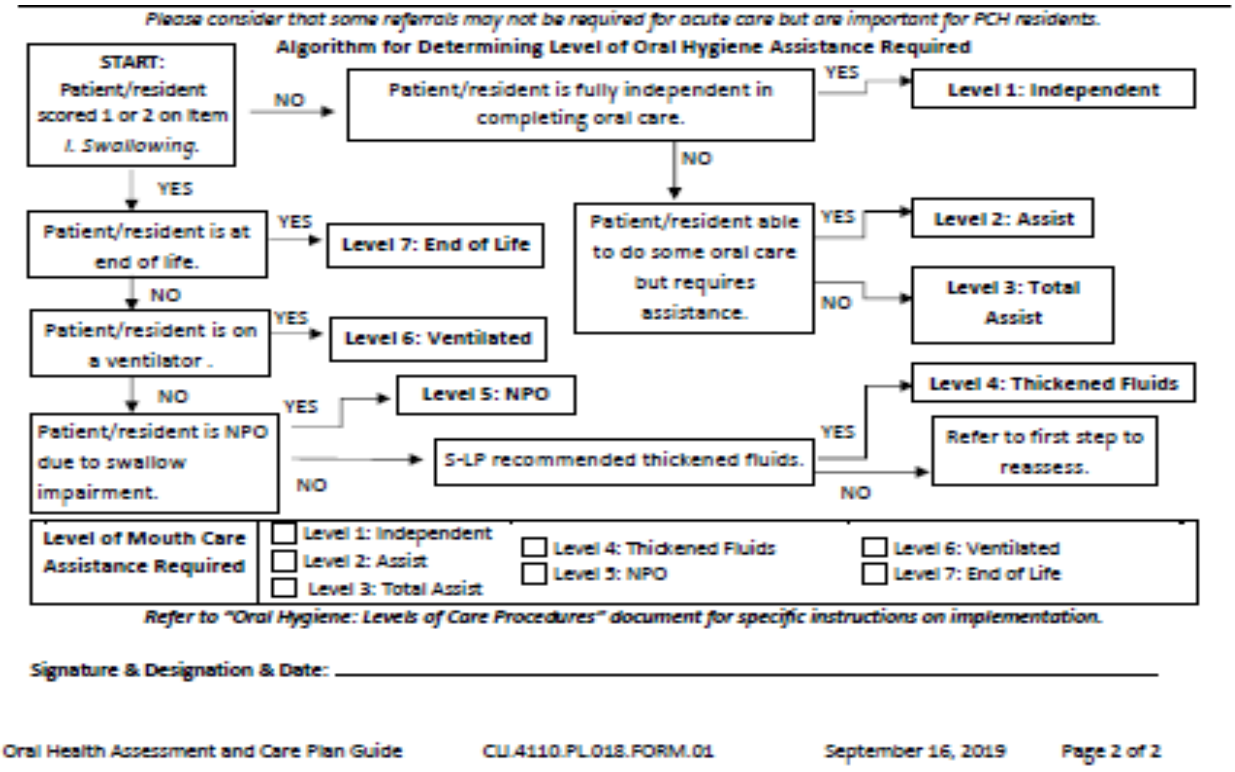
Intervention

5. Provide oral hygiene as per the developed care plan.

Information from Oral Hygiene Policy CLI.4110.PL.018 September 16, 1019

Supplies available for mouth care:

- Soft bristled toothbrush
- Hydrogen Peroxide 1.5%
- Chlorhexidine 0.12% oral rinse
- Thickened non-foaming oral care product (Perivex)
- Denture adhesive
- Oral Care product (toothpaste), non-fluoridated (Sodium Bicarbonate) if the resident has swallowing impairment.
- Water-based, non-petroleum lip/mouth moisturizer



Level	Frequency	Procedure			
LEVEL 1: INDEPENDENT	AM/PM	Provide materials (toothbrush, K basin, face cloth, oral care product, denture adhesive, etc.); provide verbal reminders.			
LEVEL 2: ASSIST	AM/PM	Provide materials assist with set-up, help when needed, and check for effectiveness.			
LEVEL 3: TOTAL ASSIST	AM/PM	Provide oral care using a toothbrush and toothpaste or water. Consider two-toothbrush technique or bite block.			
LEVEL 4: THICKENED FLUIDS	AM/PM, after PO intake	Use thickened non-foaming oral care product and toothbrush. Apply water-based mouth moisturizer. Use Yankauer suctioning as appropriate.			
LEVEL 5: NPO DUE TO SWALLOW IMPAIRMENT	Every 4-8 hours	Every 4-8 hours:	Use thickened non-foaming oral care product, toothbrush and Yankauer suctioning to clean surfaces of mouth. Apply water-based mouth moisturizer.		
			OR		
			Use a suction toothbrush kit when patient is in SCU or acutely ill.		
		As ordered by prescriber:	Consider use of Chlorhexidine 0.12% once per day. Apply with a toothbrush or as a spray.		
LEVEL 6: VENTILATED	Every 2 hours	Every 8 hours:	Use a suction toothbrush kit if available	OR	Use a toothbrush, water, and Yankauer suction.
			Apply 1.5% hydrogen peroxide with toothbrush or as a spray. Apply water-based mouth moisturizer.		
		In addition, every 2 hours:	Use a toothbrush and water. Suction oral cavity with Yankauer suction.		
		Once per day, as ordered by prescriber:	Apply Chlorhexidine 0.12% with a toothbrush or spray. Do not apply Chlorhexidine and hydrogen peroxide in same oral care session.		
LEVEL 7: END OF LIFE	AM/PM at minimum	Use toothbrush as tolerated. Alternatively, use gauze or a cloth moistened with water to clean the mouth. Apply a water-based moisturizer gel or spray to the inner surfaces of the mouth, tongue and lips as necessary.			

ORAL CARE *Questions*

Please refer to the highlighted areas on page 1 and the top half of Page 2 (previous pages) of the Oral Health Assessment and Care Plan Guide to complete the following.

Mr. R moved in to the PCH last week. You read in the IPN that his family has arranged for resident to see a dentist in 2 weeks. The Speech Language Pathologist has see the resident as there were some concerns from his feeding and swallowing assessment. The SLP has put him on thickened fluids.

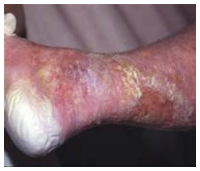
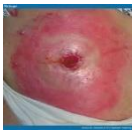
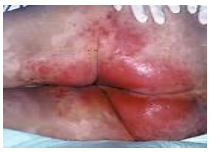
1. Using the algorithym at the bottom of page 2 what level of mouthcare assistance is Mr. R?
   a. Level 1: Independent
   b. Level 3: Total Assist
   c. Level 4: Thickened Fluids

Now that you know the Level of Mouthcare assistance Mr. R requires please answer the following using The Oral Hygiene: Levels of Care Procedures.

2. How often does Mr. R. need mouthcare?
   a. Every 4-8 hours
   b. AM/PM, after PO intake
   c. AM/PM
3. Which product does Mr. R. need in his room to provide oral hygiene according to his level?
   a. Thickened non-foaming oral care product
   b. Toothpaste

Pressure Injury Prevention *Information*

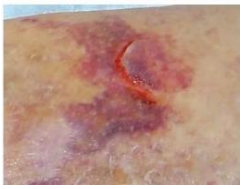
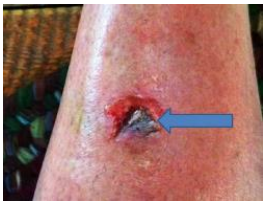
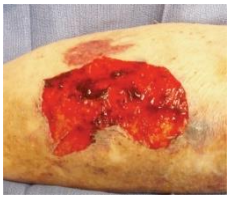
Moisture-Associated Skin Damage (MASD)

Type of MASD	Moisture Source	Brief Description
Periwound MASD 	Exudate	Erythema and inflammation of skin within 4 cm of the wound edge, can be accompanied by erosion, denudation caused by exposure to wound exudate, infection and/or traumatic removal from adhesive materials.
Peristomal MASD 	Urine or fecal effluent	Erythema and inflammation of the skin around the stoma, can be accompanied by denudation caused by exposure to stool or urine occluded under the skin barrier of the pouching system.
Incontinence Associated Dermatitis 	Urine, liquid stool	Erythema and inflammation of the skin, can be accompanied by erosion and denudation caused by exposure to urine or stool
Intriginous Dermatitis 	Perspiration	Erythema and inflammation of the skin inside and adjacent to skin folds, can be accompanied by erosion or denudation caused by exposure to chronic perspiration.

Suggestions for Prevention: How can we stop moisture to the area?

1) Barrier cream – can create barriers to reduce irritation giving the skin a chance to heal.
2) Bathroom regimens – can reduce length of time skin remains moist
3) Tranquility thin liner moisture management – can help wick moisture away from the areas, great in skin folds, and can be used in other situations; consult Wound Care Specialist prior to using as part of dressings
4) Consult with incontinence product rep – are we using the right incontinent product, what options do we have?

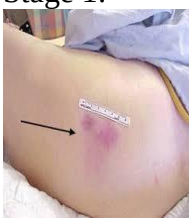
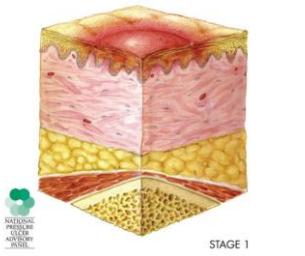
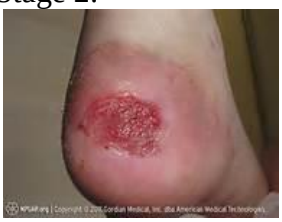
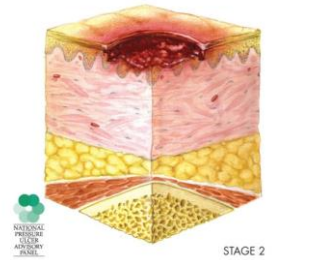
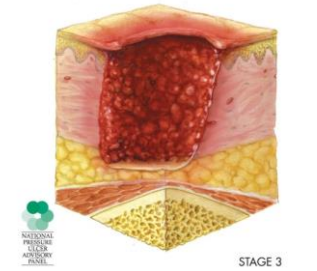
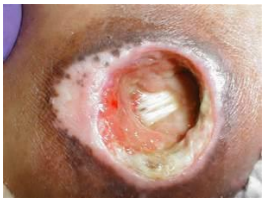
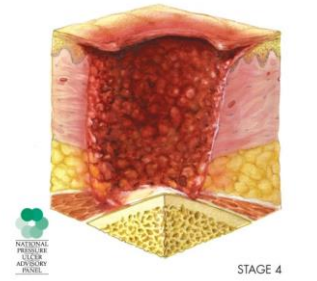
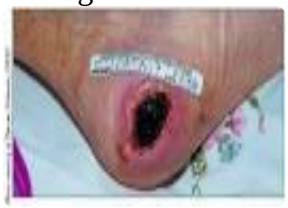
5) Check out the *Product Information: Advanced Wound Care Fomulary* (On HPS → Staff Resources → Wound Care Best Practice Recommendations) for recommended products based on wound care need (absorption, compression, antimicrobial effect, etc.)
6) Consult with Prescriber for issues related to infection, tissue edema
7) Consult with Wound Care Specialist – can suggest special dressings, provide advice if wound is not healing as expected

Skin Tear Types	Description	Dressing options
Type 1 	No tissue loss; can be linear tear or tissue flap	1) Approximate edges. Cover with silicone or low tack foam dressing. Use alginate if skin tear is bleeding. 2) Approximate edges. Control bleeding. Cover with absorbent clear acrylic dress. Do not remove for 21-28 days. Reassess if signs of infection.
Type 2 	Tear with partial flap loss	1) Approximate edges. Cover with silicone or low tack foam dressing. Use alginate under foam if skin tear is bleeding. 2) Approximate edges. Control bleeding. Cover with absorbent clear acrylic dressing. Do not remove for 21-28 days. Reassess if signs of infection.
Type 3: 	Total flap loss	1) Approximate edges. Cover with silicone or low tack foam dressing. Use alginate under the foam if skin tear is bleeding. 2) Approximate edges. Control bleeding

Examples of Dressings:

- Silicone: Mepilex foam, Mepitel
- Low tack: Mepilix foam, Mepitel
- Acrylic: Tegaderm Absorbent: wear up to 30 days. Barrier to external contaminants. Absorbs wound exudate.
- Skin prep: No-sting prep wipe/spray; reduces friction and shear under dressings and tubing

Stages of Pressure Injury:

Stage	Description	Layers of tissue affected picture
Stage 1: 	Intact skin. Non-blanchable erythema (will appear different in darker skin pigments). Found over a bony prominence.	
Stage 2: 	Partial thickness skin loss with exposed dermis. Also can present as an intact or ruptured serum filled blister. Wound bed is pink or red, moist and viable.	
Stage 3: 	Full thickness skin loss. Reportable to Manitoba Health. Is a Critical Incident.	
Stage 4: 	Full thickness skin and tissue loss. Depth will vary. May be undermining and sinus tracks. Reportable to Manitoba Health. Is a Critical Incident	
Unstageable: 	Obscured full-thickness skin and tissue loss-dark eschar. Slough or necrotic tissue and/or black discolored tissue is present. Can be reportable to Manitoba Health, may be a Critical Incident.	

When choosing dressings, consider the following:

Lots of exudate? → Foams, Aquacel ribbon || Needs moisture? → Intrasite gel
Signs of infection? → Antimicrobials (require prescription) || Area needs extra protection? → Foams || Needs packing? → Intrasite gel, Aquacel ribbon

Prevention is the best treatment for pressure injuries. Use the Braden Scale and the interventions lists to promote prevention. Consult as needed with Wound Care Specialist, Physician, Dietitian, Occupational Therapy, etc

Interested in Learning More? Check out LMS Level 1: Wound Care

Product Information Sheets Advanced Wound Care Formulary https://www.southernhealth.ca/assets/Staff-Resources/Wound-Care/5d52217068/Advanced-Formulary-Wound-Care-Product-List-February-3-2020.pdf

Information taken from: Pressure Injury Prevention and Treatment Guideline CLI.4110.SG.002, Skin Tear Treatment Guideline CLI.4110.SG. 003, and Pressure Injury PowerPoint Presentation 2017 and the Product Information Sheets Advanced Wound Care Formulary.

PRESSURE INJURY PREVENTION *Questions*

Case Study 1: During a night shift, you were doing rounds. One of the residents, Ingrid, was sleeping soundly so you and your coworker decided not to wake her to turn her, until the next round. Ingrid typically grimaces when she is turned and often calls out. On the next round Ingrid was turned, she did call out and grimaced as expected. Ingrid's incontinence product was changed for a large void, peri-care provided and barrier cream applied, as per her care plan. When you have her positioned on her left side at 30 degrees, with pillows placed in between her staggered legs and back and head support in place, you note redness to her right hip.

1. Could this be a pressure injury?
    a. Yes
    b. No

2. How does the nurse check to know that it is a pressure injury?
    a. Its red and over a bony prominence, it must be.
    b. Its red and over a bony prominence, its a distinct in shape fitting the structure of the bone underneath and its not blanchable.
    c. Maybe its MASD, the incontinent product is wet.

3. If this is a pressure injury, what stage would it be?
    a. Stage 1
    b. Stage 2
    c. Unstageable

4. How would we treat, this wound?
    a. It doesn't need anything, it will heal.
    b. Creating a turning schedule, ensure Ingrid is at 30 degrees and pillows are positioned properly when turned on side, encourage Ingrid to report pain over bony prominences.