Nursing Matters

Leading Change at the Point of Care

Creating fair, equitable, safe, and appropriate nurse-patient assignments is challenging. In 2017, nurses were asked to troubleshoot the nursing assignment on the 5E Complex Continuing Care (CCC) unit. Ashley O'Neil reviewed several tools used to assist nurses in making nurse-patient assignments, but they all focused on acute-care settings, and did not consider factors in the CCC patient population. This led her to develop a nurse -patient assignment tool, specific to CCC.

The newly developed tool included CCC patient factors such as nutrition, hygiene/elimination, mobility and activity needs, treatment/ observation/ monitoring of wounds and tracheostomy care needs, teaching needs for staff, client or family, psychosocial needs, and administration of complex intravenous and other medications – all factors not commonly captured in acute-care tools.

Ashley took on the initiative in collaboration with Beatrice Anderson, Adela Belisario, and Michael Maralit. Together, they refined the tool and led a quality improvement pilot project on the 5E hospital unit. The team utilized the College of Nurses of Ontario's three factor framework as a guide to create fair, equitable, safe, and appropriate nurse-patient assignments that matched each nurses' competencies. Staff were encouraged to work to their full scope in collaboration with other team members. With the utilization of this nurse-patient assignment tool, it was more feasible to reflect on the acuity and predictability of the patient in an objective manner.

Sharing nursing knowledge beyond Baycrest

Because of the limited number of post-acute care tools available for organizations to use, the team wanted to share their tool with others. With the help of Ben Hartung, Advanced Practice Nurse, Ashley, Adela, and Beatrice worked together to develop an abstract and poster presentation to submit to the Canadian Nurses Association (CNA) Bi-Annual Conference in Ottawa, and presented at Canada's national nursing conference in June 2018.

Pictured from Left to Right:

Beatrice Anderson, Ashley O'Neil, Adela Belisario and Ben Hartung.

Still keen to share their story, they submitted another abstract to the Registered Practical Nurses Association of Ontario's (RPNAO) Conference and presented their poster at the conference at Deerhurst Resort in Huntsville this October 2018. The poster is available for viewing on 5E.

Advice for nurses wanting to get involved in quality improvement

We encourage nurses to be involved in quality improvement to advocate for better outcomes for the clients and their families. Baycrest's core values are CARE: compassion, advocacy, respect, and excellence. We embrace these values as a team. It is rewarding and fun to be part of a quality improvement initiative. It builds stronger relationships with colleagues, increases knowledge, and improves health outcomes for our clients. We encourage staff at the point-of-care to become involved, to share your initiatives at conferences, and utilize funds that Baycrest can provide for these initiatives. Step up, become involved, and lead to make a change!

AN INVITATION FROM THE BAYCREST DENTAL CLINIC

Did you know?

We have a new state-of-the-art dental clinic right here at Baycrest, across from the NOSH cafeteria, where staff can receive a full range of exceptional dental care.

Here are the Top 10 Reasons to Take Advantage of our New Dental Clinic

1. It is right onsite - no travelling required.
2. Times are flexible – before or after work, or during your lunch break.
3. New state-of-the-art technology including digital x-rays.
4. Completely renovated facilities on the main floor.
5. A complete range of dental services available under one roof.
6. A skilled and caring dental care team.
7. Automatic submission of invoices to your dental insurance provider.
8. It is a leading training centre for dental care, affiliated with the University of Toronto.
9. Affordable fees and great value if you don't have dental benefits.
10. It's easy to call and make an appointment - just dial extension 2600.

Privacy and confidentiality are important to us and we know you trust us with yours.

Check out our services at baycrest.org/dental

Please JOIN US on Friday, November 23, noon to 3pm for our special OPEN HOUSE, organized especially for Baycrest staff!

More details to follow!

"Not all superheroes wear a cape"

"Not all superheroes wear a cape" is certainly a true statement when it comes to Janet Edwards from 5 East Baycrest Hospital. An incident occurred when Janet was enjoying her vacation travelling by plane - when suddenly she heard a call "is there a doctor or a nurse on the plane?". Janet stepped up! She first observed the scene to understand the situation. There was a woman in her 60's sitting in her chair with low level of consciousness. Janet performed her assessment and she took the woman's vital signs. Janet realized that this unknown woman had low blood pressure and was most likely experiencing dehydration and hypoxia evident from her pale colour, cyanosis and poor level of consciousness. Janet truly demonstrated her strong clinical expertise by raising patient's legs in order to help the blood flow to the vital organs. She then started an IV—a miracle given the woman's dehydrated status and very thin veins. Janet accomplished this feat with very minimal resources available on the airplane. Amidst all of the chaos Janet did not forget to get consent and to demonstrate nursing professionalism at its finest! After receiving approximately 500mls of Normal Saline the woman's level of continuousness improved, she perked up, opened her eyes and requested water to drink.

Not only did Janet possibly save a life, but the plane full of people rejoiced that they did not have to be redirected and everyone got to arrive at their destination safely with EMS awaiting the woman at the tarmac. Janet credits her years of experience working at Baycrest with elderly patients for her ability to provide emergency interventions, for her IV starting skills and her comfort with leading the first response efforts.

Kudos to Janet on her heroism!!

By: Taranvir Dayal, RN APN & the 5East Clinical Team

Day Treatment Centre takes on a "Lean 6S"

The Day Treatment Center (DTC) is a rehabilitation program where community-dwelling older adults, with complex medical conditions, come to participate in group exercise activities and identify goals to help maintain their health and wellness by working with an interprofessional team. Given the amount of services and limited space, the clinic was cluttered with excess equipment, supplies and items that were hardly used. Furthermore, with the ambulatory clinics returning to the same area, there was a need to rethink the use of the space and free up space for patient care.

The team launched an improvement project to maximize use of space, improve the patient experience and the appearance of the area, to maximize safety, and to promote efficient workflow. They followed Lean techniques such as '6S' and 'Physical Layout redesign'.

6S is a lean process improvement tool that stands for:

Sort

Set in Order (aka Straighten or Stabilize)

Shine (aka Scrub or Sweep)

Standardize

Sustain

Safety

The team quickly rolled up their sleeves and, with the help of all the team members, a significant amount of unnecessary items were removed. Together, the group came up with ideas to optimize the use of the rooms, workflow and appearance.

Some of the improvements included, creating an additional exam room and reconfiguring 2 additional rooms to enable patient consultations and reduce the time that rooms were not used. Patients immediately saw the benefit. One patient even commented to Delia Silva, RN: "what happened to this room? It seems much bigger!" Dr. Terumi Izukawa said: "I really appreciate the additional space in the Exam Room."

Shirley Lee, an Occupational Therapist in the DTC has also seen how reconfiguring the room has engaged clients into discussion about goals and treatment plans. "Having the equipment visible to the patient makes it easier for them to understand our role. The pegboard which displays common assistive devices catches a client's curiosity 'what is that device for?' and facilitates meaningful conversation about their challenges in day-to-day activities". Shirley also mentioned that "the 6S process allowed us to remove a number of excessive devices or supplies and to place the frequently used items within easy access, which helps us by reducing the time we spend looking for items".

The power of team work was the key to this success; "all staff were involved and collaborated in decision making, e.g. reassigning space, sorting through supplies, taking turns to audit and sustain the gain. Our team upheld client's need and best interest above personal benefit, by sharing space or giving up individual offices" (DTC staff).

The Lean 6S in the Day Treatment Centre is a great example of how the combination of teamwork, commitment and structure provided by quality improvement techniques can have a positive impact on the experience for our patients as well as our staff.

Virtual Care for Homebound Frail Seniors Using Telemedicine
Highlights of a Pilot Study

Background:

The Integrated Community Care Team (ICCT) at Baycrest provides a unique, comprehensive spectrum of integrated care for homebound, frail, older adults who are at risk for emergency department visits, acute hospitalization, and institutionalization. The team piloted the use of virtual care (VC) using the Ontario Telemedicine Network (OTN) to provide remote assessment and treatment of clients using technology. With the integration of VC, the ICCT aimed to provide enhanced access of healthcare services through two VC visit types, including geriatric follow-up consultations and just-in-time visits (JIT) which are urgent VC assessments.

Objective:

The study examined the feasibility of VC for the 2 visit types, as well as client, caregiver and staff satisfaction with VC visits.

Methods:

Evaluation participants included three main groups:

1) Senior clients living in the community; 2) Their caregivers, if they were present during the VC visits and 3) ICCT healthcare staff: i) Visiting Providers-Staff visiting the home; ii) Providers-staff providing remote patient assessments.

Feasibility:

ICCT staff rated knowledge, confidence, and readiness to use VC as good or approaching good and indicated that VC was not overly difficult to explain to clients and did not make their work too onerous. Staff reported they were very satisfied with the eKits used.

Satisfaction:

Staff, client and caregiver overall satisfaction with VC visits were relatively high. They were generally comfortable, satisfied and willing to use VC again. A minority of clients/caregivers did not indicate a preference for an in-person visit and the majority of participants would choose VC if it meant that they could be seen more often.

Clients/caregivers felt that their problems and concerns were understood during the visits.

Caregivers saw value in the VC visits in terms of decreasing wait times, however, also felt it was possible to miss important tactile cues during a remote VC visit. This concern was similar to one raised by providers.

Limitations:

Due to the small sample size it is unclear if thematic saturation was reached .

Clients/caregivers who did not consent to research may have different opinions than those presented.

Response bias: client/caregiver satisfaction surveys were often administered by visiting providers at the end of each VC visit.

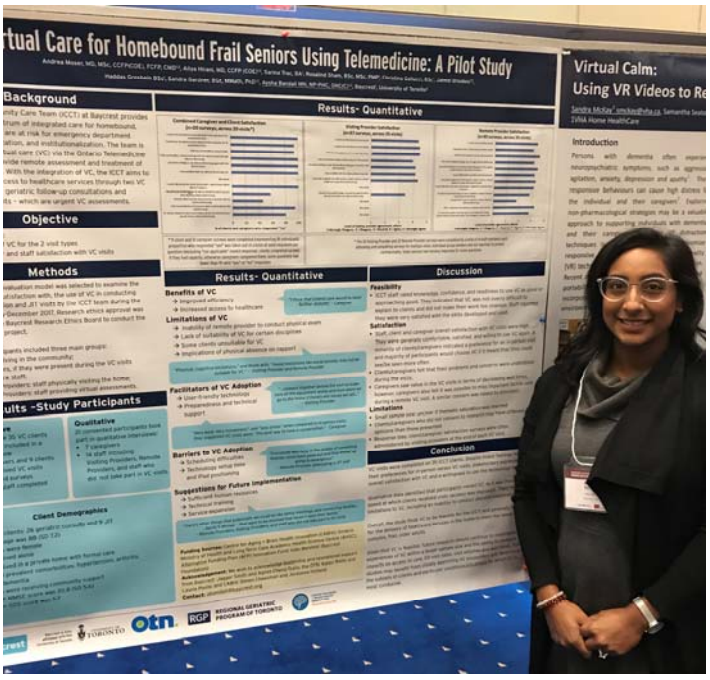
Conclusion:

Overall, the study finds VC to be feasible for the ICCT outreach team, and generally for the delivery of healthcare services in the home to meet the needs of complex, frail, older adults.

Given that VC is feasible, future research should continue to investigate the experiences of VC within a larger sample size with the ability to measure impacts on access to care, ED visit rates, visit volumes and wait times. Moreover, future studies may benefit from closely examining VC encounters and identifying the subsets of clients and particular conditions/situations for which VC is most conducive.

For more information about this study please contact Aysha Bandali NP- PHC ext. 2182

A transcript of the Q&A session with Aysha follows.



Virtual Care for Homebound Frail Seniors Using Telemedicine

Questions and Answers with Aysha Bandali

Hi Aysha, in your article you mentioned Virtual Care through OTN – is this new?

A: No, virtual care and OTN have been around for quite some time. You might know about OTN as we use it at Baycrest to videoconference with different sites when conducting educational events in Classroom ABC. We are now using this technology in a new way with our outreach team, by connecting homebound elderly clients to a practitioner on the Integrated Community Care Team (ICCT) via videoconference.

For this study and in your practice, are you both a visiting provider as well as a direct provider? And if so, do you prefer one over the other?

A: I had the opportunity to do both for the study and I enjoy both. I liked that I could be in the home with the client and be able to explain the technology and make them feel comfortable using it as well as have access to another team member to complement my assessment. As a provider I liked that I could see and hear the client and ICCT team member clearly, I was able to understand the concern and put an action plan into place sooner without having to travel to the patient myself.

In your article, you mention barriers to adopting VC in this population, can you please explain this further?

A: Sure, one of the main barriers to adopting this technology is that it would not be appropriate for all disciplines, for example Physiotherapy is a very hands-on discipline. As the remote provider you are not able to physically examine the client yourself, however in our pilot study we still had a nurse who was with the client and could complete assessments and report back. This was very helpful.

As a remote provider did you have any issues developing a therapeutic nurse to client relationship?

A: Most of the clients that I saw as a remote provider were clients that I had previously seen in person, so it was a continuation of an already established relationship. I can see how this might be a potential challenge with new clients, I think it would just take time similar to any patient relationship, you need to listen to what matters to the client most and develop a care plan in conjunction with the client.

Can you tell me a little bit about your experience with being a principal co-investigator on this study?

A: It was a lot of work, but such a great and positive experience. Our team has been looking at options to expand our reach into the community to help increase access to our services for those frail homebound seniors who are in need.

The entire team worked collaboratively on this pilot project, we were bravely led by our manager Jagger Smith, steered in the right direction by Jordanne Holland and Simon Cheesman and had a dedicated Telemedicine Coordinator, Agnes Cheng-Tsalis. We were also very fortunate to have help from several research assistants from CABHI and research advisors from KLcare to help us develop our idea, design the project from start to finish, and collect and analyze the results.

What was it like presenting this work at the Canadian Association of Gerontology (CAG) this year? Was there a lot of interest in the work your team did?

A: The amount of interest the poster and our research received was exciting and it made me realize how technology is taking an increasingly greater role in health care delivery.

This study was looking at the feasibility of bringing this technology to a population of seniors that we might have assumed would not be open to accepting this model of care delivery.

Where do you think this can go next? Is there potential to collaborate with any external partners?

A: There are so many opportunities … the possibilities are endless. The next thing I would like to see would be to have the patient and families be able to initiate a virtual care connection with their healthcare practitioner based on their needs. Right now our team is scheduling the visits. If the patient, caregiver or family has a smart device they could download the OTN app and could initiate the virtual connection. Being able to connect with the team without having to deploy our staff out to see the patient, could dramatically reduce the time it would take to complete the assessment and it can remove travel time and cost.

How many disciplines collaborated on this study?

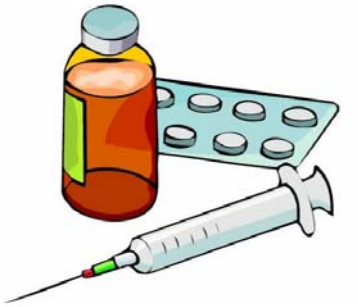
A: There was interprofessional collaboration … on our team we have an OT, PT, NP, SW, Manager, geriatricians, nurses, and physicians with a Focused Practice in Care of the Elderly. As mentioned we also collaborated with research assistants from CABHI.

Will the poster you presented at the CAG be displayed somewhere for our nurses to be able to read more?

A: Yes, it will be posted in the hallway in the Ambulatory Care Clinic for anyone to come down and take a look.

Thank you to Aysha Bandali, Nurse Practitioner (ICCT) for taking the time to answer these questions and for telling us more about her experience participating in research at Baycrest.

Preventing Drug Diversion in Healthcare Organizations



Across Canada, the inappropriate use of opioids is affecting patients, families, the general public, and the healthcare system. When drugs are diverted in healthcare facilities, the care, comfort and safety of patients can be put at risk. Diversion can also result in poor pain control for patients, as patients may be given partial doses, a substitute drug, or no drug at all. In general, there are three potential participants in bedside diversion.

Diversion may arise from the actions of:

a. staff administering the drug;
b. patients diverting the administered drug (e.g. a patient "cheeks" an oral medication)
c. third party, such as a family member or a patient in a neighboring bed, diverting an unsecured drug.

Controlled substances are regulated under the *Controlled Drugs and Substances Act* (CDSA) and its regulations such as the *Narcotic Control Regulations (NCR), Benzodiazepine and other Targeted Substances Regulations,* and others. Accreditation Canada assesses healthcare facilities against standards developed by Health Standards Organization (HSO). Beyond regulatory and accreditation requirements, all regulated health professionals have standards of practice that must be met. Within any healthcare facility, no single department holds accountability for controlled substances – it is a shared responsibility among all staff.

As trusted patient and family educators, nurses are well positioned to help reduce the occurrence and potentially fatal consequences of opioid diversion. Key principles of successful management include keeping the stock secured at all times, maintaining accountability and sign-offs at all transition points, and checking for completeness of the order and the quality of the product (e.g. broken ampules or tablets) prior to drug administration.

When administering a controlled substance:

Verify that an order for the controlled substance exists on the patient's chart;
Sign out the controlled substance (i.e. remove it from secure storage);
Bring the medication to the patient's bedside and confirm the patient's identity using two patient identifiers;
Prior to administration, verify the medication order, dose, route, and frequency;
Administer the medication, directly witnessing ingestion and absorption;
Document within the medication administration record as soon as possible after administration; and
Document any wastage as soon as possible after administration. Partial doses should not be saved for later use.

At the time of shift change, the nurse signing in and the nurse signing out are responsible for completing a physical count to ensure that the quantity of controlled substances matches the Narcotic Administration Record sheet.

Nurses can track patients' analgesic use and inform the prescriber of analgesic requirements to help improve pain management. If nursing staff have suspicions that a patient may be diverting an administered medication, they should share their concerns with the care team so that the prescriber can assess the patient for risk of substance use disorder.

References:

Controlled Drugs and Substances in Hospitals and Healthcare Facilities: Guidelines on Secure Management Diversion Prevention. Canadian Society of Hospital Pharmacists. 2018.

Nurses' Role in Preventing Prescription Opioid Diversion. *American Journal of Nursing*. August 2015; 155(8): 34-40.

Thank you to the Palliative Care team on 6West for hosting the Ontario College of Pharmacists' visit.

The OCP expressed how impressed they were with the interprofessional collaboration for medication management that they observed during their visit on the unit. Congratulations Team!

Pressure Injury Prevention
A Quality Improvement Project in Complex Continuing Care

Since 2011, the Advanced Practice Nursing (APN) team has been coordinating and conducting annual Pressure Injury Prevalence and Incidence Studies. These studies evaluate the rate of patients with pressure injuries across Baycrest. According to Health Quality Ontario (2017), wounds represent a significant burden for patients, their caregivers and families, clinicians, and the health system, but the human and financial costs of wounds are not fully appreciated. People with pressure injuries report low levels of health-related quality of life, high rates of depression, pain and discomfort.

From 2011 to 2013, a number of capacity building activities were implemented at Baycrest that had a positive impact on reducing prevalence and incidence rates of pressure injuries. However, these were found to be not sustainable due to the amount of resources required to support them.

Since 2015, the prevalence and incidence rates began to increase. Additionally, the complexity of patient needs also increased. The APN team took notice of this and began the quality improvement work needed to address it in late 2017. This work commenced with the inclusion of pressure injury prevention on the 2018/2019 Quality Improvement Plan.

An interprofessional team was brought together in Fall 2017 to work on this initiative. This team included APNs, point of care nurses, physicians, Occupational Therapists, a Physiotherapist, and a Dietician. Together, the team participated in quality improvement activities to identify contributing factors driving the increase in pressure injury incidence rates. Once identified, the team prioritized which contributing factors would become the focus for year. The team brainstormed activities that could address those contributing factors, leading to a reduction in pressure injuries.

The three improvement activities included:

1. Improve patient positioning

   (Action: standardized patient positioning poster)

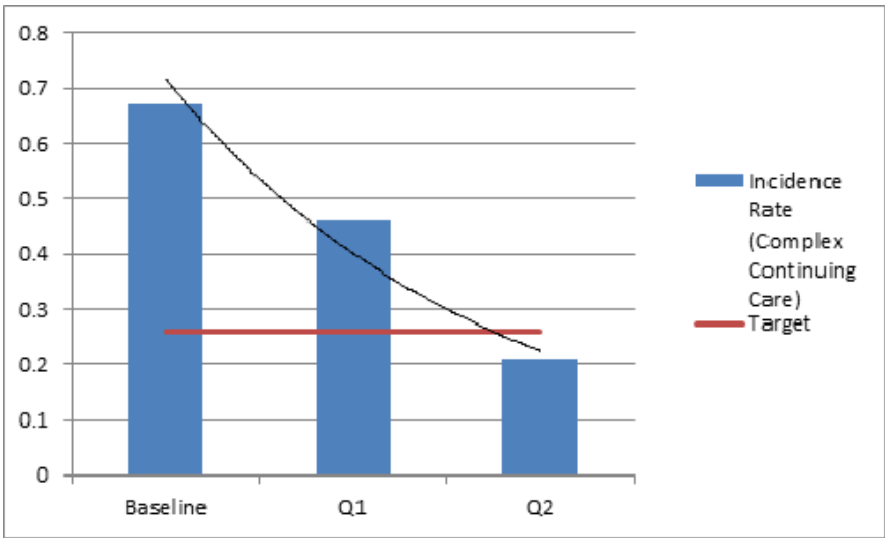
2. With input from patients and families, introduce a new process for selecting support surfaces for pressure relief

   (Action: revision of the mattress selection tool and air mattress setting resources)

3. Collect and share pressure injury incidence data more regularly with point of care staff

   (Action: Prevalence and incidence studies every 3 months on complex continuing care (CCC) units)

These improvement activities were chosen based on the expert opinion of the team members and input from patients and families, and by reviewing the research literature and the practices of other similar organizations.



To date, the results speak for themselves! The team has had the chance to reflect on what has contributed to this success:

- Nursing-led prevalence and incidence studies are possible with limited interruption to the nurses' daily routine.
- Smooth process due to the organized involvement of APN and Clinical Manager.
- Nurses valuing the ability to receive the prevalence and incidence data within a week in order to make meaningful practice changes.
- Nurses leading the effort of standardizing the patient positioning poster.

Congratulations CCC teams!

Call-Out for *New* Preceptors

The Academic Education department is looking to expand the number of available nurse preceptors and are reaching out to all current nurses who are thinking of becoming preceptors. Serving as a preceptor is just one way of helping to train and prepare the next generation of nurses. Thank you for your continuing support of nursing students at Baycrest.

If you are interested and available to serve as a preceptor please contact Mary Akuamoah-Boateng at extension 2518 or by email makuamoah-boateng@baycrest.org.

Be a flu fighter! Get your annual flu shot!

The Influenza season is here and it is time to get your flu shot to protect yourself and to help fight the flu in our community.

"The flu shot is your best defense against the flu," says Nadia Boroja, Manager, Occupational Health and Safety (OH&S). "We urge all staff at Baycrest to get the flu shot early to make sure they are protected."

The Flu Buggy has begun rolling out to the clinical areas since October, launching this years' annual staff influenza vaccination campaign. This year, teams from different areas of the organization will be competing for the highest vaccination rates and the Flu Champion trophy as well as an Early Bird incentive for a team pizza lunch. Watch for more details on prizes on the Baycrest Intranet.

Where to get your flu shot:

- The Flu Buggy, making its rounds on all clinical departments and units. The schedule will be made available on all units and on the Intranet.
- On-site Rexall Pharmacy will once again be providing the influenza vaccine to staff, physicians, volunteers, students as well as family members and visitors. They are located on the ground floor of the hospital building.
- Drop by the OH&S office on the second floor of the hospital, Monday to Friday, 8 a.m. to 4 p.m.
- Visit your own healthcare provider and provide OH&S with written confirmation that you have received the vaccination.

Nursing Matters

is an internal publication for the nursing staff at Baycrest.

Please send your feedback or submissions to: **Roxana Nagra** (Editor) rnagra@baycrest.org

All submissions will be edited for style, grammar, readability and length.

Baycrest

UNIVERSITY OF TORONTO

Baycrest Health Sciences is fully affiliated with the University of Toronto

3560 Bathurst Street | Toronto, Ontario
Canada M6A 2E1 | 416-785-2500

www.baycrest.org