DLC Welcomes our Summer Researchers!

The Interdisciplinary Summer Research Program (ISRP), located in the Collaborative Research Unit, resumed in June 2011. Michael Kaan is the manager of the unit. The investigators are Drs. Lorna Guse, Dr. Genevieve Thompson, Bill Wiehl-Jones, and Elaine Mordoch from the Faculty of Nursing, Dr. Kerstin Stieber Roger from the Faculty of Human Ecology and Angela Osterreicher from the J.W. Crane Memorial Library. We are grateful for the support of Daryl Dyck and Rod Kebicz, Clinical Nurse Specialists, who are assisting the team during the process of the project.

This year’s research study “Reducing Discomfort in Personal Care Home Residents with Dementia: A Pilot Study of a Social Assistive Robot Activity” will build on last year’s study with PARO the robot baby Harp Seal. The study focuses primarily on residents who experience pain and experience cognitive limitations. We will explore possible changes in mood, discomfort and affect following interactions with PARO over a four week period. This summer’s research team consists of Heather Thompson and Jacky Phalen who are both students from the University of Manitoba. Jacky Phalen will be entering her final year, and Heather will be entering into her third year of Kinesiology.

The Investigators and Research Assistants are looking forward to the continued collaboration with staff, residents, and families at Deer Lodge Centre for the summer of 2011. If you have questions about the project or would like any further information, please don’t hesitate to call us at the Collaborative Research Unit (204-831-2576). We sincerely hope that our research contributes to the quality of life for the residents of Deer Lodge Centre and their families. Keep an eye out for our friendly team on Main Street and stop by to visit PARO. We look forward to seeing you there!
Falls & Hourly Rounding
Daryl Dyck, Clinical Nurse Specialist (CNS)

Falls are an important issue that we are working hard at addressing. We are not able to prevent all falls, but perhaps there is something that can be done to decrease the number of falls and to decrease the rate of serious injury. In addition to the current recommendations provided in our Falls Clinical Practice Guidelines, the Tower 6 Personal Care Home unit agreed to trial an additional intervention to see if the number of falls on that unit could be reduced. We have been working on an hourly rounding project over the past 6 months as research has shown that the number of falls can be reduced up to 50% by checking on patients more frequently. No long term care studies have been done, but three research projects based out of hospital have commented on rounding interventions to address fall rates:


2) Meade, Kennedy, Kaplan (2008). The effects of Emergency Department staff rounding on patient safety and satisfaction. Trial of three different rounding techniques over a 4 week period (28 ED departments) carried out by Nurses and ED technicians: 1) rounds every 30 minutes; 2) rounds every 60 minutes; 3) rounds every 60 minutes with specific protocol (plan, pain, duration of wait, reassurance) The three protocols combined resulted in the following findings:

1) 23% reduction in patients who left without being seen
2) 23% reduction in patients who left against medical advice
3) Significant improvement in patient satisfaction and in pain management
4) Call light use was reduced by 35%
5) 40% reduction in approaches to the nursing station
6) Fall rate reduced by 59%

3) Meade, Bursell, Ketelsen (2006). Effects of Nursing Rounds on Patients’ Call Light Use, Satisfaction, and Safety. Nationwide trial (14 hospitals – medical/surgical units) of two different rounding techniques over a 6 week period: 1) Rounds every hour (6 AM – 10 PM, then every 2 hours) and; 2) every two hour rounding. Rounds to include assessment of pain, offer toileting, assess positioning, offer reassurance). Nurses rounded on even hours, HCA’s rounded on odd hours. Findings:

1) Significant improvement in patient satisfaction – rounding better than no rounding and hourly better than 2 hour rounding. Increase also seen in nursing satisfaction.

Intervention Study (27 bed surgical unit; average age 60) involving the Charge Nurse completing rounds every 2 hours to include addressing 4 p’s (pain, potty, position, presence). Findings:
1) Increase in patient satisfaction
2) Decrease in call light use by 50%
3) Fall rate reduction by 50%

The CNS ‘Nitty-Gritty’

Daryl Dyck, CNS
2) Call light use was reduced with 2 hour rounding, but more so with hourly rounding.

3) Significant fall rate reduction occurred only with one-hour rounding.

Research also tells us that most falls are unwatched and that 85% of falls occur behind closed doors in resident’s rooms/bathrooms. We also know that amongst individuals with dementia, they may not verbalize their needs, or have the insight to refrain from risk-taking behaviors. Fall rates can fluctuate from time to time depending on the number of high risk fallers on a unit and are dependent on staff availability and interest in an hourly rounding intervention. On Tower 6, a Nurse and/or HCA will check the rooms of High fall risk residents, as determined by the Falls Risk Assessment Tool, every hour during the day and evening and every 2 hours during the night. Checking means more than just looking into the room from the hallway to see if someone is breathing - it means the nurse and/or HCA enters the room and observes and asks the resident some key questions in an attempt to anticipate needs relating to the following areas with each rounding done:

1) **Comfort**
   - Observations: Does the resident look comfortable? Is the call light within reach? Is there a clear pathway to bathroom? Is the table in reach with juice/water, urinal?
   - Questions: Would you like the blinds up/down, TV on/off, door open/closed? Would you like a drink/something to eat? Are you having any pain? Is there anything more I can do for you?

2) **Toileting**
   - Observations: Does their brief/incontinent product need changing?
   - Questions: Do you have to use the bathroom? Are you having any trouble going to the bathroom? Constipation?

3) **Positioning**
   - Observations: Are their feet out of the bed and does it look like they are trying to get up? Do they need to change position (turns at least every 2 hours)?
   - Questions: If they have been in one position for more than 1-2 hours, ask them if they want to get up/lie down, sit in a different chair.

Our experience thus far on Tower 6 is that the staff who are participating in the hourly checks (anticipating needs through observation and questioning) have reported that potential falls have been prevented. We continue to monitor our efforts on Tower 6 and hope to have a more complete report available sometime this Fall and look forward to having other units adopt the project. It is a time well spent and I would encourage all staff from all departments to be involved in addressing fall risk reduction when you happen to be with a patient/resident in their room.

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**Falls & Hourly Rounding continued**

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In the last Bulletin I mentioned that our brain is important in identifying our pain. However, before it can do that our brain has to first get the message that a painful event happened somewhere in our body. Today I want to talk about the three stages of pain and the two different classifications of pain. I will begin by discussing the two classifications of pain first because it will help us understand the last stage of pain better.

The two classifications of pain are acute and chronic. By definition acute pain lasts from a split second up to six months in duration. So if you get bitten by a mosquito you have pain but it only lasts a few moments but if you have an operation the pain will last longer. If the pain lasts less than six months it is still acute pain. However if your pain lasts longer than six months (for whatever reason and no matter what type of pain) the pain becomes chronic.

Acute pain is usually due to a specific injury or occurrence and may or may not go away with or without any kind of treatment. Acute pain can usually be well controlled with various treatment methods – most often with some type of pain medication.

Chronic pain can start as acute pain but if the pain lasts longer than six months it then becomes chronic pain. This type of pain often requires some type of treatment to help the person continue to function normally. Unfortunately chronic pain can be difficult to manage and often will require more than just pain medications to control the pain. Pain treatments for acute and chronic pain will be discussed in future articles.

There are three stages to the pain experience – that is, our body does three things when it is exposed to a painful event:

1) It receives the pain (reception)
2) It interprets the pain (perception)
3) It responds to the pain (reaction)

Whenever we experience anything that hurts us (for example we burn our finger on the stove) special nerve endings that are throughout our body get damaged (or stimulated) and these nerve endings either release special chemicals that cause an electric current to be sent or they send an actual electric current through the nerve to our spinal cord (remember the small fibers getting stimulated and opening the gate?) and up to our brain. The information about the pain can travel at a rate of about 3 meters (10 feet) per second – so it can go from our toe to our brain in less than one second!

However, our body is so amazing when it comes to pain that it also has a special protective system called a reflex arc that in the example above causes us to very quickly remove our hand from the stove. The great part is that this happens even before our brain knows what caused our pain! Have you ever stepped on something and quickly pulled your foot away and then looked to see what it was? That’s the reflex arc moving your foot before your brain knows what happened! The speed this occurs is a whopping 100 meters (330 feet) per second!

After the painful message gets sent to our brain the brain interprets what the pain is, where it is from, what caused it, how bad it is, what it means to us, and in normal circumstances what we need to do about it. Do we rub the area, take a pain medication or do nothing? This leads us to the last stage of pain – the response.

When our body experiences pain two different types of responses occur. There is a physiological (or body) response and there is a behavioral (or psychological or emotional) response.

In the physiological response two things can happen depending on the type of pain and the length of time the person has been experiencing the.
Pain Classification continued

pain. Normally if the pain is acute, our body responds by increasing our heart rate, blood pressure and breathing (other changes also occur but these are the easy ones to identify). Normally if the pain is chronic or long lasting the person’s heart rate and breathing can decrease or remain normal and the blood pressure may rise or stay in the normal range.

In the behavioral (psychological or emotional) response the person reacts to the pain again depending on whether the pain is acute or chronic. Some of the common behaviors with acute pain are: crying, moaning, grimacing, striking out, yelling and aggression. With chronic pain you may see some of the above behaviors but you may also see decreased sleep, poor eating, anxiety or depression.

People in chronic pain often have difficulty convincing the health care system that they are in pain – because they don’t have the “normal signs” of being in pain. They don’t look like they are in pain and they seem to be functioning well so therefore the belief is “They can’t be having pain”. Or, “They can’t be in as much pain as they say they are.” Please remember the definition of pain is “Whatever the person says it is, existing whenever he or she says it does.” It is not up to us to decide how much pain a person is in when they can tell us. It is up to us to do something about the pain the person says they are having. The problem lies in determining how much pain the person is in when they cannot tell us.

In the next article I will discuss some of the methods that can be used to assess pain in people who can and cannot communicate.

Best Wishes to Darryll Martel

After six years with DLC, painter, Darryll Martel, is leaving to take a position at the Misericordia Health Centre. Darryll will be a busy man as Misericordia is currently undergoing major renovation and new construction. We wish Darryll all the best in his new position.
The Nursing Practice Council (NPC) has had a very busy and productive year. Following a retreat to reorganize and re-energize the group, four Working groups evolved and various projects have been worked on. The titles of the groups are: Promoting Nursing Practice Council, Health Care Aids/Nurse Relationship, Leadership/Mentorship, and Documentation.

Besides the working groups NPC is working on decreasing medication errors resulting from nurses being interrupted while administering medications. The literature states that our health care system suffers from a widespread lack of respect for the medication administration process and that interruptions create a greater risk and severity of errors in medication administration. Medication errors may be preventable if we solve the problem of so many interruptions. The highest source of interruptions has been found to be amongst the health care team members talking to the Nurse. Other sources of interruptions come from patients, families, or visitors.

Visual cues to signify “medication administration is in progress,” are suggested in the literature. Nursing Practice Council has been working on doing just that. In the near future watch for posters at the DLC main entrances, signs/flags on medication carts stating, “Medications being given. Please do not interrupt”, as well a video on the TV on Main Street demonstrating the problem of interruptions.

So we ask for your support as we strive to “Make lives better…. one uninterrupted medication pass at a time.”

**NPC Highlights**

**November 2010**
NPC member proposed changes to the crani-check form. Another member offered to help and a new form was put into practice by January of 2011.

**January 2011**
NPC member identified concern that hairdresser requesting patients not be in their specialty chairs for appointments with her. Put forward the idea of a remodel as patient population has changed dramatically since the department was set up. Any concerns should be forwarded to Kevin Scott.

**March 2011**
NPC member questioned the need to safety caps on ward stock medications. Also, asked if possible to get smaller bottles of some ward stock to make getting one dose easier. NPC chairperson is to get in touch with MSSC for response.

**May 2011**
NPC member forwarded a question from HCAs regarding the practice of weighing patients monthly. Response was it is a PCH standard and will continue with current practice.

**May 2011**
There has been concern regarding lack of equipment throughout the centre. NPC member that is also on the equipment supply committee has asked units to forward him a list of items they are often short of so he can take it to the committee.

**June 2011**
Discussion regarding the use of soakers throughout the centre. List of “dos and don’ts” to be distributed. Suggested to do an audit on each unit to ensure only those that really need soakers have them.

**June 2011**
Discussion regarding the update of the nursing shift report. Nursing coordinators to revamp the sheet and forward to documentation committee.

The second edition of Symptom Relief In Palliative Care is a clear, concise resource that can be quickly consulted to guide patient care. It continues to serve as a distinctly practical and problem-oriented resource for clinicians providing palliative and end-of-life care. The text has evolved to reflect continued developments in available treatments, changes in areas of policy and ethics, and the ever-broadening scope of the clinical practice of palliative care.


The third edition of this popular textbook, formerly Physical Management in Neurological Rehabilitation and now renamed Physical Management for Neurological Conditions, maintains its scientific and research base with extensive use of references and case studies. It is the only book for physiotherapists that offers a comprehensive overview of the basic principles of neurological rehabilitation, specific neurological / neuromuscular conditions and the related physiotherapy treatment approaches used.
What is Accreditation?
Accreditation means to certify as meeting a certain set of standards. The WRHA follows the standards established by Accreditation Canada. The Accreditation process incorporates a review by peers. It is one of the most effective ways for health services organizations to examine and improve the quality of their services. Health care organizations are evaluating their performance against national standards of excellence, so they can provide the best possible care and service to their patients and clients.

What is Accreditation Canada (AC)?
Accreditation Canada (AC) is a not-for-profit, independent organization accredited by the International Society for Quality in Healthcare (ISQua). AC has been around for over 50 years and provides national and international health care organizations with an external peer review process to assess and improve the services they provide to their patients and clients based on standards of excellence.

What is the Qmentum program?
Qmentum is the name of AC’s accreditation process. It consists of a self assessment (including a questionnaire), an onsite survey and follow-up actions for improvement.

What is the self assessment?
A self assessment consists of three processes that an organization must complete in the accreditation process. The first is the questionnaire which is web based. Various team members are invited to complete the questionnaire. The second is specific indicators that program teams must report on; i.e. medication reconciliation upon admission. The third is instruments, which are questionnaires that are distributed from the region in areas of patient safety and work-life.

What is an ROP (Required Organizational Practice)?
An ROP is a necessary practice that organizations must have in place to enhance patient/client safety and minimize risk. As of 2011 there are 36 ROP’s.
Level 1 Wound Care Courses this Fall

Course Name:  Level I - Wound Healing Overview
Course Description:  This workshop provides information in the treatment and prevention of all wounds. Completion of this workshop or the successful completion of the SWAT Basic Education Program or other recognized wound care programs is required prior to participation in any of the Level II Wound Care Education workshops.

Course Length:  7.5 hour(s)
Course Cost:  $0

Please note that this list is sorted by facility name. Please scroll down to see all available dates.

Tuesday, October 25, 2011
Grace General Hospital
Auditorium
300 Booth Drive

Wednesday, January 11, 2012
Victoria General Hospital
Classroom 1, 2 & 3
2340 Pembina Highway

Thursday, October 27, 2011
Grace General Hospital
Auditorium
300 Booth Drive

Wednesday, December 07, 2011
Seven Oaks General Hospital
Auditorium
2300 McPHillips St.

Wednesday, September 21, 2011
Riverview Health Centre
Basement Classroom AB - Day Hospital
1 Morley Street

Friday, December 09, 2011
Seven Oaks General Hospital
Auditorium
2300 McPHillips St.

Friday, September 23, 2011
Riverview Health Centre
Basement Classroom AB - Day Hospital
1 Morley Street

Monday, November 21, 2011
Concordia Hospital
Lecture Rooms 1, 2 & 3
Ground floor, near library
1095 Concordia Avenue

Friday, January 27, 2012
Deer Lodge Centre
Large Conference Room - Learning Centre
2nd Floor
Learning Centre 2nd Floor
109 Portage Avenue

Monday, November 28, 2011
Concordia Hospital
Lecture Rooms 1, 2 & 3
Ground floor, near library 1095
Wound Scene Investigation this Fall

Course Name: Wound Scene Investigation (WSI)
Course Description: Get your investigator hat on and learn how to apply knowledge gained from Level 1 wound care workshop by working through and discussing case studies. This problem solving discussion will enhance your skills on product selection and treatment decisions based on wound assessment.

Pre-requisite: Level 1 Wound Healing Overview workshop or other similar education

Course Length: 7.5 hour(s)
Course Cost: $0

Please note that this list is sorted by facility name.
Locations & Times offered:

Wednesday, October 26, 2011
Grace General Hospital
Auditorium
300 Booth Drive

Thursday, December 08, 2011
Seven Oaks General Hospital
Auditorium
2300 McPhillips St.

Thursday, January 12, 2012
Victoria General Hospital
Classroom 1, 2 & 3
2340 Pembina Highway

Tuesday, November 22, 2011
Concordia Hospital
Lecture Rooms 1, 2 & 3
Ground floor, near library
1095 Concordia Avenue

DEER LODGE CENTRE
CPR Recertification
Health Care Provider Level C Refresher

Please be advised that the Centre will be holding CPR Recertification sessions on:

Wednesday, September 14, 2011
1200 to 1600 hours – North Pavilion Room 4

These sessions are subject to cancellation if the minimum of nine participants are not enrolled ten days prior to the scheduled training session.

Offered to all staff at a cost of $28.00.
Manuals are available at a cost of $16.50.
(3 East employees, Nursing Coordinators and Respiratory Services will be sponsored by DLC)

PLEASE REGISTER WITH CATHY SCOTT AT EXTENSION 2574.

If you have any questions regarding the training please contact Carol Anderson at ext. 2135.
BITE-SIZED FRENCH GRAMMAR AND VOCABULARY WORKSHOPS

They were a huge success last year, so we’re offering seconds. WRHA French Language Services is repeating a series of short, easy-to-digest grammar and vocabulary workshops. In only 90 minutes, you can brush up on some long-forgotten, or never learned, grammar concepts and vocabulary. It’s grammar and vocabulary as you’ve never tasted them before.

This year we’ve added two new tastings:

Friday, September 16  Grammar Free For All – Ask all your burning questions
Thursday, October 13  Vocabulary Free For All – Come with your words; leave with confidence (A step beyond “Vocabulary Builder”)

Repeat tastings:

Thursday, November 10  Past Participles - Are they in agreement?
Friday, December 9  Object Pronouns - le, la, les, lui, leur, leurs - What’s the difference?
Friday, January 13  Homonyms - Don’t let them fool you
Thursday, February 9  Idiomatic Expressions - What do they really mean?
March (TBA)  Anglicisms - Which to use; Which to avoid

All will take place at Collège universitaire de Saint-Boniface, from 8:30 a.m – 10:00 a.m.

❖ Return registration form to: Lise Grégoire, WRHA French Language Services, A1153, 409 Taché Avenue (St. Boniface Hospital), R2H 2A6. Questions? lgregoire2@sbgh.mb.ca 235-3986

❖ Open to all WRHA staff at an intermediate level, or higher, of French. Suitable for employees working on their verbal or written French.
Nurses, Doctors, Psychologists, Psychiatrists, Dietitians, Social Workers, Dentists....

Do you interview patients or clients in French? Are you comfortable with the process? Do you want to feel more comfortable?

We’ve developed a workshop for you!

CONDUCTING PATIENT INTERVIEWS IN FRENCH

Content:

- Approaches to interviewing
- Formulating open and closed questions
- Advanced communication strategies
  - Paraphrasing;
  - Communicating empathy;
  - Confirming understanding; and
  - Maintaining lines of communication
- Spontaneity exercises
- Group case studies and observation

Thursday, November 3, 2011
9:00 a.m. - 4:00 p.m.
Université de Saint-Boniface
Final Sale of the season

Second Debut

Great Bargains!

Fill-a-Bag!