



Newsletter

Fall Edition / September 2010

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It has been a long and busy year for GNABC and here we are enjoying a beautiful summer and getting ready for our annual educational conference.

GNABC has been busy the last two years that I have been president. We successfully made the transition to an independent association from a PPC, and although our membership has not increased we are holding our own. We still have 7 active chapters in the Province and with Kamloops already looking good with new members for 2010-2011 we are confident they will be rejuvenated. Keep up the good work everybody.

One of our goals has been to connect electronically with more nurses and others interested in promoting quality health care for all older adults in BC. Further development of our website www.gnabc.com will assist with that.

Right now, look for a video of the September Nanaimo 2009 Conference available on the website. There were some excellent education sessions presented at that conference. At present anyone can access all this great educational information including the newsletter, but in the future it will only be available to members. **Therefore we are making it easier to become a member with online and phone in registration.** This can be done either with a connection directly from the gnabc.com website or through the CGNA website:

CGNA Head Office | www.cgna.net
375 West 5th Avenue, Suite #201 | Vancouver, BC | V5Y 1J6
T. 604.874.4004 | F. 604.874.4378
sharon.leung@malachite-mgmt.com

Attending meetings is a most satisfying way to maintain connections with others of

PRESIDENT'S MESSAGE

like mind. It is also a way to prove that you are maintaining your competency as a practitioner in the field of Gerontology as each chapter provides a certificate of attendance to members of the GNABC.



All of the chapters throughout the province have had excellent educational presentations this past year and our AGM and conference will be held in Prince George: **Aging: Honouring the Journey.** I hope you will attend and support the Chapter in the North who has organized a great time for us. We are looking at chartering a bus from the Lower Mainland to take people interested in attending the conference September 16th to 18th. Again the website will have more information or email me at hhutchinson@telus.net.

As this is my last newsletter report I will end by saying that the experience of being President of GNABC has been very rewarding made even more so by the fact that I have had the opportunity to meet people from all over BC who are passionate about making a difference in the lives of older persons. I am looking forward to meeting more of you wherever my journeys take me.

A very Special Thanks to the GNABC executive and members for their support and dedication.

Sincerely,
Heather Hutchinson, RN, BSN, GNC(C)
GNABC President

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Contributions Welcome

This quarterly newsletter is produced by the Gerontological Nurses Association of B.C., a society affiliated with the Canadian Gerontological Nurses Association. It is designed to provide information and support for Gerontological nurses.

Everyone is welcome to contribute. We would like your articles, viewpoints, letters, book reviews, news about workshops, jokes, anecdotes, pictures or whatever you wish to share with your gerontological nursing peers.

The newsletter is produced by our members, and is posted on our website in March, June, September and December. The cost of membership is for RNs \$65/year and includes GNABC membership, CGNA membership, and the CGNA newsletter. RPNs and LPNs membership is \$45/year for full GNABC membership.

Our Mailing Address is: GNABC, c/o Brent Oxenbury, Oxy's PC Services, 2366 Bonny Road, Quesnel, B.C. V2J 7G6

Please send written contributions to the Newsletter Editor's email address in Word format.

Lottie Cox
Email: lcox@shaw.ca

2010-11 Newsletter Deadlines

| | |
|---------------|---------------|
| Nov. 12, 2010 | May 6, 2011 |
| Feb. 4, 2010 | July 25, 2011 |

Advertising rates are: 1/4 page, \$75; 1/2 page, \$100; full page, \$150. (Please send ad enquiries to the editor.)

Editor's Note

The focus of this newsletter is on assessment of the older adult. This edition will bring you the first of a series of articles on assessment and management of common concerns in the elderly titled a "Potpourri of Practices". The first in this series of topics is appropriate to this wonderfully warm time of year, focusing on assessment and management of hydration and heat stress. Future articles in this series will relate to continence, bowel function, use of restraints and mental health concerns. This edition will also bring you an article relating to another important aspect of assessment – risk assessment in infection control.

I am so pleased we can use this newsletter to share Chapter information as well as the great accomplishments and the wealth of knowledge we have within our own Province. In this way we can create connections and learn from each other in order to improve the life of the older adult. Keep the articles coming! This newsletter is open to articles relating to development of projects and programs, new research or evidence-informed information, GNABC member bios, requests for information on a particular topic of interest, or product information.

Have a great time at the upcoming conference. For more information see the ad in this newsletter.

Lottie Cox, RN, BSN, MHS, GNC(C)
Newsletter Editor

Potpourri of Best Practices: Hydration and Heat Stress



Submitted by Anne Earthy, Clinical Practice Leader, Residential Practice Team, Vancouver Coastal Health

Gerontological nursing is changing and growing each day. It is difficult to keep pace with the latest research, literature and acceptable best practices. This article is meant to briefly outline some key messages within recent Clinical Practice Guidelines (CPG's) developed to guide point of care staff (interdisciplinary) who work in residential care within Vancouver Coastal Health (VCH). Again the focus is to promote consistent assessment criteria. The team will need to analyze the data and develop a care plan to address the resident's needs.

Hydration: Promoting Fluid Intake and Preventing Dehydration (June 2010). Endorsed by VCH Residential Quality Practice Council, on Residential SharePoint

This CPG was developed to provide individuals with adequate hydration as well as to assess the facilities ability to provide sufficient hydration. Water is essential for life. Dehydration occurs when the body contains insufficient amount of water and electrolytes to carry out the normal functions. "Dehydration is considered a sentinel event and in the US is monitored as a quality indicator of care in residential facilities" (Grandjean & Campbell, 2004, p, 24). Water constitutes 50% or less of body weight in older adults, which is less than younger persons, thus reducing the margin of safety for any fluid loss. Adverse effects on cognitive function can be noted when there is only a 2% reduction in hydration. Drinking fluids helps keep the body flushed of waste products and decreases the risk of infection, dry skin, constipation and other common ailments. Key messages of CPG include:

Assess:

- Assess for risk factors: female over the age of 85, a person who has a recent weight loss of more than 5% in the last month
- Five or more chronic diseases and/or taking medications that affect fluid intake
- Cognitive loss, inability to feed self, pain, depression which may decrease wish to obtain fluids, decreased mobility and dysphagia
- Assess and record the fluid intake for 3 days.

Strategies to provide a fluid intake of at least 1500 mL:

- Offer fluids of choice "*caffeine containing beverages do NOT negatively affect hydration status and in fact they increase fluid options and improves their quality of life*" (Grandjeans & Campbell, 2007, p. 25).
- Fluid should be offered in an easily held cup throughout the day, before and after meals, before and after toileting, medications, during family visits, recreational activities, before a nap or bedtime and during the night if the person awakens.
- Sit with the resident while they are encouraged to drink a full glass.

Facility to consider following options:

- Each facility is to have a written plan stating who is at risk and strategies to assist the person to consume more fluids.
- A hydration program should be recognized by using a symbol such as a glass of water, a drop of water, WOW (wonders of water), and is to be used as a reminder to all staffs to offer and encourage the resident to drink fluids. The logo can be placed beside the person's name in the shift report, on the ADL, care plan and other team communication tools.
- The facility should assess their ability to provide fluids of choice such as a kettle to provide warm fluids and a fridge to store residents' personal foods.

Heat Stress: Planning for and Preventing in Residential Care CPG (June 2010). Endorsed by the VCH Residential Quality Practice Council, on SharePoint.

This CPG is meant to guide facilities to review/assess their own sites abilities to provide "livable" space for the vulnerable elderly when the weather gets warmer. Older, frail persons have impaired sweat mechanisms and find it difficult to regulate their body temperature. If a core body temperature exceeds 40° it is a serious condition and the person may succumb to respiratory and cardiovascular related conditions which require prompt medical attention.

Many older persons do not recognize when they are hot and may not be able to take initiatives to keep cool. Decreased thirst sensation may prevent the intake of sufficient fluids to prevent dehydration and multiple

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GNABC

Chapter Reports

SIMON FRASER

The spring months for the Simon Fraser Chapter included three educational meetings with interesting and informative sessions plus our April AGM. In March, Jennifer Foster spoke on Parkinson's Disease, and in April, Maureen Stoqua shared an update on Diabetes.

During our spring meeting, Jan Spilman presented session one on Compassion Fatigue. Jan is a Compassion Fatigue Specialist and a Registered Clinical Counsellor. She is the founder and director of Caregiver Wellness, and provides educational programs that support emotional wellness helping professionals and family caregivers (www.caregiverwellness.ca). In this first presentation, Jan defined compassion fatigue as the serious but natural consequence of working with people or animals who are suffering or traumatized. "It is the symptoms of post traumatic stress and burnout culminating in the caregiver's loss of capacity or interest in being empathetic with another's pain" (Figley, 2006).

This past year our chapter had 50 members with an average attendance of 20 at our meetings. 90% (45) of the members reside in the Fraser Health Region and 10% (6) in the Vancouver/Richmond areas. At our AGM we expressed thanks and appreciation to the committed and hard-working out-going executive members Rea Braithwaite, Evelyn Coxon, Gwendolyn de Geest, and Patty Roy. Rea is honoured for being the longest serving executive member in our chapter (and perhaps in the whole GNABC) as she has served

faithfully in the positions of treasurer and member-at-large (newsletter) since our chapter was initiated some 10 years ago. Rea also worked on the 2008 conference planning committee. She has been treasurer of the GNABC Provincial Executive and served on the Transitional Team when GNGBC transitioned to the GNABC. Thanks again, Rea, for the many hours, great energy and contribution to GNABC. It has been hard for Rea to "let go" as she told me, she has retired three times! This is really IT, and we wish her a happy and healthy retirement. Don't be surprised if you see her in Prince George in September as I know she still values the many friends she has made over the years and the enjoyable learning experiences. May Rea be an inspiration to all of us!

We welcome new executive members, Hilda Li (treasurer/member-ship), Andrea Horsley and Anna Kryanowski (Education Coordinators) to our executive, joining current executive members Li MacTaggart (president), Hersy Yu (president-elect), Kim Martin (past-president), Barb Gardiner (secretary), and Aruna Dholakia (member-at-large/refreshments). We will continue to meet on the last Tuesday of each month at New Vista Care Home in Burnaby at 1845 hours. Our first meeting will be on September 28 for a Welcome Back "Meet and Greet" Pizza Night (starting at 1730 hours this evening only) and education meeting. Please feel welcome and plan on joining as a member to share in a great year together.

Kathy Johnson, Member at Large/
Registration and Newsletter

PRINCE GEORGE

The Prince George Chapter is busy with the final preparations for the GNABC Conference and AGM September 16-18, 2010. We are excited to host the conference for the first time so hope you can make it!

We continue to meet at bi-monthly dinner meetings and were fortunate to have informative guest speakers at each meeting. At our last meeting we had representatives from the Prince George Council of Seniors (PGCOS) who told us about a pilot project they are working on with Northern Health, a non medical home support service – IADL – for frail seniors. This service will focus on ways to maintain independence and will provide transportation and housekeeping services. We wish the PGCOS success with this pilot and hope it will evolve into a service for any senior in need.

We had our AGM in June and all our executive members have been elected for another year. Thank you everyone for agreeing to take on one more job in a busy life.

See you in September.

Carol Mooring, President

CENTRAL OKANAGAN

The sunny days of summer have finally arrived and we are enjoying the sandy beaches and fresh fruit that the Okanagan is well known for.

This spring's AGM saw the retirement of our Treasurer, Christine Matijew, who balanced our books and made sure we had plenty of refreshments at our meetings for two terms. Michelle Earl was elected as the new Treasurer. Our Secretary, Sheilagh Simes, who kept an accurate set of minutes for two terms, was also due to step down. Since we had no other candidates, the majority of members chose to re-elect Sheilagh to the

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Chapter Reports

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position of Secretary, which she graciously agreed to accept. Our President-Elect, Shannon Paul-Jost, needed to step down from the position due to personal reasons and the position was filled by Marliss Magas. I would like to thank Christine, Sheilagh, and Shannon for their dedication and hard work.

In celebration of Nurses' Week, we held a special golf and dinner event at the Kelowna Springs Golf Course. We had an overwhelming attendance with numerous door prizes generously donated and the evening was enjoyed by all.

Our June meeting was the last meeting before summer and we spent a significant amount of time discussing and developing criteria for awarding education funding.

We are pleased to finally have the logistics worked out for hosting our chapter meetings by Live Meeting to our rural and remote locations and are currently recruiting host sites. We hope to have our first Live Meeting session in September. September is also when we will resume our planning meetings for our Stroke Recovery workshop in spring 2011.

Respectfully submitted,
Sheila Farrell, Chapter President

KAMLOOPS

We had our last meeting of the summer on May 19th. We hold our meetings at Ora's Restaurant every 2 months. We honoured one of our consistent members on her up-coming retirement this summer. We do have one new member in our chapter. We have ideas on up-coming education meetings in the fall.

Two of our chapter members will be taking a seminar on the ABC's of fraud, and will do this presentation to the group.

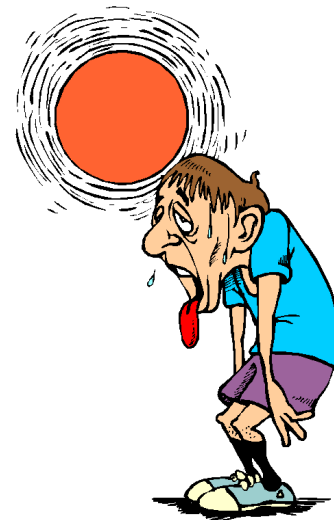
Ann Stoughton, Chapter President

Hydration and Heat Stress

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medications may affect the ability to sweat, maintain thermoregulation and electrolyte balance (NHS, May 2009). "It is important to maintain the care facility environment as cool as possible, usually 24 ° C (75 °) with a relative humidity between 40% – 50%" (Miller, 2004, p. 467). Goals of care include:

- Regular temperature checks and fluid intakes on the most vulnerable persons during hot weather.
- Facilities will put measures in place to monitor and maintain environmental temperatures as cool as possible, ideally around 23 – 24 ° C (75 °F) (Miller, 2004).



Heat stress refers to the inability of the body to cool itself and can lead to a fatal condition (WorkSafe BC, 2007).

Observations during a Period of Heat (exceeds 30° in day and 15° at night):

Observe all residents for the following signs during each shift for:

- Changes in behaviour, e.g. headaches, weakness, unusual fatigue, sleepiness
- Signs of heat rash, difficulty breathing, sufficient saliva
- Level of responsiveness and nausea and vomiting.

In addition, assess the "most vulnerable" core body temperature at least every shift. In addition observe urine output and fluid intake and review medications that may affect the thermoregulation system.

Interventions include consistent monitoring of the person and a plan to ensure they are in the coolest parts of the building during the hottest times of the day. Some suggestions to keep the residents' core body temperature within normal limits include wearing loose, lightweight cotton clothing or they may enjoy a cool compress to the back of their neck or a cool mist of water to their face. In addition, encourage additional fluids and foods high in water content and fun snacks such as ice pops, ice cream and floats. If the facility is not air conditioned keep windows closed and covered in the day, open at night. Ensure there are window coverings to decrease the heat entering the building and provide fans to keep the air circulating. *If the resident is experiencing heat exhaustion or a heat stroke then medical aid should be promptly sought.*

Appendices: a colourful educational pamphlet, great poster – *Universal Precautions for Heat Stress:* **DRINK!!** D – Daily Intake, R – Respect the Sun, I – Ice Water, N – Nurse to observe & Report and K – Keep it cool!



The R&R of Infection & Control – Reducing the Risk Using Point of Care Risk Assessments

Submitted by Nicki Gill, RN, BSN, CIC

Here we go again – Infection Control telling us to “wash your hands” so our patients, clients and residents don’t get sick. Isn’t there anything else that can be done? You bet!! How about a Point of Care Risk Assessment? So, what does that look like and how to we apply this information in our real everyday work lives?

Ideally, care should be provided in a manner that prevents all transmission of potential pathogens from all asymptomatic colonized, as well as symptomatic persons in all health care settings. Outside of acute care hospitals, health care is provided in a variety of chronic care facilities, ranging from convalescent homes, rehabilitation centers, mental health group homes, and residential centers for the elderly. The risks to residents and the circumstances of the care given are very different from the acute care setting, making direct application of additional precaution techniques challenging. Impediments to such application include shared rooms and toilets, inadequate hand washing facilities, common dining rooms and living areas, wandering or confused residents, high resident to staff ratios, non-professional staff, and limited resources for infection control. Conversely, characteristics that support a lower risk of transmission include residents who are generally not severely ill, have few invasive devices and are usually fully dressed with minimal contamination of the environment. The philosophy of long term care where it provides a home-like setting with participation in activities of daily living, requires

a balanced approach offering a safe environment without undue restrictive measures that could be detrimental to the individual’s well-being or quality of life.

First and foremost is the ALL of Routine Practices – that is implementing infection prevention and control practices with ALL people, ALL the time, in ALL settings to prevent and control transmission of microorganisms (4). Routine Practices must be incorporated into the culture of each health care setting and into the daily practice of each health care provider. The first step in the effective use of Routine Practices is to perform a point of care risk assessment. The point of care risk assessment is a dynamic process based on continuing changes in information as care progresses hence, must be done **before each interaction** with a client/patient/resident. Components of every risk assessment include the following:

- consideration of the care setting or environment
- nature of care to be provided and potential for exposure to body fluids
- client/patient/resident presenting symptoms (active vomiting, explosive diarrhea, coughing/sneezing droplets, contact with contaminated environmental surfaces)
- client/patient/resident’s level of cooperation and ability to comply with instructions.

Where there is a risk of transmission of infection based on the risk assessment, risk reduction strategies need to be implemented and may

include the following:

- **JUST WASH EM’**; hand hygiene is most important and always necessary
- client/patient/resident screening
- using personal protective equipment (PPE)
- cleaning of environment, equipment, and laundry
- using “single use” only equipment or ensuring proper disinfection and sterilization of reusable equipment
- appropriate waste management and safe sharps handling
- client/patient/resident placement
- using preventative workplace practices such as staff immunization policies
- education of staff, client/patient/residents and families/visitors/caregivers.

A strategy to assist in the risk assessment of client/patient/residents, especially in light of the constant movement throughout a facility environment is to follow the “**4 C’s**” prior to client/patient/residents leaving their room:

- **Clean Hands:** wash for 15 seconds with soap and water or with hand sanitizer; remember to assist the client/patient/residents as necessary with this task
- **Clean Clothes:** wear a clean patient gown or clean clothes when outside of room
- **Contained wounds/body fluids:** all wounds covered with a clean dry dressing; urine/feces and other body fluids contained; cough/

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Infection & Control

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sneeze can be contained using appropriate respiratory etiquette either independently or with assistance

- **Copus Mentus:** client/patient/resident is co-operative and able to follow the above instructions.



Some examples of appropriate control measures to implement, based on the point of care risk assessment and the 4 C's assessment, include the following:

- a) If the client/patient/resident has uncontained diarrhea, PPE such as gloves and gown should be considered when changing the bed sheets to prevent contamination of staff hands and clothing.
- b) If the client/patient/resident's continence cannot be controlled outside of the immediate bed area, a single room is preferable to limit transmission to other clients/patients/residents.
- c) If the client/patient/resident cannot contain their cough/sneeze, use avoidance procedures that minimize contact with droplets such as limiting face to face contact when providing care and avoiding group activities until cough/sneeze can be contained.
- d) Screening and assessment must be done to identify any communicable disease risk with each client/patient/resident contact. There are two levels of screening assessment required:
 - i. Point of entry – complete a screening for fever, cough or respiratory symptoms, rash or diarrhea.
 - ii. Ask about recent exposures to infectious diseases such as Chickenpox, Measles, Tuberculosis and recent travel depending on what is prevalent in your community.
 - iii. Screening questions include:
 - Do you have a cough and are you able to follow respiratory etiquette?
 - If yes – Do you have a new fever or chills in the last 24 hours?
 - Do you have new onset diarrhea? Are you incontinent?

- Do you have drainage or leakage? Is it contained?
- Do you have a new undiagnosed rash?

With the **point of care risk assessment** completed before ALL client/patient/resident interactions and the application of the **4 C's** and of course **hand hygiene**, the R&R of Infection Prevention and Control to reduce the risk of transmission of potential pathogens in the ALL care settings will be met. Let's be sure to implement these best practices in our work places and **Keep Washin' Em'!!**

Here is a helpful tool titled **Routine Practices Risk Assessment Algorithm for All Client/Patient/Resident Interactions** © Ontario Ministry of Health and Long-Term Care/Public Health Division/Provincial Infectious Diseases Advisory Committee, Toronto, Canada; August 2009. ISBN: 978-1-4249-9725-1 Link http://www.health.gov.on.ca/english/providers/program/infectious/diseases/best_prac/bp_routine.pdf (see page 75)

References:

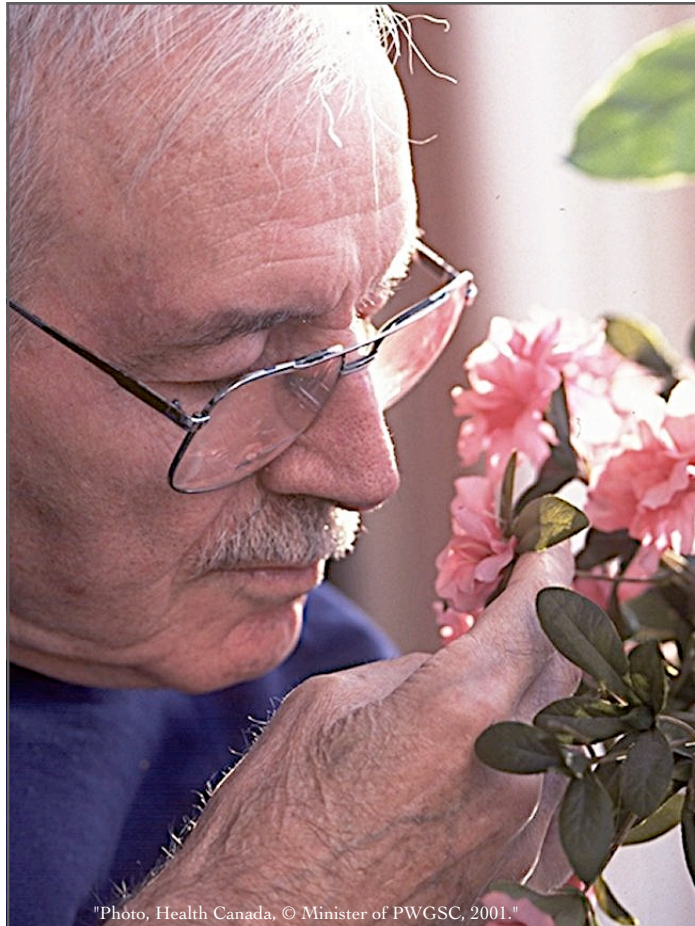
1. **Infection Prevention and Control Best Practices** for Long Term Care, Home and Community Care including Health Care Offices and Ambulatory Clinics; Canadian Committee on Antibiotic Resistance (CCAR); June, 2007.
2. **PICNet Infection Control Guidelines: Providing Health Care to the Client Living in the Community**; Provincial Infection Control Network of British Columbia (PICNet); August, 2009.
3. **Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Health Care**; Health Canada (now called Public Health Agency of Canada – PHAC); July 1999.
4. **Routine Practices and Additional Precautions** in All Care Settings; Provincial Infectious Diseases Advisory Committee (PIDAC) Ministry of Health and Long-Term Care; August, 2009.

GNABC Member Biography: Nicki Gill RN, BSN, CIC

Nicki Gill is the Educator for the Interior Health Infection Prevention and Control Program. Nicki has been an Infection Control Practitioner for the past 21 years, working across the continuum of care where she assists in guiding the infection control practices at acute and residential care facilities as well as providing consultation to Community Care programs. Nicki is also an active participant in the Provincial Infection Control Network (PICNet) of BC where she has been a member of several working groups including the Management of GI and Respiratory Outbreaks and Providing Health Care to the Client Living in the Community.

AGING: HONORING THE JOURNEY

GERONTOLOGICAL NURSES
ASSOCIATION OF B.C.



"Photo, Health Canada, © Minister of PWGSC, 2001."



**CONFERENCE AND ANNUAL GENERAL MEETING
SEPTEMBER 16-18, 2010
COAST INN OF THE NORTH
PRINCE GEORGE BC
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