Recommendations Report: Violence, Aggression and Responsive Behaviors (VARB) in Long Term Care

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Submitted to: Eastern Health, Workplace Safety

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EXECUTIVE SUMMARY

Every worker has the fundamental right to a healthy and safe workplace. Workplace violence is recognized as a significant threat to staff psychological wellness and physical safety in health care environments. Providing care for residents in long-term care – many with cognitive limitations - presents unique challenges in both anticipating and addressing triggers that may result in aggressive behaviours.

There is much work being done nationally and internationally around reducing exposure of health care staff to violence, aggression and responsive behaviors (VARB). Much of this information specifically addresses VARB in long-term care (LTC) environments. This area is very dynamic and changing quickly with new best practice initiatives, research and guidance. What is reflected in this report is limited to an internal review of VARB processes and incident data in LTC from January 2014 – December 2017 as well as recent external stakeholder releases and updates which may not reflect the full breath and scope of what is happening globally to address VARB in LTC.

In an effort to consider the way forward, a working group of stakeholders were brought together to examine three key perspectives: literature review, internal analysis of VARB incidents in LTC as well as internal analysis of current VARB processes in LTC.

The review of scholarly literature on preventing VARB incidents in LTC reflected the complexity of the issue and was clear that the solution requires a multifaceted approach. Organizations that have reflected successes in decreasing VARB incidents in their facilities demonstrated that it takes a multipronged, targeted approach with consistency and commitment from all stakeholders to be impactful.

An examination of the VARB incidents in LTC also echoed many challenges faced surrounding this issue in LTC both in what the data showed but also by what was not evident. From the incidents that were reported by staff, the majority of VARB by residents happened during care activities (bathing, dressing, etc.) and mostly identified by staff as during “AM Care”. The challenge from a prevention perspective is that staff most often kept incident details very brief, if at all, and most often failed to identify specific task details being conducted during the event. Many reports included descriptors that included “during change out of resident he became ++aggressive” “resident became very aggressive while trying to complete AM care” “resident was +++aggressive during AM care” “helping resident with care, resident acted aggressive”. These general statements do not get to root cause(s) or triggers for targeted prevention initiatives to assist staff in reducing these incidents with residents. Although this report looks thru a staff safety lens, we also acknowledge the rich data that exists in the Clinical Safety Reporting System (CSRS) which captures patient safety occurrences. The CSRS and Employee Incident and Investigation processes are two separate systems that hold valuable information to improve the safety of both staff and residents. This report does not include an analysis of CSRS data for the reflected report timeframe but it is included in Appendix E for reference purposes.

An analysis of current VARB processes in LTC indicated that Eastern Health LTC has a significant number of tools and forms currently to identify and assess the potential for and existence of VARB in LTC. Current VARB tools, forms and processes need to be more effectively communicated, streamlined and

improved rather than adding more of them. Staff regularly state they are overwhelmed with paperwork and documentation throughout their shifts.

The authors of the report identified the following recommendations as a result of their analysis:

OH&S Management System

1. Develop and implement a process for managing violence, aggression and responsive behaviors (VARB) in long term care (LTC) within Eastern Health's OH&S Management System.

2. Develop and implement an assessment tool/guide to assist staff in the identification of possible high-risk resident behaviors or triggers.

Incident Reporting

3. Increase staff knowledge and effective reporting of both client and staff incidents, using both the Clinical Safety Reporting System (CSRS) and Employee Incident Report and Investigation process, where appropriate.

4. Increase the specificity and details of the incident when reporting using the Employee Incident Report and Investigation form.

5. Ensure mechanisms are in place that communicate both CSRS and Employee Incident Report and Investigation findings with staff who are directly impacted as well as program and corporate-wide, where applicable.

6. Quality, Patient Safety and Risk Management and Workplace Safety teams collaborate to analyze and disseminate CSRS and Employee Incident Report and Investigation learnings to improve patient, resident and staff safety.

Communication

7. Bolster communication of VARB with staff throughout LTC.

8. Collaborate with all members of care team to identify care situations known to trigger responsive behaviors and mitigation measures. Modify shift report form to include communication specific to VARB.

9. Focus and promote communication regarding bathing/personal care/morning care.

10. Identify and implement a staff training program specific to bathing/personal care/morning care.

11. Identify frontline staff champions to regularly observe peers during bathing/personal care/morning care and provide point of care feedback and support for positive practice change.

12. Promote more effective use of the LTC Interdisciplinary Kardex ensuring it is updated on a regular basis and used as a reporting and care tool on a daily basis.

13. Ensure shift report includes updates on behaviors and strategies.

14. Implement “All About Me” Policy throughout Eastern Health LTC, ensuring information is completed for every resident and readily visible and available to all care providers at the point of care.

15. Include a point of care communication tool and process, in addition to ‘All About Me’, that is readily visible and available to all care providers that offers awareness that a resident has demonstrated VARB for the purpose of communicating with clinicians and support staff.

16. Ensure staff huddles occur daily at minimum, discuss relevant behavior, behavior assessment tools and interventions.

17. Provide support for staff champions to conduct regular peer observations/role model behavior change.

18. Ensure resident families receive on-going information and communication regarding VARB policies and processes.

19. Liaise with community stakeholder groups, i.e. Alzheimer’s Society, to collaborate and share best practices, information and expertise within the care environment.

Education

20. Ensure all staff, both clinical and non-clinical, working in Eastern Health LTC have the Gentle Persuasive Approach (GPA) training.

21. Ensure a refresher process is in place to reinforce prior GPA learning.

22. Increase and/or enhance internal education for Licensed Practical Nurses (LPNs) and Personal Care Attendants (PCAs) about VARB.

23. Consult with post-secondary institutions to improve Registered Nurses (RN), LPN, PCA knowledge and competency related to workplace violence, aggression and responsive behaviors before entering the workforce.

Leadership

24. Resident Care Managers (RCMs) and clinical leaders take an active leadership role in staff health and safety.

25. RNs need to be the facilitators of the plan of care. RNs need to review, assess, consult and make changes to the care plan based on individual resident need.

Environment

26. Promote and support continuity of care and consistency of staff assignment. Processes must be developed to ensure that residents receive care by consistent care providers.

27. Ensure policy for Resident Assignment – Nursing - Long Term Care 307-RC-300 is followed to ensure that Assignment Record for Nursing reflects consistent staff assignment. Audit regularly.

28. Examine flexible care approaches in resident care particularly as it relates to schedules for personal care, dining, sleep and recreation.

29. Review the design of the working environment to minimize VARB risk exposure, e.g. bolt down any furniture that could be used to harm others, reduce noise as much as possible to support calmness etc.

Process

30. Identify and assess for VARB on pre-admission assessments forms/tools.

31. Ensure that the problem "High Risk for Violence-LTC" is immediately added to the Care Plan on the day of admission if applicable.

32. Encourage team analysis of assessment tools and forms (e.g. Behavior Assessment, DOS, CAM etc.) to help care plan interventions to manage VARB.

33. Ensure staff follow policy and procedure for Transfer of Accountability (TOA) at change of Shift in a Nursing Home Environment (307-DOC-190), promoting a team approach to shift report and handover *(e.g. managers attending huddles, support from educators, ongoing reinforcement)*. Audit regularly.

34. Include behavior assessment in the responsibilities for the RN/LPN Liaison completing the Nursing Admission Checklist.

35. Examine/explore the need to synchronize/coordinate RAI-HC and RAI-MDS 2.0.

Evaluation and Measurement

36. Ensure process is in place to evaluate the implementation of these recommendations as well as related metrics and trends.

LITERATURE REVIEW

In reviewing the literature on managing and preventing resident violence, aggression and responsive behaviours (VARB) in long-term care (LTC) settings, it is clear that the solution requires a multifaceted approach.

The available scholarly research literature provides little conclusive direction as to which kinds of non-pharmacological interventions may be most effective for reducing agitation and aggression in LTC residents with dementia. At present, staff training in behavioural analysis and management appears to be the most promising avenue for experimentation. There are currently a few different standardized, evidence-based approaches to such training, including Focused Intervention of Training for Staff, a 10-month LTC staff training package offered by the Association for Dementia Studies at the University of Worcester in the U.K. (https://www.worcester.ac.uk/discover/dementia-fits-programme.html), and Dementia Care Mapping, a person-centred approach to dementia care offered by the University of Bradford in the U.K. (http://www.bradford.ac.uk/health/dementia/dementia-care-mapping/).

Whichever approach is chosen, planners need to be aware that there appear to be certain essential conditions for implementation success, the absence of which is likely to fatally compromise any intervention. These include training periods lasting four months or more; availability of clinical supervision and support once staff training has concluded; adequate staffing levels and minimal staff turnover, particularly at the direct caregiver level; and the achievement of the maximum possible consistency in nursing staff-resident assignments. It may be that these conditions are at least as important to intervention success as the intervention itself, and the rarity with which they are found in the North American LTC landscape may help to explain the lack of conclusive evidence on the subject:

> [A]n efficacious intervention targeted at managing a problem behavior must be implemented with a high degree of consistency so that the target behavior (e.g., physical or verbal aggression) is reacted to in the same way each time it occurs or the alternative desirable behavior (e.g., cooperation with care) is supported in the same way each time it occurs. This consistency is difficult to accomplish and requires a high degree of training, as well as a therapist or caregiver who knows the person well. Given the high rate of staff turnover in nursing homes at all levels, but most importantly at the direct caregiver level (nurses' aide), and studies that suggest that there may not be sufficient nurses' aides to consistently provide multiple aspects of daily care (e.g., toileting, feeding, mobility assistance), it is likely that many nursing homes do not have the direct caregiver capacity to implement effective nonpharmacological interventions consistently in daily care practice. Such consistency would further require critical staff on all shifts (weekdays, weekends; day, evening, night) to be competent in the implementation of the intervention (Schnelle & Simmons, 2016, p. 489).

Upon admission to a LTC facility, residents should undergo a risk assessment for VARB. Assessing residents at time of admission allows early preventive measures to reduce the risk of injury to residents and staff. Possible indicators for VARB may include: age less than 85 years, history of physical aggression, physically aggressive/threatening, anxiety, confusion/cognitive impairment and threatening to leave (Kim S.C., Young L., Berry B., 2017, 1747-1756). Risk assessments should also be done on an ongoing basis prior to interacting with a resident. Risk factors that may lead to VARB include: language or cultural barriers, time of day or week ("sundown syndrome"), loneliness, frustration, boredom, fear, etc. (Ontario Safety Association for Community and Healthcare, 2006).

Working under difficult conditions has also been identified by nursing staff as being a barrier to resident care, particularly when caring for residents living with dementia (Ostaszkiewicz J., Lakhan P., O'Connell B, Hawkins M., 2015, 506-516). At times when staffing levels are low it is difficult to provide residents with the necessary levels of supervision and care. Also, when nursing staff have heavy workloads they can feel pressured to rush care. It is also important to try and maintain consistency of staff working with each patient so that patients can develop a relationship with their caregivers and are not constantly being introduced to strangers to help with their care. This also provides caregivers the opportunity to get to know their residents, including their likes, dislikes, and cues to possible VARB which may prevent events of workplace violence.

The design of the working environment can also play a role in reducing resident aggression. There is a growing body of evidence in how health service buildings can be designed to reduce the risk of violence. Aspects designed to stop someone from carrying out a violent act could include bolting down furniture so that it cannot be used as a weapon and/or having furniture designed without sharp edges. Aspects designed to stop residents from feeling angered and frustrated - and therefore prone to VARB - includes noise reduction and the use of colour and light to influence mood, for example waiting rooms painted in pastel colours (Violence against staff. National Health Service, United Kingdom).

Staff training on how to respond to behaviors associated with dementia and how to help prevent resident VARB is also important. Eastern Health currently uses Gentle Persuasive Approaches (GPA), a person-centred dementia care education program which has been shown to be an effective training program that may be extended to residents with diagnoses other than dementia as well as to other care settings, such as orthopaedics (Gillies L., Coker E., Montemuro M., Pizzacalla A., 2015, 70-73; Pizzacalla A., Montemuro M., Coker E., Schindel-Martin L., et al., 2015, 101-107; Speziale J., Coatsworth-Puspoky R., O'Regan T., 2009, 570-576). While training is an important aspect of preventing and managing resident VARB in LTC, it is important to remember that is one part of what should be a multifaceted approach to this issue.

Finally, in the event that a resident becomes aggressive and injures a worker or caregiver it is important to have a standardized reporting system for staff to complete following the incident. Collecting detailed information about the event plays an important role in preventing something similar from happening in future. Proper reporting will identify the situation in which the incident happened so that other caregivers are aware of what may trigger individual residents when they are receiving care. This will also ensure that residents have positive care experiences while they are in LTC.

The above reflects the literature review. There is much happening globally to address VARB in healthcare settings. Appendix D includes a sampling of initiatives occurring mainly across Canada in the healthcare environment and even more specifically in LTC.

INTERNAL ANALYSIS OF VARB INCIDENTS IN LTC

The working group began this analysis by determining a time frame to assess. It was decided to review the last four calendar years (January 2014 – December 2017). The analysis included all LTC aggression incidents identified for that period in Human Resources Information System (HRIS): (204 Lost Time [LT], 95 Medical Aid [MA], 934 Near Miss [NM] for a total of 1233).

When staff report an incident and selects that they were "Dealing with Non-Cooperative/Aggressive Person" at the time of the incident, there are no parameters to capture further task details currently in HRIS. Therefore, a manual review of the narrative portion of each report had to be conducted to find possible commonalities and trends. The final analysis concluded 24 groupings determined by the details provided by staff in their incident reports (Appendix A).

The analysis of these narratives first showed that there are significant gaps in the information provided. The majority of reports contained very brief statements with very little detail of the event in terms of when, where, task being performed, potential triggers, who else may have been involved etc. Many reports included descriptors that included "during change out of resident he became ++aggressive" "resident became very aggressive while trying to complete AM care" "resident was +++aggressive during AM care" "helping resident with care, resident acted aggressive".

Statements such as these offer significant challenges in conducting effective incident investigations which should be conducted to determine where safety management improvement opportunities exist to prevent recurrence.

Another related challenge with HRIS is that each of the 1233 incidents reviewed only included staff provided statements and no review of the investigation findings of each, as HRIS does no house the investigation findings, just the initial report. Investigation findings are held at the site level only with no sense of whether the investigations were even completed or if so, how comprehensively.

Incident investigations can have valuable insight for triggers, communication as well as process improvement opportunities. Managers need to ensure these events are investigated expeditiously and effectively and findings in these investigations need to be communicated back to the individuals involved, the care team as a whole and within the LTC program more broadly, where appropriate. Closing the communication loop for staff reinforces a positive safety culture, the importance of reporting, management safety commitment and enhances staff communication around safety. Managers should take every opportunity, particularly during daily huddles, to communicate investigation findings to staff.

The data analysis did show that for those incidents that were reported, the majority involved some level of providing care, with largest number involving what staff referred to as "AM care". Some reports were detailed in the task being completed, e.g. bathing, dressing, toileting however the majority were much more vague "while providing care" "during AM care" "assisting with personal care" "helping with PM/HS care".

A further analysis of the 1233 incidents in HRIS showed that in terms of job classification, the vast majority of these are occurring with LPNs and PCAs (Appendix B, C). These groups provide most of the personal care for residents and they need to be enabled to provide this care to individuals with cognitive

impairments and challenges with strategic focus on these higher risk tasks and related challenges and techniques.

EASTERN HEALTH	2014	2015	2016	2017
Patient Aggression Incidents (LT and MA)	110	126	157	105
Patient Aggression Incidence Rate (per 100 employees)	0.9	1.0	1.2	0.8
Nursing Staff in EH	-	-	-	-
Patient Aggression Incidents (LT and MA)	102	121	144	97
Patient Aggression Incidence Rate (per 100 employees)	2.0	2.0	2.7	1.5
Nursing Staff in LTC	-	-	-	-
Resident Aggression Incidents (LT and MA)	59	77	98	59
Resident Aggression Incidence Rate (per 100 employees)	5.5	4.7	5.6	3.3

(Source: EH HRIS System)

The data did reflect that incidents were not limited to clinical staff but included support staff positions as well. It is important to ensure that any education, communication, hazard assessments, safety initiatives and collaboration involve all members of the care team, including support staff.

INTERNAL ANALYSIS OF CURRENT VARB PROCESSES IN LTC

Eastern Health's current practices and processes for managing VARB in LTC was reviewed from all potential sources both theory and practice.

1. Hazard Assessment

Behavior Assessment (ch-1305) **-** electronic form completed daily starting on the day of admission (1800 hours daily and then as needed). Staff check/initial if any mood indicators or behavior is exhibited by the resident each shift. This form is an assessment form that does not trigger interventions for the care plan. If staff want to add a problem on the care plan relating to VARB they would have to enter the problem into the care plan as a separate step. For risky behavior, staff can add the problem "High risk for violence (LTC)".

Comments - staff need to not only complete these daily and more frequently, as needed, but also recognize the presence of VARB (if applicable) and take measures (care plan) to prevent the behavior or reduce/stop the behavior.

2. Controls

Policies: The following policies relate to the forms, assessments, practices and procedures mentioned in this document.

- Transfer of Accountability at change of shift in a nursing home 307-DOC-190
- Resident Assignment LTC 307-RC-300
- LTC Clinical orientation 307-ED-100
- Integrated Care Plan LTC 307-RC-110
- Transfer of Information: Resident transfer to another care setting LTC 307-RC-310
- Long Term Care Philosophy of Care-Resident Centered Care 307-RC-100
- 'All About Me' – DRAFT

Forms:

1. **Placement -** communicates resident information prior to admission. The placement referral and paneling summary forms are completed by the placement coordinator and sent to Social Worker in LTC. Nursing staff do not get any of these forms except the RAI-MDS-HC which is the initial resident information that staff receive on admission. Staff also receive a completed medical.
    - Placement services paneling summary (ch-1005) - this form has a place to document aggressive behavior
    - Placement referral LTC (ch-1002) - nothing specific to aggressive behavior
    - Placement Screening tool: Chancellor Park (ch-1339) - this shows the screening tools used to score health status, behavior status, and functional status. It specifically refers to risky behavior.
    - RAI MDS-HC (9 page) document – this is completed by acute care Social Worker or community Social Worker and sent to the LTC Social Worker for a resident's admission. It is an electronic comprehensive assessment that provides a holistic view of the resident (e.g. ADLs, behavior, needs). This document is printed and

placed on the initial LTC chart (accessible to frontline staff). There is a section in this document to communicate mood and behavior. Additional comments (e.g. on aggression/responsive behavior) can also be added to a separate comment sheet associated with RAI-MDS-HC.

2. **Work Organization -** the following forms are used for work assignment (ch-1243), shift report/communication between staff (ch-1393) and an admission checklist (for Registered Nurses) (ch-1664).
   - Assignment record for nursing staff (ch-1243) - for work assignment only, not to record resident specific information. This is important though to ensure that the right staff are assigned to the right residents – staff mix.
   - Shift Report Form (ch-1393) - this form offers a place to document current resident status and care plan updates for individual residents. Any risky behavior or issues should be communicated here especially if they are escalating in nature and emergent/urgent. A copy is given to Resident Care Managers (RCMs) each day and a copy is kept on the units for 30 days.
   - Nursing Admission checklist (ch-1664) - for RNs only, not a chart form, nothing on this to document behavior but it is a useful form to organize admission process. **Note - the behavior assessment form is not referenced in the nursing admission checklist like the Braden scale or Morse Fall scale.**

3. **Assessments**
   - Admission assessment (ch-0205) – this is completed by the RN on admission. It is the initial history taken from the resident/family. There are questions re psychological/mood, memory, and wandering but nothing specific to VARB. This assessment does NOT trigger interventions into the care plan. In other words, if staff want to add anything on risky behavior into the care plan they have to go into the care plan and add a separate intervention (see LTC basic care plan below) **This may be a good place to first record risk for VARB in LTC.**
   - RAI-MDS 2.0 - an electronic comprehensive assessment similar to the RAI- MDS-HC. This is a holistic view of the resident. It is completed in week 2 following admission however RAI-MDS interventions are *not triggered* into the care plan (from the RAI-MDS 2.0 assessment) until *week 3 after admission*. When interventions are triggered (after week 3) the RN will be able to add a Clinical Assessment Protocol (CAP) called "Behavior" and this actually links information from the RAI-MDS to the care plan. The RAI-MDS 2.0 assessment is also completed quarterly.
   - LTC Basic Care Plan **-** Staff initiate this standard care plan on day 1 of admission. They work from this basic care plan to customize a care plan based on the individual resident's needs. For risky behavior, staff can add the problem "High risk for violence (LTC)". Interventions attached to this diagnosis are:
     - Behavior, Physically abusive
     - Behavior, Verbally abusive
     - Behavior, assist in targeting change
     - Behavior, evaluate motive/reason

    - Referral, developmental behavior practitioner
    - Referral, Psychology (LTC)
- Behavior Assessment (ch-1305) - electronic form completed daily starting on the day of admission (1800 hours daily and then as needed). Staff check/initial if any mood indicators or behavior is exhibited by the resident each shift. This form is an assessment form that does not trigger interventions for the care plan. If staff want to add a problem on the care plan relating to VARB they would have to enter the problem into the care plan as a separate step. For risky behavior staff can add the problem "High risk for violence (LTC)".
- Dementia Observation System (DOS) (used from PIECES – Question) - a form used that is not an Eastern Health form as it belongs to PIECES Canada. It is specific to behavior. It is helpful for identifying patterns, frequency etc. because it shows behaviors a resident is exhibiting every ½ hour. It provides blank spaces for staff to write in specific target behavior so they can focus on that behavior and track it. Physicians, NP and staff can use this information to see if medication is needed/ not needed, to review if interventions are working etc. Staff (team) complete the DOS. Encourage to use for 7-10 days. This is another tool to help manage behavior but like the behavior assessment is does not trigger interventions for the care plan. Staff have to make changes to the care plan based on this assessment if necessary. Staff also need to become familiar with analyzing the DOS so they can brainstorm interventions to manage behavior.
- Observed Behavior Checklist (ch-0607) - this is a form that staff can use to document behavior when a resident is on surveillance.
- Cohen Mansfield Agitation Inventory (CMAI) - this form was used frequently in dementia care to document behavior. A few years ago this CMAI had to be completed on LTC residents referred to the Waterford. This is no longer requested and its use has decreased.

4. **Share/Transfer** - these forms are used when a resident is transferred for an appointment or procedure (ch-1699) or a permanent transfer (another facility) (ch-1700). On the temporary & permanent transfer forms there is a place to document notes specific to behavior (e.g. VARB). There is also a Telehealth Share form.
    - Temporary transfer of a resident LTC (ch-1699)
    - Permanent transfer of a resident LTC (ch-1700)
    - Telehealth Share form LTC (ch-1472) - also has a notes section to document changes in plan of care

5. **<u>Referral</u>**
    - Outpatient Geriatric Referral (ch-0195) - this form must be completed when a resident in LTC is referred to Geriatric Psychiatry or Waterford.

Communication tools and practices:

1. **Treatment list** - Physicians/NPs - an exercise book used by staff to record a specific need that a particular resident has to be seen by a Physician or NP. It is not a part of the health record.

2. **Kardex** - a Meditech communication tool that is initiated on admission and is updated each shift and prn (as needed) by RN, LPN, and PCA. Once a month a thorough update is required (at a minimum). In practice, this is printed regularly and placed in a binder accessible to staff. Staff must check Kardex each shift as often as needed. There is a working group currently reviewing the Kardex to make it more user friendly. This should be the "go to" record to get the most current and accurate information on a resident. Unfortunately it is not always kept current. If improvements are made to the Kardex, hopefully it will reduce or eliminate the need for extra notes/pages/binders/treatment records etc. to try and organize and communicate work. Too many places to record distracts from the actual Kardex.

3. **Shift report** - this is in written and verbal forms. The written is the shift report from (ch-1393). RN going off shift has a verbal report with RN coming on shift for emergent/urgent issues. Prior to the start of the shift the RN communicates this to the team working the current shift. Feedback is that this may not be happening regularly or include all team members. All non-urgent issues (but important to share on this report) are written in the shift report. If a staff member requires more information specific to a resident they should go to the Kardex.

4. **Daily unit conference/huddles**- The charge RN/LPN hold a midway shift conference (brief) to discuss issues on the unit. Some sites have always practiced huddles (conferences) while others this is something new is past few years.

5. **Resident Care Conference (RCC)** - a formal team meeting that invites resident/family to discuss resident's plan of care. Held within 8 weeks of admission. Subsequent RCCs can be held at any time based on need.

6. **All About Me** (DRAFT policy and form) – will be useful in getting to know the person behind the dementia so that staff can use meaningful conversation and interventions to help increase resident centered care.

7. **Resident Family Handbook on admission** - has a small section on dementia care/behaviors. This resource is provided to family/residents on admission to LTC. It is available on the Eastern Health LTC intranet page (under Resources).

Documentation RAI-MDS 2.0:

Aggressive Behavior Scale - Meditech outcome that can be viewed in Meditech for individual residents. This outcome score is the result of RAI-MDS data input and can be viewed in real-time. This ABS scale is available approximately 2 weeks after admission. It is updated quarterly.

3. Education & Training - Staff records are tracked in Learning Management System (LEAP/HRIS). Managers should be able to see this in Cognos.

1. Dementia care training in Orientation - 2.5 hours for all new hires to LTC.
2. Gentle Persuasive Approaches in dementia care (GPA) - 7.5 hours- core/foundational knowledge. GPA is offered to staff 1 time only at this point. There is GPA-recharge (2 hours) that is intended to be delivered annually (we have not been offering GPA recharge much to date). LTC has 15 GPA coaches plus 2 coaches for Chancellor Park and 2 coaches for Personal Care Homes. We have GPA coach meetings a few times a year. We offer feedback to site and program managers.
3. Behavioral and psychological symptoms of dementia (BPSD) eLearning modules (4 modules) on LEAP platform.
4. Eastern Health LTC intranet – resources on a variety of topics including: brochure on "Treating disruptive behavior in people with dementia: Antipsychotic drugs are usually not the best choice"
5. Consultations as required (Behavior Management Specialist, Clinical Nurse Specialist, Clinical Psychologist)
6. Informal coaching strategies - daily unit huddles, managers follow up on CSRS using Incident Investigation Guide for responsive behaviors in LTC
7. Safe Work Practices and Procedures (available on Eastern Health LTC intranet):
   a. Approaching a Resident with Dementia
   b. Communicating with a Resident with Dementia
   c. Bathing a Resident with Dementia
   d. Distracting and Redirecting a Resident with Dementia
   e. Caregiver Approach: Responding to Behavioral Escalation for Residents with Dementia
   f. Caregiver Approach: Using Team Gentle Redirection Technique for Person Care
   g. Using a Mechanical Lift on an Agitated Resident with Advanced Dementia (post fall)

4. Emergency Response

1. Code White - each facility has a Code White Action Plan
2. GPA Protection and Redirection Techniques:
   Self-protection techniques
   Individual redirection technique
   Team gentle redirection technique

5. Incident Reporting and Investigation

1. CSRS
2. Employee Incident Report and Investigation
3. Incident Investigation Guide for responsive behaviors in LTC
4. Hazard assessment form

Summary Notes & Comments:

- Eastern Health LTC has a significant number of tools and forms.
- Eastern Health LTC will need to improve, streamline its tools, forms and processes rather than add more. Staff regularly state they are overwhelmed with paperwork and documentation
- Eastern Health LTC needs to strengthen practices (e.g. huddles, shift report) to ensure effective communication about resident behavior.
- Any improvements with Kardex will be helpful. This should be the best place to get the most accurate and up-to-date snapshot information of a resident. Using the Kardex is a known practice (in nursing) but not always best utilized.
- On admission there is an opportunity to strengthen communication about risky behavior such as VARB. Possibly a hazard assessment could be completed prior to admission to LTC – e.g. placement services?
- RAI-MDS-HC – this assessment does not communicate with the RAI-MDS 2.0 therefore there is a gap in the time necessary to trigger risk for behavior to the RAI-MDS 2.0 care plan.
- RAI-MDS 2.0 does not allow data from this assessment to transfer from one facility to another with a resident. A resident would have to be discharged from RAI-MDS 2.0 as they leave one LTC site and a new RAI-MDS 2.0 assessment initiated on admission to the new LTC site.
- The following assessments DO NOT trigger the care plan (the only assessment that triggers the care plan is the RAI-MDS 2.0 assessment). They are important though because they provide assessment to show the presence of any behaviors. For example, behavior assessment completed on the day of admission provide staff with valuable information that they can immediately add to the care plan without having to wait for the RAI-MDS to trigger interventions:
    a. Admission assessment
    b. Behavior assessment
    c. DOS
    d. CMAI
    e. Observed behavior checklist
- Most communication processes share information between clinical team members however not with non-clinical staff.

Conclusion

The review and evaluation of current research, internal incidents and processes for VARB in LTC at Eastern Health identified that some great work has already been done in the area of staff injury prevention however there are many opportunities for improvement.

The hope of this working group is that the findings presented here will give Eastern Health's leadership team a snapshot of current staff safety challenges in LTC but also a direction of priorities where enhancements would show significant improvements towards a stronger culture of safety within the entire LTC program.

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Appendix A

HRIS Data: Aggression Incidents LTC January 2014 – December 2017

Count of Cause Category	2014	2015	2016	2017	Total
AM Care	**65**	**66**	**78**	**49**	**258**
LT	13	8	17	9	47
MA	5	2	3	3	13
NM	47	56	58	37	198
Other	**26**	**46**	**52**	**46**	**170**
LT	1	5	6	7	19
MA	3	4	8	3	18
NM	22	37	38	36	133
Changing/Dressing	**31**	**30**	**43**	**51**	**155**
LT	3	10	10	10	33
MA	3	1	4	3	11
NM	25	19	29	38	111
No 'Activity' Info Given	**22**	**28**	**23**	**7**	**80**
LT	3	6	2	2	13
MA	3	2	4		9
NM	16	20	17	5	58
Escorting Resident	**19**	**27**	**8**	**22**	**76**
LT	7	4	2		13
MA		2	1		3
NM	12	21	5	22	60
Washing/Bathing	**6**	**19**	**27**	**20**	**72**
LT		2	8	5	15
MA		3	4	1	8
NM	6	14	15	14	49
PM/HS Care	**11**	**20**	**20**	**7**	**58**
LT	1	1	4	1	7
MA		2	2	1	5
NM	10	17	14	5	46

Count of Cause Category	2014	2015	2016	2017	Total
Providing Care	**19**	**6**	**18**	**11**	**54**
LT	4		5	3	12
MA	2	1		2	5
NM	13	5	13	6	37
Separating Residents	**15**	**10**	**19**	**5**	**49**
LT	2	4	3		9
MA	1		1	1	3
NM	12	6	15	4	37
Personal Care	**4**	**18**	**4**	**6**	**32**
LT	2	3		1	6
MA		4	1	1	6
NM	2	11	3	4	20
Assist to Chair	**6**	**8**	**11**	**6**	**31**
LT	1	2	2	2	7
NM	5	6	9	4	24
Administering Medication	**1**	**8**	**13**	**9**	**31**
LT		1	3		4
NM	1	7	10	9	27
Assist to Bed	**4**	**11**	**9**	**4**	**28**
LT	1	1	1		3
MA		1			1
NM	3	9	8	4	24
Toileting	**6**	**9**	**10**	**3**	**28**
LT			2		2
MA		2	1	1	4
NM	6	7	7	2	22
Repositioning	**4**	**9**	**8**	**5**	**26**
LT	1	3	1	1	6
MA		2	1	1	4
NM	3	4	6	3	16

Count of Cause Category	2014	2015	2016	2017	Total
Cleaning Room	**8**	**3**	**6**	**3**	**20**
MA	1		1		2
NM	7	3	5	3	18
Feeding	**4**	**3**	**7**	**4**	**18**
LT			1		1
MA	1		1		2
NM	3	3	5	4	15
Delivering/Picking Up Meals	**3**	**5**	**5**	**3**	**16**
LT			1		1
NM	3	5	4	3	15
Seatbelt	**4**		**4**	**2**	**10**
LT	2			2	4
NM	2		4		6
Family	**1**	**1**	**2**	**2**	**6**
NM	1	1	2	2	6
Bloodwork	**2**	**2**	**1**		**5**
LT	1				1
MA		1			1
NM	1	1	1		3
Elopement	**5**				**5**
LT	1				1
NM	4				4
Assist from Floor	**1**	**2**			**3**
NM	1	2			3
N/A	**2**				**2**
NM	2				2
Grand Total	**269**	**329**	**370**	**265**	**1233**

Clarification of Cause Classification for Aggression Incidents in LTC Analysis

The classification and categorization determined below are not those found in Eastern Health's HRIS. These were determined by the details provided by employees in their incident reports and subsequently identifying trending categories:

AM Care – event details that included task being performed involved AM care with patient/resident with no additional specific task details provided

Other - event details that included task being performed were 'no trending type' events that could not be put in any of the main categories listed e.g. "Resident became agitated while eating lunch. Jumped from chair onto chairs and table in front of her. Employee tried to stop her from falling."

Changing/Dressing/Change Out

No "Activity" Info Given - event details that did not give any indication of task being performed e.g. "An aggressive resident scratched and twisted arms"

Washing/Bathing

Escorting Resident - event details that included task being performed involved escorting resident for a specific purpose e.g. activity, gathering, meal etc.

PM/HS Care - event details that included task being performed involved PM/HS care with patient/resident with no additional specific task details provided

Providing Care - event details that included task being performed involved providing 'care' with patient/resident with no additional specific task details provided

Separating Residents - event details that included staff having to intervene between residents in some form of altercation

Assist to Chair

Personal Care - event details that included task being performed involved providing 'personal care' with patient/resident with no additional specific task details provided

Administering Medication

Toileting

Assist to Bed

Repositioning

Cleaning Room

Feeding

Delivering / Picking Up Meals - event details that included support staff involved in incident while delivering / picking up meals in room

Seatbelt - event details that included task being performed involved engaging or disengaging chair's seatbelt at the time of incident

Family - event details that included incident involving a family member visiting site

Elopement

Bloodwork

Assist from Floor

N/A – identified in HRIS as a 'patient aggression' incident in LTC but was incorrectly coded

Appendix B

HRIS Data: Aggression Incidents LTC: Job Classification January 2014 – December 2017

2014	
LT	
Clerk II	1
Licensed Practical Nurse I	19
Medical Services Aide	1
Personal Care Attendant	21
Registered Nurse IB	1
LT Total	**43**
MA	
Domestic Worker	1
Licensed Practical Nurse I	6
Personal Care Attendant	10
Psychiatric Licensed Practical Nurse III	1
Resident Care Manager	1
MA Total	**19**
NM	
Community Health Registered Nurse I	1
Domestic Worker	2
Food Service Worker I	1
Hospital Admitting Clerk I	1
Laboratory Assistant	1
Laundry Worker I	3
Licensed Practical Nurse I	90
Medical Services Aide	1
Nurse I	1
Nursing Supervisor	1
Personal Care Attendant	78
Physiotherapy Support Worker	1
Psychiatric Licensed Practical Nurse I	2
Registered Nurse I	10
Registered Nurse IB	14
NM Total	**207**
2014 Total	**269**

2015	
LT	
Licensed Practical Nurse I	15
Personal Care Attendant	31
Registered Nurse IB	4
LT Total	**50**
MA	
Licensed Practical Nurse I	4
Personal Care Attendant	21
Registered Nurse IB	2
MA Total	**27**
NM	
Coordinator, Therapeutic Recreation & Outreach Services	1
Domestic Worker	2
Laundry Worker I	2
Licensed Practical Nurse I	89
Medical Services Aide	1
Personal Care Attendant	137
Psychiatric Licensed Practical Nurse II	3
Psychiatric Licensed Practical Nurse III	1
Recreation Therapy Worker II	2
Recreation/Development Specialist I	1
Registered Nurse I	3
Registered Nurse IB	9
Resident Care Manager	1
NM Total	**252**
2015 Total	**329**
2016	
LT	
Clinical Dietitian II	1
Licensed Practical Nurse I	22
Personal Care Attendant	40
Psychiatric Licensed Practical Nurse II	1
Registered Nurse IB	3
Resident Care Manager	1

LT Total	**68**
MA	
Laundry Worker I	2
Licensed Practical Nurse I	9
Personal Care Attendant	18
Registered Nurse IB	2
Resident Care Manager	1
MA Total	**32**
NM	
Clerk II	1
Clerk III	1
Domestic Worker	5
Laundry Worker I	4
Licensed Practical Nurse I	102
Medical Services Aide	1
Operating Room Technician	1
Personal Care Attendant	137
Recreation Therapy Worker II	2
Registered Nurse I	1
Registered Nurse IB	14
Trades Worker II - Electrical	1
NM Total	**270**
2016 Total	**370**
2017	
LT	
Domestic Worker	1
Licensed Practical Nurse I	17
Personal Care Attendant	24
Psychiatric Licensed Practical Nurse II	1
LT Total	**43**
MA	
Divison Manager, Medicine & Regional Dialysis	1
Licensed Practical Nurse I	4
Personal Care Attendant	9
Registered Nurse IB	3

MA Total	**17**
NM	
Clerk II	1
Domestic Worker	5
Laundry Worker I	5
Licensed Practical Nurse I	70
Personal Care Attendant	105
Psychiatric Licensed Practical Nurse II	1
Psychiatric Licensed Practical Nurse III	1
Psychiatric Registered Nurse I	1
Recreation Therapy Worker II	2
Registered Nurse I	3
Registered Nurse IB	7
Registered Nurse IC (85ER/OP/CHEMO 15F)	1
Registered Nurse IC (85ER/OP/CHEMO15F)	1
Supervisor, Support Services	1
Trades Worker II	1
NM Total	**205**
2017 Total	**265**
Grand Total	**1233**

Appendix C

HRIS Data: Aggression Incidents LTC: LPN PCA January 2014 – December 2017

	2014	2015	2016	2017	Total
LT					
Licensed Practical Nurse I	19	15	22	17	73
Personal Care Attendant	21	31	40	24	116
Subtotal LPN PCA	40	46	62	41	189
Other Staff	3	4	6	2	15
LT Total	**43**	**50**	**68**	**43**	**204**
MA					
Licensed Practical Nurse I	6	4	9	4	23
Personal Care Attendant	10	21	18	9	58
Subtotal LPN PCA	16	25	27	13	81
Other Staff	3	2	5	4	14
MA Total	**19**	**27**	**32**	**17**	**95**
NM					
Licensed Practical Nurse I	90	89	102	70	351
Personal Care Attendant	78	137	137	105	457
Subtotal LPN PCA	168	226	239	175	808
Other Staff	39	26	31	30	126
NM Total	**207**	**252**	**270**	**205**	**934**
Incidents Combined					
Licensed Practical Nurse I	115	108	133	91	447
Personal Care Attendant	109	189	195	138	631
Subtotal LPN PCA	224	297	328	229	1078
Other Staff	45	32	42	36	155
Incident Total	**269**	**329**	**370**	**265**	**1233**

Appendix D

Cross-Jurisdictional Scan of VARB Initiatives

Public Services Health & Safety Association (PSHSA) of Ontario has released and continues to update their Violence, Aggression & Responsive Behavior (VARB) Project http://www.pshsa.ca/workplace-violence/ This is a new resource website with a wealth of prevention information, assessment tools, communication plans, etc. included throughout.

Ontario Nurse's Association published in 2009 a Best Practice Guideline for Preventing and Managing Violence in the Workplace.

Ontario's Sunnybrook Veterans Centre published a care planning guide: Responding to Behaviors Due to Dementia

Ontario Alzheimer Knowledge Exchange published a family and friend resource guide to help those living in LTC and experiencing responsive behaviors.

WorkSafeNB has identified nursing homes as a high-risk industry and has a number of tools, resources and information available from their website to address VARB.

SafeCareBC collects information and resources specific to safe work practices in the continuing care sector. WorkSafeBC's website also holds a wealth of information to support workers that care for people with dementia.

Alzheimer Society of Canada's website has a full section of resources for health care professionals.

The Alzheimer Association recently launched comprehensive dementia care practice recommendations.

Appendix E

CSRS Occurrence Data Aggression Incidents LTC January 2014 – December 2017

Resident to Resident

Adverse Event	2014	2015	2016	2017	Total
Assault with a weapon/object	22	22	21	8	**73**
Other	2	0	0	1	**3**
Physical abuse, assault or violence	481	447	482	361	**1771**
Sexual abuse	35	25	32	20	**112**
Threatening behaviour	27	27	23	16	**93**
Verbal abuse	28	15	24	25	**92**
Total	**595**	**536**	**582**	**431**	**2144**

Resident to Staff

Adverse Event	2014	2015	2016	2017	Total
Assault with a weapon/object	22	19	13	8	**62**
Other	0	0	0	1	**1**
Physical abuse, assault or violence	621	668	618	382	**2289**
Sexual abuse	6	19	4	6	**35**
Threatening behaviour	19	27	20	12	**78**
Verbal abuse	18	22	23	11	**74**
Total	**686**	**755**	**678**	**420**	**2539**