TORONTO

STAFF REPORT
INFORMATION ONLY

Update Regarding Quality Improvement Work, 2009

Date:	December 2, 2009
To:	Advisory Committee on Long Term-Care Homes and Services
From:	General Manager, Long-Term Care Homes and Services
Wards:	All
Reference Number:	

SUMMARY

The Long-Term Care Homes and Services Division and the Advisory Committee on Long-Term Care Homes and Services jointly agreed to implement a revised process in quality management reporting, whereby the Quality Advisor would provide qualitative reports on quality work, in addition to the statistical reports received in relation to satisfaction. This is the second such report submitted to the Advisory Committee on Long-Term Care Homes and Services in 2009. This report will focus on the various collaboratives that the division has been involved in order to improve, expand and/or enhance the quality of care and service for residents, clients, families and/or staff and volunteers while improving the utilization of healthcare resources. This is consistent with the division's integrated quality management framework which aligns mission, values, strategic planning, with the management of quality, risk, safety, ethics and utilization of resources. The goals of the division's collaborative work are:

1. To enhance community engagement, while responding to the City's diversity and respecting the values and traditions of stakeholder groups;
2. To create collaborative working environments with internal and external stakeholders;
3. To enhance satisfaction of residents, clients, families, staff and volunteers, while achieving positive results related to quality and safety.

The benefits of collaboratives are many, including the ability to bring subject matter experts together to address opportunities for improvement. This report highlights some key collaboratives that the division has participated in, with a goal of improving healthcare outcomes and processes.

Financial Impact
There are no financial implications arising from this report.

COMMENTS
A collaborative provides a venue for diverse organizations to work together, with shared values towards a common goal. Collaboratives support the division in analyzing practices, participating in best/leading practice work, working with external subject matter experts, building capacity and competency and gaining new knowledge.

In assessing the potential of participating in various collaboratives, the division has used the quality dimensions as defined by Accreditation Canada:

1. population focus (working with communities to anticipate and meet needs);
2. accessibility (providing timely and equitable services);
3. safety (keeping people safe);
4. worklife (supporting wellness in the work environment);
5. client-centred services (putting clients and their families first);
6. continuity of services (experiencing coordinated and seamless services);
7. effectiveness (doing the right thing to achieve the best possible results); and
8. efficiency (making the best use of available resources).

Key activities in 2009 have included collaborative work in Toronto Central LHIN long-term care – mental health interface, suggesting improvements in long-term care home and emergency department (ED) communication through a shared transfer form. Also initiated in 2009 was the division's collaborative work with the Ontario Health Quality Council (OHQC) in LEAN methodology and indicator reporting.

At the individual homes' level, the division participated in seven (7) specific collaboratives related to quality of life and/or quality of care and service. This report highlights learning, benefits and successes of each.

Medication Reconciliation – Effectiveness, Efficiency
In the spring of 2009, Castleview Wychwood Towers was selected as the first long-term care home in Ontario to collaborate with the OHQC. The home chose to apply LEAN methodology in improving medication reconciliation. Using LEAN, improvement ideas were generated to improve measures related to quality, safety and time. Key successes included: (1) enhancing the one write admission/re-admission physician order form and developing a Best Possible Medication History (BPMH) checklist; (2) revising the admission acceptance letters to include a request to the resident/substitute decision-maker to bring in the current list of medications on admission; (3) empowering the unit nursing staff to communicate directly with hospital staff in advance of the admission to obtain current medication lists, including an indication of the last dose given; (4) strengthening documentation to eliminate/reduce undocumented intentional and/or unintentional discrepancies; and (5) re-formatting the fax machines to receive faxes directly on the units. As a result of the changes, the medication reconciliation process for resident admission and/or re-admission now takes an average of 1.5 hours to complete (87.5

percent reduction in overall process time). Moreover, the team has identified the six (6) prominent types of medication/clinical information missing when a resident is admitted or re-admitted to the home. This improvement was possible through improved clarity and timeliness of information needs in transition of care and in the admission or re-admission package received by the home.

Reduction of Falls for Residents with Parkinson's Disease – Safety, Client-centred Services, Effectiveness

The team at Carefree Lodge collaborated with the medical director, consulting clinical pharmacist and therapists to improve resident mobility and independence by improving medication administration process for residents with Parkinson's disease. Through this collaborative, the team was able to link the timing of medication administration to the ability of residents to participate in rehabilitation programs without their bodies "freezing" and being unable to participate. As a result of this work, medication administration for residents with Parkinson's disease has been modified to meet a strict medication administration regime. The ability of residents to more actively participate in muscle strengthening and balancing programs has led to a reduction in falls. For one resident included in this work, his/her rate of falls in 2008 was 33 falls; year-to-date in 2009, this resident has sustained 6 falls.

Reducing Unnecessary Emergency Department Transfers – Client-centred Services, Effectiveness, Efficiency

In late 2008, the Long-Term Care Homes and Services Division began participating in a collaborative pilot project with the University Health Network (UHN) and the Toronto Western Hospital (TWH) entitled the "Emergency Mobile Pilot Project". The project proposed to provide emergency department (ED) outreach to selected long-term care homes as a strategy to avoid unnecessary Emergency Medical Services (EMS) transport and ED admission when the residents could be safely treated in the long-term care home. Castleview Wychwood Towers (CWT) and Fudger House (FH) joined the project at the outset; Lakeshore Lodge (LL) became involved in October 2009, when the project was expanded. The Emergency Mobile Pilot Project has now been operating for thirteen months. When compared to data in the twelve months preceding the pilot project, Toronto EMS data in the thirteen months since implementation of the project demonstrates the total number of consultations for CWT was 99; of those, 24 were transferred to the emergency department for further assessment (76 percent of residents were assessed and safely treated in the home). In the case of FH, 60 residents were seen for consultation with 8 being transferred to hospital (87 percent of residents were assessed and safely treated in the home). Although participation at Lakeshore Lodge is still relatively new, to date there have been 4 on-site visits and 8 telephone consultations; 100 percent of residents were assessed and safely treated in the home.

The Toronto Central Local Health Integration Network (LHIN) has also recently initiated a similar Emergency Mobile Outreach Project from Toronto East General Hospital (TEGH), in which True Davidson Acres will be participating.

In addition to this work within the Toronto Central LHIN, other LHINs have initiated collaboratives to enhance outreach to long-term care homes and avoid unnecessary ED transfers. In the Central East LHIN, the LHIN have just started a fairly comprehensive program with Nurse Practitioners (NP) from the Scarborough Hospital providing outreach to long-term care; of the City's homes, Bendale Acres and Seven Oaks will be involved (the pilot has not commenced as yet). The Mississauga Halton LHIN will be providing NP outreach from Credit Valley Hospital; Wesburn Manor will be involved (the pilot has not started yet). To date, the division has not heard of confirmed plans within the Central West LHIN.

Of note is the fact that one of the division's medical directors who practices at Lakeshore Lodge and Wesburn Manor has recently retained a Nurse Practitioner in his own practice and this NP is available to the homes.

Reducing Falls, a Divisional Collaborative – Safety, Client-centred Services, Effectiveness

As part of the Quality Plan of the division's Quality Councils, collaboration, learning and application of best practices have focused on various strategies to reduce the frequency and severity of falls, particularly falls that may result in hip fractures. There are numerous factors that contribute to falls, prevent falls and reduce the severity of falls. Since falls are not one hundred percent preventable, some teams have assessed and implemented strategies, some having a preventive outcome, whereas others have focused on reducing severity. Some of the strategies have included:

Education:
Involving residents and their families/substitute decisions makers is an integral part of the teams' approach and success. We believe that residents have a key role to play in their own safety and our work focuses on education and engagement as much as is possible.

Exercise, Balance and Relaxation:
Exercise, balance and relaxation were other strategies implemented to assist residents with falls prevention. Complementary therapy staff promoted relaxation for specific residents, with approaches designed to reduce anxiety and pacing.

Equipment and Environment:
Equipment was also a focus for the teams, particularly high-low beds and floor mats. A strong preventive maintenance program, ensuring the safe functioning of care equipment and collaboration with families to ensure that personally owned mobility aids were well-maintained was also a key. Included in this strategy was ensuring that all residents had the appropriate mobility devices. If not, the team followed up to see what alternatives could be put in place.

Environmentally, enhanced lighting, focused strategies to reduce trip hazards in the homes, proper flooring types/finishes, attention to floor transition points, handrails, properly placed grab bars, raised toilet seats and removing obstacles have contributed to a reduction of falls and the severity of falls.

Monitoring Residents during Acute Illness and Post-Surgery:
The urgency and frequency of the need for toileting was verified as a frequent root cause of falls, when residents attempted to navigate to the washroom on their own, falling due to weakness and limited mobility. Increased monitoring and planned continence scheduling has been shown to be an effective utilization of healthcare resources which reduces the incidents of falls. Literature research also noted that increased hourly rounds for high risk patients/residents was a very effective strategy, especially for those with increased urgency for toileting due to an unstable/recently changed health condition, medication or post surgery.

Hip Protectors:
The division's strategies focused on educating residents and families about the benefits of hip protectors, designed to prevent hip fractures if a fall does occur. Hip protectors are most commonly used in older adults who have a high risk of falls and hip fractures (e.g. due to history of a previous fall and underlying osteoporosis). The homes have found that there were benefits in using hip protectors with residents which were compliant.

Medications Review:
Medication review is an integral part of the falls assessment strategies at time of admission (Part 1 of the Falls Assessment Admission Screening Tool). After any fall, the home applied the Fall Assessment – Phase 2 Assessment Tool. There are several drugs that are known to have the potential to increase the risk of a fall. The Part 1 and Part 2 assessments include the following factors: residents receiving sedatives, anxiolytic or psychotropic medications, medications in the antihypertensive, diuretic, enemas, cathartics or laxative class, drugs which suppress thought processes and drugs with hypertensive effects.

Equally important, the use of more than five (5) medications is also a trigger for assessment for potential to fall. Other factors that were found to be contributors to falls in the literature review and through the team's medication assessments were: dose, time of administration and the need to monitor individual resident's reaction to changes in prescribed medications.

Engagement and Awareness – Falling Leaf Logo:
The "falling leaf" logo, that is, a picture of a falling leaf on a resident's door, mobility device(s) and healthcare record provide visual reminders to all members of the care team that prevention of falls strategies are applicable to this resident. All staff, visitors and family members were educated regarding the significance of the falling leaf logo.

The team conducted ongoing audits to measure compliance with the implementation of the falling leaf logo, to ensure they were maintained on residents' doors, mobility devices and resident healthcare records as required (and updated). The team also focused resources on ensuring informed consent and on assessing the perception and acceptance of the logo. The overall conclusion was that residents are safer, since there is greater

awareness by all staff (clinical and non-clinical), family and visitors of the residents that have an increased potential to fall.

The division has experienced a 50 percent reduction in hip fractures when compared to 2007 data.

In Case of Emergency card (I.C.E.) – Safety, Client-centred Services, Effectiveness

Homemakers and Nurses Services and Supportive Housing collaborated with Emergency Medical Services (EMS) in promoting and evaluating the ICE program. The ICE program is a simple but effective way of providing important medical information through a card. Each client participating in the project is given a card that allows them to write any relevant medical history, medication information and contact information. The premise is that whenever a 911 call is responded to in a client's home, EMS staff will ask for the card or look for it if the client is unable to speak. The information on the card will assist the paramedics in providing the most appropriate intervention at the site and in facilitating triage and treatment at the hospital. The success of this work will be measured in six months.

iGUARD – Safety, Worklife, Effectiveness

In early 2009, the Homemakers and Nurses Services Program introduced a life-safety system for staff working alone in the community that has the potential for staff to immediately connect with a security monitoring system that will provide immediate emergency response if faced with an unsafe situation, simply by pressing a discreet "panic button" on the underside of the nametag holder. Introduced in collaboration with CUPE Local 79, although iGUARD has not been needed for emergency response since implementation, staff report an increase in satisfaction in all seven indicators used as part of the evaluation. These indicators range from ready access to communication, a feeling of safety and security, access to innovative technology and recognition of the importance of community work.

Reducing Musculoskeletal Disorders (MSD) – Safety, Worklife, Effectiveness

In 2008, Castleview Wychwood Towers began a collaborative improvement project with CUPE Local 79 to reduce the number of MSDs sustained by staff in the workplace. MSDs are the top contributor of workplace injuries in healthcare. CWT's work focused on assessing the current status of MSDs, determining and analyzing root causes, controlling and/or eliminating MSD hazards, educating staff and empowering the Joint Health and Safety Committee (JHSC) in MSD prevention. The parties agreed that the results of the pilot project at CWT would guide strengthening of division-wide MSD prevention programs. To date, the division has achieved a significant reduction in MSDs, including a reduction from a high of 84 lost time incidents in 2005 to a projected year-end total of 49 in 2009. This is a reduction of 46 percent. From the start of the project in 2008, there were 68 MSD-related lost time incidents; in 2009, there is a year-end projection of 49, accounting for a reduction of 28 percent.

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