Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

2022-2023

OVERVIEW

Mackenzie Health Long Term Care (Mackenzie Health-LTC) has been part of Universal Care Corporation (UniversalCare) since December 1, 2010. UniversalCare/Mackenzie Health-LTC is a 170-bed facility within Mackenzie Richmond Hill Hospital and is a member of the Western York Region Ontario Health Team. UniversalCare/Mackenzie Health-LTC aligns with Accreditation Canada and operates following the Long-Term Care Home Service Accountability Agreement. Our strategic goals are to provide exceptional care and services to its seniors by respecting residents' Bill of Rights and meeting all requirements stipulated in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

Universal Care/Mackenzie Health-LTC Pillars of success are:

- Compassionately caring for our residents and team
- Uncompromising value to our Partners
- Leadership – Stronger together, go beyond industry standards
- Trust - Always transparent, honest, and forthcoming
- Unwavering delivery of quality and safety
- Respect - Earn it every day
- Entrepreneurial Spirit - Invigorate it

In UniversalCare/Mackenzie Health-LTC residents are treated with the utmost respect and receive excellent services from staff providing culturally sensitive and diverse care. The various programs provided in the facility ensures that residents are living in an exceptional environment for recreational activities and socialization. Through various programs and active participation, residents are experiencing autonomy and satisfaction along with increased self-esteem and quality of life.

Quality improvement is greatly emphasized at our facility and is a part of our daily routine. Our goal is to enhance resident care and services by providing compassionate, holistic-centered care through innovation and excellence. Our interprofessional team demonstrates a friendly and kind attitude to residents and their family members with the focus of obtaining resident satisfaction and advancing the quality of care.

UniversalCare/Mackenzie Health-LTC is a place where we encourage a collaborative practice and community partnership to achieve excellence in resident care. Our interprofessional team work continuously to maximize access to care by strong collaboration with Mackenzie Richmond Hill Hospital teams from Dialysis, Emergency, Complex Continuing Care, Infection Prevention & Control, and Nurse Led Outreach Team (NLOT).

DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

Best Practice Spotlight Organization

A notable highlight in 2021-2022 - UniversalCare/Mackenzie Health LTC was awarded pre-designate status as a Best Practice Spotlight Organization (BPSO) by the Registered Nurses Association of Ontario (RNAO). Full designation will be achieved in a 3-year period. BPSO is a quality improvement project that uses Best Practice Guidelines (BPGs) to enhance programs and services in the home.

Avoidable Emergency Department Transfers

A decrease of avoidable ED Transfers at MHLTC was achieved in 2020-2021, above the target set in the QIP plan. In light of the COVID-19 pandemic, we will continue to work on decreasing avoidable ED transfers for 2022-2023. The results of this collaborative effort between the hospital and LTC interprofessional team resulted in achieving our

target from the previous year as evidenced by the reduction of total transfers to ED.

Our interprofessional team worked together to reduce avoidable ED transfers using several change ideas. Most notable, our home continued with the formalized pre-admission process. The pre-admission meeting is held the day before the admission of a new resident and involves the home's interprofessional team, the resident, and their family. Due to the COVID-19 pandemic and IPAC protocols, pre-admission meetings were held virtually. The pre-admission meetings help to gather a comprehensive understanding of the resident's past medical history, psycho-social needs, and goals of care. The goals of care are reviewed at the six-week admission care conference, annually and when a significant change in status occurs. Our home's proactive approach to discussing and documenting goals of care promotes the early identification of changes in resident health status and ultimately contributes to the reduction in avoidable ED transfers as families and residents are able to make informed decisions. Overall, our goal is to discuss expectations of the resident and family and to ensure our team has the most accurate information about the resident in order to provide the right care by the right provider in the manner in which the resident prefers.

Our nursing team is educated on the use of hypodermoclysis, ongoing assessment and pain management, scheduled and special care conferences with residents, families and interprofessional team to discuss individual goals of care for each resident and the stages of palliative care which allows for timely application of aging in place.

Our interprofessional team reviews and analyzes all ED transfers at a risk management meeting. Using this approach and analysis, we are able to determine if a transfer could have been avoidable and if so, what measures could have been put into place to continue providing care to the resident in the home. We have built strong relationships with Mackenzie Richmond Hill Hospital in acute care specialities such as Geriatricians, Dialysis, Ethicist, GI and wound care specialists. Access to this level of healthcare support for residents allows them to remain comfortable in the home without unnecessary transfer to the ED. Our home sustains continuous collaboration with NLOT as well as ongoing partnerships with external health care providers such as the Home and Community Care - Ontario Health support with intravenous therapy.

MHLTC continues to employ a full-time Nurse Practitioner (NP)/Director of Clinical Services to support the right care at the right time by the right provider and is a resource for capacity building for all registered staff. The NP provides direct resident care through education, health promotion, prevention, treatment, and management of chronic conditions through assessment, diagnostics, consultation and referrals. Synthesizing knowledge, skills and judgement as well as incorporating current evidence into practice to ensure the delivery of optimal care.

On-site PT, OT, SLP, RD and Chiropodist support and services are also provided to our residents to ensure timely assessments for mobility, swallowing, nutrition, and foot care contributing to the aging in place philosophy of care.

Alternative Approaches to the Use of Restraints

MHLTC completed the RNAO - BPSO gap analysis and created an action plan for restraint use reduction in the home. An interprofessional approach was utilized to find alternative interventions to restraint use based on reason for use and "Risk factors for restraint use". Staff, residents, and family members were educated on the legislation surrounding restraint use, the requirements to have a least restraint program, and alternative approaches that were considered. A restraint

brochure was provided residents, families, and staff for further information.

MHLTC initiates relationship building with resident and families on preadmission and continues throughout the admission process. Upon admission, risks are immediately identified regarding responsive behaviours and risk of restraint use. Building trust with the residents allows for effective communication and information about medical history or events that may not have been easily offered on admission.

Resource support includes, but not limited to, Nurse Practitioner, Social Worker, Geriatric Psychiatrist, BSO, referral to Ontario Shores, TRI and Baycrest, with one-to-one observation 24/7 as needed. Individualized care plans are created based on the individual resident and their mental health history.

After an adjustment period, a care conference review is booked at six (6) weeks and as needed. All residents are assessed as soon as possible for risk of violence (i.e. self-harm, suicide ideation), history of trauma (i.e. PTSD), responsive behaviours (i.e. agitation), and substance use disorder in collaboration with the resident and family members to identify and understand care needs. Interprofessional team observes for triggers or cues in demonstrating a therapeutic team member-resident relationship, and delivery of care includes identification and management of responsive behaviours.

MHLTC works well with Home and Community Care pre-admission to review applicant paperwork and concludes suitability for admission. Our home identifies the residents within our facility that currently uses restraints on an ongoing basis. Assessment is completed in collaboration with Resident/SDM/Interprofessional team in order to find alternatives to the restraint based on the reason for use (i.e., falls, bed mobility, wandering, agitation, and behaviours).

Possible/Suggested Alternatives to Restraint Use will be provided to residents and their family members during a special care conference. Reassessment with new or worsening behaviours or signs and symptoms of mental illness as precursors to escalation of agitation/violence is needed to help identify residents that may be experiencing delirium. The Behaviour Assessment Checklist is completed to assess for new or worsening Responsive Behaviours.

Restraint free environments in our facility is based on assessment, prevention, and alternative to restraints. In addition, nursing staff conduct hourly rounds to ensure safety of our residents. Ongoing restraint reduction education is held annually and as needed and is also included in the orientation package for all newly hired staff.

A variety of resources are offered to families, i.e. pamphlets as well as consultations with families on restraint free alternatives and promotion of a restraint free environment. Evaluation and sustainability programs are established to monitor the rate of restraint use and reduction. Awareness of the process of implementation of least/free restraint program and ongoing education/discussion with staff, families, and residents to reinforce best practices of least restraint program.

Designated quality champions are in place for least restraint program to educate staff and residents/families, collect data, monitoring, auditing, and complete monthly reporting, in addition to the annual evaluation of the restraint program.

The Medical Cannabis use program is continuing to be offered to residents in order to decrease use of antipsychotic drugs, management of chronic and neuropathic pain, improve appetite, reduce responsive behaviours as well as use of physical restraints.
A non-pharmacological approach helps to maximize opportunities to stimulate our residents and reconnect them to a world they are losing access to. The recreation team tracks and monitors the resident's peak

hours for brain stimulation and implement programs using the Montessori Method. This method consists of implementing activities that are simple, modifiable, practical, and familiar. By doing this, residents will activate and satisfy their five senses, refraining from the need to seek stimulation elsewhere. For advanced dementia, residents can participate in activities that result in a definite sense of accomplishment such as having a basket of clean socks that need to be matched and folded. Through sensory experiences, the resident will be able complete a task that is within their skills set such as buttoning a shirt or folding and putting away their laundry. Puzzles pertaining to the resident's skill set, like matching words with objects will keep the mind active and engaged. Activities that encompass a variety of motion with slow and calming movement will help the resident identify with different parts of their body and activate muscle memory. Simple interactions with music and art will captivate the resident's attention by allowing them to create and express themselves. Incorporating meaningful and purposeful activities during peak hours of stimulation will decrease the number of falls and combat the use of restraints.

In summary, use of restraints have decreased by 80% compared to December 2020, with the implementation of our Best Practice Guideline (BPG) as of January 2022. In collaboration with the interprofessional team, the physiotherapist continues to assess residents currently using restraints and have seen a total of 5 residents who currently utilizes restraints in our facility. This has demonstrated a great achievement aligned with our best practices and will continue to improve on this initiative.

Management of the COVID-19 Pandemic

In 2020-2021, Infection Prevention and Control was a primary focus in order to maintain the health and safety of our residents, staff, essential caregivers, and visitors. These efforts include Pandemic Preparedness Plans, IPAC education, IPAC audits, maintaining PPE supply and vaccine roll-out.

MHLTC was selected by McMaster University as an "Exemplary LTC Home in Wave 1", a notable success as our home has not experienced a COVID-19 outbreak despite being located in a COVID-19 hot zone for a large facility.

Our team initiated the Pandemic Preparedness Plan early in March 2020 and has been revised as we progressed throughout the pandemic, including Safety and Security of Residents, Medication Treatments, Activities of Daily Living, Documentation by Priority and Staffing Plan. Continuous IPAC education and auditing of all staff and essential caregivers conducted by both in house IPAC Manager and leadership team as well as Mackenzie Health Hospital IPAC team.

As per direction from Ministry of Long-Term Care, our home maintained strict adherence to COVID-19 testing and active screening of all residents, staff and visitors. Adequate supply of PPE is maintained through continuous monitoring of inventory and is readily accessible to front line staff at all times. Our team collaborated with York Region Public Health to conduct several in house vaccine clinics for residents, staff, and essential caregivers. To date, 98% of residents and 100% of staff are fully vaccinated.

COLLABORATION AND INTEGRATION

UniversalCare/Mackenzie Health-LTC collaborates with various partners and stakeholders to improve integration and continuity of resident care. UniversalCare/Mackenzie Health-LTC clinical team members collaborate with specialists assisting residents in their continuum of care in dialysis, psychogeriatric, urology, dermatology, endocrinology, infection prevention & control, spiritual care (chaplain), and social work.

The Ontario Shores Psychogeriatric Outreach Team provides various specialized Geriatrics programs for our elderly residents with serious mental illness and challenging behaviors. This program includes psychogeriatric assessment, diagnosis, treatment and rehabilitation services. Our interprofessional team works closely with Behavior Supports Ontario to support our residents with responsive behaviors and prevention of transfers to the ED.

The pharmacist consultant conducts medication review including consulting in medication appropriateness, minimizing the use of antipsychotics, effective pain management, and involvement in palliative care. The pharmacist consultant is also essential in the prevention of fall incidents by providing health promotion regarding fall incidents and conducting reviews of high-fall risk medications. The pharmacist works closely with our team to enhance pain and symptom management. Our pharmacy representatives participate in quality improvement meetings in Pharmacy and Therapeutics, Nursing Practice, and Professional and Advisory Committees.

RNAO Best Practice Spotlight Organization Coach supports our interprofessional team completing gap analysis, organize education for staff related to Best Practice Guidelines, and to provide ongoing guidance throughout the duration of the BPSO project.

Our home is fortunate to collaborate closely with our partners at Mackenzie Richmond Hill Hospital. Specialities such as the Ethicist, Geriatricians, Nephrologists, GI and wound care specialists are available to support our residents and team. Mackenzie Health's IPAC team provides on-site support and guidance to our interprofessional team.

VIRTUAL CARE

Throughout the pandemic, our home maintained a high-quality resident centered approach to care when managing the mental and health challenges faced by residents and families due to isolation. Our team worked together to offer continuous virtual resident and family visitation, virtual recreation programming such as music therapy and pet visits. Our team was also able to arrange virtual Behavior Supports Ontario and pharmacy consultations when additional mental health support was indicated for the resident.

Virtual care has also been offered to address the physical health of the residents and facilitate virtual assessments with our attending physicians, dermatologist, and BSO. Our team ensured that families were always involved in resident care by maintaining care conferences virtually due to the pandemic and IPAC best practices.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

The primary goal of our interprofessional team at Mackenzie Health LTC has always been to provide high quality resident centered care at all times. This approach has never been more important than it was during the pandemic Beginning March 2020, the pandemic caused major changes in the lives and routines of the residents.
In response to the challenges of pandemic restrictions our team pivot approaches on supporting resident's physical, mental, emotional, and spiritual well-being. Many of our recreational programs were restructured to accommodate physical distancing and IPAC practices. Many programs such as pet visits and music therapy were switched to virtual. In addition, we facilitated outdoor visits in accordance with Government of Ontario and Public Health directives and recommendations. On average, our home also facilitates 15-20 virtual visits for our residents and their loved ones.

CONTACT INFORMATION

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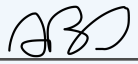
SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on March 24, 2022

Fay Lim-Lambie Board Chair / Licensee or delegate



Azi Boloorchi, Quality Committee Chair or delegate

Altaf Stationwala, Chief Executive Officer

Other leadership as appropriate

Mackenzie Health

2022/23 Quality Improvement Plan for Ontario Long-Term Care Homes

Aim		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Number of Emergency Department (ED) visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Unit of measurement : Rate per 100 residents*	MOHLTC / Period: Q1 2022	54252*	Current performance = 7 (data provided by MOHLTC / / Q1 2021)	Target = 7	Considering the complexity of our LTC population, we will continue to maintain current rate (7) of avoidable ED transfers.	Mackenzie Health Hospital, Home and Community - Ontario Health, BSO, NLOT, RNAO	1) Continue to improve resident centred care approach which can reduce ED transfers and potential hospital admissions.	Continue to: 1. Indentify early on any of resident's changes in health status and timely comunicate them to NP/MD; 2. Implement preventive care interventions and early treatment for common conditions leading to potentially avoidable ED visits. 3. Provide testing (i.e. COVID-19 rapid tests) and treatments (i.e. hypodermoclysis) in the facility, x-ray, blood work. 4. Identify and discuss residents at high risk of repeat ED transfers at daily nursing huddles, interdisciplinary meetings and CQI meetings so action plans can be initiated. 5. Prevent acute care hospital transfers by active participation from all members of the interdisciplinary team.	The number of unscheduled ED visits made by long-term care home residents for the selected conditions	The number of unscheduled ED visits in 2022 to remain at the level of 7, same as 2021.	
											2) Continue to educate members of the LTC health care team regarding strategies in the prevention of emergency department transfers.	Continue to: 1. Reeducate registered staff on non-urgent services such hypodermoclysis/continues subcutaneous infusions, in-house IV therapy, pain management, and palliative care; 2.Provide consistent education regarding multiple chronic medical conditions requiring frequent monitoring, as wellas, the recognition, evaluation, and management of common causes of hospital transfers 3. Review all hospital transfers which did not have physician/ NP consultation; 4. Review any readmissions back to the hospital within 30 days of their discharge and any non-admited ED transfers and provide data at the leadership meeting and Mackenzie Hospital meetings.	The number and freaquency of education sessions provided to staff	Percentage of members of the healthcare team have received education about the benefits of approaches to preventing ED visits before transfering to ED.	
											3) Continue to educate residents and families about the benefits of and approaches to preventing emergency department visits. The resident not being transferred to hospital improves outcomes and safety. The elderly transfered to ED are at risk of picking up infections, becoming confused and frustrated.	Continue to: 1. Provide feedback regarding benefits of and approaches to preventing emergency department visits to residents and family members by registered staff, nurse practitioner and physicians; 2. Communicate prompt residents' changes in health conditions to family members and decision discussed regarding ED transfer.	The number and freaquency of education sessions provided to residents and families	Persentage of family members have received education about the benefits of and approaches to preventing ED visits before transfering to ED.	
											4) Continue to utilize external partnerships, supports and services. These will include: BSO, Mackenzie Health Dialysis Liaison Committee, Geriatric Outreach Services Ontario to help support our staff and residents to decrease need for unnecessary ED transfers.	Continue to: 1. Establish partnership with other stakeholders. This will result in increasing residents' quality of care, residents' quality of life, as well as the reduction in ED transfers. 2. Communicate efficiently with the hospital healthcare team before transfering resident to hospital, during their hospital stay and transition back to LTC. 3. Collaborate digilently with all possble healthcare providers and agencies such as Ontario health, hospitals, public health, etc.	Number of referrals to external partners	The number of follow-ups, re-assessments and evaluations from referrals.	
Theme III: Safe and Effective Care	**Safe**	To reduce the use of restraints	C	Unit of measurement : % of daily physical restraints use	Complex Continuing Care Reporting System (CCRS) Period: average of Q1 & Q2 2022	54252*	2.50%	2.50%	Mackenzie Health Long Term Care will continue maintaining the percentage of restraints achieved in 2021 (average of Q1 & Q2)	Mackenzie Health Hospital, Home and Community - Ontario Health, BSO, NLOT, RNAO	1) Continue to reduce or elimate use of restraining physical devices, from which a residents is not able to both physically and cognitively release themselves.	Continue to: 1. Offer restraint alternatives in collaboration with interdisciplinary team by assessing the appropriateness of the alternative, the benefits provided to residents, and the safe use of the alternatives 2. The least restrictive type of physical restraint is used as an intervention after all alternatives to restraining have been considered or tried and found to be ineffective. 3. Avoid application of bed rails and/or restraints to new admissions, review restraint free phylosophy with resident and family at pre-adnission conference.	Percentage of restraints used in the home, Percentage of restraint reduction over the period of 12 months.	Percentage of residents using restraints assessed for use of alternatives to restraints. Percentage of the restraining devices discontinued.	
											2) Continue to actively engage residents and their family members in reducing the restraint utilization.	Continue to: 1.Discuss with residents and their loved ones on the type of restraints, the risks associate with their use, as well as, the expected outcome. 2. Offer to residents and families educational tools and materials to support the decision-making processes regarding the use or removal of restraints. 3. Provide our least restraint policy to new resident/ family members upon admission. 4. Offer educational sessions during Resident and Family Council meetings regarding the risk of entrapment and alternative to restraints.	Percentage of residents, families educated on use of physical restraints and risks associated with the use.	Percentage of residents using restraints assessed for use of alternatives to restraints. Percentage of the restraining devices discontinued.	
											3) Continue to provide educational sessions for LTC staff on the policy for minimizing restraining of residents and updates on evidence-based practice guidelines.	Continue to: 1. Offer educational sessions to all staff on the restraints policy, updates and on the evidence based practices regarding the use of restraints. 2. Provide orientation including LTC restraint policy for newly hired staff.	Percentage of staff educated of risks associated with restraint use and alternatives to restraints.	Percentage of LTC staff completed education regarding least restrictive environment policy.	