Ontario Health
Quality

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

2021-2022

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 Health 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. UniversalCare/Mackenzie Health-LTC 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.
UniversalCare/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 utmost respect and receive excellent services. Residents receive culturally sensitive and diverse care from the staff. The various programs provided in the facility ensures that the resident is in an exceptional environment for recreational activities and socialization. Through various programs & active participation, residents are

experiencing autonomy and satisfaction along with an increase of self-esteem and quality of life.
Quality improvement is greatly emphasized at our facility as 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 inter-professional team demonstrates friendly and kind attitude to the 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 interdisciplinary team worked continuously to maximize access to care by strong collaboration with Mackenzie Health Hospital teams from Dialysis, Emergency, Complex Continue Care, Infection Prevention & Control and the Nurse Led Outreach.

A notable highlight in 2020/21, UniversalCare/Mackenzie Health LTC was awarded pre-designate status as a Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization (BPSO). This is a 3 year long quality improvement project that uses Best Practice Guidelines (BPGs) to enhance programs in the home.

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

Avoidable Emergency Department Transfers
A decrease of avoidable ED Transfers at MHLTC was achieved in 2019-2020, above the target set in QIP plan.
UniversalCare/Mackenzie Health-LTC opted to hire a full-time nurse practitioner (NP)/Director of Clinical Services.
The results of the collaborative effort between the hospital and LTC interprofessional team resulted in achieving the target from the previous year as evidenced by the reduction of total transfers to ED reduced by 32%.
Our interprofessional team worked together to reduce avoidable ED transfers using several change ideas. Most notable, our home implemented formalized pre-admission process 4 years ago. The pre-admission meeting is held the day before the admission of a new resident and involves home's interprofessional team, the family, and at times the resident. This meeting is used 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 again 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 in the use of hypodermoclysis, applying pain management, and the stages of palliative care which allows for timely resident care and aging in place when there is a change in resident status. Our interprofessional team reviews and analyzes all ED transfers at each risk management meeting, which takes place three times per week. Using this approach, we are able to determine if a transfer could have been avoidable and if so, what measures could have been put into place to maintain the resident in the home. Our home sustains continuous collaboration with NLOT as well as ongoing partnerships with external health care providers such as the CLHIN for support with intravenous therapy. Our team also has strong relationships with Mackenzie Health Hospital - acute specialities such as Geriatricians, HD, Ethicist, GI and wound care specialists. Access to this level of health care support for residents allows for our residents to remain comfortable in the home without being transferred to the ED. A highlight of our relationship with Mackenzie Health Hospital was the development of the G-Tube reinsertion process map. This decision-making tool allows for residents to be seen on site by a GI specialist for assessment and g-tube reinsertion to avoid a transfer to the ED. Our home is fortunate to have an NP on site full time. This asset allows for 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.

Our home is also providing onsite PT, OT, SLP, and RD support and services to our residents. The availability of these resources allows for our residents to receive timely assessments for mobility, swallowing, and nutrition contributing to the aging in place philosophy of care.

Early Identification of Residents who would Benefit from Palliative Care

Approximately 4 years ago, our home implemented a formalized pre-admission process as a quality improvement measure to enhance the care provided to our residents and families from the very beginning. Once a resident and/or family has accepted a bed offer, our Admissions Coordinator works in collaboration with the Placement Coordinator from the CLHIN to arrange a pre-admission meeting with the new resident/family. This inter-professional meeting includes our Nurse Practitioner, Nurse Manager, Food Services Manager, Programs Manager, Social Worker and Admissions Coordinator. The Administrator and managers also have the opportunity to introduce themselves and offer support to the resident/family. The purpose of this meeting is to corroborate medical and social history between the admission application and the family/resident, to explain the high-quality care that is provided by our interprofessional team, and to review goals of care. If appropriate, the option of long-term palliative care is presented to the resident and/or family at that time. Care conferences are held at six weeks, annually; special care conferences are scheduled if there is a change is the residents health status. The interprofessional

team will use these meetings with the families and/or resident to review goals of care and again present the option of palliative care if appropriate. It is essential to have a full time Nurse Practitioner on site to assess residents in a timely manner and work to reduce avoidable ED transfers and promote aging in place. If palliative care is deemed as the resident's approach to care, ongoing psychosocial support is provided to the resident and family by Social Worker, Chaplain, and other members of the interprofessional team. Referrals can be made to the CLHIN Hospice Palliative Care clinical nurse consultant for pain and symptom management support if needed.

Our team implemented the use of a validated screening tool called the Palliative Performance Scale (PPS) which is used on admission, quarterly, annually, and as needed when a significant decline is noted. The registered staff was educated on the use of the PPS.

Our interprofessional team developed and implemented the formalized palliative care program and palliative care decision tree which guides decision making when addressing the palliative care needs of the resident. In collaboration with the CLHIN, our home was a member of a working group that developed a Palliative Care Resource Toolkit that was disseminated to all homes in the CLHIN.

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 residents, staff, essential caregivers and visitors. These efforts include Pandemic Preparedness Plans, IPAC education, IPAC audits, maintaining PPE supply and vaccine roll-out.

A notable success experienced as our home was selected by McMaster University as an "Exemplary LTC Home in Wave1".

Our home was selected as being a large home located in the hot COVID-19 zone and having no outbreak with COVID-19 spread. Our team initiated the Pandemic Preparedness Plan early on in March, 2020 which included Safety and Security of Residents, Medication Treatments, Activities of Daily Living, Documentation by Priority and Staffing Plan. Continuous IPAC education and auditing for all staff and essential caregivers conducted by both in house IPAC Manager as well as in close collaboration with 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. The home ensures that adequate supply of PPE is maintained by continuous monitoring of inventory and is readily accessible to front line staff at all times.

Our home was the second LTC in York Region to receive and administer the Moderna vaccine for our residents. Our team collaborated with York Region Public Health to conduct several in house vaccine clinics for residents, staff, and essential caregivers. To date, 96% of residents are fully vaccinated. Mackenzie Health Hospital was instrumental in providing access to the Pfizer vaccine for our staff and essential caregivers at the new Cortellucci-Vaughn Hospital.

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 teams' members collaborate with specialists assisting residents in their continuum of care such as in dialysis, psychogeriatric, urologist,

dermatologist, endocrinologist, dermatologist, infection prevention & control physician, chaplain, social worker.
Ontario Shores Psychogeriatric Outreach Team provides various specialized Geriatrics programs for our elderly with serious mental illness and presented with 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 such as in Pharmacy and Therapeutic, Nursing Practice, Professional and Advisory Committees.
RNAO Best Practice Spot Light Organization Coach supports our interprofessional team to complete gap analysis, organize education for staff related to Best Practice Guidelines, and to provide ongoing guidance throughout the duration of the 3-year BPSO project.
Our home is fortunate to collaborate closely with our partners at Mackenzie Health Hospital. Specialities such as the Ethicist, Geriatricians, Nephrologists, GI and wound care are available to support our residents and team.
Mackenzie Hospital IPAC team provides on site support and guidance to the team at UniversalCare/Mackenzie Health-LTC.

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. Our team was able to offer virtual care to address the physical health of the residents as well. Our team facilitated virtual assessments with our attending physicians, dermatologist, BSO, and the pharmacist. Our team ensured that families were always involved in resident care by maintaining care conferences virtually.

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 in March 2020, the pandemic caused major changes in the lives and routines of the residents. Visitors were prohibited for several months and the social activities the residents were accustomed to attended were reduced or cancelled. The challenges this created caused our team to pivot our approaches to how we support the resident's physical, mental,

emotional, and spiritual well-being. Many of our recreational programs were restructured to become small group or 1:1, pet visits and music therapy went virtual, and when the weather and ministry directives allowed out team facilitated outdoor visits between residents and families. On any given days, our home also facilitated 15-20 Zoom visits for our residents and their loved ones.

WORKPLACE VIOLENCE PREVENTION

Mackenzie Health Long Term Care is committed to treat all employees with respect and fairness. All workers have the right to be free from all workplace harassment, including, but not limited to, sexual and psychological. Our Home has a "Workplace Violence and Harassment Prevention" policy that outlines supporting procedures to address all workplace violence and harassment incidents, including preventing, recognizing and reporting incidents in a timely manner. The policy is provided to new employees during orientation, and reviewed annually by all staff, or at anytime an incident of violence or harassment occurs. It is made accessible to all employees on our company's mandatory training website online, and posted on our health & safety board. The home's Joint Health & Safety Committee also reviews this policy, in which the policy is then acknowledged and signed by senior management, and the Joint Health & Safety Committee management co-chair and worker co-chair. In addition, workplace violence incidents are discussed at our monthly leadership meetings, at our monthly corporate meetings, and at the hospital liaison meetings. Controlling the risks and post hazard assessment are important and communicated regularly, ensuring our employees are safe and protected. We are continuously ensuring that training is kept up-to-date, that our certified health & safety members attend refresher courses as needed, and encouraging staff to attend monthly health & safety committee meetings. Our management team completes the Supervisor Health and Safety 5 Steps Awareness certification annually, and over the past year, we have increased our Joint Health & Safety Committee membership, and have included a minimum of one worker representation from each department.

ALTERNATE LEVEL OF CARE

Our home works closely with the Local Health and Integration Network (LHIN) to address ALC challenges within hospitals (not just Mackenzie Health, but all hospitals). Placement into our home is determined by the LHIN. The LHIN works in close collaboration with the hospitals to determine whether priority access to beds is given to applicants in hospitals or in the community. Our Long-Term Care program (136 beds) regularly admits applicants from all settings, including the acute hospitals as well as the hospital Reactivation Centres that were created specifically to help alleviate ALC capacity issues. Our Interim Long Term Care program (34 beds) was designed specifically for applicants who are ALC in in hospital or in the Reactivation Centres.

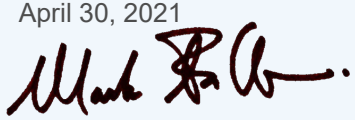
CONTACT INFORMATION

Carey Burleigh
Administrator
Mackenzie Health Long Term Care Facility UniversalCare Canada Inc.
MHLTCAdmin@universalcareinc.ca
Tel: 905-883-2442

SIGN-OFF

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

have reviewed and approved our organization's Quality Improvement Plan on April 30, 2021



Board Chair / Licensee or delegate

Chief Executive Officer

Quality Committee Chair or delegate

Other leadership as appropriate