
DATE: May 25, 2010

REPORT TITLE: **2009 ANNUAL REPORTS OF THE LONG TERM CARE MEDICAL DIRECTORS**

FROM: Janette Smith, Commissioner of Health Services

OBJECTIVE

The purpose of this report is to provide Regional Council with the Medical Directors' 2009 annual reports for the Region of Peel's five long-term care centres.

REPORT HIGHLIGHTS

- Medical Directors at long-term care centres provide annual reports to Regional Council as their governing board.
- Delivering appropriate care, receiving and providing information between health service providers was a priority in 2009.
- The Medical Directors and staff are commended for delivering compassionate, high quality and responsive services to over 700 long-term care residents each year.

DISCUSSION

1. Medical Directors' Annual Reports

The Medical Directors at Peel's Long Term Care (LTC) centres provide the governing board with an annual report on the medical status of the residents and the supporting medical programs.

Dr. Harry Earle is Senior Medical Director for the Long Term Care Division. Additionally, Dr. Earle is the Medical Director at Peel Manor and Tall Pines. Dr. Joseph Niedoba is the Medical Director at Malton Village and Davis Centre. Dr. Peter Bolland is the Medical Director at Sheridan Villa. The Medical Directors will attend the General Committee meeting of Council on June 17, 2010 to address their reports attached as Appendix I.

2. Medical Services

Medical Directors and senior management staff at each of the Region's LTC homes monitor trends in care needs. This includes deaths, falls, infections and aggressive incidents. These indicators are useful in identifying trends which require action and in identifying promising practices.

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Results are reviewed and compared with prior years at each centre. While the results vary among the five long-term care homes, the teams focus their efforts on identifying changes at the local centre. Overall changes across the Division in the 2-year period are considered within an acceptable range; particularly in light of the impact that an individual resident with repeated occurrences may have on these indicators.

Centres	2008/2009	Deaths	Falls with Transfer to Hospital	Aggressive Incidents (resident: resident and resident: staff)	Outbreaks
Malton Village	2008	29	16	29	0
	2009	32	11	32	1
	% change	10%	-31%	10%	
Peel Manor	2008	34	13	26	1
	2009	48	8	19	1
	%change	41%	-38%	-27%	
Sheridan Villa	2008	24	6	91	0
	2009	29	7	58	1
	%change	21%	17%	-36%	
Tall Pines	2008	38	19	29	2
	2009	36	19	41	0
	%change	-5%	0%	41%	
Davis Centre	2008	17	4	24	0
	2009	13	3	32	1
	%change	-24%	-25%	33%	

3. Present and Emerging Service Initiatives

The Ministry of Health and Long-Term Care (MOHLTC) and Local Health Integration Networks (LHINs) have been working towards a health system model that emphasizes integration of community health services that are supported by institutional care, such as hospitals and LTC homes. LTC homes are well suited to deliver medical care and supportive services for those suffering from multiple and complex chronic and disabling conditions, when they are appropriately resourced with staff to resident ratios needed to provide this care.

As acuity of care increases and residents are maintained in the LTC home, it is imperative that the Province resource LTC homes with medical and nursing expertise to deliver the front line care needed to provide appropriate care in the home. This concern was also identified in the "Nineteenth Annual Report of the Geriatric and Long Term Care Review Committee to the Chief Coroner for the Province of Ontario (2008)," released in September 2009. The recommendations urge the provincial government in Ontario to improve resources for several different assessed conditions typically found in LTC homes.

Communications between providers of health services are essential to a smooth delivery of the care and services each client needs. Of particular note is the sharing of information between the hospital and the long-term care home. Discussions have been initiated between the management of both organizations to review communications and to improve their impact on continuity of care and services.

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Partnerships are required to ensure that the LTC home can successfully meet the challenges and provide the right services for individuals in its care. Council will recall that last year's Medical Directors' report described a growing momentum to deal with behavioural needs through specialized services. An example of how this can serve community needs is under development at Sheridan Villa as the home prepares to open a new Behaviour Support Unit for those with dementia.

This recently approved behaviour support initiative will serve eligible clients who have a diagnosis of Alzheimer's disease or related dementia and who have unpredictable and sometimes aggressive behaviour. Its success is predicated on the system working in an integrated fashion to provide components of the services needed to meet the whole person's needs regardless of the sponsoring agency.

4. Future Direction in Medical Services

Expansion of the use of Nurse Practitioners is a promising development which the Local Health Integration Networks (LHINs) have implemented at the Region's LTC homes. They work in collaboration with physicians to provide quality care to seniors including health promotion, disease prevention, and supportive and palliative care.

Objective performance measurement, accountability and transparency of service outcomes are increasingly important in all health services and through several specific initiatives introduced by the Province of Ontario for LTC homes. Public reporting of health outcomes such as the information presented in this report related to infections and resident falls will be required of all LTC homes. Peel Long Term Care will continue to use this information to measure outcomes and to implement quality improvements.

The Long Term Care Homes Act will be proclaimed in July of this year. The regulations which guide the work of staff and physicians are being reviewed and will result in changes in practice. A report on the resulting changes will be presented to Regional Council later this year.

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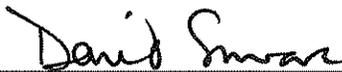
CONCLUSION

The Medical Directors and staff are commended for delivering compassionate, high quality and responsive services to over 700 long-term care residents each year.



Janette Smith
Commissioner of Health Services

Approved for Submission:



D. Szwarc, Chief Administrative Officer

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Authored By: Carolyn Clubine, Director, Long Term Care

c. Legislative Services

MEDICAL DIRECTOR'S REPORT for Year 2009 Malton Village

I am pleased to present the 2009 Medical Director's Report for Malton Village.

BASIC STATISTICS

There were 32 deaths in 2009 compared to 29 in 2008. Twenty three residents passed away at Malton village.

There were 343 falls in 2009, 80% of which resulted in no injuries and 20% resulting in injuries ranging from minor bruising to five fractures. In 2008 we had 319 falls, 82% resulted in no injuries and 18% resulted in injuries.

Managing resident behavioral issues continues to pose a challenge. The resident can become physically aggressive without provocation or warning and cause an injury to themselves, other residents or staff. The relative low number of staff to resident ratio can be a factor in managing these behaviors safely.

In 2009 there were 41 resident to resident incidents (48 incidents in 2008,) and there were 47 resident to staff incidents (32 incidents in 2008). Most of the behaviours were attributed to two residents with dementia.

In 2009, there was one respiratory disease outbreak due to influenza A. The outbreak lasted 21 days and affected 15 residents and 8 staff. There were no deaths or hospitalizations as result of this outbreak

SIGNIFICANT ISSUES

On October 15th Malton Village was honoured with a visit from 24 health leaders from China. The Region of Peel Long Term Care Division was invited to host this event as they heard of our excellence and expertise in Infection Control and Pandemic Planning. The delegates were provided with information related to long term care operations and the Ontario Health System in general.

In July 2009 we celebrated our 5th anniversary. During our five years of operation we have welcomed and supported over 370 new residents and their families. New staff, volunteers and community partners were also welcomed over the years.

PROGRAMS OF INTEREST

We are fortunate in that we have access to a Nurse Practitioner in collaboration with William Osler Health Centre and the Central West Local Health Integration Network. Their role is to visit the home to provide assessment and treatment with the goal of keeping residents in the home and thus reducing hospital emergency department visits.

The resident influenza vaccination rate was 91%. The staff influenza vaccination rate improved to 87%.

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Malton Village has developed a number of strategies to optimize care to residents with behavioural issues. This includes: involvement of the multidisciplinary care team, utilization of external resources such as the Psycho-Geriatric Resource Consultant and one to one constant monitoring of residents if the funding has been pre-approved. Personal Support Workers (PSW) also receive education and training on managing aggressive behaviour.

In an effort to further manage and reduce the number of incidents of responsive behaviours, Malton Village will be initiating a Behavioural Support Team. This team will be comprised of staff from all disciplines and specialist external resources, such as the Psychogeriatric Resource Consultant. The goals of having this team in place are to assist with early recognition of potential concerns, consultation, education and timely intervention.

EMERGING TRENDS

The Region introduced a new Continuous Quality Improvement Program where indicators are reviewed monthly to identify undesirable trends and gaps or leading practices. This focus on quality and compliance will ensure the delivery of quality care, programs and services over time.

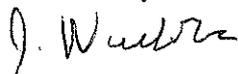
Malton Village is fortunate to have the services of physiotherapy. They do an excellent job with the residents, especially in the area of ambulation and fine motor function. There has however, been a need for a service such as acupuncture for the management of acute and chronic pain. Physiotherapy clinics in the community now often offer this service. The Region may want to consider having its physiotherapists in its long-term facilities receive training in this area.

The working relationship between Long-Term Care and Acute Care remains a challenge. In particular, the communication between the long-term care facility and the emergency room at William Osler needs to be improved. I have had discussions with the physician in charge of emergency services at William Osler. To date this continues to be a challenge.

SUMMARY

Malton Village continues to provide excellent care to its residents.

Respectfully submitted,



Dr. Joseph Niedoba

HE-81-7

TALL PINES
LONG TERM CARE CENTER
ANNUAL REPORT 2009

OVERVIEW

The admission of the complex chronically ill type of resident continues to increase. Multiple physical diseases coupled with dementia create a client that requires extra attention and often additional treatments. Dialysis, post operative wound care, respiratory therapy, and G-tube feedings are examples. Complications from these therapies add to the burden of care. Combined with dementia, this creates a challenging work environment. When staff are working at maximum capacity the risk of error is increased

BASIC STATISTICS

Resident population:	160
Deaths	36
Falls	343 without injury
	98 with injuries
	19 assessed at hospital
	13 admitted

The prevalence of falls is higher than average. The use of restraints is lower than average. The prevalence of skin breakdown is lower than average. Medication rates and drug errors were within the range of the provincial average.

Aggression: There is verbal and physical aggression. This is managed by chemical (drugs) and behavioural (e.g. redirection) mostly. There is aggression to staff when giving care. This can pose a risk to the person giving care if there is contact. Scratches bruises for example have occurred. Resident to resident aggression can manifest itself in the same way. At times outside resources are needed to address this issue such as psychiatry and psychological assessments.

Infection control: There were no major outbreaks in the past year. The most common infection is in the urinary tract. Viral upper respiratory and viral gastric infections are common as well. Pneumonias, bacterial and viral can be the most troublesome although less common.

SIGNIFICANT ISSUES

The ongoing development of accessing help from community resources is still needed in cases of complex care. Examples include advanced wound care, and use of the nurse practitioner.

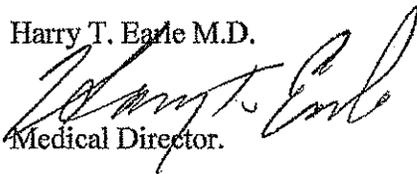
As indicated in other reports the changes in the Long Term Care Homes act will likely affect how we manage residents.

The increasing size of the aging population may affect the type of services that we will be asked or expected to offer, including more day activities (e.g. day care, meals, organized activities)

SUMMARY

The long standing issues remain as a persistent challenge in long term care. Psychological behaviours predominate as a management challenge when mixing frail elderly with demented but much more physically capable client. Separate units are being tried to cohort this type of resident. As with any group of people housed together infection control will be a constant concern. Increases in the size of the population will place increasing demands on our system requiring additional methods and services.

Harry T. Earle M.D.

A handwritten signature in cursive script, appearing to read "Harry T. Earle".

Medical Director.

PEEL MANOR
HOME FOR SENIORS
ANNUAL REPORT

OVERVIEW

Increasingly there is a general trend for residents to not only have mental impairment but also to have physical disabilities as co-morbidities. The management of these complex residents requires extra time with regard to numbers of medications and treatments. This includes complex treatments such as G-tube management. Moreover there is a further demand on staff when complications develop in this type of resident. As hospitals find the increase in ALC patients harder to cope with and costly to maintain, it can be expected that the long term care sector will be asked to take more of these residents. Staff training and staff to resident ratios will need to be increased.

BASIC STATISTICS

Resident population 177

Deaths 48

Falls with injury 40

without injury 236 admitted to hosp. 2 assessed 8

The prevalence of falls, use of restraints, pressure ulcers (skin breakdown) was well within the normal rates for provincial and regional rates. Scheduled medication rates were slightly above the provincial average.

Aggression: Resident to resident and resident to staff aggression rates depend largely on the type of resident that we have. There is physical and verbal aggression. Verbal aggression is often threats of violence and is not included in the statistics. A single resident who may be particularly aggressive may increase the rate greatly for a brief period, giving the impression that there is a general increase in the rate overall.

Infection control: Urinary tract infections are the most common and often reoccur in the same resident repeatedly. The current practice is to treat only the symptomatic patients and monitor the patients that carry an infection but are asymptomatic.

Viral gastro-enteritis is a commonly occurring infection that occurs seasonally. This is usually highly infectious and requires an inordinate amount of staff time to manage.

Respiratory infections are the third main infectious issue in a population that has reduced immunity. These take the form of viral infections and pneumonias.

There was one outbreak of Norwalk type virus (gastro enteritis) and an outbreak of Respiratory syncytial virus in 2009.

SIGNIFICANT ISSUES

Behaviours in residents continue to be a consuming issue. Extra time and staff effort is required to protect residents from their own behaviours and to protect other residents from the aggressors. External resources and one-on-one care are often needed including transfers to a specialized facility for these behaviours. Management of patients with previous chronic psychiatric illness are particularly challenging.

An increase in the acuity of residents causes transfers to the hospital. Assessment of the resident is affected by the limited availability of laboratory and x-ray on site. This necessitates the transfer for more detailed assessment. Many residents have multiple comorbidities making the care needed beyond the skill level of some of the caregivers.

The ever increasing presence of bacteria that are resistant to treatment (MRSA, VRE, etc.) use up resources in the provision of isolation.

FUTURE DIRECTIONS

The telehealth initiative may show promise with better access to consultants.

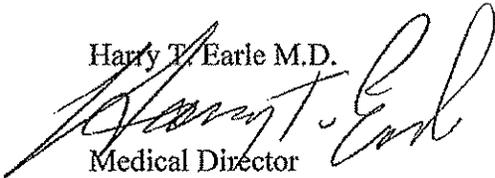
Changes to the Long Term Care Homes act may present new challenges and opportunity in this health sector.

The need for hospitals to reduce their chronic patient loads will cause pressures on the long term care homes to accept more of the complex resident rather than the frail elderly.

SUMMARY

The general trend for complexity of client continues. The need for continued training of staff, in response to the changing climate in long term care remains apparent. Psychological behaviours in long term care will continue to present challenges and require extended resources. Infection control will continue to present on going care issues. The pressures on the system will inevitably increase with the aging population and their high incidence of chronic illness.

Harry T. Earle M.D.


Medical Director

HE-81-11

MEDICAL DIRECTOR'S REPORT for 2009 Davis Centre

I am pleased to present the 2009 Medical Director's Report for the Davis Centre.

BASIC STATISTICS

In 2009, there were 13 deaths. In 2008 there were 17 deaths.

In 2009, there were 103 falls, 18 of which resulted in injury, of which 2 were fractures. There has been an increase in the number of falls from 2008 with 88 falls, however less resulted in injury than in 2008 (22). This increase was attributable to one resident who was experiencing frequent falls.

In 2009, there were 17 resident to resident behaviour incidents compared to 9 in 2008. In 2009 there were 15 resident to staff behaviour incidents; comparable to the number in 2008. This indicates that providing care to an individual with dementia, complicated by responsive behaviours, continues to be a challenge. This points to the increasing need for additional psychogeriatric resources for the management of unpredictable behaviours.

In December 2009 we had one Norwalk virus outbreak lasting 28 days, affecting 42 of our residents and 38 staff.

SIGNIFICANT ISSUES

Norwalk is an extremely pathogenic enteric virus. Acute care hospitals have had entire wards closed in an attempt to control its spread. A case in point was Mount Sinai Hospital which, despite an excellent infection disease department, had to close several hospital wings in an effort to limit its spread. What makes Norwalk difficult to manage is that the traditional medical model does not have an effective treatment except for supportive care.

The staff at the Davis Centre is to be commended for participating in the H1N1 vaccination program; 84% of the staff received the H1N1 vaccine. The participation with the seasonal flu vaccine was however, low at 64%. Fortunately, the seasonal influenza virus has not been very active this year. The Region of Peel may want to consider a flu lottery next year to increase staff participation in the vaccination program. This has been tried at Malton Village with some success.

PROGRAMS OF INTEREST

The Caledon Meals on Wheels Program (CMOW) continues to play a significant role in the community. There were 7849 meals provided in 2009, an increase of 361 meals. The CMOW also helps provide information to clients in the community about services

HE-81-12

available at the Davis Centre. In some ways it provides a friendly face to what is frightening to some people when they think of a long-term care home. Down the road, this may assist individuals with the transition from community living to a long-term home setting.

The Adult Day Service provided 4416 service days to a total of 61 clients. We applied for and received additional funding through the LHIN to enhance the ADS program through the Aging At Home Initiative. This new provincial initiative is designed to provide enhanced health services for the clients that we serve, such as assistance with bathing and physiotherapy. It also prevents premature placement in long-term care.

The Respite Program continues to provide temporary scheduled substitute care to frail individuals. In so doing their regular care givers are able to recharge.

EMERGING TRENDS

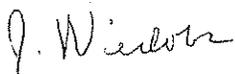
During the Norwalk outbreak, some residents with protracted diarrhea were started on a probiotic, Florastar. This resulted in a significant decrease in their symptoms. Florastar is one of the few probiotics that has been involved in clinical trials which demonstrate its effectiveness in preventing traveler's diarrhea. There have been however, no studies that I am aware of when it comes to its use with the Norwalk virus.

Florastar is extremely well tolerated. It does not react with other medication. It may well be of use in future Norwalk outbreaks not only in limiting the severity of the illness, but limiting its spread to other residents and staff. I would suggest that the Region of Peel consider doing a clinical study as to the role a probiotic like Florastar could play in enteric outbreaks.

SUMMARY

The Davis Centre continues to provide excellent care to its residents and individuals in the community that utilize its many programs. In 2009, the Davis Centre celebrated its 25th year anniversary. The Honourable William Davis was among a number of dignitaries that attended the event. He was impressed by the facility and its staff.

Respectfully submitted,



Dr. Joseph Niedoba M.D., M.B.A.

MEDICAL DIRECTOR ANNUAL REPORT TO COUNCIL FOR CALENDAR 2009

April 21, 2010

Ladies and Gentlemen:

The following is my report on the medical status of Sheridan Villa during 2009, plus comments on potential future directions.

Basic Statistics

Resident Population:	101	
Deaths:	29	This approximates the death rate of previous years.
Falls:	56	without injury
	138	with injury none with serious consequences.
Aggression:	20	incidents of resident to resident aggression and
	38	incidents of resident to staff aggression.
Infection Control:	There was one short contained enteric out break in December.	

Significant Issues

At the time of this writing, the final phase of renovations has almost finished, revealing a very upscale design and functional, comfortable, pleasant surroundings for residents as well as for outreach programs into the surrounding senior community. We are four years into renovations with the noise, dust, and physical disruption attendant upon this situation. I congratulate our staff for their professionalism through these years.

A major issue inside Sheridan Villa, as it has been for years, is the management of residents who present with 'Behavioral and Psychological Symptoms of Dementia' – BPSD – referred to in the last two years' Medical Directors report to Council.

Residents afflicted with dementing illness will occasionally develop behavioral patterns, attitudes, psychological traits which are threatening to their own health, the safety of other frail residents, and the well being of staff to say nothing of the environment shared by all. This is referred to in the literature and by experts in the field as 'BPSD'. Our Provincial health care system has few resources to manage people so afflicted. In our renovated building will be a 19 bed unit for these people, a first in Peel/Halton. As we speak, rules for admission and discharge, staffing, psychiatric liaison, and multiple other facets are being planned.

The end product is achievable, could serve as a model across the province, and certainly is necessary as care of the elderly advances.

Medicine is rapidly advancing and new diseases and their treatments affect the elderly. We currently are able to access CCAC services,

especially for our Nursing staff in such areas as complex dressings, I.V. antibiotic use, and future tracheotomy care. We can expect to house residents who need dialysis treatment in the future. We can expect to have AIDS victims as residents of the future. In short we must be ready to adjust to significant change.

In summary, 2009 in Sheridan Villa has seen the very extensive renovations continue towards their final end with elegant and functional results. Resident health has been as expected. We are addressing the problem of BPSD sooner rather than later. We must be ready immediately to deal with a pandemic flu, and plan for unmet needs including the challenges of new diseases and the provision of modern medical care to those afflicted.

Respectfully Submitted:



Dr. Peter G. Bolland
Medical Director
Sheridan Villa Long Term Care Centre