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Region of Peel
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REPORT
Regional Council

For Information

DATE: April 7, 2011

REPORT TITLE: **2010 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' 2010 annual reports for the Region of Peel's five long term care centres.

REPORT HIGHLIGHTS

- Medical Directors at the Region of Peel's Long Term Care centres provide annual reports to Regional Council as their governing board.
- Indicators are monitored to assess resident health, safety and quality of care.
- 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 the Region of 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 are attending Regional Council on May 12, 2011 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 healthcare risk factors. Over the years, Peel's Medical Directors have selected several high level indicators to monitor. A selection of key indicators acts as "proxy measures" to monitor resident health and safety quality. These indicators are useful in identifying trends which require action, and in identifying promising practices.

Centre (Beds)	Year	# of Deaths as a % of Beds	# of Falls with Transfer to Hospital	# of Aggressive Incidents (resident: resident and resident: staff)	# of Outbreaks
Malton Village (160)	2008	18%	16	80	0
	2009	20%	11	88	1
	2010	17%	16	93	1
Peel Manor (177)	2008	19%	13	26	1
	2009	27%	8	19	1
	2010	21%	18	42	1
Sheridan Villa (114)	2008	24%	6	91	0
	2009	29%	7	58	1
	2010	24%	4	72	1
Tall Pines (160)	2008	24%	19	29	2
	2009	23%	19	41	0
	2010	20%	16	87	0
Davis Centre (64)	2008	27%	4	24	0
	2009	20%	3	32	1
	2010	19%	6	34	1

Three year trend data demonstrates that the number of deaths has been generally consistent across the five homes. Falls-related incidents that require hospital assessment remain consistent with the size of the home, noting that Sheridan Villa completed a major redevelopment with reduced resident census up to the end of 2010.

Data on aggressive incidents increased over 2009. The opening of the Special Behaviour Support Unit at Sheridan Villa has lead to a greater awareness and tracking of these events. Specialized training in the Unit has provided staff with the tools and resources to recognize behaviours, and put in place interventions to diminish aggressive episodes and, in effect reduce injuries that may result from these aggressive incidents. As this training is expanded to the rest of the homes this should lead to an overall reduction of incidents.

With respect to outbreaks, Peel's LTC homes invest in infection control both through practices, education and selection of equipment and supplies. This has kept outbreaks in Peel homes to a minimum. Of the 37 reported outbreaks across Peel, four of these incidents occurred in the Region of Peel LTC homes.

A large repository of data is now being built for all of Ontario's long term care homes through a database referred to as MDS RAI in a data warehouse in Ottawa which is managed by the Canadian Institute for Health Information (CIHI). It is expected that by 2014, Peel will be able to compare its results with all other Ontario LTC homes.

3. Present and Emerging Service Initiatives

Long term care homes are well suited to deliver medical care and supportive services for those suffering from complex chronic conditions when they are appropriately resourced. 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, and sufficient personal caregivers needed to provide appropriate care in the home.

As referenced above, in September 2010 the Specialized Behaviour Support Unit opened at Sheridan Villa. Provision of targeted services to meet the challenge of care for those suffering with dementia has been a valuable addition to long term care resources in Peel. Collaboration across organizations and the use of interdisciplinary collaboration to achieve the best results has been very positive. While this program was developed by the Mississauga Halton Local Health Integration Network, clients living in the north part of Peel have accessed this service because supports for psycho-geriatric needs in the Central West Local Health Integration Network are not sufficient to meet the need.

Nurse Practitioners are nurses with extended skills in assessment, diagnosis and teaching. A program to provide shared Nurse Practitioners across all of the long term care homes in the community has been effective to address care needs that are beyond the scope of the front-line nurses, and to avoid transfer to hospital.

4. Future Trends in Medical and Nursing Care Services

Communication between health providers is a limitation in ensuring continuity of care. When a resident receives care at the hospital the exchange of treatment information should help each of the providers to respond to his or her needs. A new service will be launched in 2011 for those who receive care at William Osler Hospital. The REACH portal will allow doctors and nurses access to the clinical care records of the resident no matter where they are. This will ensure that Long Term Care staff are fully aware of the resident's treatment plan.

Peel's Long Term Care centres also provide the support and skilled staff to deliver community care services through Adult Day Services based at four of the homes. Clients receive enhanced services to ensure that the personal care help that they need to maintain their independence in the community is provided effectively while they are in attendance at the program. The delivery of services while already receiving psychosocial support makes the provision of services in one location effective and efficient. Opportunities to continue to deepen clinical support to clients at these programs continue to be sought in collaboration with the Local Health Integration Networks.

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

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MEDICAL DIRECTOR'S REPORT for 2010
Davis Centre

I am pleased to present the 2010 Medical Director's Report for the Davis Centre.

BASIC STATISTICS

In 2010, there were 12 deaths. In 2009 there were 13 deaths.

In 2010, there were 108 falls (2009- 103), 25 of which resulted in injury, four of which included fractures. One resident experienced frequent falls and contributed to the increased number of falls for 2010.

In 2010, there were 26 resident to resident behaviour incidents compared to 17 in 2009. One resident accounted for 12 of these incidents. In 2010 there were 8 resident to staff behaviour incidents (2009-15).

In October 2010 the Davis Centre had a respiratory outbreak lasting 10 days, affecting 7 residents and 9 staff. No causative organism was identified. There were no deaths.

The staff influenza vaccination rate was 82%. This is a welcome increase from 64% in 2009.

SIGNIFICANT ISSUES

There remains an increased need for additional psychogeriatric resources for the management of residents with behaviour disorders. There is one resident for example, who has assaulted staff on several different occasions. This is despite numerous psychiatric consultations. What complicates this situation is the Ministry of Labour is reviewing what the Davis Centre is doing to provide a safe work environment for its employees. So not only is resident safety a factor, but increasingly, so is staff safety.

PROGRAMS OF INTEREST

The Caledon Meals on Wheels Program (CMOW) continues to play a significant role in the community. There were 7833 meals provided in 2010.

The Adult Day Service provided 4741 service days to a total of 61 clients.

The Central West LHIN requested an evaluation of the Aging At Home initiative at the Davis Centre which included the provision of bathing and physiotherapy to our ADS clients. The LHIN was impressed by our success as a demonstration of a best practice.

The Respite Program provided 6912 care units to 27 clients.

In response to requests from Peel Region's medical community to improve the access to vaccines, the Davis Centre launched the Vaccine Fridge Program. With the help of the Public Health Department, we became the central depot for vaccine pick up for the community physicians. The benefits of this program are improved vaccine safety, a decreased risk of cold chain breaks and the reduction of travel time to Brampton to pick up the vaccine.

EMERGING TRENDS

With the escalating costs of health care and the impact on the tax payer, the Region of Peel should continue to encourage the LHINs to support more cost effective programs of delivering primary health care to our seniors. This would help reduce transfers to hospitals and specialists for consultations and treatments. Telemedicine at Peel Manor, the Vaccine Fridge Program at the Davis Centre and use of the Nurse Practitioner are examples of such programs

We are on the cusp of developing effective community psychogeriatric resources for North Peel. Continued support from the LHINs is necessary.

SUMMARY

The Davis Centre continues to be well respected in the community for its provision excellent care to its residents and clients.

Respectfully submitted,

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

MEDICAL DIRECTOR'S REPORT for Year 2010
Malton Village

OVERVIEW

I am pleased to present the Malton Village Medical Director's Report for 2010.

BASIC STATISTICS

In 2010 there were 27 deaths in total at Malton Village; of these deaths 40% occurred at the centre. These residents received Palliative Care services offered by our staff. Malton Village has an active Multidisciplinary Palliative Care Team that provides holistic, supportive services to residents and their loved ones. If feasible a palliative care conference is held with the resident and/or family members to overview the treatment plan and options. Additional supportive services offered may include: music therapy, one to one psychological or spiritual supports and opportunities for other social interactions. End of life care and disease/death management are of key importance to ensure as peaceful and pain free a transition as possible is achieved.

There were a total of 382 falls in 2010, 80% of which resulted in no injuries and 20% resulting in injuries ranging from minor bruising to fractures. The percentage resulting in injury remains the same as 2009 at 20%.

We continue to be challenged by residents' responsive (aggressive) behaviours. In 2010 there was a total of 47 resident to resident incidents (41 in 2009) and a total of 46 residents to staff incidents (47 in 2009). It should be noted that the majority of the incidents can be attributed to four residents with significant behaviours. We were successful in securing one to one staffing from the Ministry of Health and Long Term Care to assist with managing these residents. Other resources utilized are the Sheridan Villa Specialized Behavioural Unit during the last quarter of 2010 and Toronto Rehabilitation Institute; however there is a significant wait time for the latter.

Resident influenza immunization rates were 93% and staff influenza immunization rates were 52% in 2010. This percentage of staff immunized has subsequently increased to 63% at this time. This relatively low staff immunization rate continues to remain a challenge as discussed in earlier reports and this may be one of the contributing factors to a recent outbreak at Malton Village.

SIGNIFICANT ISSUES

Malton Village successfully submitted a proposal for Aging at Home funding which allowed the centre to hire a full time Supervisor, Adult Day and Community Services and a full time Adult Day Support Worker, to enhance the services that were being provided to clients from the community. These enhanced services include: baths, physiotherapy, music and horticultural therapies, restorative care and individual sensory programs. Additional professional resources include Physiotherapists, Occupational Therapists, Registered Dietitians and Registered staff. This initiative supports clients remaining in the community for a longer period of time and also assists with averting transfers to the hospital emergency rooms.

Since commencement of this program in November it has been noted that 70% of our clients require high to very high levels of care. Currently there is a high demand in the community for these enhanced services. The increased funding has enabled us to meet that need and as a result our program has increased to full capacity.

The new Long Term Care Homes Act and Regulations came into effect in July 2010. This Act replaces the Ministry of Health and Long Term Care Compliance Standards. The centre is working diligently at reviewing and revising Policies, Procedures and Care Programs to ensure legislative compliance and to prepare for accreditation in 2011.

PROGRAMS OF INTEREST

Malton village was successful in reducing the number of restraints in the home by 18% through the Restraint Reduction Program in 2010. This process involved consultation with the care team, resident and family member in reviewing and assessing suitable residents for the safe removal of the restraint.

One of the Continuous Quality Improvement Priorities for Malton Village 2011 is Falls Prevention. Work has already begun on one of the six Resident Home Areas (RHA) that contribute to 35% of all falls in the Centre. This RHA is home to a highly mobile and active group of residents with various types of Dementia. Over the next 6 months, the revised Falls Prevention and Management Program will be rolled out to all RHAs in the centre.

The program is multidisciplinary in nature and includes components such as risk assessment, personalized care planning, physiotherapy intervention and the utilization of fall prevention equipment such as chair and bed alarms. The goal of this initiative is to reduce the number of falls in the centre by 25% by August 2011

The "Just Clean Your Hands" campaign was launched as a pilot at Malton Village. This is a Ministry of Health and Long Term Care initiative aimed at increasing hand hygiene compliance and decreasing the acquisition of infections. In this pilot on one RHA; staff was provided with education about the program, hand sanitizers were placed at points of care such as at the bedside, and staff's compliance with hand hygiene was audited. This is an ongoing initiative and will be rolled out to the entire centre this year to include physicians and other service providers.

The nurse practioner program at Malton Village has been very successful. This program has helped reduce unnecessary transfers to hospital and consequently improved the quality of life of the residents. The number of residents transferred to hospital decreased from 65 between the months of January and June, to 30 between the months of July and December. This represents a decrease of 46 percent.

EMERGING TRENDS

In last year's report, it was noted that communication between Long Term Care and Acute Care required improvement. The Acute Care sector has also recognized this gap and will be initiating the Rapid Electronic Access to Clinical Health Records (REACH) initiative in partnership with Long Term Care Centres. REACH will enable authorized

staff at the Long Term Care Centre to access real time health records of residents who are in the hospital. The program is set to launch in the spring.

In 2009's report I discussed the role of Florastar within a Long Term Care environment. Since then I have had consultations regarding this matter with professionals within the medical community. A literature review was also conducted and I plan to discuss the feasibility of doing a study with my colleagues within the next few months.

SUMMARY

Malton Village continues to provide excellent care to its residents.

Respectfully submitted,

Dr. Joseph Niedoba

HE - A1-10

PEEL MANOR
LONG TERM CARE HOME
ANNUAL MEDICAL REPORT
2010

OVERVIEW

In spite of being the oldest home in the group of long term care Municipal homes, Peel Manor remains a stable contributor to long term care for the Region of Peel. There are significant links with community programs such as Meals on Wheels, and an Adult Day Program. Ongoing renovations to the home have supported service delivery and ensure that the residents have a comfortable and secure environment.

The pressures of more complex patient management are similar to what all LTC Homes are coping with. Expectations of families are often a challenge. In particular the desire to have more individualized meal choices with less processed food is voiced by some families. Other family expectations relate to individualized one on one care for their loved one. Complex resident management is also another challenge in long term care that is often related to chronic illness management. Currently we have three residents who require dialysis three times a week and need to be transported to hospital to receive these services. Some residents who are unable to swallow require tube feeds, some of Peel Manors residents who have cognitive impairments have responsive behaviours which require specialized care and often one-on-one assistance for a period of time.

BASIC STATISTICS

Deaths: 38
Admissions: 52
Aggressive Incidents: Resident to resident: 24
Resident to staff: 18

The numbers on aggression can be misleading. One resident had many episodes with both staff and other residents, necessitating the implementation of 'one on one' management with extra staff needed. As well the resident had to be sent to the hospital under a Form 1 (without consent) with police escort. This can happen when a resident has a prior complex psychiatric history, revealing some of the limitations of long term care capabilities. There are a significant number of incidents of a minor nature not documented. Psychiatric support is available but has to be called in on an as needed basis. This means that in the acute situation the staff is left to their own resources.

Falls: 238; with injury 30; of these 18 went to hospital for assessment and 10 were admitted. This indicates that most falls were minor. Also the majority that were sent to the hospital required admission and were not unnecessary transfers.

Infection control: Residents with resistant strains of bacteria; 13
Residents vaccinated for influenza 91%, Pneumococcal 88%
Staff immunization rate 62%
Outbreak Enteric type March 23 to April 1, 2010. Residents affected 16

SIGNIFICANT ISSUES

Families can be challenging when they are dysfunctional. They can and do often bring extra issues other than the medical care of their relative to the home. This can be stressful for the staff as well as the resident. Family members are reported to have been physically and verbally aggressive to the staff. Resident behaviours are sometimes unpredictable The physical and mental needs of our residents have increased. For example the resident that needs dialysis requires preparation, transport and return for this procedure. This takes extra time from the routine care needed by other residents. Complexity of care is expected to increase in the future.

SUMMARY

Long term care continues to be a most challenging area of health care. Increased resources will be needed to deal with the increasing number and complexity of the senior population that we will be managing. Community partners will be increasingly involved in the management of seniors.

Sincerely

Harry T. Earle M.D.

Region of Peel
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MEDICAL DIRECTOR ANNUAL REPORT TO COUNCIL FOR CALENDAR 2010

February 18, 2011

Ladies and Gentlemen:

The following is my report on the medical status of Sheridan Villa through 2010, with particular emphasis on the establishment of the Special Behavioural Support Unit - SBSU.

Basic Statistics

Resident Population:	101	in January 2010 rising to
	142	by early Fall 2010
Deaths:	27	lower than recent years
Falls:	139	without injury
	41	with injury
Aggression:	49	resident to resident *
	23	resident to staff **
Infection Control:	0	there were no significant infectious outbreaks through the year

* includes 29 for SBSU

** includes 6 for SBSU

In September 2010 the long awaited renovations to Sheridan Villa were substantially completed and 41 new residents began the process of admission. Rapidly, 22 people were admitted to the traditional long term care beds, now provided in the new design environment, elegant and upscale replacement for the old facility. Nineteen other people were more slowly selected to occupy beds in the new treatment unit designated for transitional care of demented people with behavioural disorders. The residents of this SBSU came from hospitals, other Long Term Care facilities and the community, having met the criteria of: a) progressive dementia, b) prior but failed treatment, and c) inability to live in their situation because of behaviours. It is clear that our unit is a treatment unit and transitional in nature.

To date, the clinical result has been excellent but the flow through is below our expectations. The reasons for this phenomenon are convoluted. Firstly, we are pioneers in this field when one considers administration, funding and regulations. Secondly, in Geriatric Psychiatry through the Local Health Integration Network–LHIN there is a lack of unification between the 3 hospitals, the LTC facilities, and the outreach programs. Each functions alone, disconnected from the others. Thirdly, there are new Provincial regulations which make adaptation in this new unit difficult. As a result, discharges to home or other LTC homes is too slow. New admissions are held up.

Over time, all of these problems can and will be solved. The important fact is that previously hopelessly ill people are being treated, a large gap in our health care of the elderly is being filled, we professionals are learning. The Region of Peel is leading and other jurisdictions will follow. The important requirement is to adjust the funding, the regulations and the clinical behaviour into a cohesive, resident centered, therapeutic force.

Respectfully Submitted:

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

HE - A1-15

TALL PINES
LONG TERM CARE HOME
ANNUAL MEDICAL REPORT
2010

OVERVIEW

Pressures from the community and acute care facilities to admit more complex patients remains as an issue in long term care. As many as 35% of acute care beds contain chronically ill patients waiting for alternate levels of care. Inevitably long term care homes will be asked to assist in accepting these patients to help the flow of acute care in congested hospitals. Our long term care homes will be part of the solution. As indicated last year there is an increase in the complex type of patient. Even a minor procedure such as blood glucose monitoring takes about 5 to 7 minutes each to perform and document. If there are 40 residents in the home with diabetes this translates into 3hours and 20 minutes of work time per day, if each patient is checked only once per day. Often the checks are several times a day. This consumption of time takes away from direct contact needed for other residents. At the same time it research has established that increased person to person contact reduces the incidence of problematic behaviours such as aggression or agitation for example.

BASIC STATISTICS

Deaths in the past year: 32
Falls: 455
Transfers to hospital:76 of which 6 were admitted.
Outbreaks 0
Infections: Respiratory 28
Urinary 63
Open wounds and ulcers: 14
Aggression: Resident to resident occurrence 50
Resident to staff occurrence37
The number of falls has increased. This is believed to be due to the increasing frailty of the type of resident being serviced as well as increased diligence in reporting. Aggression is probably underreported as some incidents are minor or cause no ill effect.

SIGNIFICANT ISSUES

The increase in the use of the Nurse Practitioner is proving to be effective in the management of medical issues. Transfers to hospital have been avoided.
Family members sometimes have unrealistic expectations of what can be accomplished medically with the elderly in general and in the long term care setting as well.

CCAC applications are being received that have more complex behaviours that cannot be managed in long term care. Complex mental health diagnoses are being referred for long term care as well which are difficult to manage.

The palliative care committee has been working on increasing family and resident participation where appropriate.

SUMMARY

The ongoing pressures to meet the needs of the community remain a continuing trend. There will be a higher ratio of patients with multiple co-morbidities in long term care. As the demographic population that we serve increases, the resources needed to manage them will inevitably increase as well.

Harry T. Earle M.D.

Medical Director