Best Practices in Long-Term Care
Working together towards excellence in resident care

Nurse Practitioners in LTC homes
Clara Nisan, RN, BScN, MN, NP-PHC, GNC(C), RAC-C

A nurse practitioner armed with best practice guidelines (BPG) and backed by institutional leadership can dramatically improve the lives of residents in long-term care, as shown in the results from Mackenzie Health Long-Term Care (LTC).

The results at the home are dramatic: Mackenzie Health reduced transfers to acute care by 45 per cent, enabled accommodation of 15 to 20 residents to palliative care and increased to 30 the number of complex residents receiving hemodialysis on-site, including 17 with G-tubes.

But while the changes led by a nurse practitioner improved care, while better managing spending, they did not come easily at Mackenzie Health LTC, a 168 bed non-profit home in Richmond Hill, Ontario, affiliated with Mackenzie Health Hospital and managed by Universal Care, Inc.

In February 2015, the facility hired a full-time director of care (DOC), clinical services/nurse practitioner (NP) to ensure that residents receive appropriate care in a timely fashion, within the LTC setting, to avoid unnecessary trips to the emergency department and/or admission to hospital. Until then, it was all too common for the home to transfer a large number of residents with complex medical conditions to the hospital.

Mackenzie Health’s LTC team collaborated with Sue Bailey, RNAO’s LTC best practice coordinator to complete gap analyses for multiple BPGs:

- Assessment and Management of Pressure Injuries for the Interprofessional Team, 2016
- Preventing Falls and Reducing Injuries from Falls, 2017
- Prevention of Constipation in the Older Adult Population, 2005
- Promoting Continence using Prompted Voiding, 2011

The team attended the various webinars offered through the LTC Best Practices Program on the subject of pain, continence/constipation, end of life (comfort feeding only), medical cannabis and others. This accumulation of knowledge has helped them to collaborate with acute care and in the care planning.

The NP role initially faced certain barriers such as lack of awareness as well as full understanding of the role from other interdisciplinary team members who have not been fully informed regarding the role and responsibilities of NPs in LTC settings. This is also common among residents, family members, and the general public.

There are also some preconceived notions of NP primary health care and biases against NPs because of the lack of awareness. For example, other members of the interdisciplinary team who are not fully informed about the NP role and have no previous experience working with NPs may not be fully aware of NPs scope of practice. The rapid change and expansion of NPs scope of practice demands consistent efforts to increase the awareness and keep other team members updated.

As an NP, she uses her knowledge about research to collect and evaluate outcome data ensure that goals are met, findings are disseminated and necessary changes are made. A DOC/NP needs to work effectively as a leader to promote the NP role and advocate for LTC residents and their families’ rights. Finally, the role requires NPs to consult and collaborate with interdisciplinary team members, externally and internally.

To overcome barriers, a NP must solve problems quickly and communicate effectively, skills that are essential to continually and accurately assess residents, provide the best care possible and acquire appropriate funding from the Ministry to look after a unique and vulnerable resident population. These tasks require a NP to draw upon her or his clinical background and experience managing...
Editor’s note: Delivering person-centred care in LTC homes through intra-professional collaboration
Suman Iqbal, RN, MSN/MHA, Senior Manager, Long-Term Care Best Practices Program

When professionals collaborate to deliver health care, access is improved and better focused on the needs of those receiving it. That’s why RNAO has long advocated for NPs in LTC homes, efforts that led the Ministry of Health and Long-Term Care (MOHLTC) in 2015 to announce it would fund 75 new NP positions over three years. The goal of MOHLTC was to address the complex care needs of residents by delivering and coordinating services that included proactive assessments and screenings, follow-up care, timely referrals, chronic disease management and end-of-life care.

This newsletter spotlights experiences of some of the NPs working in various roles across Ontario LTC homes. The articles showcase how effective collaboration among health professionals strengthens evidence-informed decision-making through use of best practice guidelines, protocols and resources. NPs and other health professionals’ work together to identify and continuously evaluate the effectiveness and appropriateness of services provided.

LTC homes can utilize the NP role to address the rising complexity of resident care. The NPs are knowledgeable about the care of older adults and can have a positive impact on residents by identifying illness and preventing or slowing its progression.

Through collaboration with health-care teams, NPs drive evidence-informed quality improvement initiatives and support staff with education and mentorship.

In collaboration with their respective LTC Best Practice Coordinator, homes can effectively utilize the NP role to improve resident outcomes and build capacity amongst their staff. The LTC Best Practices program supports LTC homes in adopting evidence-based practices through the implementation of BPGs that support systematic and consistent approaches to providing quality care for residents.

On a personal note, this will be my last editorial note at RNAO. After 30 years of nursing service in Canada I will be retiring at the end of March 2019. I want to take this opportunity to thank RNAO for this opportunity to work with the program during the past four years. I would also like to thank the many staff and leaders from LTC homes across Ontario that have worked with me and supported me to enhance the work done in this sector.

Nurse Practitioners in Long-Term Care Homes

projects and organizations, experiences that she drew upon from 25 years of caring for the geriatric population.

More on the role of the Nurse Practitioner in LTC

The role of the Nurse Practitioner-Primary Health Care (NP-PHC) builds on the five core competencies of an RN, which are professional responsibility and accountability, knowledge-based practice, ethical practice, service to the public and self regulation. The core competencies of an NP further include health assessment and diagnosis, therapeutic management, health promotion, and prevention of illness (CNO, 2011). NP-PHC incorporates evidence-based research into their everyday practice. NPs engage in ongoing professional development and accept responsibility for maintaining competencies as a member of a self-regulating profession and collaborate with other members of the health care team to ensure that patients receive high quality and comprehensive care.

An NP, practises within the Canadian health-care system to their full potential, and that expands accessibility to those who seek care.

The cooperative leadership and interdisciplinary team members in collaboration with acute hospital teams are very happy with the outcome of implementation of this role at Mackenzie Health.

Residents and their loved ones noted greater satisfaction with NPs due to the preventative care; increased time spent explaining diagnoses, treatment, and side effects, which empowered them to manage their health conditions. NPs provide holistic care that address all psychosocial and personal issues. The residents and their families are very happy that they have medical support on daily basis, especially for the prevention of the avoidable transfers to hospital emergency departments.

NP-PHCs in LTC can make considerable quality improvements by providing direct client care through education, health promotion, prevention, and treatment as well as promotion of health and management of chronic conditions through assessment, diagnostics, consultation and referrals to a geriatrician or other specialist as required.
Benefits of intra-professional collaboration

Jonathan de Witte, MN, NP-PHC

Every day registered nurses (RN) play a critical role in determining health outcomes and promoting quality living for residents of LTC homes across Ontario. As the attending NP at Collingwood Nursing Home and Bay Haven Nursing Home, I rely on the RNs to be fully aware of residents whose health status has become less stable and more unpredictable. And, as health among frail and complex LTC residents can fluctuate unpredictably and spontaneously, effective collaboration with RNs is an essential aspect of my role. One goal as attending NP is to improve access to primary health-care services and prevent unnecessary hospital transfers by diagnosing, testing, referring, and treating residents in the home. Since I am caring for more than 120 residents, it helps me immensely to know who to concentrate my efforts on when I'm there.

To illustrate the importance of NP collaboration with RNs, I would like to highlight one nurse in particular who I have the pleasure of working with at both homes. Not only does RN Gurmeet Sekhon usually have all the answers to my questions, she is organized and engaged with the pulse of the facility. Gurmeet knows all of the residents, their relevant medical histories, and their families and friends. Her role at both facilities is clinical charge nurse on the floor and as such, she supervises the provision of ongoing care for residents of the home. Gurmeet also attends other meetings and appointments, and facilitates a seamless flow of relevant health information within both facilities.

Most importantly to me in my role as an NP, Gurmeet has the knowledge, skill, and judgement to care for residents who are experiencing a dynamic change in health status, and, as such she also knows when and when not to refer residents to me for further assessment. Gurmeet communicates in a respectful and professional manner and she also uses vital critical thinking skills when the situation calls for it. For example, she has helped us to avoid unnecessarily testing and treating residents for bacteriuria by providing key information - as over-testing and unnecessarily treating people for urinary tract infections is a common problem in LTC.

Gurmeet also appreciates the collaborative relationship with NPs. In her view, the value of the collaborative relationship is also about how quality of living improves and the need for hospital transfers diminishes when residents have greater access to needed primary care. As stated by Gurmeet, “collaboration with NPs is valued because more details about complex situations can be discussed and articulated in the home.” From this perspective, clear collaboration between RNs and NPs can only serve to benefit quality living for residents in LTC.

Building capacity as a Nurse Practitioner

Heather Woodbeck, LTC Best Practice Coordinator in conversation with Mike Limerick, Attending NP

In August 2016, Mike Limerick moved back to his home town of Kenora to take up the role of Attending NP in two LTC homes – Birchwood Terrace and Pinecrest LTC homes. He brought with him 10 years of experience as an acute care NP in the fast paced emergency room of Winnipeg Health Sciences Centre, and more recently as an instructor in the masters NP program at the University of Manitoba. Using evidence-based practices had been the key to establishing the NP role with physicians and specialists in this tertiary care, academic setting.

The first order of business in his new job was to assess the situation in the LTC homes. Initially, he encountered some lack of understanding and knowledge of the new NP role. The biggest area of challenge was that registered staff were not working to their full scope of practice and generally lacked an appreciation of the importance of evidence based practice. A major gap in wound care was that the accepted practice had become to send all residents with wounds to the wound clinic at the local hospital for assessment. Transferring was disruptive for residents and expensive for the health-care system. Limerick strongly felt that LTC nurses had the capacity to do wound care for their residents.

As part of the NP role, he began assessing and treating residents’ wounds within the homes. He championed evidence-based practice among team members. He helped registered staff to understand that they do not need a physician’s order for a
Building capacity as a NP…

wound dressing. He brought together team members to brainstorm individualized approaches for wound care. The physicians at the hospital soon appreciated their decreased workload. Closing wounds in-house helped residents to have a better quality of life.

Limerick demonstrated his commitment to ongoing education by enrolling in the University of Toronto’s International, Interdisciplinary Wound Care program. Since it is difficult to get nurses off the floor for training, he started doing a lot of ‘just-in-time’ one-on-one education. With his new knowledge, he implemented electrical stimulation as a modality for residents with chronic non-healing wounds. The latest success has been in bringing a surgeon into the LTC home to assess and treat wounds.

Along the way, Limerick noticed a huge gap in palliative and end-of-life care. He collaborated with his LTC homes and me as the RNAO’s LTC Best Practice Coordinator to do a gap analysis for the BPG End-of-Life Care During the Last Days and Hours, 2011. Next, he developed for staff an end-of-life protocol that clearly described the medications and end-of-life care. This “enabler” helps to guide registered nurses to give symptomatic palliative care medications in a more timely way by having non-registered and registered staff monitor hourly for physiological indicators of pain, dyspnea and agitation. This standardized and improved approach to palliative care in the two LTC homes had a second, unintended benefit: family members received more psychological support from staff monitoring residents more regularly. Limerick continues to drive best practices by serving as a member of the local palliative care committee.

Most recently, he tackled the issue of overprescribing of antibiotics for urinary tract infections (UTI). Antibiotics often seemed to be prescribed for behaviours, rather than true UTIs.

First, Limerick asked management to remove all urine dipsticks as these are no longer considered best practice. He challenged the nurses to use their critical thinking skills, by systematically asking questions to determine whether the resident actually needed treatment. Since using this approach, the use of antibiotics has dropped dramatically and there have not been any cases of missed urinary sepsis.

In reflecting on two years of practice, Limerick has come to believe that LTC is an area where NPs can make a critical difference in people’s lives. Residents need to have timely access to acute chronic care for complex needs and symptomatic palliative care. In his view, the NP role is about building capacity in team members, so that every team member can efficiently work together to their full scope of practice.

Nurse Practitioner Interest Group (NPIG): RNAO Membership – Interest Groups

RNAO represents all RNs, NPs and nursing students in Ontario. Nurse Practitioner Interest Group (NPIG), co-chaired by Larissa Gadsby, RN (EC), BScN, MScN, NP-Pediatrics, and Mae Katt, PHC-NP, HBScN, MEd, is RNAO’s interest group that represents NPs in Ontario. NPIG’s objectives are:

- To advance the voice of nurse practitioners within the RNAO and promote a strong, collective nursing voice by adhering to RNAO’s mission and values
- To advocate for healthy public policy on issues related to nursing, health and health care, providing a nurse practitioner perspective
- To facilitate a place for networking and leadership for nurse practitioner members of RNAO
- To foster leadership, advocacy, and capacity building skills among nurse practitioners by empowering them to take action on issues that affect the nursing profession and the public they serve

NPIG welcomes all NPs, NP students, RNs and undergraduate nursing students to join their group to be part of the process to shape policies that affect NPs and the clients they serve. Membership fee is only $25 for RNs and NPs. For undergraduate nursing students, the fee is only $10. To join RNAO/NPIG, go to MyRNAO.ca/join or call 1-800-268-7199.
Nurse practitioner role in long-term care: Models of Care

Susan Clark, NP-PHC, MScN, Attending NP

I am sharing my insights as a NP who has worked in both the Attending NP role and the Nurse Practitioner Led Outreach role (NLOT) in LTC. Several NP program models over the past 20 years have been implemented. In 1998, Ontario’s MOHLTC announced a pilot project to support the placement of NPs in LTC. Introduced in 2008, the Ministry provided funding for the first NLOTs across the province. In June 2015, the Ministry announced it would once again; begin implementing nurse practitioners in full-time attending roles within selected LTC homes across Ontario. Over time, it has become apparent that nurse practitioners are an efficient resource to manage exacerbated chronic conditions on site by supporting LTC staff and reducing avoidable transfers to emergency rooms.

The NLOT and Attending NP roles strive to provide timely, comprehensive clinical care for increasingly frail elderly residents with multiple co-morbidities, complicated by one undeniable factor, dementia.

Working as an Attending NP, I have come to understand that dementia care requires time, patience and unlimited compassion. Each member of the team must be carefully chosen. Those taking on the daunting daily duties must come to work fully prepared, dedicated to giving everything of themselves, then leaving at the end of day just a little more humbled, exhausted and thankful for everything they’ve learned about themselves, and working with this unique, vulnerable population.

As an attending NP, I offer consistent day-to-day clinical support to residents and their families. One of the most rewarding aspects of my role is the opportunity to collaborate with staff and physicians to improve outcomes for residents. The moment a resident feels ill or has a small change in health, the RN or NP (or both) can assess the situation, collaborate and ultimately establish earlier diagnosis and treatment. I cannot over-state the impact and value added by being present and available as a clinical resource to staff and physicians on a day-to-day basis. Whether in the attending or NLOT role, NPs enhance care when they building trust with interdisciplinary team members, residents and families. Improved planning and a systematic approach would ensure more successful implementation of new NP roles. For nurses, the NP is a liaison, mentor, role model and clinical leader. For LTC homes whose physicians lack the time to continually monitor care, NPs form a critical link to ensure the needs of residents are dealt with directly and effectively.

Regardless of the NP model chosen, NPs must have a voice in the governance and operations of a workplace. Funding models need to reflect the health needs of residents, support interprofessional collaboration, enable NPs to practise at full scope and place the focus on residents and their needs. Only then will barriers to practice and care be eliminated.

Evolution of the NP role in Ontario

1973 NPAO was founded in Ontario

Early 1970s Establishment of NP role to fill the physician shortage

1973 NPAO was founded in Ontario

1978 Ontario legislature established Primary Health Care NPs as a new class of Registered Nurse

1998 Ontario introduced the Nurse Practitioner-Led Clinic model

2006 Canadian Nurse Practitioner Initiative formed

2007 Government of Canada approved the New Classes of Practitioners Regulations, granting NPs authority to prescribe, administer and provide controlled drugs

2012 Ontario funding 75 Attending NPs in LTC homes

“Over time, it has become apparent that nurse practitioners are an efficient resource to manage exacerbated chronic conditions on site by supporting LTC staff and reducing avoidable transfers to emergency rooms.”

– Susan Clark
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- Assessment and Management of Pain
- Assessment of Pressure Injuries for the Interprofessional Team
- Crisis Intervention for Adults Using a Trauma-Informed Approach, 3rd Ed.
- Integrating Tobacco Interventions into Daily Practice, 3rd Ed.
- Person-and Family-Centred Care
- Preventing Falls and Reducing Injury from Falls, 4th Ed.
- Promoting Safety: Alternative Approaches to the Use of Restraints

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