

# Best Practices in Long-Term Care

Working together towards excellence in resident care.

Spring 2010  
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## Linking Best Practices with Quality Improvement

By **Josephine Santos, RN, MN**

**Program Manager, LTC Best Practices Initiative**



Josephine Santos

In November 2009, the Long-Term Care Best Practices Initiative received the Minister's Award of Excellence for Innovation for Improving Quality and Patient Safety. Although this news has been featured in several RNAO

publications, I would like to highlight it here in our very own newsletter in order to share this award with all the Long-Term Care (LTC) homes and the staff in the sector. Our Initiative has been successful because you have welcomed us into your homes and have worked with us in various creative ways to bring best practices to the point of care. I would like to congratulate my team of LTC Best Practice Coordinators and all of you who work in the LTC sector for your dedication and commitment to improving quality and resident safety using best practices.

Since the category of the award that we received was on improving quality and resident safety, our team has decided to focus this issue of our newsletter on best practices and quality improvement collaboratives. Over the past year, our team has been involved with many LTC homes in implementing best practices using the quality improvement collaborative methodology.

In this issue, we learn from two LTC homes (The Cardinal Ambrozic Houses of Providence and Sun Parlor Home) that were involved in the Pressure Ulcer Awareness and Prevention (PUAP) Collaborative. They share how quality improvement methodology used to support guideline implementation significantly reduced the prevalence of pressure ulcers by over fifty

percent during the year they participated in the Collaborative. The PUAP Collaborative is a partnership between the Ministry of Health and Long-Term Care, Ontario Health Quality Council, Canadian Association of Wound Care and RNAO.

Carleton Lodge, one of the LTC homes involved in the Improving Continence Care Collaborative (IC3) through the Seniors Health Research Transfer Network, also shares with us their challenges in participating in a Collaborative. They describe how they overcame these challenges and how proud they are of the improvements that they were able to achieve in residents' quality of life by implementing strategies they learned in IC3.

The work being done in the Bridges to Care Project, a Ministry of Health and Long-Term Care funded initiative through HealthForceOntario, is also highlighted in this newsletter. LTC homes in the North West and East Regions such as Pinewood Court, Helen Henderson, Rideaucrest, Providence Manor, Maxville Manor and Residence St. Louis share their quality improvement experiences and the significant progress they have made in reducing transfers to acute care for pneumonia, reducing falls, improving resident focused communications and reducing the behavioural and psychological symptoms of dementia during mealtime.

The Davis Centre and Kristus Dārzs Latvian Home, two of ten Ontario homes in a group of 32 from across Canada that participated in the National Falls Collaborative led by

RNAO and Safer Healthcare Now!, share with us the importance of team work and measuring progress within the Collaborative as well as having the opportunity to engage in discussion with colleagues in order to share ideas.

The four articles featured in this newsletter illustrate how quality improvement methodology using a collaborative approach to implement guideline can significantly improve resident outcomes. This approach is gaining more popularity in the LTC sector and as more LTC homes participate in the Ontario Health Quality Council's Resident First Project, we will definitely have more stories to share.



RNAO received the Minister's Award of Excellence Innovation for Improving Quality and Patient Safety at the November 2009 Celebrating Innovations in Health Care Expo for its innovative program, "Strategies to Support Long-Term Care in the Uptake of Best Practices."

# PUAP Collaborative Results in Significant Decrease in Resident Pressure Ulcers

By Beverly Ann Faubert, RN, BScN, Long-Term Care Best Practice Coordinator, South West Region and Susan Bailey, RN, BA, MHScN, Long-Term Care Best Practice Coordinator, Toronto Region

The Pressure Ulcer Awareness and Prevention (PUAP) Collaborative was a one year program that involved 30 Long-Term Care (LTC) homes from across Ontario. This initiative married evidence-based clinical practice from the RNAO best practice guidelines and the Canadian Association for Wound Care PUAP program with quality improvement methodology shared by the Ontario Health Quality Council (OHQC). The Collaborative was funded by the Ministry of Health and Long-Term Care and its AIM was to reduce the incidence and prevalence of pressure ulcers to zero with a midway target of a reduction of 50%. Here are the experiences of two of the participating LTC homes:

## ***The Cardinal Ambrozic Houses of Providence***

The Cardinal Ambrozic Houses of Providence at Providence Healthcare was one Toronto LTC home that joined the 2009 PUAP Collaborative. Myrna Loyst, Resident Care Manager, relates that The Houses was able to realize their personal AIM of reducing pressure ulcers by 50% within four months. Other positive outcomes of belonging to the PUAP Collaborative included team development, strengthening of assessment skills and facilitation techniques. Ongoing team leadership is evident as staff continue to gather together for weekly wound and skin rounds for residents at high risk of pressure ulcer development, as determined by the Braden Scale. Staff, and many residents and families are benefiting from the learning sessions which were offered by the PUAP Champion Team.

## ***Sun Parlor Home***

Sun Parlor Home in Leamington met and dramatically exceeded their AIM of having a 50% reduction in pressure ulcers by June 2009 and are now working towards sustainability and spread.

High risk rounds were done weekly by the Improvement Facilitator, Sharon Beggs, RPN, a dietitian and physiotherapist. Sharon indicated that by using the Braden scale, the team discussed the care of residents who had a high risk score and developed a plan of care to address identified pressure ulcer risks. For example, if the high score was due to moisture, a strategy was developed to address moisture, reducing the risk score from high to moderate. When a high score was due to reduced mobility, the physiotherapist helped determine what appropriate actions could be taken to improve mobility, turning and positioning, reducing the score to moderate. Staff followed a turning schedule that identified when residents had been repositioned. When residents were positioned on their left side at the end of a shift, the turning schedule had been followed. Any residents sitting in a chair at the end of the shift were also repositioned. Sun Parlor Home no longer has residents with high risk Braden scores.

The Quality Improvement (QI) methodologies used included the Defect Checklist and Plan-Do-Study-Act (PDSA) cycle to assess and develop change strategies. The Defect Checklist used throughout the facility for two weeks helped determine why staff were bringing in their own soap products for use on residents, rather than using the pH balanced soap provided by the Home. Staff was asked to provide the reasons why they did not use the supplied pH balanced soap, which is a best practice guideline recommendation. They were instructed to select only one reason from an established list. There were 10 reasons provided, however, 50% of staff indicated there was urine or body odour after being bathed. A new trial using a different pH balanced soap product for a few weeks will be completed followed by another checklist. This demonstrates the use of a PDSA cycle to test a change. This example also demonstrates one of the key principles testing a change, to test on a small scale.



"Wear your Pajamas to Work Day" at the Houses of Providence was a way to make it fun for residents and staff to change the routine for the morning and get all the skin assessments done.

Integrating Resident Assessment Instrument – Minimum Data Set (RAI-MDS) with PUAP resulted in staff studying a sample of residents on a unit to determine if those who are deemed independent with repositioning are actually turning themselves during the night.

A non-registered staff member assesses to see if residents classified as being independent turn themselves during the night. It was discovered that one of the residents did not turn at all during the night, resulting in a referral to physiotherapy to improve the plan of care for this resident.

Due to the training received in QI methodology and improvement facilitation, Sharon has been selected as the Improvement Facilitator for other projects including improving dining and meal times, reviewing the job posting process, Residents First and least restraint/falls. Sharon states she enjoys the quality initiatives as they create better care for residents and help to ease the nursing workload a little bit too.

Eighty-two percent of LTC homes involved in the PUAP Collaborative were successful in reducing pressure ulcers by fifty percent over their Collaborative year, reported by Maryanne D'Arpino, OHQC's Improvement Facilitator Lead. Ongoing support is available from internal improvement facilitators, the Residents First legacy group and RNAO LTC Best Practice Coordinators.

# Improving Continence Care Collaborative (IC3) in Ontario Long-Term Care Homes

**By Heather Woodbeck, RN, HBScN, MHSA  
Long-Term Care Best Practice Coordinator,  
North West Region and Co-lead, IC3**

Improving Continence Care Collaborative (IC3) is a 3.5 year old Community of Practice (CoP) that has involved over 20 Long-Term Care (LTC) homes in Ontario using quality improvement methods to make measurable improvements and sustained changes in continence care. IC3 is funded by the Seniors Health Research Transfer Network (SHRTN). RNAO has been the sponsor for the CoP for the last year.

IC3 Phase III included seven LTC homes from Ottawa, Hamilton and Toronto areas who met over a one year period from June 2009 to May 2010. Participants were a mix of urban and rural homes including:

- Baycrest Jewish Home for the Aged-Apotex Centre, Toronto, with 372 residents;
- Lakeside Long-Term Care, with 128 residents, which is part of Toronto Rehabilitation Institute and professionally managed by Extencicare;
- Carleton Lodge, Ottawa, with 160 residents;
- Salvation Army Grace Manor, Ottawa, with 128 residents;
- John Noble Home, Branford, with 156 residents;
- Maple View Lodge, Athens, with 60 residents; and,
- Rosebridge Manor located near Smiths Falls, with 78 residents.

Carleton Lodge was in the planning phase of making improvements in continence care when Rebecca Séguin, their Best Practice Coordinator, heard about the IC3 at an Ontario Health Quality Council (OHQC) Workshop in March 2009. She was impressed with the stories she heard from other Homes about successfully implementing prompted voiding

with their residents, including those with dementia.

As the Team Leader, Rebecca's first task was to recruit another Registered Nurse (RN), a Registered Practical Nurse (RPN), and two Personal Support Workers (PSWs) to form a Continence team. At the kick-off Learning Session in June 2009, teams met through video conference and participated in sessions on continence and the Rapid Cycle Method of Improvement (RCMI). Carleton Lodge set an aim that was consistent with the overall aim of the IC3 CoP, which was to improve the Quality of Life (QOL) for all residents by reducing prevalence of bowel and bladder incontinence. This first Learning Session was followed with three additional full-day video conference workshops held quarterly. Between sessions, Team Leaders met and shared their activities in monthly teleconferences.

Carleton Lodge had many successes in improving continence in their residents. Starting on their Nepean Unit, they adapted a 3-day urinary assessment tool to assess all of the residents who could use the toilet and needed staff assistance, and used the results to create an individualized toileting schedule for each assessed resident. Next, a toileting worksheet was created which tells staff the time when the resident is to be toileted and allows for communication between staff. By March 2010, ten residents on the unit who were previously incontinent were continent during the day and evening. Other benefits for some residents included: being able to use liners instead of briefs because incontinence became occasional, and a decrease in anxiety as they are aware when staff will be in to assist them with toileting.

Team members are proud of the improvement in the resident's quality of life brought about through the implementation of the program.

Other IC3 teams were also able to implement prompted voiding in their LTC homes. Other successes included: a decrease in constipation by encouraging defecation in a squatting position at the time when the resident is most likely to have a bowel movement; a decrease in the prevalence of urinary tract infections; and, less continence product usage. Most homes noted increased communication with staff and family members with any incontinence issues/concerns.

Carleton Lodge, like many of the other IC3 teams, faced many challenges along the way. An outbreak in the winter stalled progress. At that time, the team focused on holding the gains that they had made by continuing to toilet residents with prompted voiding according to their individualized routines.

Resident Assessment Instrument – Minimum Data Set (RAI-MDS) was a competing initiative that required time as well. However, it also benefited IC3 because by the end of Phase III, all of the teams were able to track their progress using the RAI-MDS questions on bladder and bowel continence. RAI-MDS gives the teams an ongoing way of monitoring continence changes.

Another challenge was getting all staff involved in the continence care improvements. Although it was slow work at times, providing knowledge and skills to better manage continence care, helped staff understand the importance of prompted voiding. Having enough time to work on continence improvements was a big challenge for not only staff, but also for the IC3 team members leading change in the homes. Teams/staff were encouraged to connect with short meetings at different times of the day to accommodate different schedules. Huddles or quick talks at the end of shift helped keep everyone involved in the improvement and working towards achieving the goal of continence.

IC3 Teams learned many lessons along the way related to successful changes leading to improved continence, such as keeping focused on the aim, taking baby steps in moving forward and not giving up. Incorporating the new approaches into orientation programs for new staff has also helped to maintain improvements in continence care.

## Promote urinary continence and prevent constipation

Urinary incontinence is a symptom, not a disease. It is not a natural part of aging.

There are many ways to prevent constipation. Understanding the reasons for constipation is the first step.

Visit <http://ltctoolkit.rnao.ca> to obtain resources on Continence and Constipation.



## The Bridges to Care Project

**By Janet Evans, RN, BScN**  
**Long-Term Care Best Practice Coordinator,**  
**East Region**

The Bridges to Care (BTC) project is a knowledge to practice (KTP) initiative for long-term care (LTC) funded by the Ministry of Health and Long-Term Care through HealthForceOntario. The project aims to facilitate improvements in resident outcomes through the delivery of KTP resources in key areas by trained internal champions and supported by local external facilitators following a quality improvement (QI) model.

LTC homes were invited to submit letters of interest to participate in QI process in one of the three topic areas: falls and osteoporosis, behavioural and psychological symptoms of dementia (BPSD), and LTC acquired infections including pneumonia and bacteriuria. Local project leads performed an environmental assessment on interested sites, resulting in the selection of three homes from Kingston, two homes from Ottawa and one home from Thunder Bay participating in the project.

Each participating LTC home nominated three internal facilitators including a non-registered staff, a registered health professional and an administrative staff member. In addition, each site identified external facilitators with an ability to facilitate the quality improvement initiative. The science of QI was lead and supported by the Ontario Health Quality Council (OHQC) and used to guide the KTP process and workshop development.

In November 2009, Kingston hosted the first KTP two-day workshop where the LTC homes were introduced to the clinical topic, its related resources, and the science of QI.

The QI journey for the LTC homes in this project looked at eight aspects:

- a) Assemble the team – who should be on the LTC QI team?
- b) Define the AIM – what are we trying to accomplish?
- c) Understand the problems – what are our quality issues?
- d) Identify the measures – how will we know if a change is an improvement?



- e) Define the changes – what changes can we make that will result in improvement?
- f) Get ready to test changes – what changes should be tested and implemented first?
- g) Test the changes (Plan-Do-Study-Act or PDSA) – how can we test, refine, and widely implement our changes?
- h) Demonstrate the impact – how do we assess the impact?

These eight QI aspects were the guiding principles for the project which built upon existing knowledge.

Pinewood Court in Thunder Bay developed procedures to reduce residents' transfer to acute care as a result of pneumonia. Their challenge initially was internal stakeholder engagement, but through education, this hurdle was overcome.

Helen Henderson, Rideaucrest, and Providence Manor, all from the Kingston area, used PDSA cycles to develop protocols to reduce the frequency of falls in residents who are known to fall frequently. Aspects that they looked at included staff education, organizational policy reviews, and linkages to existing initiatives within the home.

Maxville Manor in Maxville and Residence St. Louis in Orleans focused their AIM statement on developing strategies to decrease the incidence of BPSD on site. Residence St. Louis focused on mealtimes with environmental and procedural changes providing the greatest success. Maxville Manor focused their AIM statement on resident focused staff communications by using the PIECES 3 question template as a guide.

Facilitators used the projects' educational resources and the principles of adult learning, supported by the fields of appreciative inquiry, coaching and quality improvement, in order to achieve organizational change.

The project developed enhanced relationships through the collaborative process with project and community partners, and fostered a sustainable model of knowledge exchange and transfer within LTC and other sectors.

This collaborative process was demonstrated during the second KTP two-day workshop held in Kingston in March 2010. The participating LTC homes presented their work to date on their respective topics. Significant progress was made in reducing transfers to acute care for pneumonia, reducing falls, improving resident focused communications and reducing BPSD behaviours during mealtime.

Participants expressed satisfaction with the learning that occurred throughout the project. Comments made by the internal facilitators echoed the learning about QI as a new way of thinking. The LTC homes identified the need for a strong AIM statement, and having PDSA cycles that were easy to follow and tracked the QI teams' actions in relation to achieving the AIM.

Overall, the project continues to meet with rave reviews and positive comments from all participants, including internal and external facilitators, community partners and project leaders. Next steps for this project include presentation at key conferences and further project development opportunities for the homes involved.

# What Do Inukshuks, Apples, and Falls in Long-Term Care Have In Common?

**By Heather Thompson, RN, Long-Term Care Best Practice Coordinator, North East Region and Natalie Warner, RN, MN, BFA Long-Term Care Best Practice Coordinator, Central East Region**

The National Falls Collaborative was an initiative of the RNAO and Safer Healthcare Now! (SHN) which involved 32 homes across Canada of which 10 came from Ontario. The Collaborative was structured around four learning sessions in Halifax, Toronto, Montreal and Edmonton with expert and peer support between sessions facilitated by teleconferences and a web based community of practice.

The Inukshuks became the symbol used to identify residents at risk of falling at the Davis Centre in Peel Region. The symbol was a suggestion by one of the care staff on the falls prevention team. It seemed a natural choice because it echoed the Inukshuk at the entry to the building and embodies the home's falls prevention motto "we will stand tall, we will not fall".

Project Granny Smith was the initiative of falls collaborative team at Kristus Dārzs Latvian Home in Woodbridge. Apples which in nature fall from trees, became not only an identifier of falls risk but also a theme associated with all falls changes and events, carried through in materials and snacks provided at events.

The goal of the Collaborative was to reduce the number and severity of falls in long-term care using recommendations from the Best Practice Guideline *Prevention of Falls and Falls and Injuries in the Older Adult* and quality improvement methodology. The focus was on assessment and modification of risk factors and maintaining the dignity of the residents living in the LTC Home while using principles of least restraint.

Participating Homes were encouraged to develop teams which were guided by a change package containing four key interventions which could be effected by four change categories. Key interventions areas included: awareness of level of risk; prevention of falls; falls intervention or actions; and, reduction of injuries if falls occur.

Change categories included: develop standardized routine practice; design system to avoid mistakes; engagement of the resident, family, care provider; and, improve environmental design. The combination of intention and change resulted in a recommended intervention and examples to test. For example, the Inukshuks and apples are exemplars of using symbols to identify residents at high risk of falling.

In order to know whether the goal of decreasing falls and severity of falls was met the Collaborative had a database into which homes entered data on falls each month. Charts generated by the database allowed homes to compare their own progress over time and amalgamated data from all homes within the Collaborative.

Data was an overall measure, but actual practice change was important and the Collaborative encouraged participative strategies such as huddles on units to decrease the falls of individual residents. Lauma Stikuts, Executive Director at Kristus Dārzs Latvian Home explains how statistics alone would not accurately reflect the change. She gives the example of the story of a resident who fell frequently on nights. Staff on this shift met with representatives from the falls team to develop and refine strategies to assist this resident and decreased his falls rate and the Home's fall rate. However, in respecting the resident's autonomy, some falls still occurred – this was still within the goals of the Collaborative but not captured effectively by the statistics.

Barb Swail, Administrator at the Davis Centre, has a similar story about a resident that fell frequently during the evening and on nights and the changes the front-line staff made to try to prevent these falls. In discussing the story, a different message emerges, Barb concludes that: "small things that you do, make a big difference".

A year after closing congress for the Falls Collaborative both homes are still involved in maintaining and growing changes related to decreasing falls and severity of falls although both admit competing priorities are a challenge. Echoing Barb Swail, Lauma Stikuts notes the importance of keeping it on the agenda and "just doing something" toward the effort rather than becoming overwhelmed by not being able to do something large and intense.

*While the National Falls Collaborative wrapped up in May 2009, Safer Healthcare Now! and RNAO are preparing to launch a new free "Getting Started Kit" that shares successful strategies from the Collaborative and provides information on using the SHN database to track your home's falls rate. Information can be obtained from the Safer Healthcare Now! website at [www.saferhealthcarenow.ca](http://www.saferhealthcarenow.ca). There is also going to be a Virtual Falls Collaborative for health care organizations across Canada. Watch out this summer for Calls-for-Participants or contact Brenda Dusek, RNAO Program Manager at [bdusek@RNAO.org](mailto:bdusek@RNAO.org).*

*Visit the LTC Best Practices Toolkit at <http://lctoolkit.rnao.ca> for more detailed stories about the falls implementation at Davis Centre and Kristus Dārzs Latvian Home in the future.*

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**now!**



Prevent Falls and Injuries from Falls





## Welcome to the Team!



RNAO is delighted to introduce Elaine Calvert (left) and Susan Bailey (right) as the new LTC Best Practice Coordinators in the Central South and Toronto regions, respectively. Both Elaine and Sue joined RNAO in January 2010.

## Mark Your Calendars!

### June 7-9, 2010

OANHSS 2010 Annual Meeting & Convention – “Get Inspired”

### June 13-18, 2010

RNAO’s Annual Nursing Best Practice Guidelines Summer Institute

### August 8-13, 2010

RNAO’s Creating Healthy Work Environments Summer Institute

### September 26 – October 1, 2010

Chronic Disease Management Fall Institute

### October 18-20, 2010

RNAO’s Knowledge, the Power of Nursing: Celebrating Best Practice Guidelines and Clinical Leadership

Visit [www.RNAO.org/CentreEvents](http://www.RNAO.org/CentreEvents) for more information!

## Announcements

### Who are the LTC Best Practice Coordinators?

Below is the contact information of the LTC Best Practice Coordinators and their Host Homes.

LTC Region	LTC Best Practice Coordinator	Host Home
<b>CENTRAL EAST</b> Covers: York, Durham, Northumberland, Kawartha Lakes, Peterborough, Haliburton, and Simcoe	<b>Natalie Warner, RN, MN, BFA</b> Mobile: (705) 768-8434 Phone: (905) 579-1777 ext. 235 Fax: (905) 579-3911 Email: <a href="mailto:nwarner@rnao.org">nwarner@rnao.org</a>	<b>Hillsdale Estates</b> 590 Oshawa Blvd. N. Oshawa, ON L1G 5T9
<b>CENTRAL SOUTH</b> Covers: Hamilton, Brant, Haldimand, Niagara, and Norfolk	<b>Elaine Calvert, RN</b> Mobile: (289) 407-9658 Phone: (519) 756-2920 Ext 236 Fax: (519) 756-7942 E-mail: <a href="mailto:ecalvert@rnao.org">ecalvert@rnao.org</a>	<b>John Noble Home</b> 97 Mt Pleasant St Brantford, ON N3T 1T5
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<b>EAST</b> Covers: Renfrew, Ottawa, Eastern Counties, Kingston, Frontenac, Lennox & Addington, Lanark, Leeds & Grenville, and Hastings Prince Edward	<b>Janet Evans, RN, BScN</b> Mobile: (613) 864-0238 Direct: (613) 735-4693 ext. 213 Fax: (613) 735-8061 Email : <a href="mailto:janete@rnao.org">janete@rnao.org</a>	<b>Miramichi Lodge</b> 725 Pembroke St. West Pembroke, ON K8A 8S6
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**RNAO’s Delirium, Dementia and Depression e-Learning Course is FREE and can be found at:** <http://elearning.rnao.ca>

