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Long Term Care

Tuesday, June 5, 2018

Michelle Thompson

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- Registered Nurse for 26 years. Graduate of St. Martha's School of Nursing, BScN from St Francis Xavier University, and MEd (Counselling) from Acadia University
- Worked across the healthcare continuum including acute care, critical care, Public Health, Community Health, youth health, School Health Liaison Nurse with the SRSB and now LTC ☺
- Part time instructor at St FX University in the Distance Nursing Program as well as an instructor within the SON from time to time.
- CEO of R.K. MacDonald since January 2016

Program Area/Scope of Responsibility

- Seniors with complex chronic conditions & dementia
- Some younger adults (under age 65)
- Residents' families (a fully vested partner in care)
- Individuals who are medically stable but require nursing, medical & physical intervention to remain stable
- Individuals who can no longer live in the community with available supports

Key Contacts

- CEO Michelle Thompson: 902-863-2578 ext 233
- Director of Clinical Services: Terry MacIntyre 902-863-2578 ext 272
- RN Supervisor: 902-714-5656

Common Myths – Other Program Areas and Providers

- Myths around scope and number of licensed staff in the facility (ratios particularly at night)
- Limits regarding the care and procedures in LTC is governed by the Homes for Special Care Act rather than ability or preference of the care providers; may assume we have more authority than we do
- Access to primary care providers can be challenging both for onsite assessment and by phone
- As a "government" facility, access to medications, treatments and equipment happens immediately/onsite
- Misunderstanding of why we transfer people to acute care
- DNR does not mean no treatment
- Don't realize that licensed homes have enforced program requirements that are monitored twice yearly at a minimum
- Licensed staff are less skilled or don't require as many clinical skills

Common Myths-Public

- Many still think individual facilities manage their own wait list ("the list")
- Poor understanding of the prioritization of the "the list" and where they are on "the list"
- There is occasionally speculation and concern about how LTC is paid for by the resident (still worry about losing their assets @ times)
- Necessity of an SDM and POA prior to admission
- LTC is the place you go to die…..generally find out that there is a vibrancy and a lot of living in the facilities
- Fear regarding responsive behaviours and quality of care in LTC (stigma)
- Don't realize that licensed homes have enforced program requirements that are monitored twice yearly at a minimum
- Dementia is more than memory loss

Our Realities

- LTC is a dynamic and challenging area of the health care continuum
- Industry shortage of CCA's and licensed staff working in LTC
- Frailty of residents and therefore complexity is increasing related to comorbid conditions
- Very knowledgeable public and increasing expectations from families and residents
- We do not currently have the ability to track and share consistent data regarding the realities which makes it difficult to measure and articulate what's happening in LTC (across the sector)
- Facilities aren't connected in the same ways as acute care facilities in terms of p&p, resources etc….we don't run like the acute care system
- Ageism exists across healthcare and healthcare providers.

Our Realities

- Staff are generally trained to respond to dementia related behaviours
- Do not have appropriate access to training & resources to effectively care for individuals with complex mental health needs
- Mental health, physical disease, cognitive functioning, rehabilitation, palliative care
- Staffing levels vary based on number of residents, level of care, & facility
- Different models for physician coverage/on-call services (e.g. Care by Design, APA, etc.)
- Impossible to operate like hospital due to structure, staffing, services, & available resources (e.g. equipment, medications, etc.).
- Administration have various roles (e.g. clinical admissions & financial accountability)
- Nurses have full responsibility for clinical care of residents & facility (no backup)
- Complexity of care is increasing in terms of physical & cognitive function

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The Challenges

- Disparate ability to measure, record and report information that assists in facility based, local, zonal and provincial decision making
- Increasing complexity for many clients admitted through AP process; risk can be higher and potentially less known prior to admission.
- Pressure to accept people from acute care is ever-present; we have to be aware of the potential risks when we hurry.
- Communication and understanding roles and responsibilities can be difficult at times across the continuum
- Communication, risk assessment, and identifying potential “problems” after admission
- Duplication related to more frequent interfacility transfers (Home of first choice)
- Negative portrayal of nursing homes; good news doesn’t sell

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The Challenges

- Difficulty accessing specialty services, most especially specialty psycho geriatric services.
- Challenges navigating complex organizational structures
- Need for strategic investment in required resources
- Need for a strategic plan for changing landscape & future LTC provision
  - Continuing Care Strategy completion pending

The Opportunities

- More uniform data collection and reporting to communicate and make decisions (Resident Assessment Instrument-RAI Tool)
- Essential to have strong local dialogue and relationships. Opportunities to work together; leverage the knowledge & experience of local partners
- Collaboration to address local issues; can LTC come into the circle of care earlier or potentially for case conferences in complicated transitions
- Acknowledge the experience and expertise in LTC. Often overlooked in the continuum. LTC has much to offer partners- especially around responsive behaviours and the aging process.
- Is there opportunity to have facilities to have a “one door” approach for our collective clients. Are there opportunities to share spaces, economies of scale and become more integrated (How could we measure this?)
- Are there opportunities to work on electronic tools that reduce duplication, particularly around transfers and admissions in relation to Program requirements

Opportunities

- Communication processes with partners to give feedback about transitions to improve the experience for the resident, family and facilities (interagency quality)

Our Offer

- Join the continuing care team earlier to support transitions and effective communication either on an individual case or at a systems level
- Bring our expertise and trainers to partners to support their work and enhance the experience of the client (resident)
- Open to developing different models of access to other providers and processes to improve the continuum; one door concept, providers are welcome to come to us

Our Ask

- Complete and current information regarding the clients
- Honest, respectful feedback about experiences with our services
- Acknowledgement of the sector as an important part of the continuum; raise the profiles, improve understanding and deepen relationships
- Willingness to reshape how we work together with a person and family centred approach
- Consider the impact of policy change on LTC; ensure there is collaboration and the right people at the table to inform how policies that impact the sector.

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Top Priority for Collaboration & Change

- Explore a restructuring of how we do business as a continuum
- Improve transitions to and from facilities through efficiencies and reduction of duplication
- Communication and relationship building is essential
- Highlight the great things that happen in facilities and across the continuum
- Shared resources & expertise
- Equal the playing field for LTC across the province

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Final Comments

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