Alberta Long-Term Care Quality Indicators 2015- 2016

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Introduction: A focus on quality in Long-Term care homes

Residents of Long-Term Care facilities across Alberta must be provided with high quality care. Everyone can play a role in quality. Sharing information about health service quality and success stories are ways that quality of care can be reviewed, monitored and improved. This report on the Alberta Health Services (AHS) website is designed to share such information.

Quality indicators (QIs) flag areas where more attention may be needed to sustain and improve the quality of resident care. QIs are drawn from clinical assessments (known as RAI MDS 2.0 http://www.interrai.org/long-term-care-facilities.html) completed every three months on individuals living in all Long-Term care facilities across Alberta. The information is shared with the Canadian Institute for Health Information (CIHI), an independent, not-for-profit organization that collates essential information on Canada's health system and the health of Canadians.

On June 10, 2015, CIHI began publicly reporting nine Long-Term care QIs focused on safety, appropriateness and effectiveness of care on its public website www.YourHealthSystem.cihi.ca. The website features 45 health indicators, which are reported provincially, by zones and by sites and presented in a way that is accessible to the public. Most of the indicators are already publicly reported by CIHI or Statistics Canada.

CIHI continues to report improvements for several LTC indicators:

- In Canada, the rate for Potentially Inappropriate Use of Antipsychotics in Long-Term Care improved from 32.5% in 2011–2012 to 23.9% in 2015–2016.
- The Canadian average for Restraint Use in Long-Term Care continued to decline, showing an improvement from 13.4% in 2011–2012 to 7.4% in 2015–2016.
- Results for Experiencing Pain in Long-Term Care have also decreased, improving from 12.3% in 2011–2012 to 8.5% in 2015–2016.

Users are able to view and compare results for residents in Long-Term care facilities across Alberta and in other parts of Canada. By sharing information on each facility, region and province can learn from one another to improve the quality of care being delivered to residents.

This report complements the CIHI data and illustrates how Alberta is doing compared to national averages, shows comparisons between zones and describes what actions have already been taken, or are underway to improve care for residents in the zones across Alberta. Actions may take time to make a difference as Long-Term care homes differ, training of staff may be needed and residents vary in their needs, strengths and preferences.

The ongoing public reporting of QIs raises everyone's awareness of good, quality care and flags areas for improvement. Seeing, understanding and using information on quality inspires everyone involved in Long-Term care to do a better job and create good quality of life for residents, their families and caregivers.

Table of Contents:

Performance Measures Dashboard

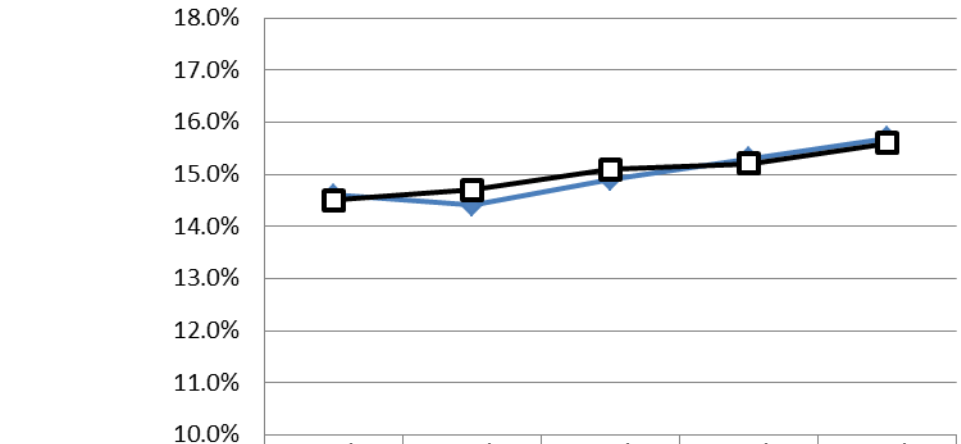
		2014-15 AB Average	2015-16 AB Average	2015-16 National Average [1]	How does AB compare
Safety	**Falls in the Last 30 Days in Long-Term Care (FAL02)** What percentage of residents had an unintentional change in position where they end up on the floor, ground or lower level? This QI captures falls with and without injury. It does not reflect how often residents fall. *A lower percentage is better as it means a lower percentage of residents have fallen.*	15.2%	15.6%	15.7%	Same as Average
Safety	**Worsened Pressure Ulcer in Long-Term Care (PRU06)** What percentage of residents had a pressure ulcer at Stage 2 to 4 and upon re-assessment the stage of the pressure ulcer is greater? *A lower percentage is better as it means resident's stage 2 to 4 pressure ulcers are improving or being maintained at the current stage.*	3.1%	3.2%	2.9%	Below Average
Approriateness & Effectiveness	**Potentially Inappropriate Use of Antipsychotics in Long-Term Care (DRG01)** What percentage of residents received an antipsychotic medication without a diagnosis of psychosis? *A lower percentage is better as it means fewer residents received a potentially inappropriate antipsychotic medication.*	21.1%	18.1%	23.9%	Above Average
Approriateness & Effectiveness	**Restraint Use in Long-Term Care (RES01)** What percentage of residents is being physically restrained daily? *A lower percentage is better as it means fewer residents are being restrained daily.*	8.6%	6.9%	7.4%	Above Average
Health Status	**Improved Physical Functioning in Long-Term Care (ADL05)** What percentage of residents showed improvement in their performance of activities of daily living (walking, transfer, locomotion)? *A higher percentage is better as it means more residents are more independent in certain activities of daily living.*	33.7%	33.0%	31.7%	Above Average
Health Status	**Worsened Physical Functioning in Long-Term Care (ADL5A)** What percentage of residents showed a worsening in their performance of activities of daily living (walking, transfer, locomotion)? *A lower percentage is better as it means fewer residents became more dependent in certain activities of daily living*	35.1%	35.7%	33.1%	Below Average
Health Status	**Worsened Depressive Mood in Long-Term Care (MOD4A)** What percentage of residents had a higher score on the Depression Rating Scale (DRS) upon re-assessment? *A lower percentage is better as it means fewer residents are experiencing depressive symptoms on their most recent assessment compared to their previous.*	29.5%	27.8%	22.3%	Below Average
Health Status	**Experiencing Pain in Long-Term Care (PAI0X)** What percentage of residents has daily, moderate or horrible pain? *A lower percentage is better as it means fewer residents are experiencing such pain.*	7.8%	7.3%	8.5%	Above Average
Health Status	**Experiencing Worsened Pain in Long-Term Care (PAN01)** What percentage of residents has daily, moderate or horrible pain that is getting worse? *A lower percentage is better as it means that there are fewer residents whose pain has gotten worse.*	13.2%	13.5%	10.5%	Below Average

[1] National figures from CIHI as of 2016 includes participation from approximately 60% of Long-Term Care facilities across the country. Results are for the following provinces/territories participating completely in CCRS (SK, BC, AB, ON, NL, YK) and partially (MB, NB, NS).

Please note: This data is from the CIHI all data export preview, dated November 14, 2016.

- CIHI reports their data as rolling quarters for the fiscal year from April 1, 2015 to March 31, 2016**.**
- Alberta is at or above the national average in five out of the nine QIs for Long-Term care.
- The following pages highlight achievements in continuing care in our province and provide examples of quality improvement initiatives underway or planned. These pages will be updated as more information on successful quality initiatives becomes available.
- We are committed to ongoing action to improve and ensure Long-Term care residents have the highest quality of care possible.

Safety: Falls in the Last 30 Days in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	14.6%	14.4%	14.9%	15.3%	15.7%
Alberta Average	14.5%	14.7%	15.1%	15.2%	15.6%

Please note: The axis of this chart does not start at zero, to allow more detail to be seen

Definition

A fall is defined as any unintentional change in position where the resident ends up on the floor, ground or other lower level. The measure is the percentage of residents who had a fall in the last 30 days in a Long-Term care facility.

Understanding this Measure

Falls are a serious health concern as they are one of the leading causes (30%) of hospital admission due to serious injury and about one-third of in-hospital deaths. As people age their risk of falling may increase. Falls may cause a person to lose their independence, or be unable to remain in their own home and they may have a lower quality of life. Many falls can be prevented so it is important to act if a resident's health is changing due to an illness, infection, reactions to medication, or because they are not eating or drinking enough of the right things.

Considerations and Initiatives:

- A falls risk management (FRM) strategy has been put in place in Alberta.
- The goals of the comprehensive FRM strategy are to:
  - Identify who is at risk for falls;
  - Identify ways to prevent unintentional falls;
  - Reduce fall-related injuries; and,
  - Collect information on falls and use it to create and measure programs to prevent or reduce falls.
- AHS has a Falls Risk Management Level 1 Policy and must meet Accreditation Canada requirements for Falls Prevention. This policy can be found at https://extranet.ahsnet.ca/teams/policydocuments/1/clp-prov-falls-risk-mgmt-ps-58-policy.pdf

Examples of initiatives include:

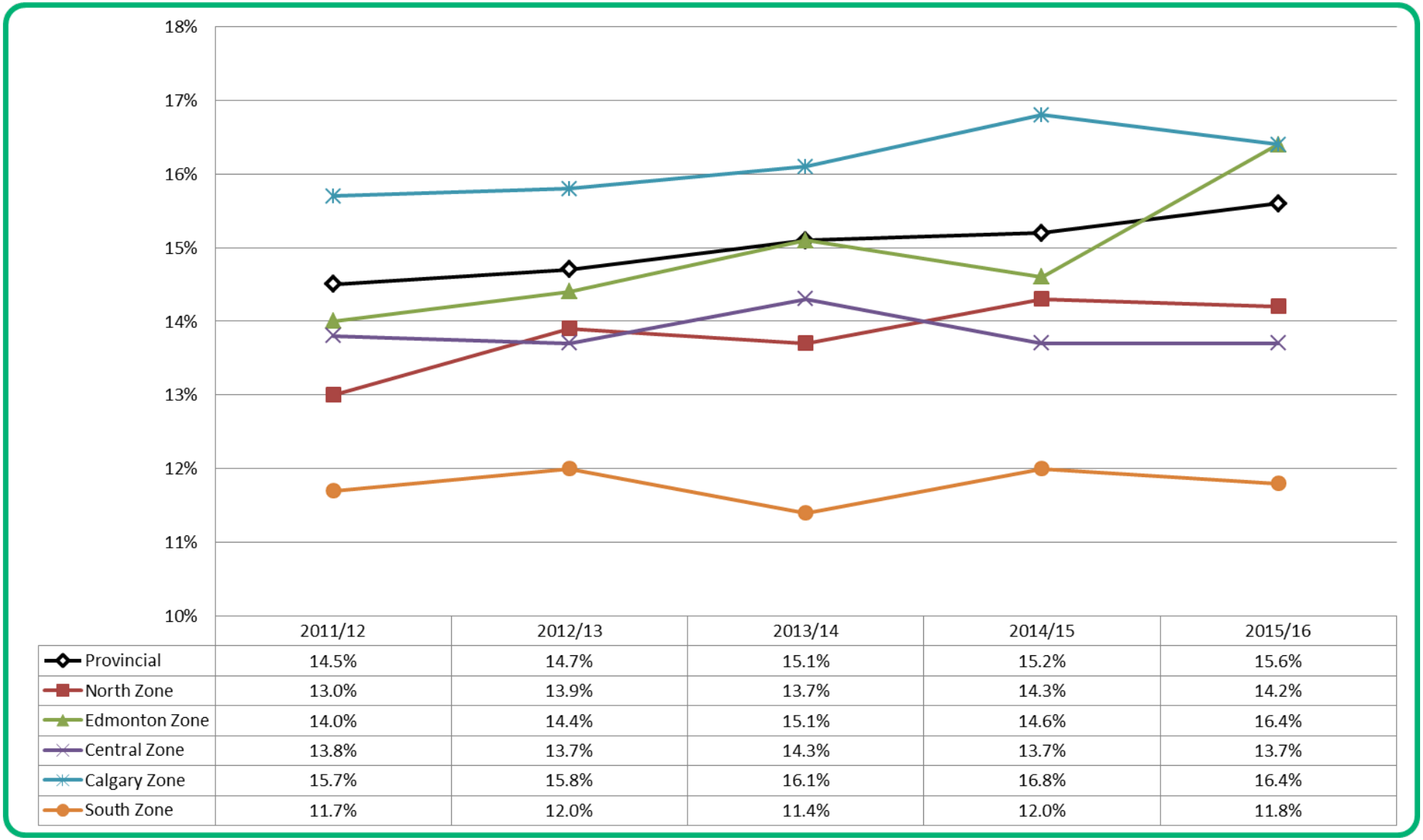
Extendicare Canada has had tools in place for many years to reduce/minimize falls. In 2016 these tools were updated to ensure the approach captured the most recent evidence of Best Practice Guidelines for falls. Tools include updated post-fall assessments, falls huddles and comfort rounds. The following sites have reduced falls rates from Q4 2014/15 to Q4 2015/16:

- Extendicare Fort Macleod 11.7% to 9.4%
- Extendicare Cedars Villa 15.0% to 12.8%
- Extendicare Hillcrest 16.8% to 11.6%
- Extendicare Michener Hill 13.7% to 11.0%
- Extendicare Eaux Claires 15.0% to 12.6%
- Extendicare Holyrood 21.6% to 16.9%
- Extendicare Bonnyville 19.2% to 13.6%
- Extendicare Mayerthorpe 14.5% to 10.1%

At Brenda Strafford Foundation sites in Calgary a falls prevention program "KNOW more falls" was implemented June 2015 consisting of an interdisciplinary care team and education on falls risk/prevention for residents, families and staff. Further work is planned to continue improvements (15.3% to 13.7% at Bow View Manor and 18.7% -15.6% at Clifton Manor) to identify residents at risk for falls. These improvements were gained without an increase in antipsychotic medication or restraint use.

Safety: Falls in the Last 30 Days in Long-Term Care – Zone Details

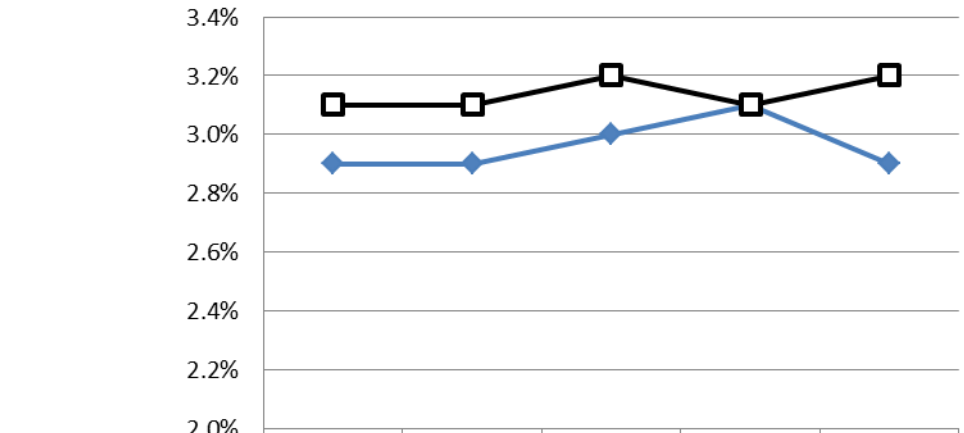
The measure is the percentage of residents who had a fall in the last 30 days in a Long-Term care facility.



	2011/12	2012/13	2013/14	2014/15	2015/16
Provincial	14.5%	14.7%	15.1%	15.2%	15.6%
North Zone	13.0%	13.9%	13.7%	14.3%	14.2%
Edmonton Zone	14.0%	14.4%	15.1%	14.6%	16.4%
Central Zone	13.8%	13.7%	14.3%	13.7%	13.7%
Calgary Zone	15.7%	15.8%	16.1%	16.8%	16.4%
South Zone	11.7%	12.0%	11.4%	12.0%	11.8%

Please note: The axis of this chart does not start at zero, to allow more detail to be seen

Safety: Worsened Pressure Ulcer in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	2.9%	2.9%	3.0%	3.1%	2.9%
Alberta Average	3.1%	3.1%	3.2%	3.1%	3.2%

Please note: The axis of this chart does not start at zero, to allow more detail to be seen

Definition

A pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Stage 2 to 4 wounds range in severity from partial loss of skin layers (e.g. abrasions, blisters) to full thickness of skin and subcutaneous tissue loss with exposure of muscle or bone.

Understanding this Measure

Pressure ulcers that occur and get worse over time may lead to pain and suffering, increased risk for infections, poor general health and even death. A person with a pressure ulcer has three times the risk of dying compared to a person without an ulcer.

If a pressure ulcer is not present when a resident enters Long-Term care, the goal of care is to prevent one from occurring. If a pressure ulcer is present, the goal is to heal or close it. These goals are not always easy or possible to achieve but every effort should be made to do so.

Considerations and Initiatives:

- Research has shown that turning residents, routinely according to a schedule is effective to prevent and heal pressure ulcers.
- AHS has trained pressure ulcer prevention, assessment and treatment teams in all settings (hospital, Long-Term care, designated supportive living, and home living) and specialized teams available to help staff.
- Organizational Practices for Pressure Ulcer Prevention is followed by AHS in all settings (hospital, home, supportive living and Long-Term care).
- A Skin and Wound Care Manual is used and includes education, training resources, assessment tools, outcome scales and prevention strategies for staff to follow.
- Other resources being developed include:
  - AHS Pressure Ulcer Prevention Procedure and Policy;
  - Reporting, tracking and auditing of pressure ulcers; and a
  - Patient/family/caregiver brochure.

Examples of initiatives include:

Revera sites have implemented an initiative using a “How2Trak” mobile application used at the point of care for residents with wounds. The application measures, takes photos and tracks clinical notes. Revera also promotes wounds education for all staff. The following sites have made improvements from Q4 2014/15 to Q4 2015/16:

- Bow Crest Care Centre 2.0% to 0.8%
- Mount Royal Care Centre 1.1% to 0.8%
- McKenzie Towne Continuing Care Centre 3.1% to 1.8%

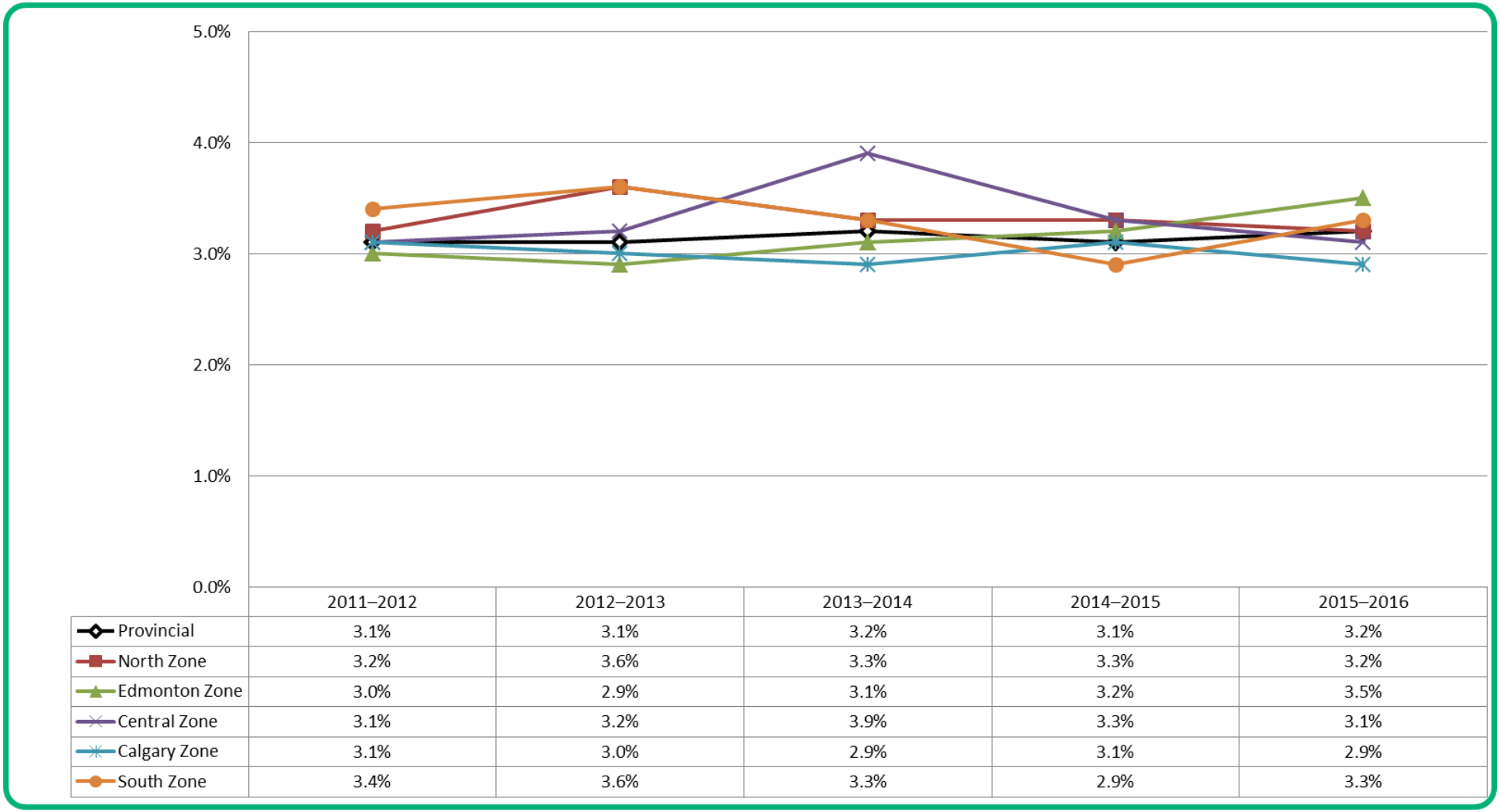
At Revera’s Bow Crest Care Centre in Calgary Zone they have a dedicated wound care team (Registered Nurse and Occupational Therapist), tracking residents with wounds weekly and holding a monthly multidisciplinary wound care meetings.

Brenda Strafford Foundation sites use a trained skin wound assessment team (SWAT) of nurses who follow up on any residents with pressure ulcers to ensure their wounds are properly treated and managed. The wound program was recently reviewed to improve tracking and monitoring by the multidisciplinary team. The following sites have made even more improvements from Q4 2014/15 to Q4 2015/16:

- Bow View Manor 1.0% to 0.4%
- Clifton Manor 1.9% to 1.4%
- Wentworth Manor 2.9% to 1.0%

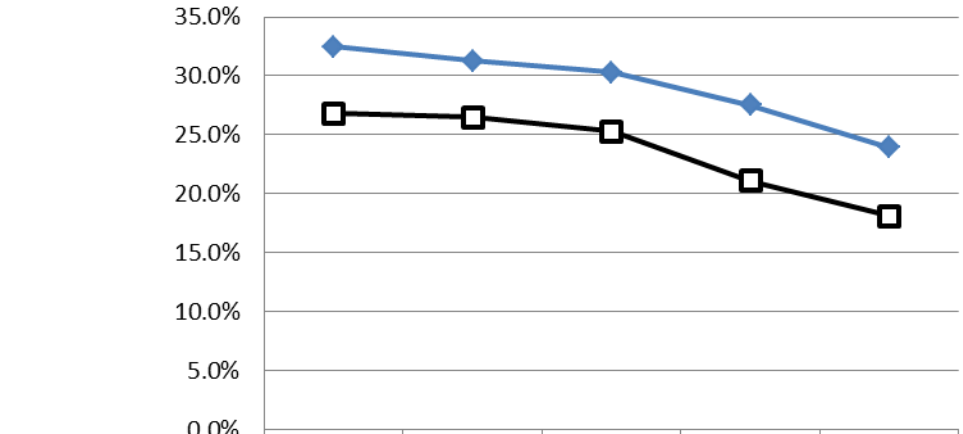
Safety: Worsened Pressure Ulcer in Long-Term Care – Zone Details

The measure is the percentage of residents who had a worsened pressure ulcer in the last 30 days in a Long-Term care facility.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	3.1%	3.1%	3.2%	3.1%	3.2%
North Zone	3.2%	3.6%	3.3%	3.3%	3.2%
Edmonton Zone	3.0%	2.9%	3.1%	3.2%	3.5%
Central Zone	3.1%	3.2%	3.9%	3.3%	3.1%
Calgary Zone	3.1%	3.0%	2.9%	3.1%	2.9%
South Zone	3.4%	3.6%	3.3%	2.9%	3.3%

Appropriateness and Effectiveness: Potentially Inappropriate Use of Antipsychotics in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	32.5%	31.3%	30.3%	27.5%	23.9%
Alberta Average	26.8%	26.5%	25.3%	21.1%	18.1%

Definition

Potentially Inappropriate Use of Antipsychotics in Long-Term Care: A lower percentage is desirable as it indicates a lower proportion of Long-Term care residents who received a potentially inappropriate antipsychotic medication. The frequency of administration or dosage is not factored into the inclusion criteria. If a resident has received an antipsychotic medication once within the seven day look-back period of the RAI-MDS 2.0 assessment, they are included in the QI (providing they do not have a diagnosis of schizophrenia, hallucinations, Huntington's disease or are end-of-life).

Understanding this Measure

Antipsychotics are a class of medications used for the treatment of acute and chronic psychosis. Antipsychotic drugs have been associated with numerous adverse effects (e.g. increased risk of strokes, confusion) and as such, should be used with caution, especially among the elderly. Antipsychotic drugs are appropriate when used in the treatment of chronic mental health conditions such as schizophrenia and to manage psychosis (hallucinations or delusions that are troublesome to the person).

Considerations and Initiatives:

- Accreditation Canada will require Long-Term care facilities to assess the appropriateness of antipsychotic use.
- Alberta has the lowest rate in Canada (18.1%) for this indicator and will strive for ongoing improvement.
- The Seniors Health Strategic Clinical Network (SH SCN) in collaboration with the Addiction and Mental Health Strategic Clinical Network involved 11 early adopter long (see AUA Fall/winter bulletins – beyond 11 sites now) term care units, to reduce the use of antipsychotic medications without a diagnosis of psychosis.
- Read more on inappropriate use of antipsychotics on Healthy Debate.ca.

Examples of initiatives include:

Radway Continuing Care Centre in North Zone is a small facility where staff has close relationships with residents and their families that has helped them reduce potentially inappropriate antipsychotic use from 9.0% (2014/15) to 3.9% (2015/16).

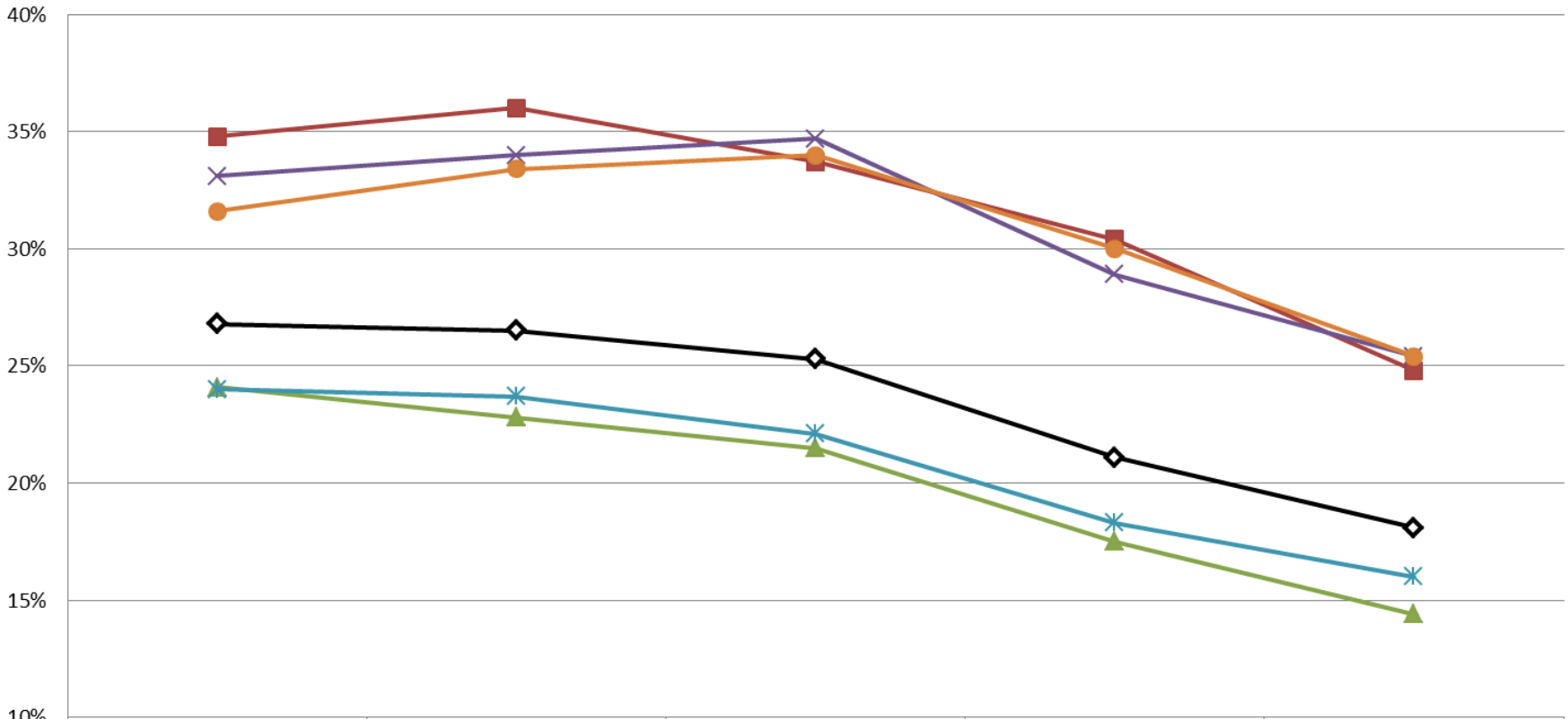
In Drayton Valley Hospital and Care Centre the rates for Residents on Antipsychotics that do not have a diagnosis of psychosis has reduced from 25.9% to 12.5% over the last 5 quarters. The interdisciplinary team review RAI outcomes including antipsychotic medication usage at weekly meetings. The RN's review and complete a monthly Pharmacological restraint form which is discussed with the team and pharmacist. Additionally, PRN's are discontinued when no longer required instead of leaving the option open to use the medication at a later date.

Staff is on board at Points West Living in Grande Prairie and seeing the positive benefits of reducing and discontinuing inappropriate antipsychotic use by using more responsive behaviours, 45.8% (2014/15) to 10.9% (2015/16).

Capital Care sites across the province have also shown improvement overall on this indicator (20.3% in Q4 2013/14 to 13.5% in Q4 2015/16).In addition, Capital Care has been involved in the Seniors Quality of Life (LEAP) research since 2012 and translating the results into resident care.

Appropriateness and Effectiveness: Potentially Inappropriate Use of Antipsychotics in Long-Term Care – Zone Details

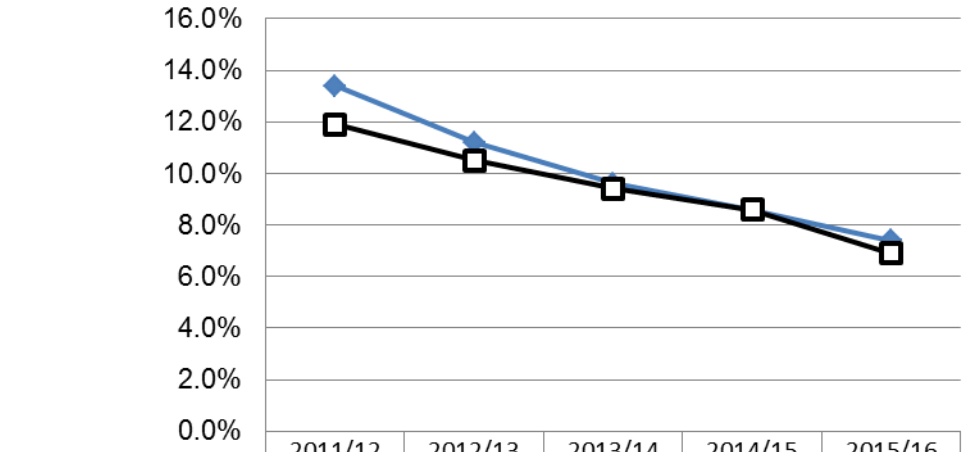
The measure is the percentage of residents who receive an antipsychotic medication without a diagnosis of psychosis in the last 30 days in a Long-Term care facility.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	26.8%	26.5%	25.3%	21.1%	18.1%
North Zone	34.8%	36.0%	33.7%	30.4%	24.8%
Edmonton Zone	24.1%	22.8%	21.5%	17.5%	14.4%
Central Zone	33.1%	34.0%	34.7%	28.9%	25.4%
Calgary Zone	24.0%	23.7%	22.1%	18.3%	16.0%
South Zone	31.6%	33.4%	34.0%	30.0%	25.4%

Please note: The axis of this chart does not start at zero, to allow more detail to be seen

Appropriateness and Effectiveness: Restraint Use in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	13.4%	11.2%	9.6%	8.6%	7.4%
Alberta Average	11.9%	10.5%	9.4%	8.6%	6.9%

Definition

A physical restraint is defined as any manual method, or any physical or mechanical device, material or equipment that is attached or adjacent to the resident's body, that the resident cannot remove easily, and that restricts the resident's freedom of movement or normal access to his or her body. It is the effect the device has on the resident that classifies it into the category of restraint, not the name or label given to the device, nor the purpose or intent of the device.

Understanding this Measure

Physical restraints are associated with negative physical and psychosocial outcomes. If used for any significant period of time, the physical consequences may include loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, social isolation, emotional distress and incontinence. Further, persons who try to free themselves from restraints may fall and be injured. Physical restraints should be used as a last available option after all other supportive interventions have been trialed. Where physical restraint use is unavoidable, the outcomes of the restraint on resident status must be evaluated regularly.

Considerations and Initiatives:

- Restraints should only be used as a last option to protect the safety of the resident, other residents and staff only after all other options have been explored, including the provision of additional care support.
- Alberta Health Services is completing a policy aimed at reducing the use of daily physical restraints with a focus on the care and safety of all residents and staff.
- Accreditation Canada requires restraint use be monitored and limited in use.
- Staffs are trained to apply other methods and if a restraint is used, it is to be on a temporary basis with careful, scheduled monitoring.
- Alberta Long-Term care homes are doing well to reduce and adhere to minimal use of restraints as reflected by the downward trend on the graph.
- If a facility reduces their use of restraints, an unintended consequence could be increased falls, however this risk must be balanced with the potential benefits of improved resident quality of life within a facility.

Examples of initiatives include:

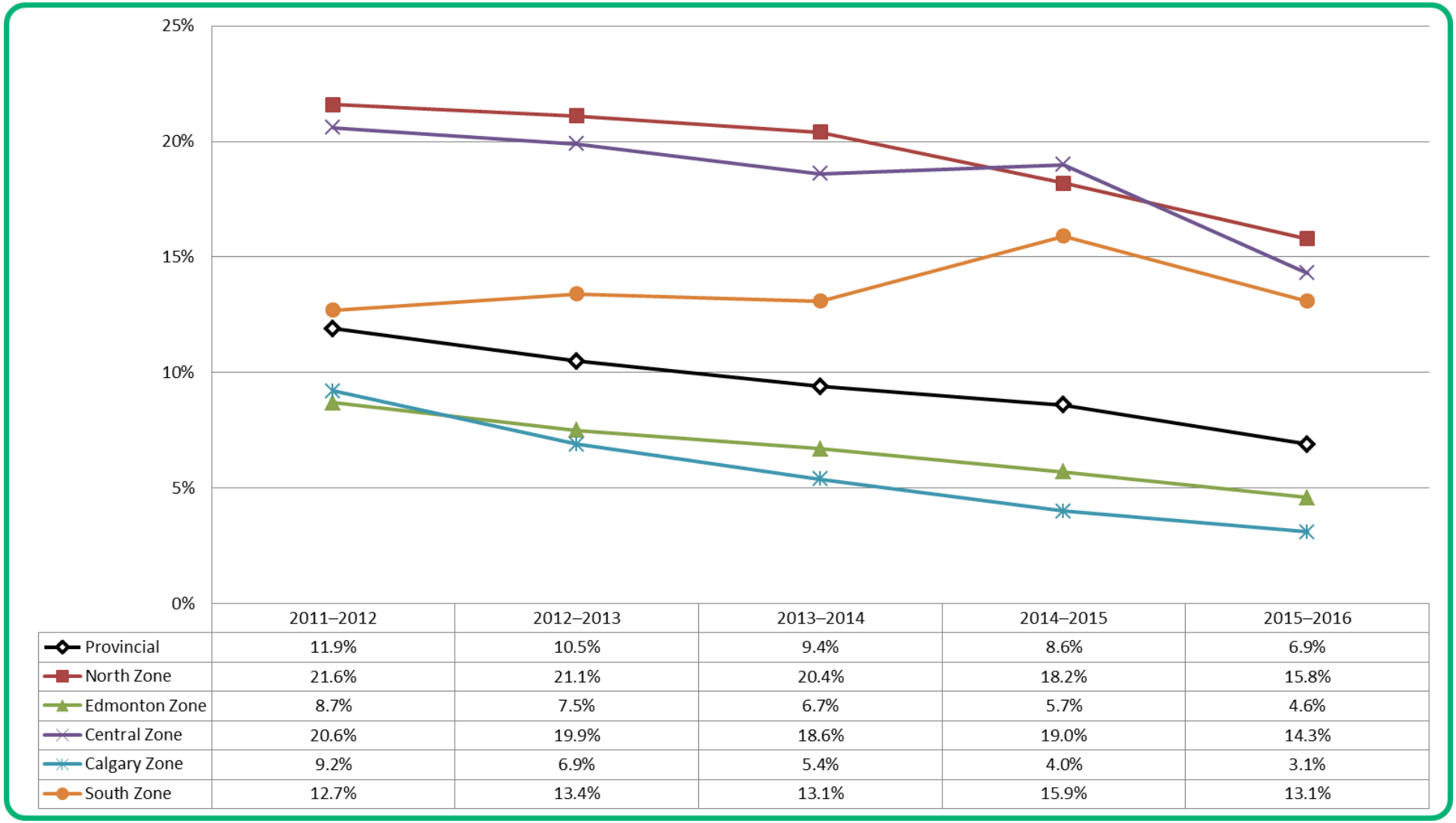
Manning Community Health Centre participated in the Appropriate use of Antipsychotics program, which increased staff awareness of reduced restraint use and alternative behavioural management techniques.

St. Therese-St. Paul in North Zone follows the “least restraint policy”, taking all alternative actions possible, including visible reminders to reduce dementia clients from wandering, rather than using restraints. This is in addition to participating in the Appropriate use of Antipsychotics initiative and has no clients receiving antipsychotic medication without a proper diagnosis.

Extendicare Viking has been restraint-free for so long it is part of their culture! They educate their staff on alternatives to restraints, they also consult their psychogeriatric nurse to assist in sharing alternatives to restraints and they have consistent staff that supports the policy on zero restraints. They speak with families about the fact that everyone lives at risk and that the facility has systems in place to support those residents who are at a high risk for falls such as chair alarms for our most severe cases.

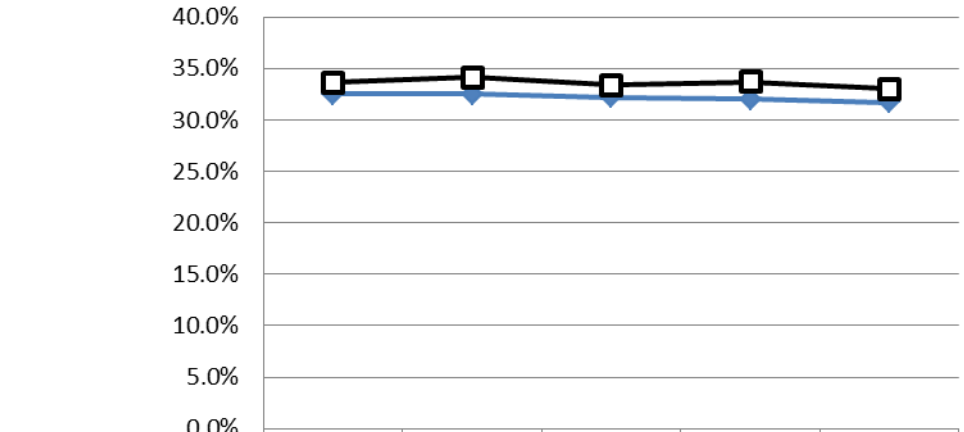
Appropriateness and Effectiveness: Restraint Use in Long-Term Care – Zone Details

The measure is the percentage of residents who are restrained in the last 30 days in a Long-Term care facility.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	11.9%	10.5%	9.4%	8.6%	6.9%
North Zone	21.6%	21.1%	20.4%	18.2%	15.8%
Edmonton Zone	8.7%	7.5%	6.7%	5.7%	4.6%
Central Zone	20.6%	19.9%	18.6%	19.0%	14.3%
Calgary Zone	9.2%	6.9%	5.4%	4.0%	3.1%
South Zone	12.7%	13.4%	13.1%	15.9%	13.1%

Health Status: Improved Physical Functioning in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	32.5%	32.5%	32.2%	32.0%	31.7%
Alberta Average	33.6%	34.1%	33.4%	33.7%	33.0%

Definition

A higher percentage is desirable for a facility because it indicates their residents are improving their mid-loss activities to daily living (transfer and locomotion) and are more independent in these activities.

Understanding this Measure

Activities of Daily Living (ADL) range from dressing and personal hygiene (early loss) to walking, transfer and locomotion (mid-loss) to eating and bed mobility (late loss). The indicator is triggered after the current assessment is lower than the previous assessment (over a period of three months). Most Long-Term care residents are at risk of physical decline and a resident's potential for improvement or optimal ADL functionality is often underestimated by family, staff, or the resident himself or herself. The mid-loss ADLs such as ability to walk and self-transfer are very decisive factors in a resident's quality of life.

Considerations and Initiatives:

- Engaging residents in regular physical activity has many benefits, avoids health complications and prevents decline and loss of independence.
- Staff in Alberta facilities uses ideas from residents and their families to understand their likes and dislikes. In this way, a resident can be engaged in activities that interest them and are most suited to their abilities.
- Movement through activities is a key part of nursing restorative and specific therapeutic recreation, occupational and physical therapy programs in facilities.

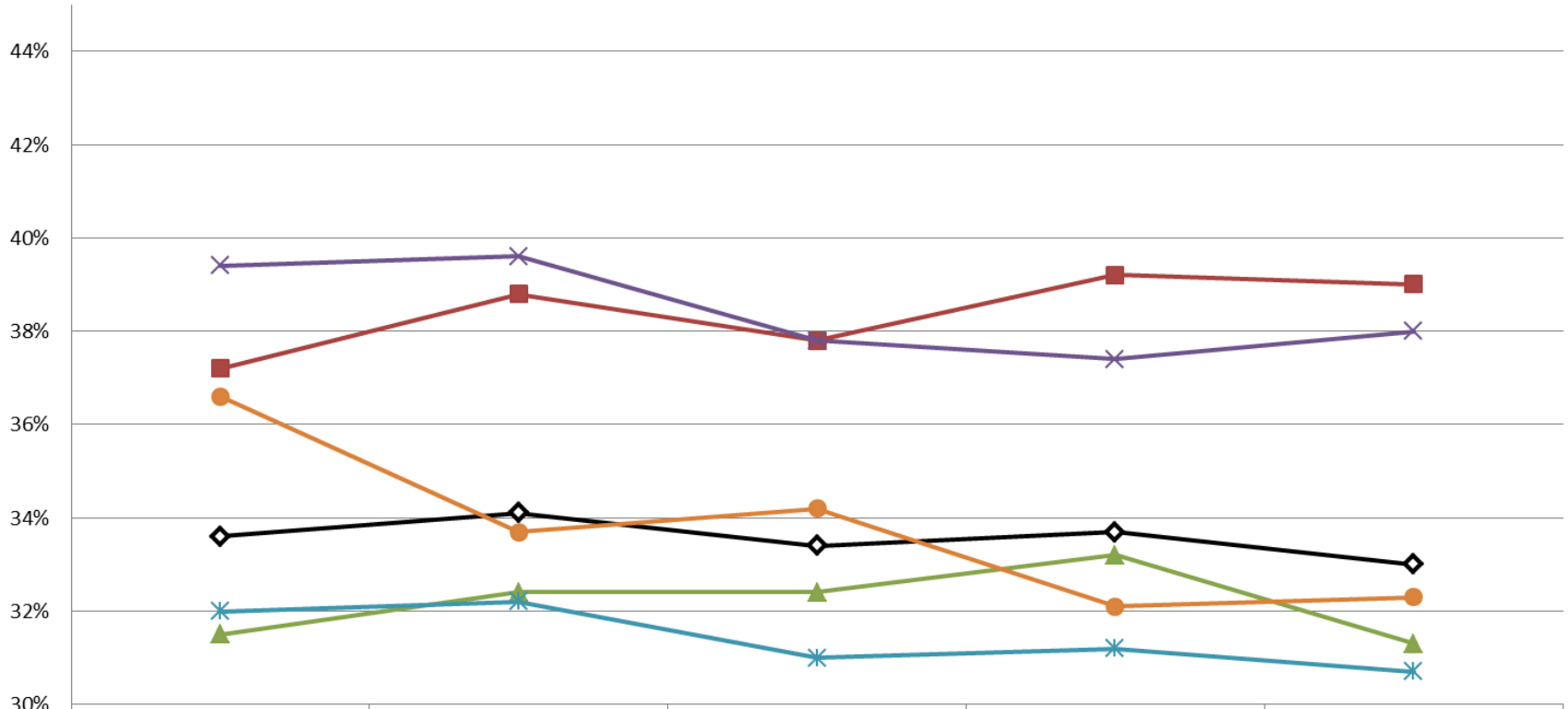
Examples of initiatives include:

Staff at the Dr. W.R. Keir – Barrhead Continuing Care Centre seek opportunities to work together to promote and maintain resident independence. The rehabilitation team provides individualized exercise and strengthening programs to promote independence in mobility and activities of daily living.

Vulcan Community Health Centre has implemented walking programs to help residents stay mobile and by using the Mark assessment for recreation therapy, to help target programing to best assist residents with activities to increase their independence and function. Additionally, the site has RAI champions working collaboratively with residents and their families to ensure those residents' activity goals are documented and achieved as much as possible.

Health Status: Improved Physical Functioning in Long-Term Care – Zone Details

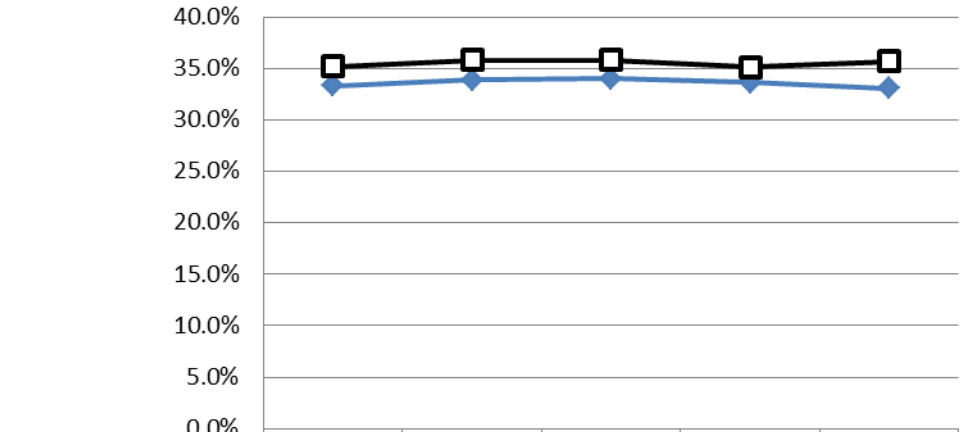
The measure is the percentage of residents who had improved physical functioning in the last 30 days in a Long-Term care facility. **NOTE:** higher is better for this measure.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	33.6%	34.1%	33.4%	33.7%	33.0%
North Zone	37.2%	38.8%	37.8%	39.2%	39.0%
Edmonton Zone	31.5%	32.4%	32.4%	33.2%	31.3%
Central Zone	39.4%	39.6%	37.8%	37.4%	38.0%
Calgary Zone	32.0%	32.2%	31.0%	31.2%	30.7%
South Zone	36.6%	33.7%	34.2%	32.1%	32.3%

Please note: The axis of this chart does not start at zero, to allow more detail to be seen

Health Status: Worsened Physical Functioning in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	33.3%	33.9%	34.0%	33.6%	33.1%
Alberta Average	35.2%	35.8%	35.8%	35.1%	35.7%

Definition

Residents whose mid-loss ADLs worsened get a higher ADL self-performance score on their most recent assessment than the previous assessment (or a maximum score on both previous and most recent assessments) for one or more of three mid-loss ADLs: i) transfers, ii) walk in corridors, and/or iii) locomotion on unit. A higher ADL self-performance score is not desirable as it indicates less independence in these ADLs.

Understanding this Measure

Activities of Daily Living (ADL) range from dressing and personal hygiene (early loss) to walking, transfer and locomotion (mid-loss) to eating and bed mobility (late loss). The indicator is triggered after the current assessment is lower than the previous assessment (over a period of three months). The mid-loss ADLs such as ability to walk and self-transfer are very decisive factors in a resident's quality of life. A lower percentage is desirable as it indicates that mid-loss ADL functioning is worsened in a lower proportion of Long-Term care residents.

Considerations and Initiatives:

- Many residents in Alberta LTC facilities face a number of difficulties remembering, understanding and learning new information.
- The benefit of therapies, recreation activities and nursing/restorative care is a challenge to measure as the residents' potential to improve or at the very least, slow the rate of decline is variable and difficult to measure.
- Residents, like anyone, despite their challenges are more likely to take part in activities they did before, are familiar with / culturally appropriate and ones they enjoy.
- In addition to routine activities available to all residents in a facility, it is also important to target recreation therapy programs (not routine activities) and rehabilitation resources to residents who may be most able to benefit from increased physical activity. In this way, QI information may then show improved results from such targeted care.

Examples of initiatives include:

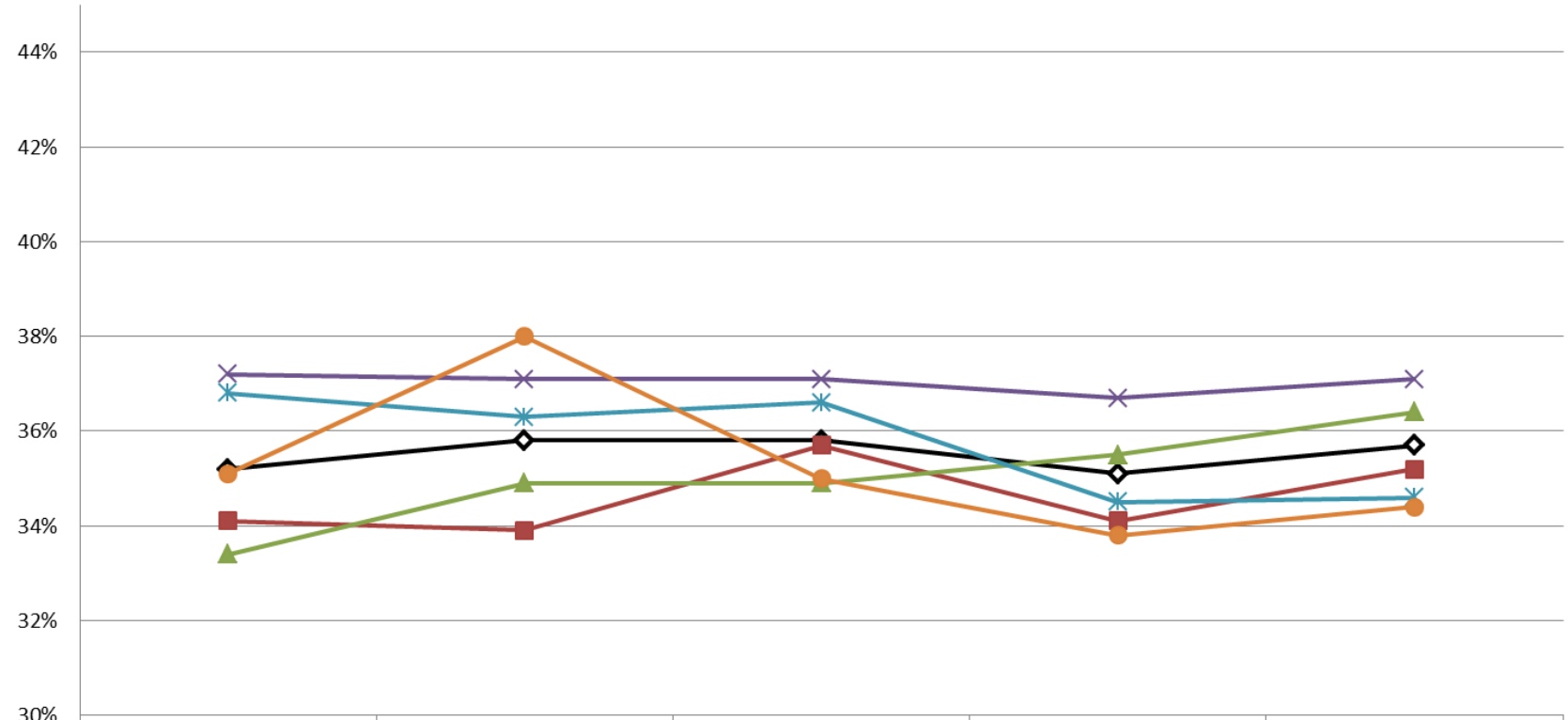
Westview Care Community in Central Zone (Linden, AB) uses their therapy staff to help address the reduced physical function of many of their residents. It is noted that the site's QI results reflects this focus of care, 44.4% (2013-14), 35% (2015-16), and approaching the national average of 33% (2016-17).

Carewest George Boyack in Calgary assesses residents upon admission for capacity and promoting independence and referring to occupational and physical therapy as needed.

Wing Kei Care Centre in Calgary promotes independence for all residents. Wing Kei residents are motivated to participate in activity programs every day and their rehab exercises are tailored to their needs, desires and preferences (with choices for timing for rehab, various types of exercise equipment to choose from, 1:1 or groups such as Balance training, circuit strengthening and cardio spin class). The rehab team to design and implement rehab programs (with goals either to improve or maintain ADL physical functioning) in order to meet individual resident's unique needs, and the team regularly evaluates for progress and positive outcomes.

Health Status: Worsened Physical Functioning in Long-Term Care – Zone Details

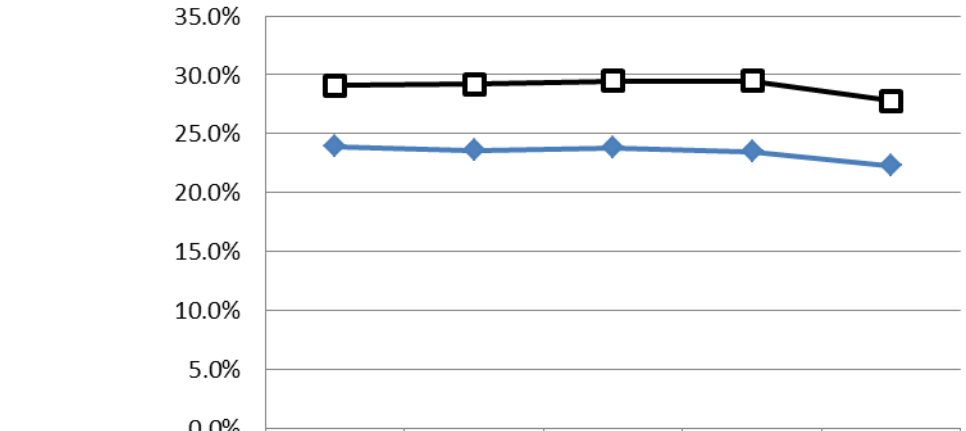
The measure is the percentage of residents who had a worsened physical functioning in the last 30 days in a Long-Term care facility.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	35.2%	35.8%	35.8%	35.1%	35.7%
North Zone	34.1%	33.9%	35.7%	34.1%	35.2%
Edmonton Zone	33.4%	34.9%	34.9%	35.5%	36.4%
Central Zone	37.2%	37.1%	37.1%	36.7%	37.1%
Calgary Zone	36.8%	36.3%	36.6%	34.5%	34.6%
South Zone	35.1%	38.0%	35.0%	33.8%	34.4%

Please note: The axis of this chart does not start at zero, to allow more detail to be seen

Health Status: Worsened Depressive Mood in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	23.9%	23.6%	23.8%	23.5%	22.3%
Alberta Average	29.1%	29.2%	29.5%	29.5%	27.8%

Definition

The Depression Rating Scale (DRS) is a direct output of the RAI-MDS 2.0. It can be used as a clinical screen for the severity of and change in depressive symptoms; it is not a diagnostic tool. If a resident has a score of three or more on the DRS they should be further assessed for a clinical diagnosis of depression. The RAI Clinical Assessment Protocol Manual states that 20% of persons in Long-Term care facilities will have a DRS score of three or higher. Therefore, this QI should not reach 0%.

Considerations and Initiatives:

- This indicator looks at the rate of residents in Long-Term care whose symptoms of depression got worse over a period of time.
- Resident with symptoms of depression often experience significant medical, social and quality-of-life challenges.
- The use of the RAI MDS 2.0 standardized assessment in all Long-Term care homes across Alberta helps staff identify depressive symptoms so that it does not go un-diagnosed and untreated.
- There are many things that can contribute to a mood problem. Staff in Long-Term care facilities has the information from the RAI assessments to identify when a resident is at risk and can then involve mental health professionals in the resident's assessment and care.

Examples of initiatives include:

Edith Cavell Care Centre in Lethbridge has reduced depression by improving education and awareness. Educators are teaching staff through learning fairs, dementia education and non-violent crisis intervention and therapy staff is spending more one-on-one time with each resident.

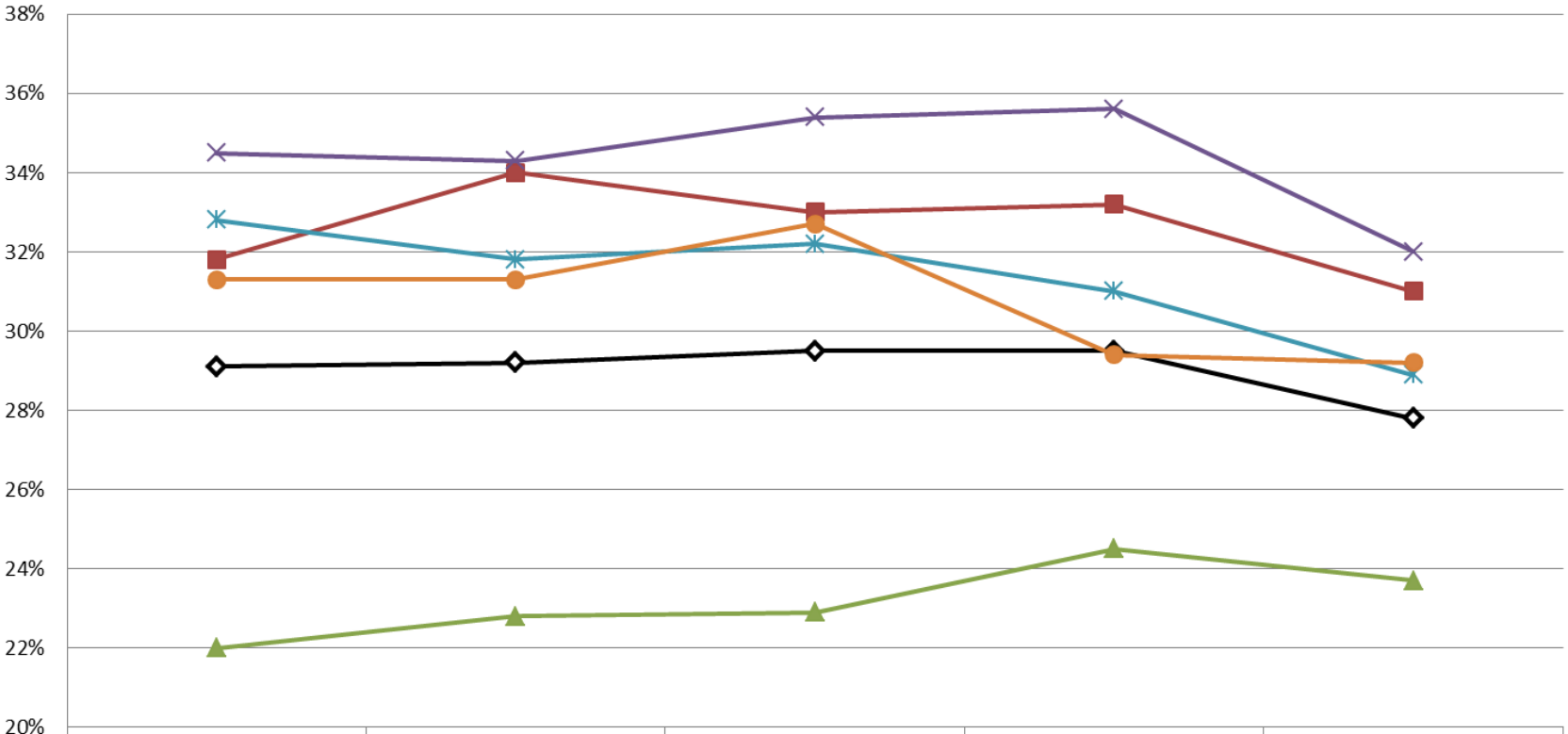
Venta Care Centre uses a whole-person model and ensures that care planning addresses both medical needs and the residents' spirit by engaging residents and their families to identify each person's specific interests and keep them more engaged and less institutionalized. Under this model they have reduced mood symptoms of depression from 17.1% (2014/15) to 10.4% (2015/16).

Understanding this Measure

DRS scores range from 0-14 with higher values indicating that the resident has more numerous and/or frequent depressive symptoms. Symptoms used to calculate the DRS include the resident making negative statements, persistent anger with self or others, expressions of unrealistic fears, repetitive health complaints, repetitive anxious complaints/concerns, sad/pained/worried facial expressions, and crying/tearfulness. Depression is a serious condition and if left untreated is associated with significant morbidity, functional decline and unnecessary suffering by the person, family and caregivers. Residents in Long-Term care are at high risk due to factors including relocation adjustment to the facility, functional impairment (including vision, hearing and speech and ability to participate in activities), socially withdrawal and increased risk of medical illness, cognitive impairment and issues with pain. It is important to identify signs and symptoms of mood distress, as it is very treatable.

Health Status: Worsened Depressive Mood in Long-Term Care – Zone Details

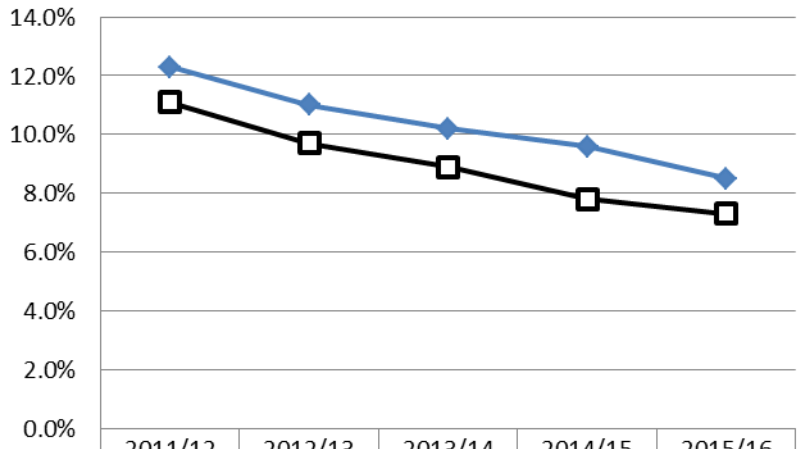
The measure is the percentage of residents who had a worsened depressive mood in the last 30 days in a Long-Term care facility.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	29.1%	29.2%	29.5%	29.5%	27.8%
North Zone	31.8%	34.0%	33.0%	33.2%	31.0%
Edmonton Zone	22.0%	22.8%	22.9%	24.5%	23.7%
Central Zone	34.5%	34.3%	35.4%	35.6%	32.0%
Calgary Zone	32.8%	31.8%	32.2%	31.0%	28.9%
South Zone	31.3%	31.3%	32.7%	29.4%	29.2%

Please note: The axis of this chart does not start at zero, to allow more detail to be seen

Health Status: Experiencing Pain in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	12.3%	11.0%	10.2%	9.6%	8.5%
Alberta Average	11.1%	9.7%	8.9%	7.8%	7.3%

Definition

Pain refers to any type of physical pain or discomfort in any part of the body. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. It is a subjective experience, and the inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment.

Understanding this Measure

Pain directly impacts the resident's quality of life and can impact social engagement, ability to perform activities of daily living, mood and behaviours, and nutrition status. A lower percentage is desirable as it indicates fewer Long-Term care residents who suffer from moderate daily or excruciating pain. This QI is triggered for residents with moderate (a "medium" amount) pain at least daily or horrible/excruciating pain (worst possible pain which can interfere with daily routines, socialization and sleep) at any frequency during the seven day look-back period. Pain experienced outside of this reflective period is not included in the calculation. For residents with chronic pain, if pain management strategies (e.g. receipt of regularly scheduled analgesic or other therapeutic interventions) are effective to the extent that the resident does not report experiencing pain or does not demonstrate behaviours associated with pain, then the resident would be coded as having "no pain".

Considerations and Initiatives:

- This indicator measures the percentage of Long-Term care residents who indicated they were experiencing moderate to significant levels of pain on assessment.
- Pain can have a significant impact of quality-of-life, function and mood, and is not a "normal" part of aging.
- Rates of residents indicating they were experiencing moderate to significant pain have dropped over the last 4 years in Alberta, from 14% to 9%.
- Pain relief for Long-Term care may be due to many factors and must be accomplished in a number of different ways.

Examples of initiatives include:

St. Michael's Health Centre in South Zone has reduced pain in their residents with continued collaboration between residents, families and the pharmacist.

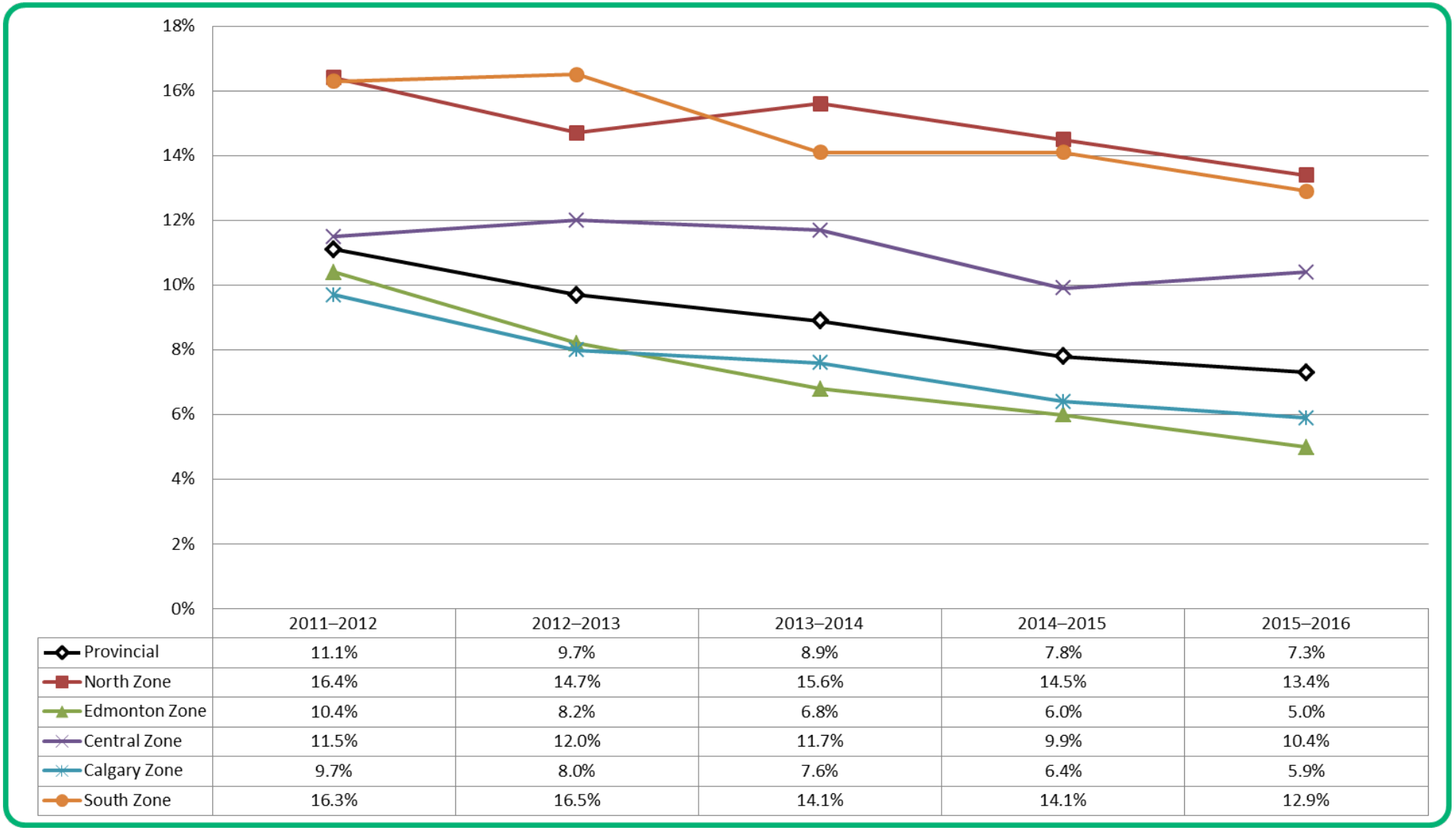
Wing Kei follows up closely with resident's health condition for any experience of pain or discomfort. Residents at Wing Kei actively participate in regular exercise programs and recreation activities to improve their quality of life and reduce their experience of pain. In addition to providing person-centered care, staff is trained to identify pain and support pain management through activities and therapeutic measures prior to pharmacological usage, per resident's choice. 16.2% (2013-14), 13.5% (2015-16) closer to the provincial average with a goal of further improvement over time.

The Diane and Irvings Kipnes Centre for Veterans monitors their quality indicator results for areas that can be improved. Once they eliminated coding errors, they looked how to assess resident pain, strategies to manage pain and document in the individual care plans. While participating in the Appropriate use of Antipsychotic project, they aligned their tools to address pain in the monthly AUA rounds. Pain is addressed in the monthly Interdisciplinary team meetings by embedding pain assessments in various tools, discussing pain treatments and assessing treatment effectiveness.

CapitalCare has participated in the Seniors Quality LEAP initiative since 2013, which includes collaboratively sharing quality improvement strategies and tools with facilities across Canada and the United States.

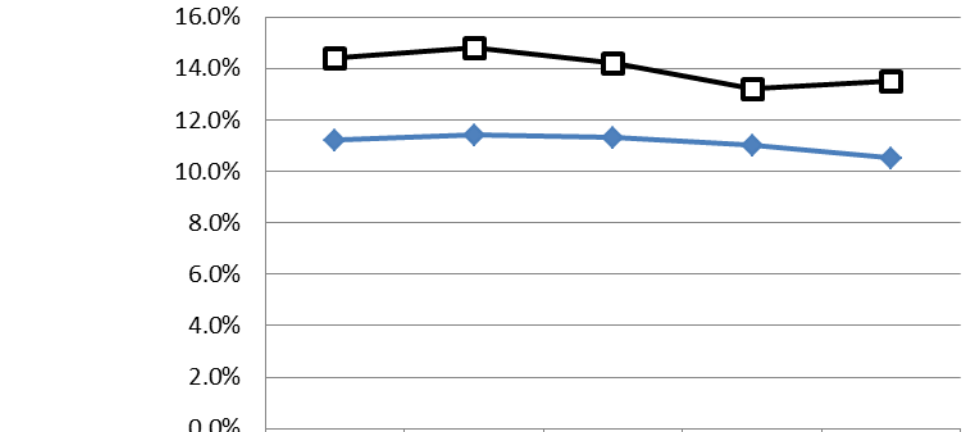
Health Status: Experiencing Pain in Long-Term Care – Zone Details

The measure is the percentage of residents who are experiencing pain in the last 30 days in a Long-Term care facility.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	11.1%	9.7%	8.9%	7.8%	7.3%
North Zone	16.4%	14.7%	15.6%	14.5%	13.4%
Edmonton Zone	10.4%	8.2%	6.8%	6.0%	5.0%
Central Zone	11.5%	12.0%	11.7%	9.9%	10.4%
Calgary Zone	9.7%	8.0%	7.6%	6.4%	5.9%
South Zone	16.3%	16.5%	14.1%	14.1%	12.9%

Health Status: Experiencing Worsened Pain in Long-Term Care – Provincial Details



	2011/12	2012/13	2013/14	2014/15	2015/16
National Average	11.2%	11.4%	11.3%	11.0%	10.5%
Alberta Average	14.4%	14.8%	14.2%	13.2%	13.5%

Definition

Pain refers to any type of physical pain or discomfort in any part of the body. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. It is a subjective experience, and the inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment.

Understanding this Measure

Pain directly impacts the resident's quality of life and can impact social engagement, ability to perform activities of daily living, mood and behaviours, and nutrition status. A lower percentage is desirable as it indicates fewer Long-Term care residents whose pain has worsened. Coding of the RAI-MDS 2.0 assessment uses a seven day look-back period for this data element. Pain experienced outside of this reflective period is not included in the calculation. Clinical judgement is used when assessing pain. If difficulty is encountered in assessing intensity level (i.e. mild, moderate, severe), the clinician will code for the higher intensity level of pain.

Considerations and Initiatives:

- AHS and operators continuously analyze available resident outcome data to find opportunities for quality improvement. Pain is one of these indicates and must be identified and managed in a timely manner.
- Various ways to reduce pain using appropriate medications and medication dosing times and alternative therapeutic methods are used and monitored.

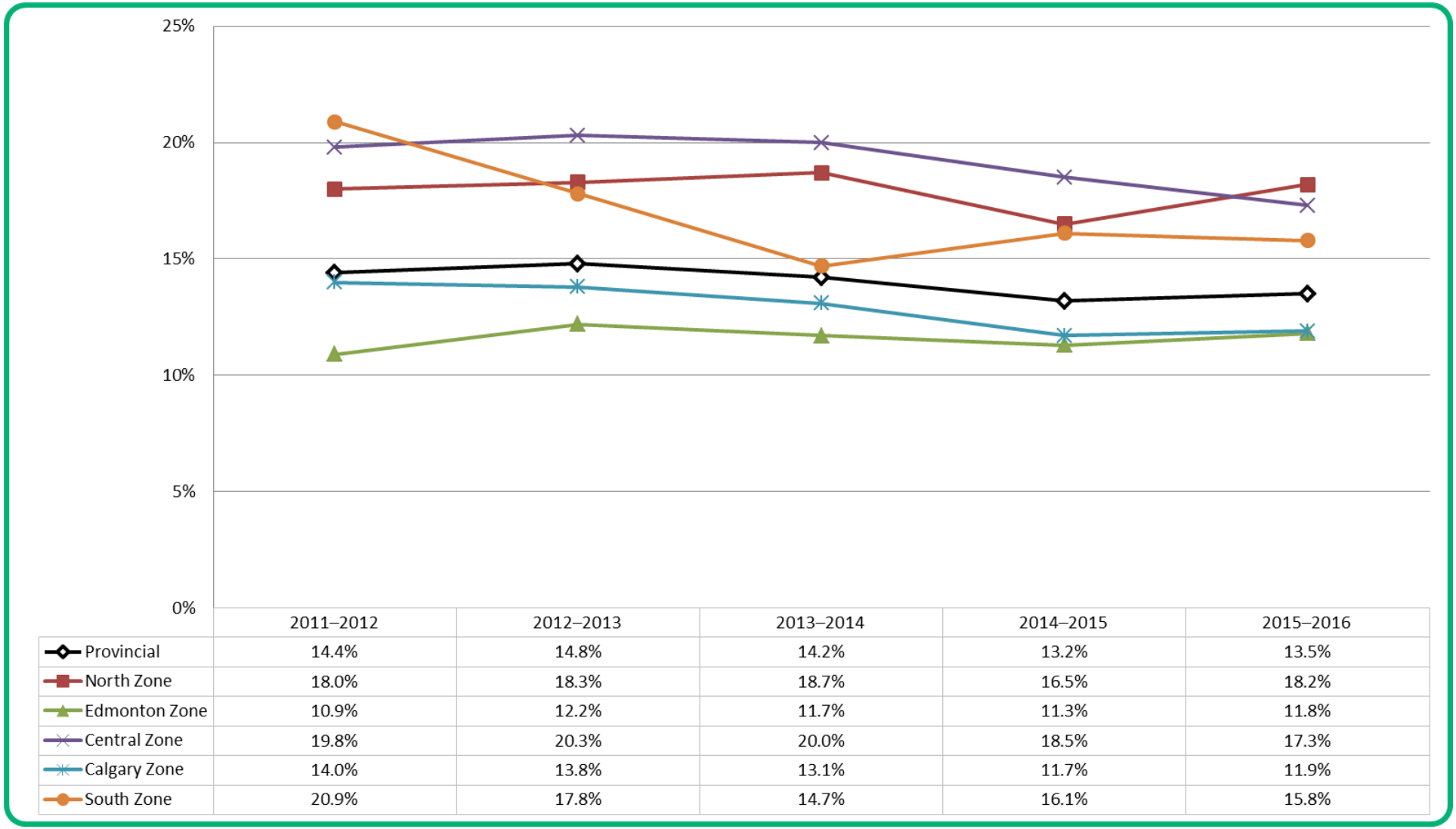
2016-2017 Examples of initiatives include:

Extendicare has set a target of below 10% for worsened pain, and has been focusing on reducing this quality indicator over the past 5 years. As of 2015/16 the vast majority of Extendicare sites are below the provincial average and under 10% for worsened pain. The following sites have made improvements from Q4 2014/15 to Q4 2015/16:

- Extendicare Cedars Villa 6.9% to 6.0%
- Extendicare Hillcrest 6.4% to 3.1%
- Extendicare Michener Hill 6.1% to 4.4%
- Extendicare Eaux Claires 4.8% to 2.3%
- Extendicare Holyrood 4.6% to 3.3%
- Extendicare Leduc 11.2% to 3.4%

Health Status: Experiencing Worsened Pain in Long-Term Care – Provincial Details

The measure is the percentage of residents who are experiencing worsening pain in the last 30 days in a Long-Term care facility.



	2011–2012	2012–2013	2013–2014	2014–2015	2015–2016
Provincial	14.4%	14.8%	14.2%	13.2%	13.5%
North Zone	18.0%	18.3%	18.7%	16.5%	18.2%
Edmonton Zone	10.9%	12.2%	11.7%	11.3%	11.8%
Central Zone	19.8%	20.3%	20.0%	18.5%	17.3%
Calgary Zone	14.0%	13.8%	13.1%	11.7%	11.9%
South Zone	20.9%	17.8%	14.7%	16.1%	15.8%