MyPractice
Long-Term Care

A tailored report for quality care

Screenshots of the online *MyPractice*: LTC sample report

Email PracticeReport@ontariohealth.ca for more information

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Overview

Reporting period: Jan 1, 2020 – Mar 31, 2020

ANTIBIOTIC PRESCRIBING

27 %

of my residents were prescribed an antibiotic

Higher than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

ANTIBIOTIC PROLONGED TREATMENT

10 %

of my antibiotic prescriptions were longer than seven days

Lower than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

ANTIPSYCHOTIC PRESCRIBING

15 %

of my residents with dementia without psychosis were prescribed an antipsychotic

Lower than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

BENZODIAZEPINE PRESCRIBING

24 %

of my residents were prescribed a benzodiazepine

Higher than most of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

CNS-ACTIVE MEDICATIONS

11 %

of my residents were prescribed three or more specified CNS-active medications

Similar to many of my peers

VIEW MY TREND DATA | VIEW CHANGE IDEAS

Who are my residents?

See a detailed view of your resident profile

About this report

Learn more about the *MyPractice: Long-Term Care* reports

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Antibiotics

Reporting period: Apr 1, 2018 – Mar 31, 2020

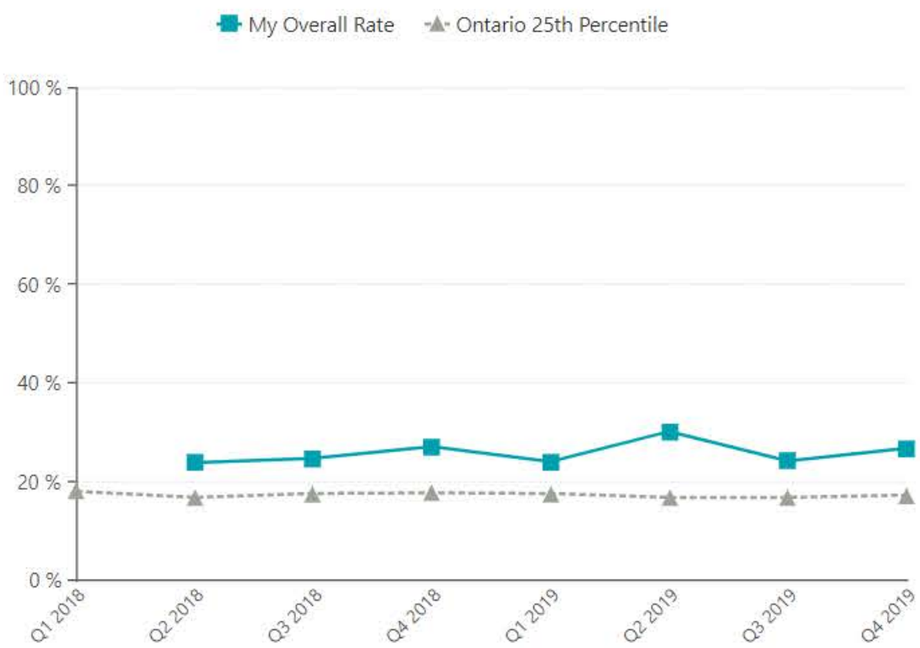
My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile

Home: My Overall Rate

What percent of my residents were prescribed an antibiotic?



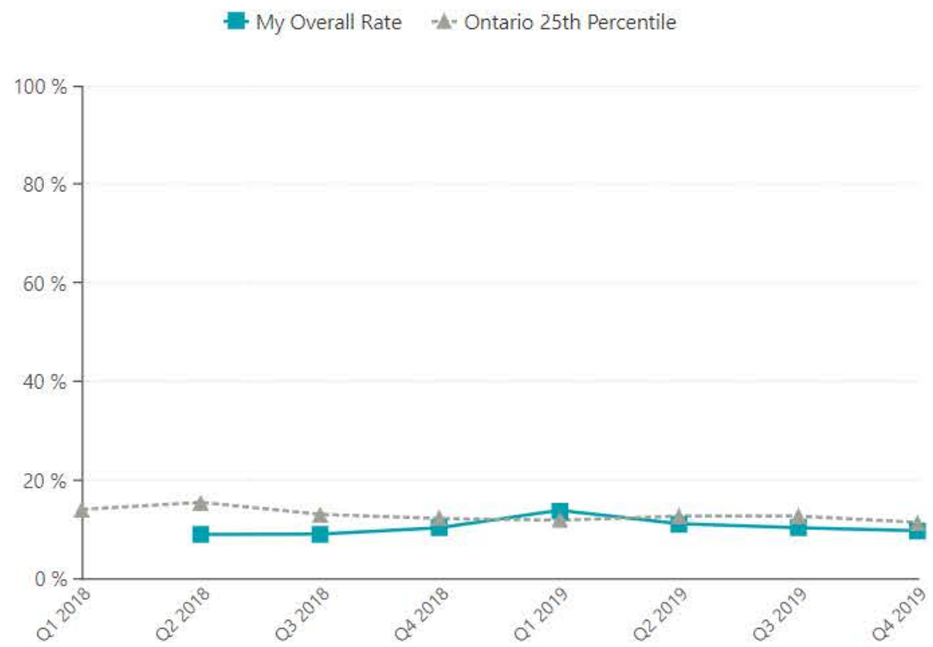
Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, **36** of my residents were prescribed an antibiotic.

Key change: Don't do a urine dip or a urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).

Change Ideas: Antibiotic Prescribing

What percent of my antibiotic treatments were longer than seven days?



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, **13** of my **135** antibiotic treatments were longer than seven days.

Key change: Optimize duration of therapy to 7 days or less for uncomplicated cystitis, pneumonia and cellulitis.

Change Ideas: Antibiotic Prolonged Treatment

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others? Collapse

Table: Select resident characteristics

Reporting period: Jan 1, 2020 – Mar 31, 2020

	My Practice	Ontario
Residents with asthma	15 %	15 %
Residents with chronic obstructive pulmonary disorder	35 %	15 %
Residents with congestive heart failure	25 %	21 %
Residents with dementia	55 %	70 %
Residents with diabetes	45 %	37 %

N/R: Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent calculation of suppressed data. N/A: Data not available.

Data sources: ICES-Derived Cohorts

How do I know these data are accurate? Expand

How is my antibiotic prescribing rate calculated? Expand

How is my antibiotic prolonged treatment rate calculated? Expand

What are some limitations of these data? Expand

Is low antibiotic prescribing reasonable and safe? Expand

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Antipsychotics

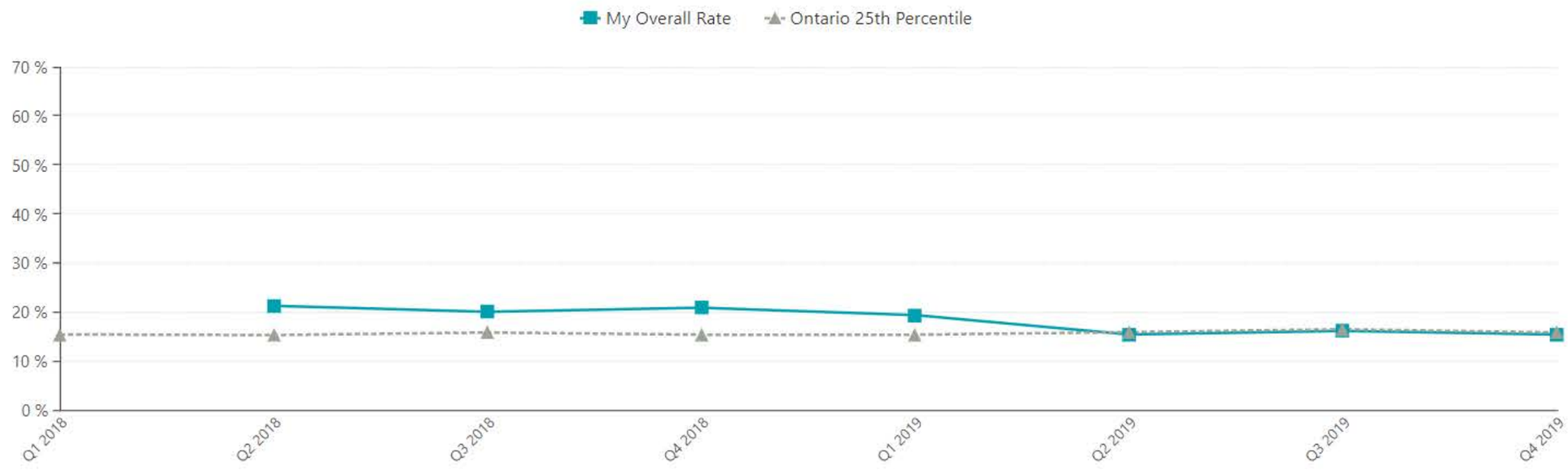
Reporting period: Apr 1, 2018 – Mar 31, 2020

My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile Home: My Overall Rate

What percent of my residents aged 66 and older who have dementia without psychosis were prescribed antipsychotics?



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, among my residents who have dementia without psychosis:

18 were prescribed an antipsychotic.

9 were prescribed an antipsychotic for over 90 days.

0 were newly prescribed an antipsychotic.

Key change: Consider a trial of weaning residents off antipsychotic prescriptions where appropriate.

In some cases, antipsychotics are indicated for management of responsive behaviours and BPSD. The data cannot weigh the benefits against the possible harms for a particular resident, but they can point to practice patterns worthy of reflection.

Change Ideas: Antipsychotics

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others?	Expand
How do I know these data are accurate?	Expand
How is my antipsychotic prescribing rate calculated?	Expand
What are some limitations of these data?	Expand

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Benzodiazepines

Reporting period: Apr 1, 2018 – Mar 31, 2020

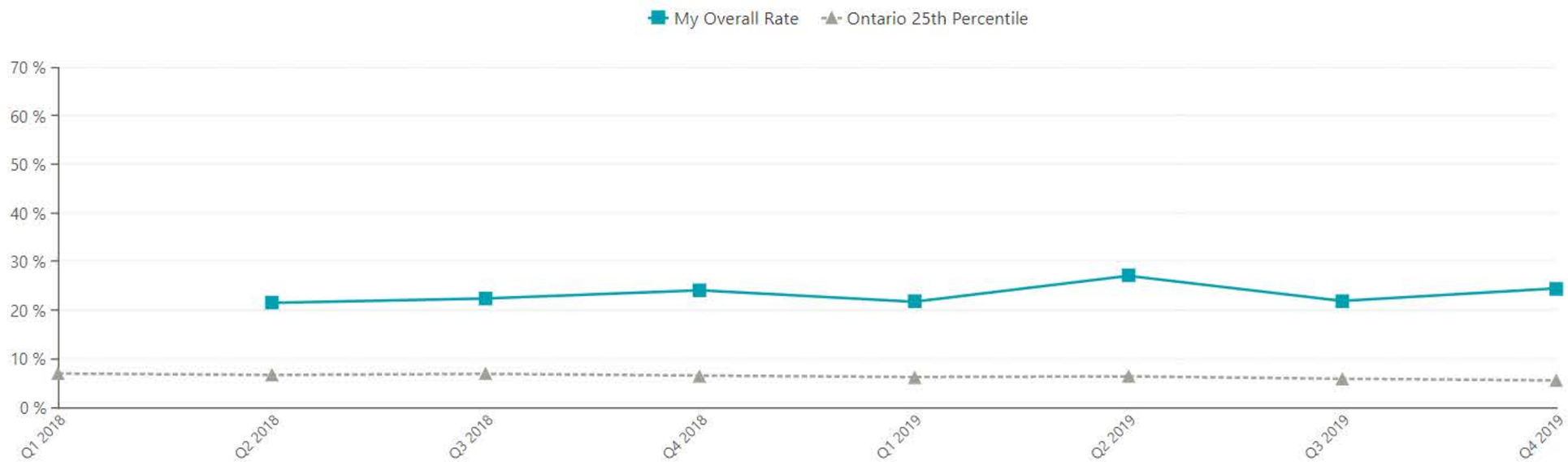
My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile

Home: My Overall Rate

What percent of my residents aged 66 and older were prescribed a benzodiazepine?



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, among my residents:

33 were prescribed a benzodiazepine.

16 were prescribed a benzodiazepine for at least 90 days.

Key change: After reflecting on your rates and indications for benzodiazepine use in individual residents, you may consider a trial of weaning where appropriate.

Sometimes benzodazepines are appropriate, but benzodiazepine do contribute to the risk of falls which can lead to injury.

Change Ideas: Falls and Mobility

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others?	Expand
How do I know these data are accurate?	Expand
How is my benzodiazepine rate calculated?	Expand
What are some key limitations of these data?	Expand

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CNS-Active Medications

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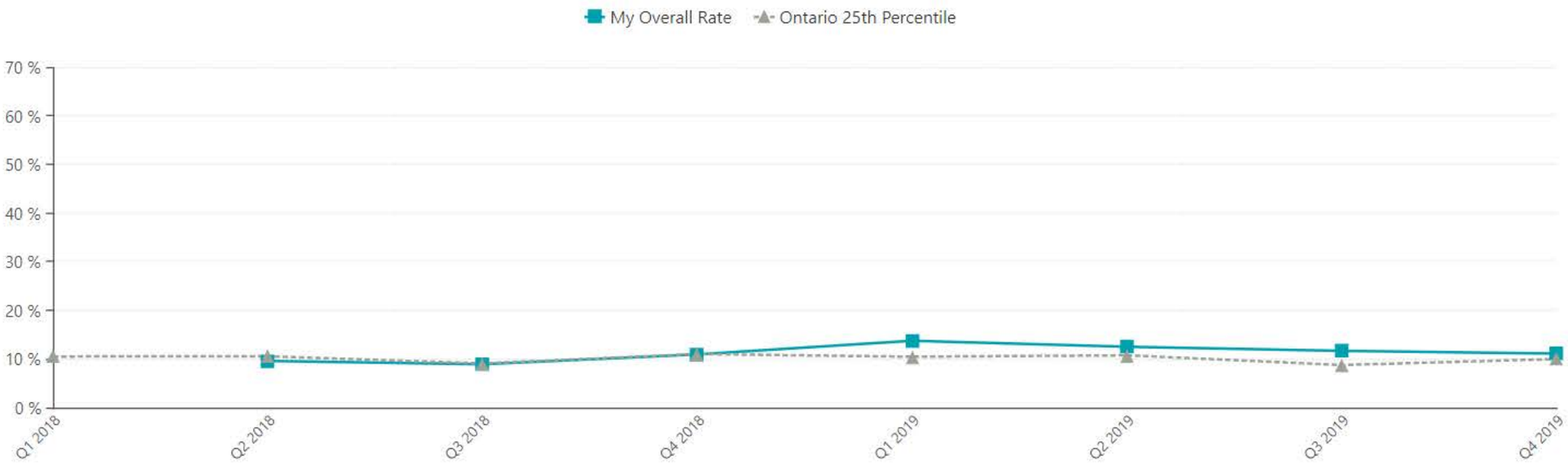
My LHIN: Sample LHIN

Select Your:

Comparator: Ontario 25th Percentile Home: My Overall Rate

What percent of my residents aged 66 and older were prescribed three or more specified CNS-active medications?



Gaps in the graph are due to suppression as per ICES' privacy policy and data availability. Q4 2019 represents Jan 1, 2020 to Mar 31, 2020

In the most recent quarter, among my residents:

15 were prescribed three or more CNS-active medications (including antipsychotics, opioids, benzodiazepines [oral], and antidepressants, including TCA and trazodone).

Although there are valid indications for these medications, there is an additive increased risk of falls and confusion that should be monitored. Consider a trial of weaning where appropriate or substituting with a safer medication.

The data cannot weigh the benefits against the possible harms for an individual resident, but they can point to practice patterns worthy of reflection.

Change Ideas: Falls and Mobility

IMPORTANT QUESTIONS

Are my residents sicker or more complex than others?	Expand
How do I know these data are accurate?	Expand
How is my three or more CNS-active medications rate calculated?	Expand
What are some limitations of these data?	Expand

Ontario Health

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Change Ideas: Antibiotic Prescribing

Things I Can Do | Things I Can Do With My Team

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Avoid Treatment of Asymptomatic Bacteriuria

1) Don't do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).

*Common situations where systemic antibiotics are generally **not** indicated:*

- Positive urine culture in an asymptomatic resident.
- Urine culture ordered solely because of change in urine appearance (e.g. cloudy) or odor.
- Nonspecific symptoms or signs not referable to the urinary tract, such as falls or mental status change (with or without a positive urine culture).
- For additional guidance, use the Public Health Ontario's UTI Program: Assessment algorithm

2) Prescribe antibiotics only when resident has clear signs and symptoms of UTI and reassess once urine culture and susceptibility results have been received.

Review/Establish Criteria or Guidelines for Treatment of Infections

*3) Review other common indications where antibiotics are **not** required in LTC residents.*

- Upper respiratory infection (common cold).
- Bronchitis or asthma in a resident who does not have COPD.
- "Infiltrate" on chest x-ray in the absence of clinically significant symptoms.
- Suspected or proven influenza in the absence of a secondary infection (but DO treat influenza with antivirals).
- Respiratory symptoms in a resident on palliative care or at the end of life.
- Skin wound without cellulitis, sepsis or osteomyelitis (regardless of culture result).

Educate residents, families, clinicians and other staff

Use the SymptomFreeLetItBe handout when talking with residents, families and staff.

Suggested Tools and Resources

- Choosing Wisely Canada. Using Antibiotics Wisely Campaign
- AHRQ. 12 Common Nursing Home Situations in Which Systemic Antibiotics are Generally Not Indicated
- AMMI Asymptomatic Bacteriura Toolkit. Fillable resident/family letter.
- Public Health Ontario. UTI Program: Assessment algorithm for urinary track infections (UTIs) in medically stable non-catheterized residents

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Avoid Treatment of Asymptomatic Bacteriuria

- Implement a program to reduce unnecessary urine culturing.
- Standardize guidelines of how and when to test cultures and interpretation of urine culture results.
- *Discontinue routine annual urine screening and screening at admission if residents do not have indicated clinical signs and symptoms of a UTI.*
- Refer to Public Health Ontario's UTI Program

Review/Establish Criteria or Guidelines for Treatment of Infections

Work with home's infection control personnel to implement minimum criteria guidelines for antibiotic initiation in your LTC home.
Refer to AHRQ. Minimum Criteria for Common Infections Toolkit (UTI, LRTI, SSTI).

Implement structured nursing communication tools (e.g. SBAR tools) to aid in clear communication between nurses and prescribers and standardize assessments of residents suspected with infection.

Educate residents, families, clinicians and other staff

Provide education and resources for prescribers, nurses, front-line clinicians and on-call staff about common infections, and the importance of appropriate antibiotic use. Include a consistent message regarding antimicrobial resistance and role of antibiotics.

Refer to AMMI Asymptomatic Bacteriuria Toolkit. Myths and Truths about Urinary Tract Infections in Long Term Care Residents.

Provide education and resources for residents and families about common infections, antibiotic resistance and improving antibiotic use.

Refer to AMMI Asymptomatic Bacteriuria Toolkit. Fillable resident/family letter or DBND FAQ for Families, Guardians and Health Care Aides-UTI in LTCF.

Suggested Tools and Resources

Public Health Ontario has developed a primer and checklist to identify gaps and provide helpful tools for implementation.

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Prescribe shorter courses when appropriate

Optimize duration of therapy to 7 days or less for uncomplicated cystitis, pneumonia and cellulitis.

In most cases of uncomplicated infections seen in LTC, short courses of antibiotics are equally effective and result in lower risk of harm.

- Uncomplicated cystitis ≤ 7 days
- Uncomplicated pneumonia 5-7 days
- Uncomplicated cellulitis 5-7 days

Suggested Tools and Resources

Infographic on **Shorter is Smarter:** Reducing duration of antibiotic therapy in long-term care.

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Prescribe shorter courses when appropriate

Implement guidelines or resources to reduce antibiotic exposure for specific infections to the shortest effective duration. Refer to Fact Sheet and Evidence Briefs on **Shorter is Smarter:** Reducing Duration of Antibiotic Treatment for Common Infections in Long-term Care.

- Uncomplicated cystitis ≤ 7 days
- Uncomplicated pneumonia 5-7 days
- Uncomplicated cellulitis 5-7 days

Collaborate with pharmacists to ensure appropriate duration is selected for each infection.

Systematically re-evaluate duration of antibiotic therapy

Implement an "antibiotic time-out" and review antibiotic therapy after 48-72 hours or as early as possible.
Refer to Public Health Ontario's Antibiotic Time Out Strategy.

Reassess resident status, laboratory cultures, and duration of therapy.

Discontinue antibiotic where appropriate.

Narrow spectrum of antibiotic therapy where appropriate: de-escalate or streamline.

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Change Ideas: Antipsychotics

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Identify improvement efforts planned or underway and what resources and supports are available

- Ask the Medical Director or Quality Committee about the home's Quality Improvement Plan and approach to antipsychotic prescribing. Ask the home to review the Behavioural Symptoms of Dementia Quality Standard
- Explore opportunities to work with the home's Behavioural Response Team and Champions
- Consult external outreach teams such as Psychogeriatric Resource Consultant, Behavioural Supports Ontario (BSO), Seniors Mental Health services

Verify current resident data

- Review data from your home and pharmacy provider (indications, new starts, summary of responsive behaviours, interventions)
- Verify the data related to the number of residents prescribed antipsychotics, new starts, PRN orders and administration rates
- Request a medication tracking tool from your pharmacy provider

Improve medication review process

- Consider a team approach to quarterly medication reviews involving physician, pharmacist and nurse
- Use a standardized and simplified medication review process. See sample worksheet from Alberta Health Services
- Review the Continuous Use indicator at quarterly multi-disciplinary medication review and summary of resident recent behaviours and identify residents appropriate for a trial of adjusting antipsychotic use/dose

Update and implement individualized behaviour care plans

- Use standardized assessment tools to inform care plans (DOS, CMAI, KSBA)
- Rule out triggers such as medical problems (pain, constipation, infection). Use P.I.E.C.E.S. assessment tool
- Trial non-pharmacological strategies before antipsychotic medications, where appropriate

Choose optimal pharmacological interventions

- Trial lowest effective dose for shortest duration. Monitor effectiveness and tolerability using BSMT Tool
- Check Centre for Effective Practice Use of Antipsychotics in Behavioural and Psychological Symptoms of Dementia (BPSD) Discussion Guide

Learn from your peers

- Dr. Auger's Story: Reducing Antipsychotic Prescribing Rates in My Practice
- Behavioural Supports Ontario (BSO)
- Choosing Wisely Canada Toolkit for Reducing Inappropriate Use of Antipsychotics in LTC

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Change Ideas: Falls and Mobility

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Identify improvement efforts planned or underway and what resources and supports are available

- Ask the Medical Director or Quality Committee about the home's Quality Improvement Plan approach to falls prevention
- Consult with your Falls Prevention Team

Verify current resident data

- Review the data from your home and pharmacy provider for the number of residents prescribed benzodiazepines and 3+ CNS active drugs, duration/administration rate
- Consider using the Falls risk assessment Centre for Effective Practice Discussion Guide

Improve medication review process

- Consider a team approach to quarterly medication reviews involving physician, pharmacist and nurse
- Use a Fall Assessment and Medication Review Flow Sheet (sample below)
- Review Fall risk assessment, functional/cognitive status (CPS) and anticholinergic burden/risk scales

Update and implement individualized behaviour care plans

- Develop process to inform physician post fall. Consider BEEEACH Checklist Centre for Effective Practice Discussion Guide
- Re-assess at each transition (new admission, change in condition)

Choose optimal pharmacological interventions

- Mitigate the risk of falls from medication use. Consider using STOPP/START Toolkit and ISMP Canada BEERs List
- Check Ontario Pharmacy Evidence Network / Bruyère Research Institute Deprescribing Algorithm to help you decide when and how to reduce benzodiazepines safely

Learn from your peers

- Choosing Wisely Canada Toolkit - Less Sedatives for Your Older Relatives

Sample Fall Assessment and Medication Review Flow Sheet

Age	Number of Falls/Quarter	Fractures (Y/N)	Morse Fall Score	Central Nervous System Drugs	Blood Pressure Medications	Osteoporosis Prevention	Resident Goal

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Resident Profile

Demographics

Reporting Period: Jan 1, 2020 – Mar 31, 2020

	My Practice	Ontario
Total number of residents	200	76,023
Mean age (years)	82	84
85 years and older	49 %	55 %
Female	70 %	68 %
Male	30 %	32 %
Residents new to the LTC home (<100 days)	16 %	12 %

N/R: Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent calculation of suppressed data. N/A: Data not available.

Data sources: OHIP/ODB cohort

Chronic Disease Prevalence

Reporting Period: Jan 1, 2020 – Mar 31, 2020

	My Practice	Ontario
Residents with asthma	15 %	15 %
Residents with chronic obstructive pulmonary disorder	35 %	15 %
Residents with congestive heart failure	25 %	21 %
Residents with dementia	55 %	70 %
Residents with diabetes	45 %	37 %

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Data sources: ICES-Derived Cohorts

RAI-MDS Outcome Measures

Reporting Period: Apr 1, 2019 – Mar 31, 2020

	My Practice	Ontario
Residents without psychosis on antipsychotics in the last 7 days	22.0 %	18.4 %
Residents who fell in the last 30 days	26.0 %	15.4 %
Residents in daily physical restraints over the last seven days	18.0 %	3.5 %
Activities of Daily Living (ADL):		
• Independent (0)	10 %	2 %
• Limited Impairment (1-2)	20 %	11 %
• Extensive Assistance (3-4)	30 %	51 %
• Dependent (5-6)	40 %	36 %
Aggressive Behaviour Scale (ABS):		
• No Aggressive Behaviour (0)	10 %	57 %
• Some Aggressive Behaviour (1-2)	20 %	24 %
• Severe Aggressive Behaviour (3-5)	30 %	14 %
• Very Severe Aggressive Behaviour (≥6)	40 %	5 %
Cognitive Performance Scale (CPS):		
• Relatively Intact (0-1)	20 %	17 %
• Mild / Moderate (2-3)	30 %	50 %
• Severe (4-6)	50 %	34 %
Pain Scale:		
• No Pain (0)	10 %	70 %
• Less than Daily Pain (1)	20 %	23 %
• Daily Pain, but Not Severe (2)	30 %	6 %
• Severe Daily Pain (3)	40 %	1 %

N/R: Data suppressed as per ICES' privacy policy, additional suppression may be applied to prevent calculation of suppressed data. N/A: Data not available.

Data sources: CIHI Continuing Care Reporting System (RAI-MDS)
Note: CIHI indicators are calculated as rolling four-quarter averages