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February 2022 Edition

Drug shortages: Not just a pandemic problem

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FROM CRISIS TO CATASTROPHE

2022 started with a shocking lesson for the people of Ontario: our health-care system is running on empty. Decades of underfunding have left Ontario at least 22,000 nurses short, and there's no viable plan to build capacity. Lockdowns and school closures are desperate measures to keep hospitals from collapsing – but without nurses they will.

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Ontario Nurses' Association

February 2022 Edition

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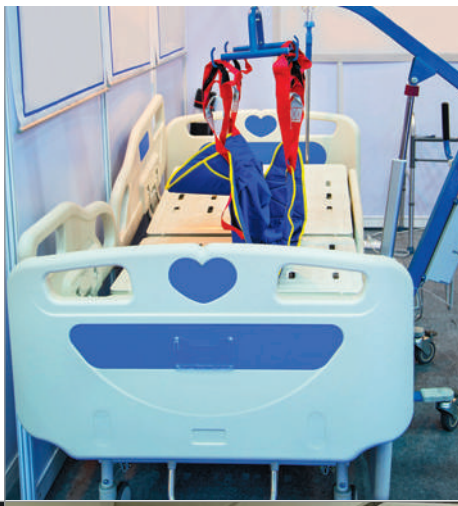

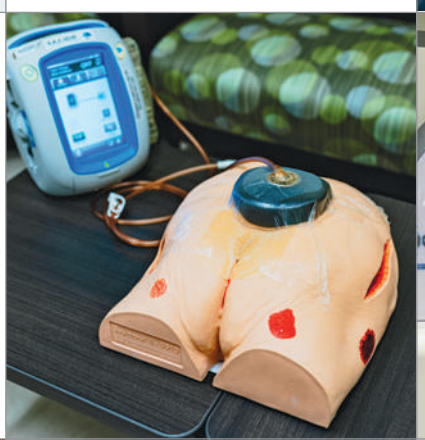

COLUMNS

Canada needs a national aging strategy that includes older women

By Paula Rochon and Surbhi Kalia

There are now more than 6.8 million older adults in Canada. By 2026, we expect our country to become a super-aged society, where 20 per tcent of the population will be 65 and over.

Yet Canada is facing a major policy gap: the lack of a national plan to support our aging population.

The impact of the pandemic on older adults, specifically long-term care homes, calls for critical action. Along with long-term care reform, we need a plan to meet the health needs of older Canadians in the community where 93 per cent of older adults live.

WOMEN HAVE SPECIFIC AND UNIQUE HEALTH NEEDS THAT ARE OFTEN UNACKNOWLEDGED BY OUR HEALTH SYSTEM AND ITS CARE PROVIDERS.

Canada has about 304 geriatricians, for example – one geriatrician per 100,000 – and a lack of access to primary care, not nearly enough to meet the demand of our older population, particularly in rural areas.

It's time we had a national aging strategy.

This strategy needs to be inclusive. A one-size-fits-all approach to support healthy aging will leave many Canadians behind, mainly women. Older women comprise the majority of the aging population.

Women have specific and unique health needs that are often unacknowledged by our health system and its care providers. Certain medical conditions such as osteoporosis, thyroid problems, and headaches, for example, present more often in women, and other conditions, like heart disease, present differently and are not always recognized by clinicians. Older women are also more likely to experience side-effects from medications and may require lower doses of some medications than men.

These health issues are further compounded by the socio-cultural and economic inequities women face throughout life. Older adults, especially older women, do not always have access to non-insured health services, such as dental, vision and hearing care. They are more likely than men to face poverty, and not able to afford proper care options to live in their communities.

An effective aging strategy would enable older adults to actively participate and contribute within their communities, provide affordable options to healthcare and social services and address systemic inequities based on sex and age.

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UPCOMING DEADLINES

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Hospital News is published for hospital health-care professionals, patients, visitors and students. It is available free of charge from distribution racks in hospitals in Ontario. Bulk subscriptions are available for hospitals outside Ontario.

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Canadian Publications mail sales product agreement number 42578518.

PRINTED IN CANADA

Previously undetected heart injury in patients recovered from mild COVID-19

In a world-first, UHN researchers used PET/MRI scans to measure heart injury in recovered COVID-19 patients, revealing that a small percentage had inflammation in their heart after infection.

This multi-disciplinary study drew on expertise from across UHN including the Peter Munk Cardiac Centre, the Joint Department of Medical Imaging (JDMI), and the Department of Laboratory Medicine and Pathology.

An MRI (magnetic resonance imaging) is a non-invasive medical imaging technique that creates a detailed image of organs and tissue within the body. A PET/MRI provides further detail by combining the MRI information with positron emission tomography (PET), a separate non-invasive medical imaging technique that measures changes in heart metabolism and other activities such as blood flow, inflammation, and more.

Photo: UHN

Dr. Dinesh Thavendiranathan, Peter Munk Cardiac Centre, and Dr. Kate Hanneman, Joint Department of Medical Imaging, use PET/MRI to assess heart inflammation in recovered COVID-19 patients.

HEART DAMAGE AND COVID-19

"One of the things we learned early on in the pandemic is that patients who sustained heart damage from severe COVID [those who required hospitalization] did quite poorly," says Dr. Dinesh Thavendiranathan, co-principal investigator of the study published Wednesday in the Journal of the American Medical Association Cardiology, and cardiologist at the Peter Munk Cardiac Centre, UHN.

"However, because over 90 per cent of individuals with COVID are not hospitalized, we started to wonder about undetected heart injury among these patients, especially given the common report of symptoms that may be related to the heart, such as palpitations."

Previous studies used cardiac MRI to identify heart damage in patients with mild COVID (those who did not require hospital admission), but with inconsistent results. To provide clarity, UHN researchers opted for a more sensitive test.

Using a PET/MRI, which tracks changes in glucose use by the heart to measure inflammation, researchers assessed a group of patients recently recovered from COVID.

HEART INFLAMMATION CAUSED BY COVID GETS BETTER ON ITS OWN

The study included 47 patients who tested positive for COVID-19 between November 2020 and June 2021. The PET/MRI detected inflammation of the heart in eight patients.

Patients with inflammation on PET also had worse markers of heart function and damage on MRI, as well as higher blood inflammatory markers, compared to those without. Dr. Kathryn Howe, vascular surgeon at UHN, and Dr. Jason Fish, senior scientist at TGHRI, led the blood biomarker analysis along with PhD candidate Dakota Gustafson.

"There has been some contention about the range of abnormalities after COVID reported in prior MRI studies," explains Dr. Kate Hanneman, co-principal investigator of the study, and cardiac radiologist, JDMI, UHN.

"Since there's no imaging before COVID for comparison, it is possible that some of the abnormalities reported were already there before the patient got COVID. Our study gives contemporary information in addition to the MRI that suggests the heart injury that we're seeing is, in fact, caused by COVID."

When patients returned for a second PET/MRI two months after the first, test results revealed the inflammation got better on its own, without treatment, further supporting the suggestion that the heart injury was caused by COVID. The improvement in inflammation on PET was also accompanied by a corresponding improvement in MRI and blood test results.

This spontaneous improvement is good news. But inflammation can result in damage to the heart which may manifest in the long term, warns Dr. Hanneman.

"It's important to remember that we don't know the long-term consequences of heart injury after COVID, or the impact of variants like Omicron," she says.

LOOKING FORWARD

Long-term follow-up is the crux of further research, says Dr. Hanneman.

"We've started following up with patients who have reached the one-year mark, and will continue to do so," she says. "Eventually, we would like to know more about the long-term cardiovascular disease risk."

For now, the data sends a clear message.

"What does all this mean? It means even if you had mild COVID, there is a small risk of potential injury to your heart," says Dr. Thavendiranathan.

"Given that we don't understand the heart consequences of more recent variants, the best protection is to remain safe and minimize the chance of getting infected." H

This article was submitted by UHN news.

New program addresses health human resource needs in Ontario

The College of Nurses of Ontario (CNO) and Ontario Health are partnering to help address the health human resource needs of the province by launching the Supervised Practice Experience Partnership. This partnership provides an opportunity for applicants, currently going through the registration process to become nurses, to participate in a work experience to help complete their evidence of practice and language proficiency registration requirements.

"We are relentlessly focused on modernizing our applicant assessment process to ensure the health care system has access to skilled nurses needed to deliver safe, quality care," said Anne Coghlan, CNO's Executive Director & CEO. "In December alone, we registered 850 nurses. With the launch of the Supervised Practice Experience Partnership, we are providing an immediate response to the workforce needs of the Ontario health care sector, while maintaining our focus on public safety."

THIS PARTNERSHIP PROVIDES AN OPPORTUNITY FOR APPLICANTS, CURRENTLY GOING THROUGH THE REGISTRATION PROCESS TO BECOME NURSES, TO PARTICIPATE IN A WORK EXPERIENCE TO HELP COMPLETE THEIR EVIDENCE OF PRACTICE AND LANGUAGE PROFICIENCY REGISTRATION REQUIREMENTS.

CNO is responsible for protecting the public by promoting safe nursing practice. This includes ensuring applicants are qualified by having the appropriate knowledge, skill and judgement to practice as nurses. Through the Supervised Practice Experience Partnership, applicants gain relevant practice experience under the supervision of a preceptor, within a CNO-approved practice setting in Ontario, to meet the requirement to register as a nurse. A 2021 pilot of this program successfully moved applicants into the system in a shorter time frame.

Ontario Health is matching applicants with program approved organizations to ensure applicants are available where the need is greatest. "We recognize that COVID-19 has created a growing need for more nurses in the province. With partners across Ontario, our focus is to connect our health care system to ensure Ontarians receive the best possible care," says Matthew Anderson, CEO, Ontario Health. "This innovative program provides much needed health human resources to support safe patient care during this challenging time."

The Supervised Practice Experience Partnership is one of several ways CNO is modernizing its applicant assessment process and responding as a system partner to support the needs of our health care system.

CNO will contact eligible Supervised Practice Experience Partnership applicants by email with details on how to apply to the program. Organizations wishing to become a partner can contact CNO. H

People suffering from depression susceptive to vaccine-related misinformation

People who feel depressed are more likely to believe vaccine-related misinformation, according to a new study coauthored by a Rutgers researcher during a time when depression rates are higher due to the COVID-19 pandemic.

The study, published in the *t* found that people with moderate or greater symptoms of depression (such as little interest in doing things, trouble sleeping or concentrating, poor appetite or overeating, and feeling bad about yourself) were more likely to believe at least one of four false statements about COVID-19 vaccines. Those who believed the statements to be true were half as likely to be vaccinated.

According to National Center for Health Statistics, approximately one-quarter of adults in the U.S. have consistently reported moderate or greater depressive symptoms during the COVID-19 pandemic. The findings suggest people suffering from depression may be at a higher risk of COVID-19, highlighting the need to address mental health disorders.

According to the data, 29.3 percent of people with moderate or more depressive symptoms supported this misinformation, compared with 15.1 percent of those without.

While the researchers did not examine why, the link may be driven by a negativity bias, which causes people suffering from depression to focus more on content that evokes negative emotions.

The study authors used data from the research group The COVID States Project, which conducted surveys approximately once every six weeks since April 2020. The researchers analyzed data from 15,464 adults in the U.S. Participants were asked to rate vaccine-related misinformation as accurate (statement is true), inaccurate (statement is not true) or not sure. The four statements of misinformation included "The COVID-19 vaccines will alter people's DNA," "The COVID-19 vaccines contain microchips that could track people," "The COVID-19 vaccines contain the lung tissue of aborted fetuses," and "The COVID-19 vaccines can cause infertility, making it more difficult to get pregnant."

Survey participants completed a health questionnaire to measure major depressive symptoms over two weeks. Additional survey items asked respondents whether they used particular social media platforms and whether they had used any of a list of news sources (including MSNBC, Fox News, CNN, Newsmax, Facebook and the Biden administration) as sources of COVID-19–related news over the previous 24 hours. H

Continued from page 6

national aging strategy

Healthy aging is a major global priority – it's on the top of the United Nations and the World Health Organization's agenda. Countries like Japan and Singapore have made major investments to support their older population such as promoting life-long learning and social integration, as well as building age-friendly home-care and assisted living and designing age-friendly technology.

In Arnsberg, Germany, deemed one of the most age-friendly cities in the world, older adults can access affordable housing and care options, contribute and participate in social life and feel connected to their communities.

The world has given us a template to build our own roadmap. We need to apply these lessons and develop a path forward to address the unique needs of Canadians and build our own age-friendly communities.

We need a strategy. H

Dr. Paula Rochon is a geriatrician and the founding director, and Surbhi Kalia is the strategy lead, of the Women's Age Lab at Women's College Hospital.

Poor housing conditions linked to respiratory health issues in young First Nations children

A study documenting indoor air quality and housing characteristics in four isolated First Nations communities in northwestern Ontario found frequent rates of respiratory infections in children under three years of age and that high rates of wheezing in this age group were related to poor housing conditions.

Researchers documented the extent to which many homes in the Sioux Lookout region, north of Thunder Bay, Ontario, did not meet even minimum standards, and they quantified the interior surface area of mould, monitored indoor air quality for 3–5 days in main living areas and conducted other detailed analyses, such as dust mite concentration and contaminants from wood smoke that could affect respiratory health.

Recent news coverage of requests for the Canadian Armed Forces to help remote Indigenous communities with COVID-19 outbreaks, which are partly attributable to poor housing conditions – particularly reduced ventilation and overcrowding – underscores the relevancy of these findings in a broader sense.

"Without adequate ventilation, these houses are like living in a plastic bag," says Michael McKay, director of Housing and Infrastructure, Nishnawbe Aski Nation, and a study author.

"Centuries of assimilation tactics, colonialism and systemic racism have created structural barriers including employment, education, economic and housing inadequacies, as well as systematically disrupting transfer of intergenerational life skills," writes McKay along with Dr. Thomas Kovesi, a pediatric respirologist and clinical investigator at CHEO, and professor, University of Ottawa, and the other coauthors.

Researchers found high levels of interior surface area of mould and high levels of endotoxin (the residue of certain bacteria), which is associated with wheeze. Eighty-five percent of the houses lacked controlled ventilation, over half had damaged windows, 44 per cent showed water penetration in exterior walls and six per cent had immediate safety issues. Twenty-one percent of the children in the study were admitted to hospital during the first two years of life, and 25 per cent of the children were medically evacuated for respiratory illness. Wheezing with colds was seen in more than one-third (39%) of children, although only four per cent were diagnosed with asthma.

"Housing Conditions and respiratory morbidity in Indigenous children in remote communities in Northwestern Ontario, Canada" is published January 24, 2022.

New research shows more than a third of all Canadians reporting burnout

As we inch towards the two-year mark of the COVID-19 pandemic, new research shows that more than one-third (35 per cent) of all working Canadians are feeling burned out.

A comprehensive research study – commissioned by Workplace Strategies for Mental Health, compliments of Canada Life, and conducted by Mental Health Research Canada in December 2021 – measured a wide range of factors relating to how employees are feeling at work. Those factors included everything from engagement and recognition to workload and safety.

While the signs and symptoms of burnout may vary, says Baynton, it's often characterized by emotional exhaustion, cynicism, negativity and reduced efficiency in the workplace. It's more prevalent in employees who set high expectations for themselves, have unreasonable demands placed on them or feel unappreciated for their efforts. While not considered a mental illness, burnout can be debilitating and long-lasting. That's why prevention and mitigation strategies are so important.

Five industries showed burnout rates above the national average of 35 per cent:

- Health and patient care (53 per cent)
- Transportation (40 per cent)
- Finance, legal and insurance (39 per cent)
- Education and childcare (38 per cent)
- First responders (36 per cent)

Within the health and patient care industry, a staggering 66 per cent of nurses reported burnout. Mental health professionals followed closely at 61 per cent and all other segments surveyed in this industry landed well above the Canadian average of 35 per cent reporting burnout.

"Burnout levels have soared among Canadian nurses throughout the pandemic," said Tim Guest, Canadian Nurses Association. "The levels were high prior to 2020, but now the pandemic has exacerbated the situation. CNA is deeply concerned, and we continue to call for accessible mental health resources tailored to healthcare workers."

Exploring surgeon-patient sex differences with outcomes

A study led by Mount Sinai researchers and published in *JAMA Surgery* looked at 1.3 million adult Ontarians who had one of 21 common complex or general surgeries. Researchers showed that female patients who were operated on by a male surgeon had a greater risk of death, complications and hospital readmission compared to female patients treated by a female surgeon. This is a stark contrast with male patients who exhibited similar outcomes after surgery, regardless of the surgeon's sex.

"As male and female surgeons receive the same training, these findings may be the result of non-technical skills learned outside of the operating room," says Dr. Christopher Wallis, Urologic Oncologist, Mount Sinai Hospital and University Health Network and co-author of the study.

The research also highlights the need for the surgical field to diversify and include more women, and for a deeper examination what's causing these outcomes to differ.

"This research presents the opportunity for all doctors to learn and improve the care and outcomes for all patients, regardless of their sex. I see this as an opportunity to be reflective and thoughtful, to think about how I'm interacting with my patients and to highlight the value women bring to surgery," says Dr. Wallis.

Creating a career ladder for personal support workers is more than our responsibility

By Dr. Kevin Smith

Some of the greatest unsung heroes of this pandemic – and our healthcare system more broadly – are the personal support workers (PSWs) who often care for our most vulnerable citizens. As we consider what lies ahead for health professions, and those who support them, it is incumbent upon us to create an attractive future and career progression for our PSW colleagues.

Sadly, we often hear from PSWs a profound feeling of under-appreciation and a plan to leave the profession, in large part due to a shortage of full-time positions, poor compensation arrangements, a lack of benefits including a predictable retirement income, and a general perception that their unique skills and abilities aren't valued. Yet it is these very individuals who we have seen, over and over again during COVID, keeping our long-term care system afloat, permitting home-care services to continue to function (thereby seeing hospitals able to discharge), and perhaps most importantly, supporting a high quality of life for those homebound residents during our last 24 months. Daily we see the need for a massive expansion of those who are called to this important work yet we also see and hear that this career path is deeply flawed and frustrating.

In many parts of the world, we are seeing extenders of regulated health providers as an important part of an evolving system. Has the time come for Canada to also embrace the model? This may be in large part due to an inadequate pipeline of regulated providers but also due to the importance of increasingly allowing regulated health providers to work their full scope of practice.

If this is a direction to which Canada aspires, then the opportunity to create specialized care roles, building upon the training and lived experience of PSWs, would allow us both from an employment and immigration perspective to attract those who might play a meaningful role in addressing the intractable problems of healthcare. These include the growing demand of geriatric patients who desire to stay at home, the post-acute care models that are de-institutionalized, the effort to create a rich and meaningful palliative care experience, and the pressure to meet the needs of complex paediatric patients and their families, to name but a few.

Dr. Kevin Smith

SOME OF THE GREATEST UNSUNG HEROES OF THIS PANDEMIC – AND OUR HEALTHCARE SYSTEM MORE BROADLY – ARE THE PERSONAL SUPPORT WORKERS (PSWS) WHO OFTEN CARE FOR OUR MOST VULNERABLE CITIZENS.

At University Health Network we have been fortunate to enjoy the expertise of the Michener Institute of Education at UHN. Indeed, we are the only academic hospital in Canada that is fortunate enough to have a health professional training school within it. As such, we see the opportunity to help address the massive human-resource shortfall of regulated providers through the creation of evidence-informed, pedagogically outstanding programming.

Such programs would ensure the very best education and training while seeing regulated providers truly work to their full scope of practice. In doing so we can and must value and respect the unique skill and ability of regulated health professions while also recognizing the important role that highly trained "extenders" can offer. This is hardly a new or bold idea internationally. This has been broadly adopted in other environments though not always based on rigorous educational programming and principles of adult education. This is an opportunity for Canadian higher education to not only impact our own healthcare system but offer a model for others to emulate and evolve.

As we combine the very best of the current professions with emerging technologies such as big data and artificial intelligence, we have the makings of a career path for those who start out as personal support workers who are willing to gain the knowledge and experience to bridge the shortcomings of our existing system. In talking to patients and families, we know that it is in the moments of transition between primary care and acute care, acute care and rehabilitation, rehabilitation and palliative care, or long-term care, where we most disappoint patients and families. Might this approach be part of the solution to our communications abyss, both between and among providers and most importantly with patients and families?

Like any skilled group of professionals, there must emerge a career path and a reward system that is attractive and desirable. We must create a meaningful plan to see the very best of our caregivers progress both in skill and reward. If the COVID pandemic has proved anything it is that it is incumbent upon all of us – governments, policymakers, healthcare organizations, and care delivery providers – to think differently about how we can coordinate care across the continuum in the future and reflect on the quality of work-life of the multidisciplinary team undertaking increasingly complex models of care.

Creating attractive career opportunities and progression for PSWs and ensuring an adequate supply of providers is not only our responsibility, it is our calling. H

Dr. Kevin Smith is the President and CEO of University Health Network.


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Drug shortages:

Not just a pandemic problem

By Christine Donaldson

By the last week of January, Canada had administered more than 75.5 million COVID vaccine doses.

It has been a gargantuan effort that, for the most part, has rolled out relatively smoothly. But what would have happened if, for example, Canada didn't have 75.5 million syringes with which to administer the vaccine?

It's a potential problem most people don't think about until it is an actual problem.

The matter of procurement of healthcare supplies — from equipment to medications — has been in the spotlight since COVID arrived in Canada in early 2020. It was a hot topic in media circles and on social media. Shortly after the country essentially shut down that March, the rush to ensure we had adequate personal protective equipment in Canada was, for lack of a better word, chaos.

Then talk turned to equipment and supplies for ventilators.

Recently, the demand has been for N95 masks. Where once they were reserved for medical professionals, now everyone from teachers to grocery store managers are looking for them. This surge of demand puts incredible pressure on the medical supply chain.

All of these are procurement issues, but the area where challenges in procurement may raise the most concern is in shortages of critical medications used in hospitals and ICUs across the country.

In January, Hamilton Health Sciences revealed that it had almost no access to the COVID medication tocilizumab. Typically used in combination with the steroid dexamethasone, tocilizumab is a drug that has shown to protect the immune system and prevent the progression to severe illness in COVID patients. There are also reports of a national scarcity of the newly approved antiviral treatment Paxlovid.

The problem is there is no single root cause for a drug shortage, and not all drug shortages are the same.

Often times, they are caused by a quality issue in the manufacturing of the drug. Canada has very limited capacity for drug production, meaning we rely on imported products over which we have limited oversight which adds complexity. We are in a global competition for supply, and it's not a competition where we always win.

Another factor is the use of medications currently used to treat COVID that weren't necessarily intended to treat COVID. The drug in short supply in many Ontario sites, tocilizumab, is actually a medication for rheumatoid arthritis. But studies have shown a benefit in treating COVID patients. It is difficult to plan for a surge in demand for a drug that is used off-label for more patients than normally anticipated.

And we cannot excuse the nature of the COVID virus for causing drug shortages. The evolving nature of the pandemic has created an ever-changing playing field. When the Omicron variant arrived in late 2021, it proved to spread faster than experts had predicted — even among those who were vaccinated. After Christmas a spike in both hospital admissions and patients in the ICU caused a run on medications to treat the virus.

But Canadians should be assured, that despite the pressures created by COVID and the lengthy list of drugs in shortage, there is a stable system in place that puts the patient first. This national network of pharmacy leaders discourages the hoarding of any medications in any one region, and if there is a need for a drug in a hospital that is in short supply, every effort is made to ensure that drug gets to where it is needed most.

And if there are any benefits coming from this pandemic, it's that we have much better data on patients, where they are and what they need.

We are also building protections and redundancies into how we do business. Since the arrival of COVID, we are seeing more cooperation between organizations in the procurement of healthcare supplies. Health Canada built a federal critical drug reserve to serve as a buffer and add capacity to the system.

At HealthPRO, we have created a Critical Drug List. Every drug manufacturer we work with is required to have 90 days of critical drugs in stock and in Canada. It is a policy designed to create some runway when a surge in demand occurs, to avoid getting to a stage where there is a critical shortage.

Another good practice is to end sole sourcing suppliers. Having multiple suppliers of an essential medication boosts the bench strength and builds redundancies into the system.

Drug shortages are cause for concern, but professionals in healthcare procurement have been managing the situation for some time now. In fact, at any given time, Canada is experiencing a shortage of some 200 drugs. The Multi-Stakeholder Steering Committee on Drug Shortages has been in place for the better part of a decade monitoring the situation, and is maintaining a drug shortages website to provide more transparency on the issue.

In non-COVID times, there is little interest in the list unless you or a loved one needs one of the medications that is in short supply.

But in the midst of a pandemic, when people are worried and scared and hospitals are at capacity and patients are dying, there is spotlight shining directly on the availability of treatments. H

Christine Donaldson is Vice-President, Pharmacy for HealthPRO. She leads the procurement of pharmaceuticals on behalf of more than 1,300 hospitals across Canada and is actively supporting hospitals to manage supply chain disruptions.

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Building wound care knowledge with competency-based education programs

By Kimberly LeBlanc and Nicole Kocajda

Throughout the Covid-19 pandemic media has highlighted the strain it places on the health system and health professionals. Providing timely and specialized care for those suffering from acute and chronic wounds has been especially challenging. The challenges are two-fold, access to care and access to specialized care. Healthcare professionals recognize the need for advanced education, however, with increasing workloads and limited access to education, obtaining advanced wound care education can be difficult.

Nurses Specialized in Wound, Ostomy, and Continence Canada (NSWOCC) work with Canadian clinicians to address the lack of access to specialized wound care. The NSWOCC owns and operates the Wound, Ostomy, and Continence (WOC) institute. The WOC-Institute offers various standards of practice and competency-based programs to assist healthcare professionals in improving their skills and understanding of wound, ostomy, and continence, with both online and in person learning opportunities. The WOC-Institute's competency-based educational programs are delivered by a team of highly knowledgeable and dedicated nurse leaders who are Canadian Association of Nurses (CNA) certified Nurses Specialized in Wound, Ostomy and Continence (NSWOC). The online programs are designed to address the education challenges Canadians face secondary to our extensive landscape and numerous remote communities. Graduates from the WOC-Institute programs work collectively to improve the lives of individuals experiencing wound, ostomy, and continence related issues.

Nurse Specialized in Wound, Ostomy, and Continence (NSWOC) Program (formerly the Wound, Ostomy, and Continence Education Program) is a state of the art, competency based, and standards driven, paced, twelve-month, online program which prepares university prepared nurses (BN/BScN's) for the role of an NSWOC. The program consists of three courses, Ostomy, Continence and Wound. The final exam for the program is the Canadian Nurses Associate (CNA) certification exam. This rigorous exam ensures that our graduates possess the knowledge and critical thinking skills to work as certified NSWOCs.

The Skin Wellness Associate Nurse (SWAN) program is a five-month, competency based, paced online program which cumulates with a self-directed, mentored, clinical preceptorship which prepares practical nurses (LPN/RPNs) or diploma prepared registered nurses for the role of a nurse with enhanced skills in the areas of wound, ostomy, and continence. The program consists of three modules, Ostomy, Continence and Wound. The self-directed clinical preceptorships are the heart of the program's success. Learners are afforded the opportunity to apply new skills and knowledge in real time with mentorship. Graduates are connected with mentors and a peer support network in order to foster continuing education and professional growth.

For healthcare professionals who would like to enhance their foundational wound care knowledge the WOC-Institute has developed the Practice Enrichment Series in Wound Management program. The courses are state of the art, 6-week self-paced online programs which are facilitated by a team of CNA certified NSWOCs. Onsite programs are available upon request. Learners are directed through a series of modules designed to provide foundational knowledge in wound management and have access to virtual mentorship and knowledge consolidation opportunities with our team of CNA certified NSWOCs on a weekly basis. The course is offered throughout the year and is a rolling start.

The WOC-Institute just launched the Advanced Wound Debridement Program.

Continued on page 16

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Diagnostic innovation in wound healing

By Marianne Stacey

The extent and the burden of chronic wounds in Canada, in people worldwide has been well documented in multiple publications. Chronic wounds are increasing at a very high rate and can lead to complications that can impact quality of life including infection, sepsis, amputation and even death. The key challenge in treating such wounds is that current traditional assessment can take a number of weeks to identify if a wound is progressing or not and at what point do clinicians modify the treatment?

There are two key questions we ask ourselves when the wound healing process is impeded:

a) How do we accurately know the wound is in a healing status?

b) Of the numerous advanced wound care products on the market, do we have a full understanding of what therapies to utilized?

Dr. Michael C. Stacey, Vascular Surgeon and currently the CME & Executive VP Academic at the Hamilton Health Sciences, specializes in wound healing and finding ways to advance diagnostics. His most recent publication in *The Journal of Wound Repair and Regeneration,* validates that we can advance wound healing with innovative point of care diagnostic testing and link therapeutic options that will revolutionize wound care for patients, clinicians and health care funding.

Let's first take a look at the current approach to treating a chronic wound which is to:

- Determine the underlying cause of the wound.
- Conduct an initial baseline assessment of the wound and identify a treatment best suited to the type of chronic wound. Eg. pressure offloading, revascularisation or other options for different types of chronic wounds.
- Apply an Advanced Wound Dressing technology by which a clinician has many options such as wound debridement, dressings that regulate bacteria/biofilm, Protease inhibitors, the addition of a matrix, negative pressure, growth factors, cellular components, oxygen therapy or other modalities.
- Monitor the healing process by observation, measurement, photography, imaging and documentation on a regular basis.
- At best it can take 3-4 weeks to determine through assessment that a wound is not healing, when time is of essence.

Globally, there are great advances in educating the clinicians specifically in the care of wounds and understanding the possibilities available for the most appropriate treatment. But not all clinicians have this opportunity for training. As a result, there is a limited structured approach in many areas and changing treatment can be slow, random, and result in wounds have prolonged healing periods.

We cannot forget wounds during these times of COVID-19 and especially in community and remote set-

tings. There is a large gap in patient's ability to access patient virtual care and it is becoming more and more important that the clinician has the tools and education to provide the most optimal treatments for their patients and have accurate test results to discuss with a specialist.

Patients with chronic wounds and additional co-morbidities are at higher risk for COVID-19 and it is essential to avoid admission to hospitals which are already at capacity and where there can be further exposure.

An exciting new innovation in biomarker based diagnostic technology has developed in light of new research that has identified a biomarker which can be measured in wound fluid to determine the status of wound healing in venous leg ulcers.

This research has identified that GM-CSF (Granulocyte macrophage colony stimulating factor) has a 92 per cent accuracy at determining the healing status of a wound and a 96 per cent sensitivity at determining if a wound is not healing. We have initiated the same study in the Diabetic Foot Ulcer population.

PATIENTS WITH CHRONIC WOUNDS AND ADDITIONAL CO-MORBIDITIES ARE AT HIGHER RISK FOR COVID-19 AND IT IS ESSENTIAL TO AVOID ADMISSION TO HOSPITALS

WoundNostics Inc., is a Canadian based start-up company and is very excited to share that we have obtained the world-wide rights to advance this technology and to develop a pocket - sized point of care test that clinicians can use immediately. The diagnostic will indicate a wound is not healing and the results can direct wound treatments in real time. With the support of investors, this technology will take approximately 12 months to develop to be ready for manufacture.

To summarize, there is great value for the clinician in utilizing a point of care diagnostic:

- Knowing in real time, in the community, hospital or clinic, that the wound is not healing the clinician immediately change treatment.
- Provision of an APP which links the knowledge of the wound's healing status to a hierarchical algorithm of advanced wound treatments on a mobile device for easy access and education.

This would eliminate weeks of not knowing the status of wound healing. Aligning a point of care test of healing status of a wound with a hierarchical algorithm of therapies will facilitate more expedient decision making which leads to increased quality of life for the patient, faster healing times, fewer complications and less burgeoning costs to the health care system.

One of the top global specialists in Diabetic Foot Ulcers and Limb Salvage, Dr. David Armstrong, Director, Southwestern Academic Limb Salvage Alliance, in support of new wound advancements in diagnostics, provided us with the following quotation. "To say we're enthusiastic about this space and "measuring what we manage" is an understatement. Here's to that next jump in wound navigation."

Our vision at WoundNostics Inc. is to develop a panel of point of care tests which will also evaluate the cause of non-healing status of the wound upon initial evaluation which will then direct the optimal therapy for a patients wound. This will add to the customization of the patients managed care and improve the quality of life for our patients. H

Marianne Stacey is Chief Executive Officer, WoundNostics Inc. Canada

Wound care specialist taps into her artistic side

Ask Stephanie Furtado to open her supplies cupboard and you'll find everything from gauze fabric squares to scissors, foam shapes, paste, tape and other specialized items for skin, wound and ostomy care.

"The dressings we use to protect a patient's skin and support their healing can be quite detailed, with a variety of components that are put together step-by-step," says Furtado, a skin, wound and ostomy nurse clinician at Hamilton Health Sciences (HHS). Dressings may also be custom-fit, depending on a patient's needs.

"Putting together these dressings feels very much like artwork to me. It definitely appeals to my artistic side."

NOT YOUR TYPICAL BANDAGE

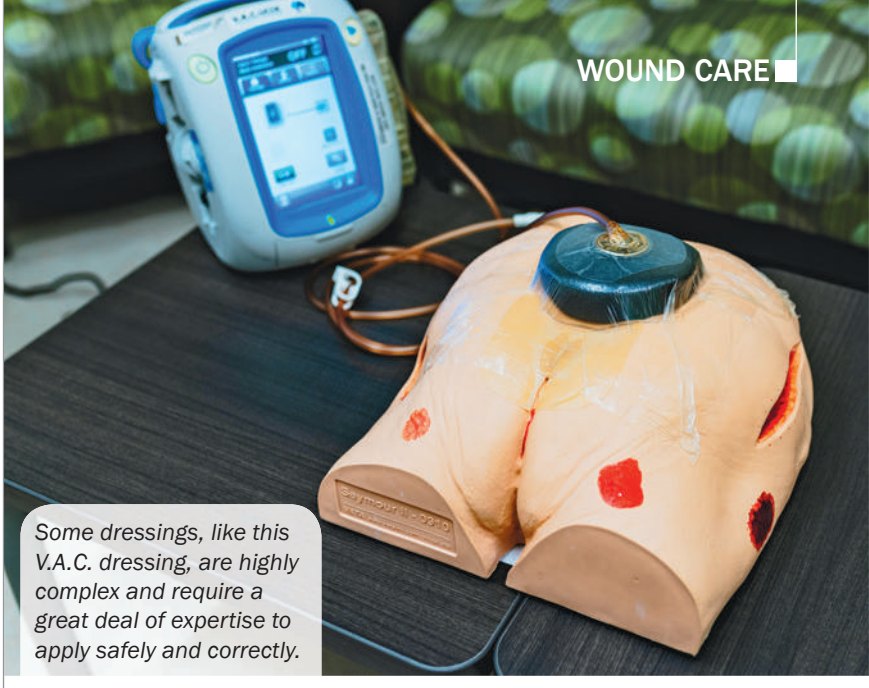
But assembling multi-piece dressings takes more than an artful hand. Some are highly complex, involving technology that keeps evolving. "I try to attend at least two conferences each year in order to stay caught up," says Furtado.

A V.A.C. dressing, for example, comes in a kit that includes dressing foam, film seal, tubing and a vacuum pump. It's used on complex wounds and pressure injuries.

V.A.C. stands for vacuum-assisted closure, a method of decreasing air pressure around a wound to draw out fluid and infection to help with healing. To apply this dressing, Furtado places a foam bandage over an open wound, and a vacuum pump is used to help it heal faster.

"It literally pulls out drainage while pulling the wound together," says Furtado. "We even have a version that cleans the wound with an antiseptic every couple of hours for infection prevention."

Continued on page 18



Some dressings, like this V.A.C. dressing, are highly complex and require a great deal of expertise to apply safely and correctly.

Continued from page 12

Wound care knowledge

The competency-based, advanced debridement course is designed by nurses for nurses and follows the Canadian best practise recommendations for nurses; however, the Wound, Ostomy and Continence Institute recognizes the course may be of interest to other disciplines. As such, non-nurses meeting the prerequisite education requirements will be accepted into the program. Healthcare professionals without a nursing background are responsible for recognizing their own scope of practice and jurisdictional policies related to their profession. In-depth knowledge of wound management is essential prior to enrollment in a competency-based debridement educational program. Prerequisite education is identified by the successful completion of a rigorous curriculum-based wound management program including stringent outcome measures such as examination. The primary objective of this program is to provide learners with advanced theoretical knowledge pertaining to all aspects of debridement. Learners are encouraged to seek out mentorship opportunities within their work environment and to work within their scope of practice. At the end of this program learners will have advanced debridement knowledge beyond the WOC-EP/ SWAN programs. It is self-paced online with access to virtual mentorship and knowledge consolidation opportunities with CNA certified NSWOCs. Once in person conferences resume, an annual workshop will be held during the NSWOCC National conference. The course is offered throughout the year and is a rolling start.

Community care paramedics play a pivotal role in the care of individuals living in the community. The WOC-Institute recently launched the Paramedic Practice Enrichment Series in Wound Care, a state of the art, competency-based, self-paced online program facilitated by a team of CNA certified NSWOCs. Onsite programs are available upon request. The course is offered throughout the year and is a rolling start.

To learn more about the programs please visit https://wocinstitute.ca/ or contact us at programmanager@wocinstitute.ca

Kimberly LeBlanc PhD, RN, NSWOC, WOCC (C), FCAN, is the Academic Chair and Nicole Kocajda, MBA, IIWCC, ISWA is the Program Manager of the NSWOCC Wound, OSTOMY and Continence Institute

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Artistic side

PEOPLE CAN HAVE SERIOUS COMPLICATIONS IF WOUNDS AREN'T CARE FOR PROPERLY. IN FACT, IT CAN BE LIFE THREATENING.

Ostomy supplies are another example. They include barrier rings, flanges, powder and spray that layer together to protect skin surrounding a stoma – an abdominal opening made surgically when there are issues with the colon, so waste can be collected in a bag attached to the patient's skin.

"We use our specialized knowledge and training to prevent the skin around the stoma from breaking down," says Furtado, whose passion for skin, wound and ostomy care was ignited when she was a nursing student at McMaster.

During a student placement with a home care agency, Furtado helped treat a case of flesh eating disease. "It was a very challenging wound, and treating this patient triggered my interest in wound care. I enjoy complex dressings, treating challenging wounds and seeing patients heal."

After graduating, Furtado worked at HHS Hamilton General Hospital's burn unit for more exposure to wound care. Seven years later she switched to part-time in order to pursue specialty certification in wound, ostomy and continence care followed by a masters in wound healing from Western University.

The fine art of wound care: Meet Stephanie Furtado, an HHS Picasso of dressings

Other roles she has taken on due to her specialty include part-time assistant clinical professor at McMaster's School of Nursing, faculty lecturer for the surgical foundations program at McMaster's department of surgery, regional director for Nurses Specialized in Wound, Ostomy and Continence Canada (NSWOCC) as well as NSWOCC's pediatric community of practice core program lead.

At HHS, much of her work involves treating burns but she also sees a wide range of skin, wound and ostomy cases including pressure injuries. "People can have serious complications if wounds aren't cared for properly," says Furtado. "In fact, it can be life threatening."

Furtado credits HHS' team approach with helping their patients recover. "With dressings, we're trying to create the ideal circumstance for patients' wounds to heal, but if they don't have good blood flow to the area and good nutrition to build tissue it doesn't matter what I do," says Furtado, who works closely with staff members including other nurses, occupational therapists, physical therapists and dietitians. H

This article was submitted by Hamilton Health Sciences.

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Patient lifts and worker risks

There are many challenges faced by healthcare workers for whom patient handling is a part of their daily job. While mechanical lifts make it much easier to move and lift patients and can help reduce the ergonomic risks associated with manual patient handling, they also introduce other workplace hazards.

Most hospitals, long term care facilities and private homes use mechanical lifting systems to move or reposition patients and clients with mobility issues. There are several different types that you may encounter including wheeled hoist/portable floor lifts, stationary hoist/fixed lifts, ceiling tracks complete with motors, sit/stand lifting aids, and bath lifts.

Although using patient lifts can make the job easier, they come with hazards to the worker and or the patient. Parts that are suspended can fall and loads can be dropped. There is risk of equipment and or structural failure, and electric shocks. There is also the risk of body strain if a hoist should fail, and an attendant tries to catch a falling client.

The following tips and good practices offer practical guidance to help prevent injuries to attendants using patient lifts.

INJURY PREVENTION: HAVE A PROGRAM IN PLACE

An ergonomic safe patient handling program can help reduce musculoskeletal injuries that result from the long-term cumulative physical effort of patient transfers as well as immediate injuries that result from incidents during transfers. The program should involve approval and commitment from management and will be more effective if developed in collaboration with union representatives, health and safety committee members and workers.

The ergonomic safe patient handling program will include steps to perform a needs analysis, create and standardize patient assessment criteria, develop decision trees to standardize actions, determine which controls are needed to implement specific tasks or patient needs and may institute a "no-lift" policy, where possible.

A no-lift policy would state that all manual handling tasks are to be avoided wherever possible. These policies successfully reduce the risk only if the organization has the infrastructure in place (technical solutions, lifts, equipment) to support the initiative. Training is also necessary to recognize the risk in activities, and how to follow appropriate steps to move or transfer a patient safely.

LEGISLATION

Find out about, and meet, the legal requirements in your own jurisdiction for the use of lifts in workplaces. Some general requirements may include providing adequate lifting equipment and proper training of employees who use this equipment. It may also include proper installing of any lifting machine, as well as the testing, operating, use of, servicing, maintenance, and repair according to the manufacturer's or an engineer's specifications.

Tips for users of patient lifts

To reduce injuries, how we approach the transfer or lift is equally important as the equipment, staffing, and workload. Share these safety tips with all workers using patient lifts.

- Make sure you are properly trained on, and understand, how to operate the lift.
- Assess the client before every transfer and ensure the path of the transfer or lift is clear from obstructions.
- Be sure that furniture and aids that the client is being transferred to are properly placed and secure.
- Fasten all clips, latches, and hanger bars securely during operation.
- Keep the base (legs) of the patient lift in the maximum open position and position the lift to provide stability.
- Ensure the patient's arms are inside the sling straps.
- Lock the wheels on any device that will receive the patient such as a wheelchair, stretcher, bed, or chair.
- Ensure that the weight limitations for the lift and sling are not exceeded.
- Do not rotate or twist the spine. Move your entire body in the direction of the transfer.
- During transfers, tighten your abdominal muscles, keep your back straight, and use your leg muscles to avoid injury.
- Position yourself close to the client and assure footing is stable.
- Try to maintain eye contact with the client and communicate while the transfer is in progress.
- Follow the instructions for washing and maintaining the sling.
- Follow a maintenance safety inspection checklist to detect worn or damaged parts that need immediate replacement.

SLING SAFETY

Slings are a key part of the lifting system. It is important to use the correct sling, approved for use by the patient lift manufacturer, for the specific hoist. The safe working load must be clearly marked on both the lift and the sling. Take care to ensure the sling is compatible with the load limits of the lift and the patient's weight. Perform sling maintenance according to the manufacturer's specifications. Inspect the sling fabric and straps to make sure they are not frayed or stressed at the seams or otherwise damaged, and if there are signs of wear, do not use it.

EQUIPMENT INSPECTIONS

The manufacturer's specifications will provide a frequency for periodic inspections and pre-use inspections. The periodic inspection requires documentation to demonstrate it has been completed. Pre-use inspections ensure that compatible parts are used and properly configured, and that load restrictions are not exceeded. They also identify any visible signs of damage to equipment that may lead to a failure. Create a system to ensure that defective equipment is clearly marked and taken out of service until replaced or repaired.

Regardless of size, all workplaces can benefit from a code-of-practice, or safe work procedure for hoist operation, inspection, and maintenance. And most importantly, healthcare workers, patients and clients will be safer.

This article was submitted by the Canadian Centre for Occupational Health and Safety (CCOHS). The Canadian Centre for Occupational Health and Safety (CCOHS) promotes the total well-being — physical, psychosocial, and mental health — of workers in Canada by providing information, advice, education, and management systems and solutions that support the prevention of injury and illness. Visit www.ccohs.ca for more safety tips.

Addressing musculoskeletal disorders and overexertion injuries related to patient handling

By Derek Morgan

The COVID-19 pandemic has increased the mental and physical demands on our frontline healthcare workers. In what was already known to be a physically and mentally demanding work environment, staff are now working longer hours to curb workforce shortages, experiencing higher patient-to-nurse ratios, and coping with increasing hostility from patients/family members and the public. Exposure to these conditions can create greater psychological stress and physical strain on an already exhausted workforce. Having to perform demanding tasks such as transferring or repositioning patients during times of stress and fatigue can also predispose staff to musculoskeletal disorders (MSD) and overexertion injuries.

An MSD or overexertion injury can occur when the physical demands of a task exceed the capacity of a worker. With an overexertion injury, an imbalance is created between what needs to be done and the worker's capabilities, causing an overloading of tissues and resulting in damage (injury). Repeated exposure to similar, less dramatic imbalances overtime exposes muscles, tendons, ligaments, joints and spinal discs to cumulative trauma, which, with insufficient rest and recovery, can increase the risk for an MSD. Traditionally, healthcare workers have faced a higher risk of injury from MSD, especially during tasks involving the lift, transfer or repositioning of patients.

Patient handling is a common activity in healthcare which can be a physical burden for staff due to the frequency of lifting/lowering or pushing/pulling movements that require high forces and awkward or static postures. Back injuries and related muscle strains of the upper body are common injuries seen amongst caregivers. Biomechanical demands such as force, posture and repetition/duration are often regarded as the primary culprits for MSD and overexertion injuries. However, psychosocial work factors (e.g., work pressure, shift work, lack of control, environmental stressors) and work organization factors (e.g., how work is structured) can also influence the risk of injury. Psychosocial work factors can alter physiological and behavioural responses whereas work organization factors can inadvertently increase exposure to greater physical demands.

Although we will not explore the interaction between biomechanical, psychosocial and work organization factors here, it is important to acknowledge that the etiology of an MSD can be multi-factorial. This can present a challenge when identifying and controlling associated hazards, particularly when it comes to patient handling activities, but interventions that incorporate multi-components and various control strategies can be effective.

A common, and often required, control measure is the implementation of a comprehensive patient handling program which addresses equipment, policies/procedures and training, among other elements. Yet, despite the presence of such a program, healthcare workplaces still face challenges and barriers, including fewer staff available, larger people with less mobility, improvised settings and satellite worksites.

So, what can we do today to support safe patient handling activities amid such challenges?

A PARTICIPATORY APPROACH

A participatory approach is used to engage and empower frontline staff, managers and internal subject matter experts to make decisions and solve problems as a team. This can be initiated at the manager level during huddles or team meetings. Internal subject matter experts have also been successful utilizing this approach. When using this approach, workplace parties become actively involved in the recognition, assessment and control of hazards in the workplace. During periods of change and growing complexity, a participatory approach can be used to address new or emerging hazards along with potential control strategies. The resulting benefits include hazard control measures that are applicable and feasible for the environment and its conditions. Moreover, as communication is encouraged and staff have input and gain control over their work, this approach also has the potential to mitigate psychosocial work factors. A participatory approach can therefore serve a dual purpose as an MSD intervention.

The Institute for Work and Health has reported encouraging findings using a similar approach applying a peer-coaching model. In this program, workers were designated as peer coaches who received training on patient handling equipment and associated procedures. Upon training completion, these peer coaches provided both formal and informal frontline coaching to their nursing peers. When the use of equipment was paired with this coaching and mentorship support, the resulting impact was a reduction in injuries. This is a great example of how leveraging knowledge and skills from within can support and sustain safe patient handling practices. Although this example requires necessary resources, which may be under extreme pressure in our current environment, it reinforces the essence of a participatory approach which engages and harnesses frontline knowledge and experience.

ASSESSING PATIENT NEEDS

An effective patient handling program requires a thorough and comprehensive patient assessment. Initial and ongoing assessment of patient mobility determines the type of patient handling equipment or procedures that should be used and the level of staff assistance required to safely move a patient. It is essential to continually review patient mobility status to ensure the frequency of handling tasks, equipment and environmental issues that may impact safe patient handling tasks have been properly estimated and identified.

A plan to communicate and document patient mobility findings and status must also be considered. Ensuring there is an efficient and consistent way to document each assessment and communicate those findings to caregivers establishes consistency in handling tasks. This could include the use of patient whiteboards, charts or bed signage.

Re-assessment of the patient's condition should also be done throughout the day at point of care to capture changes in mobility status. Throughout the day a patient could become fatigued, for instance, which could alter the prescribed equipment or procedures.

EQUIPMENT AVAILABILITY

A major objective of a safe patient handling program is to reduce the physical demands associated with lifting, transferring and repositioning patients. The most effective way to reduce the physical demands is to introduce engineering controls such as patient handling assistive devices and technologies. Ensuring access and availability to necessary equipment and devices protects staff and promotes quality care. Availability of the equipment and accessories should be clearly communicated. Device location (storage) should be considered along with labelling of equipment; slings should also be inventoried to ensure adequate supply. If equipment is not easily available, it will not be used.

EQUIPMENT MAINTENANCE

Equipment must always be in good working order to avoid unnecessary or adverse conditions. As discussed with equipment availability, if equipment is not maintained and functional, it will not be used. A preventive maintenance program must be in place. Regular inspections of all equipment such as transfer or lift devices and their attachments must be carried out. Any unsafe equipment and/or sling should be removed from service and labelled immediately for repair where possible. A clearly defined and communicated process on what to do when equipment is found to not be working should also be established.

When equipment or other devices have been redeployed to other areas of the workplace or off-site, it's imperative that staff complete pre-use checks for mechanical devices and accessories such as slings. Tip sheets can be very helpful to ensure key aspects of the equipment are reviewed.

MODEL OF CARE

Consider the use of non-clinical staff to help ease the burden on nursing staff. A recent publication found the redeployment of non-nursing clinical staff can be an effective strategy to leverage available resources while reducing nursing burden. This initiative deployed physical therapists and occupational therapists to partner with ICU nurses to help provide daily care for severely ill patients with COVID-19. This team-based approach was found to reduce the burden on nurses while maintaining standards of care.

Use of a similar model to support patient handling practices would require necessary customization to effectively support patient populations, situational needs and adherence to professional practice guidelines. However, with staff redeployment and COVID-19 surges, an effective use of resources may give rise to alternative strategies of care.

We know that MSD can be cased by many factors in the workforce. The interaction between biomechanical, psychosocial and work organization factors can create ideal conditions for MSD and overexertion injuries. Addressing these factors in combination can yield the greatest impact, but may never eliminate the risk associated with patient handling activity. In healthcare environments, a safe patient handling program is an integral component of the overall occupational health and safety program. Standardizing our approach to patient handling techniques and associated measures by utilizing staff knowledge, ensuring access to proper, functioning equipment, and good communication/training can help address the physical demands associated with these tasks.

For more information on how to enhance your current safe patient handling program, access Public Services Health & Safety Association's Handle with Care resources at pshsa.ca/ergonomics.

Derek Morgan MHK, CRSP, CHSC is a health and safety consultant with Public Services Health & Safety Association. Derek has been with the organization since its inception supporting organizations in the health and community care sector.

Addressing the complex needs of older adults undergoing major cancer surgeries

By Hayley Mick

A surgical program at St. Michael's Hospital of Unity Health Toronto received the 2021 Innovation Award from the Cancer Quality Council of Ontario (CQCO) for finding new ways to improve the patient experience for older adults who require major cancer surgery.

The Older Adults Surgery and Oncology Program at St. Michael's brings together surgeons, geriatricians, anesthesiologists, nurses, social workers, dieticians, and physiotherapists. The team works collaboratively and proactively to personalize the care for individuals and their families by recognizing and adapting to the unique care needs of older adults.

The team received the award at a virtual award ceremony hosted by the CQCO. The Innovation Awards recognize, encourage and reward the development of new processes, products, or organizations which are bold, experimental, or far-reaching, and which enhance and improve cancer care performance in Ontario.

"Going through a major cancer surgery can pose a challenge for an older adult who may already experience unique health issues," said Darren Larsen, Chair of the CQCO. "We congratulate St. Michael's Hospital for developing this innovative program to ensure older adults receive the safe and specialized care they need."

Dr. Tyler Chesney, surgical oncologist, Dr. Camilla Wong, a geriatrician, and Danielle Zvezdonkin, a registered nurse, accepted the award on behalf of the St. Michael's team.

"Many older adults are particularly worried about undergoing major surgery," said Dr. Chesney. "It is an honour to see the impact that such a dedicated team focused specifically on their care needs can make."

Dr. Wong said: "Rather than elder-friendly principles being an 'add-on' or an 'after thought', this proactive, collaborative approach tailors cancer surgery to the special considerations of older adults to align our care with the patient's values and needs."

Addressing a patient's complex needs before admission reduces their concerns and negative outcomes after surgery, Zvezdonkin added.

"This program has helped our team support our older adult patient's needs by addressing them proactively and individualizing a plan to support them and their family in their journey," she said.

The Quality and Innovation Awards are hosted by the Cancer Quality Council of Ontario in partnership with Ontario Health (Cancer Care Ontario) and sponsored by the Canadian Cancer Society. The awards, now in their 15th year, recognize and encourage the development of initiatives that have led to significant improvements to the delivery of cancer care for patients across Ontario.

"We know that some older adults have unique health needs," says Laura Burnett, Vice President, National Support Programs at the Canadian Cancer Society. "We're excited to recognize the Older Adults Surgery and Oncology Program at St. Michael's Hospital for its efforts to address gaps in surgical care and improve outcomes for older adults receiving surgery as part of their cancer treatment."

One award and two honourable mentions were presented in the Innovation category, while one award and one honourable mention were presented in the Quality category, and one award and one honourable mention were presented in the newly created COVID-19 Innovation category.

For more information, visit https://www.cqco.ca/en/quality-innovation-awards. H

Hayley Mick is manager of media and digital strategy at Unity Health Toronto

Remdesivir for COVID-19 found to reduce need for mechanical ventilation

By Samantha Sexton

Remdesivir, when compared with standard of care for COVID-19, reduced the need for mechanical ventilation in hospitalized patients, according to a new randomized controlled trial in *CMAJ (Canadian Medical Association Journal)*.

The study, Canadian Treatments for COVID-19 (CATCO), is a Canadian Institutes of Health Research funded substudy of the global World Health Organization Solidarity trial which is examining the effects of various treatments for COVID-19. CATCO is being led by researchers at Sunnybrook Health Sciences Centre and the University of British Columbia.

In the trial which involved 52 Canadian hospitals, Canadian researchers studied the effect of remdesivir in hospitalized patients with COVID-19 between August 14, 2020 and April 1, 2021. There were 1282 patients included, with about half randomized to the treatment arm and the others to the control group. Evidence has been mixed on the effect of remdesivir, a repurposed antiviral medication, in people with COVID-19.

The Canadian trial found that in patients not ventilated at the start of the study, the need for mechanical ventilation in patients receiving remdesivir was eight per cent vs. 15 per cent in the control arm receiving standard of care. Mean oxygen-free and ventilator-free days at day 28 were 15.9 and 21.4 in the remdesivir group compared with 14.2 and 19.5 in the control group – meaning, patients treated with remdesivir were able to come off oxygen and mechanical ventilators sooner than those receiving standard care.

"The benefit of treatment was most apparent for preventing the need for mechanical ventilation, suggesting probable added value for patients with less severe disease to avoid progression during hospital stay," says Dr. Srinivas Murthy, co-principal investigator of the trial and a clinical associate professor at the University of British Columbia. "This may have important implications for patients and for health systems, particularly when ICU capacity, mechanical ventilation or oxygen are in limited supply."

"While increased survival was not definitively demonstrated, the sum total of demonstrated benefits in this new trial argue fairly strongly in favour of a treatment strategy that incorporates remdesivir in the decision-making when caring for patients with COVID-19," says Dr. Rob Fowler, co-principal investigator of the trial and critical care physician and senior scientist at Sunnybrook Health Sciences Centre in Toronto, which is sponsoring the CATCO trial and helping to coordinate it at all Canadian hospitals.

The CATCO trial was able to collect more detailed data compared with some other countries, as well as engaging patients across a range of ethnicities, particularly important for applications in other countries and in our multicultural society. It also represented the largest single country trial of remdesivir reported to date.

These results add to the larger global trial around how remdesivir could be used in other countries.

"The findings of CATCO are also important and complementary to Solidarity as they help to address questions of generalizability of a large simple protocol carried out across a wide range of hospitals and health care systems from low-, middle- and high-income countries," the authors conclude. H

Samantha Sexton is a Communications Advisor at Sunnybrook Health Sciences Centre.

Having nurses deliver in-house blood transfusions enhances patient care

By Ellen Rosenberg

A blood transfusion process that once took about four hours out of a patient's day has now been cut in half, thanks to one unit's commitment to enhancing patient care.

On Toronto Rehab's 8 South Multi-System Rehabilitation Inpatient Unit, located at University Centre, a team of nurses dedicated the later part of 2021 to learning how to administer blood transfusions directly on their unit.

That means patients who used to spend hours preparing to leave the unit, transport to another UHN site, receive a transfusion, travel back and settle in, can now receive the same care, from the comfort of their own bed, in a fraction of the time.

Training unit nurses to administer blood transfusions is a natural evolution for the team on 8 South, says Yolande Geba, Program Services Manager on the unit.

"It reflects Toronto Rehab's ongoing commitment to matching patient need to scope of practice, removing barriers to admission, and enhancing patient experience," Yolande says.

It also frees up a patient's time to focus on reaching their rehab goals and spending time with essential care partners.

MATCHING SCOPE OF PRACTICE TO PATIENT NEED

Across all programs at Toronto Rehab, teams are caring for increasingly complex patients. It's part of an effort to support patient flow in acute hospitals, and ensure equitable access to rehabilitation.

Individuals recovering from oncology or transplant surgery represent just two populations whose medical needs were, until recently, beyond the scope of what was delivered on-site.

"Some of our patients may require frequent blood transfusions as part of their treatment plan," says Kristen Cunningham, an advanced practice nurse educator for the MSK and Geriatric Rehab programs.

The Blood Transfusion Team at Toronto Rehab.

ACROSS ALL PROGRAMS AT TORONTO REHAB, TEAMS ARE CARING FOR INCREASINGLY COMPLEX PATIENTS. IT'S PART OF AN EFFORT TO SUPPORT PATIENT FLOW IN ACUTE HOSPITALS, AND ENSURE EQUITABLE ACCESS TO REHABILITATION.

"In the past, we've admitted them to our unit, coordinated their outpatient blood transfusion appointments with Princess Margaret or Toronto General Hospital, organized their transfers, helped them prepare to leave, then settle back in, upon return."

From a resourcing perspective, the process was costly.

From a patient perspective, it was disruptive, and involved a number of teams and transitions where errors could occur.

The solution was to train nurses on 8 South to administer blood transfusions.

"Localizing all care needs in one place promotes patient-focused care," says Daltash Dhaliwal, a clinical nurse specialist who partnered with Kristen and UHN's Transfusion Safety Officer, Farzana Tasmin, to provide the education.

"Our nurses have the capacity to provide excellent care, and we want to continue to empower them to work to their full scope," Daltash says.

SIMULATION BRINGS EDUCATION TO LIFE

The nursing education, which took place throughout October in the auditorium at University Centre, included one hour of didactic theory, and one hour of interactive, hands-on application in a simulated lab.

From start to finish, the nurses practiced analyzing a new order, requesting blood from the lab, spiking the blood, delivering the transfusion, and monitoring the patient throughout the entire process.

"We even created a scenario where the patient had a transfusion reaction, and the team had to react and adapt, as they would in a real setting," says Daltash.

"While nurses in rehab have experience administrating IV medications, blood transfusions are different. The policies, logistical processes and assessment requirements to perform this skill is brand new."

Nicoleta Ciuca, a nurse on 8 South, says she and her colleagues have been looking forward to enhancing their skills, and found the education to be helpful in clarifying the process, from start to finish, and in identifying the resources they'd need.

"The theory is important," Nicoleta says, "but we had a lot of logistical questions that the hands-on simulation helped clarify: Who is going to bring the blood from the blood bank? How are we going to get it to our patients?"

ALLOWING PATIENTS TO FOCUS ON THEIR REHAB GOALS

Back on 8 South, Nicoleta says her confidence in this new area increases every day, thanks to ongoing support from Kristen and Daltash. But what really stands out for her is how it's enhanced her patients' experiences.

"We want patients to be focusing on their rehab goals," she says. "Now we have some flexibility to work around their therapy appointments, meals, and practicing other activities of daily life."

Kristen agrees, adding that, by the time they're admitted to rehab, many patients have had a long, complicated, and sometimes stressful journey.

"To be able to come here, settle in, and not have to be shuffled back and forth between care teams, will really enhance their patient experience and propel their rehab forward," she says.

Ellen Rosenberg is a Senior Public Affairs Advisor at University Health Network.

How an app called MAX is making a difference

By Mary Gooderham and Margaret Polanyi

At age 56, Paul Lea was working as a quality control auditor at Levi Strauss when he suffered a massive stroke in 2008 and was diagnosed with vascular dementia.

Lea was determined to continue living in his Toronto apartment. He set about renovating, wrote a book and became an advocate for people living with dementia.

"Since my diagnosis, I've had to learn my limits, but I've also accomplished things that no one would have expected," Lea wrote in a blog for the Alzheimer Society of Canada.

For Lea, like many people living with dementia, one of the challenges is keeping track of medications. He needs to take seven medications throughout the day.

But these days, it's a lot easier thanks to a new app that reminds people to take their medications or go to appointments. MAXminder™ is a personal aide, coming to market with support from AGE-WELL, Canada's technology and aging network. The app is for older adults with mild cognitive impairment, scheduling and reminding them and their caregivers about medications and daily activities.

MAX has been designed for and tested with people who will ultimately use it, and is now available in "beta mode" for anyone who wants to check it out.

Lea was introduced to the app in his role as an advisor for Open Collaboration for Cognitive Accessibility, an AGE-WELL-supported startup that uses an inclusive approach where people with dementia and cognitive disabilities provide feedback on whether products and services are usable and practical.

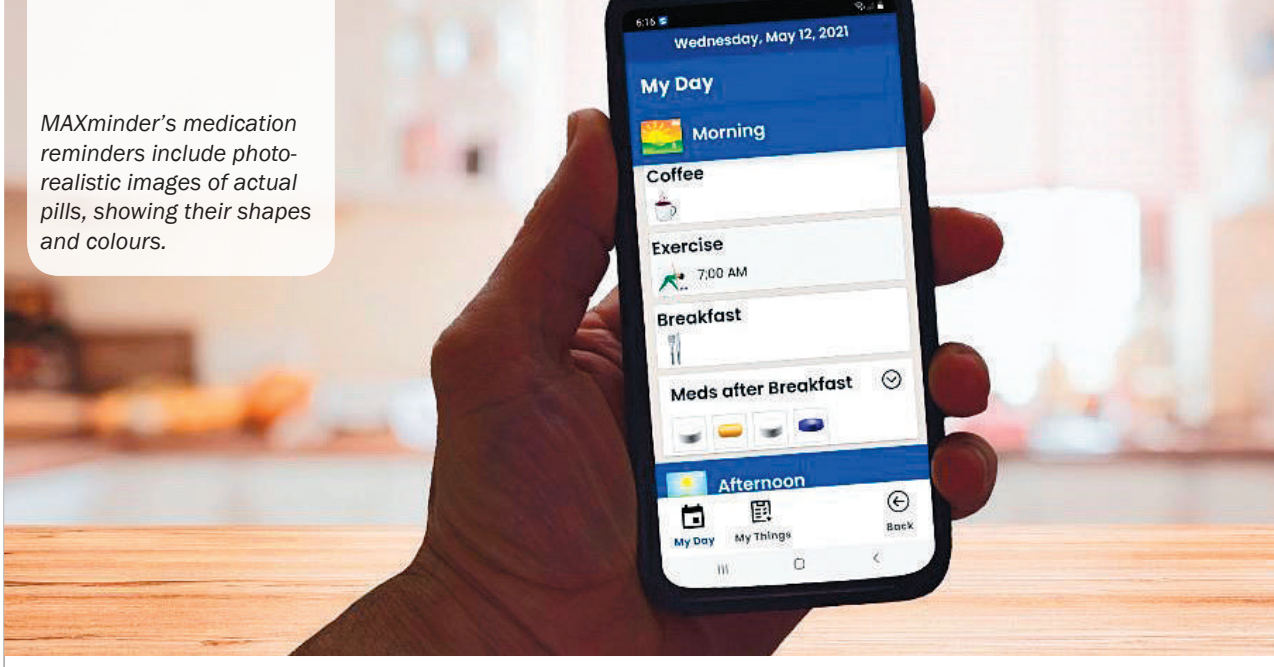
As an advisor, Lea offered input on MAX that included suggesting a way for users to edit their entries. He loves the app, especially its pop-up reminders of the medications he needs to take daily.

The app's simple menus are easier to navigate than a typical Google or Outlook calendar, says Lea. He plans to get MAX for his daughter, who lives an hour away, so that she can also keep track of his medications and activities.

MAX is personalized, requires little or no typing and is simpler to use than other calendar products on the market, says project lead Dr. Jeff Jutai, an AGE-WELL researcher and professor of health sciences at University of Ottawa. For example, its medication reminders include photo-realistic images of actual pills, showing their shapes and colours, to ensure people are alerted to take the right medication in the correct dose at the right time.

The technology also helps alleviate the stresses of people caring for older adults living with cognition and memory issues, he says, by providing timely information about how their loved one is doing, and involving them in scheduling and monitoring activities directly through the app.

Dr. Jutai says the project began six years ago as a way for people who "want independence and quality of life as they age, but face challenges with their memory, dexterity, mobility and eyesight" to safely manage medications and keep track of appointments such as doctor's appointments and meetings.



MAXminder's medication reminders include photo-realistic images of actual pills, showing their shapes and colours.

Funded through AGE-WELL's Strategic Investment Program, Dr. Jutai says the project also represents "an especially strong and productive collaboration" with industry partner JLG Health Solutions of Ottawa.

The company's CEO Dinis Cabral calls MAX "a gamechanger." He points out that with the COVID-19 pandemic, older adults "are more isolated and require more support, but restrictions make providing that support harder and we need this technology to help us." Post pandemic, the app will continue to support older people to age in place, he says, while easing pressures on caregivers, including those who live far from their loved one.

Dr. Jutai says having people like Lea involved "at every step of the process" has been critical to ensure future commercial success for MAX. The feedback has made the app more user-friendly, for example with larger icons and a more intuitive way of inputting information, adds Cabral.

MAXminder™ will be available in a few months' time at a monthly or yearly cost through app stores. The app is provided through a secure cloud-hosted system, so information is not sitting on an actual device. It's on both Apple and android platforms, and works on smartphones and tablets.

The app currently works in English and French, and an older adult and a caregiver can even use versions with different languages at the same time. Other languages should be easily added going forward, and there are plans to release the product in other countries. H

Mary Gooderham is an Ottawa-based freelance writer. Margaret Polanyi is Senior Communications Manager at AGE-WELL. For more information, visit www.agewell-nce.ca

Photo credit: Andrea Piacquadio from Pexels

Five innovations supporting people living with dementia and their caregivers

By Arielle Ricketts

Family caregivers of people living with dementia face unique challenges. Though caregiving can be a rewarding experience, it can also place a lot of strain on time, finances, and emotions, leaving many caregivers feeling overwhelmed, particularly when balancing caregiving duties with other responsibilities like work and childcare.

Supporting caregivers is more important today than ever before. The pressures of the COVID-19 pandemic on our healthcare system have made it even more challenging for family members to access the support services that they need for themselves and their loved ones.

THE PRESSURES OF THE COVID-19 PANDEMIC ON OUR HEALTHCARE SYSTEM HAVE MADE IT EVEN MORE CHALLENGING FOR FAMILY MEMBERS TO ACCESS THE SUPPORT SERVICES THAT THEY NEED FOR THEMSELVES AND THEIR LOVED ONES.

That's why the Centre for Aging + Brain Health Innovation (CABHI) invited frontline care workers, clinical managers, and clinical researchers to submit an innovative idea aimed at improving the lives of older adults, persons with dementia, and their care partners to the Spark-ON program. Spark-ON is a subsidiary of CABHI's Spark Program, which supports the development of grassroot solutions by frontline healthcare workers and researchers that solve real-world critical care challenges.

Many of the successful Spark-ON projects are focused on helping family members navigate their caregiver responsibilities, maintain their well-being, or connect with their loved ones in a meaningful way.

1. VRX@HOME: IMMERSIVE VIRTUAL REALITY THERAPY FOR PEOPLE LIVING WITH DEMENTIA AND THEIR CAREGIVERS

A University Health Network project team, led by Lora Appel (Assistant Professor at York University) is designing and rigorously evaluating the first

Virtual Reality (VR) therapy program for people with Alzheimer's and related dementias (PwAD) living at home. VR therapy is a drug-free approach to reducing symptoms of Alzheimer's dementia, such as apathy, feelings of loneliness, sundowning, and the use of harmful sedating medications. VR therapy also has the potential to improve caregiver stress levels, allowing them to continue providing support to PwAD.

2. SUPPORTING CAREGIVERS FROM ETHNOCULTURAL COMMUNITIES

The Diverse Caregivers Access Program aims to develop, test, and deliver culturally sensitive and linguistically appropriate resources for caregivers of people living with dementia in various ethnocultural communities. The program, led by Stephanie Conant (Manager, Caregiver Wellness & Social Work at WoodGreen Community Services) will increase access to affordable or free resources that are co-designed with caregiver stakeholders and frontline staff. During the COVID-19 pandemic and beyond, this project aims to improve caregivers' experience with health and community service navigation and access, improve quality of life, reduce caregiver burden, and provide integrated care for people living with dementia.

3. IGERICARE: ONLINE DEMENTIA TRAINING FOR UNREGULATED CARE PROVIDERS

Based on the award-winning iGeriCare dementia e-learning tool, a project team, led by Dr. Anthony J. Levinson (Director, Division of e-Learning Innovation at McMaster University) has created a series of four e-learning courses about dementia and caregiver well-being for unregulated care providers. The courses cover the foundations of dementia and mild cognitive impairment, responsive behaviours and mental health, home supports and safety, and health promotion and caregiver wellness. A 50 person pilot study, carried out between June 1st and July 8th, 2021 found that participants increased their knowledge about dementia and caregiver well-being by 30 percent while using the program.

4. VIRTUAL MUSIC THERAPY IN LONG-TERM CARE DURING COVID-19 AND BEYOND

Physical distancing and isolation measures implemented during COVID-19 in long-term care (LTC) homes have limited social interaction and recreation opportunities for residents. Increased caregiver distress is of high concern, especially for family members who are sometimes unable to enter the homes and spend time with their loved ones. This research project, led by Dr. Kate Dupuis (Schlegel Innovation Leader at the Centre for Elder Research) is introducing music therapy to virtual family visits to help residents make more meaningful connections with their loved ones, and engage their cognitive, emotional, and social domains of well-being. With funding from CABHI, the findings from this research will be used to create an Implementation Guide that can be shared with other LTC homes and music therapists in Ontario and beyond.

5. PAIRINGCARE: OPTIMIZING DEMENTIA HOMECARE

PairingCare is a novel dementia homecare platform through which persons living with dementia and their caregivers can connect directly with professional homecare providers. The platform, being developed under the leadership of Angie Katherine Puerto Nino (MD, MHSc in Translational Research at the University of Toronto) can be used collaboratively to optimize the dementia journey in various healthcare settings. Puerto Nino and her project team are currently surveying and interviewing people living with dementia, their loved ones, and professional homecare providers to better understand their needs and experiences and refine the PairingCare platform.

Arielle Ricketts is the Communications and Marketing Specialist, Centre for Aging + Brain Health Innovation.

Dementia Care in Canada:

Implementation considerations and the lived experience perspective

By Ashley Baddeley and Tamara Rader

More than 700,000 Canadians are currently living with dementia, a syndrome that leads to progressive memory loss and a deterioration in cognition over time. Associated symptoms range from mild and not debilitating (i.e., forgetfulness, limited attention span, mood swings, and mild coordination issues) to all-encompassing (i.e., inability to communicate and/or care for oneself). Dementia (and Alzheimer's disease — the most common form of dementia) may not only significantly interfere with a person's daily living but can also lead to a high burden of stress for affected individuals, their caregivers, and the health care system.

There is currently no cure for dementia, but four drugs are available in Canada that may modestly improve cognitive and behavioural symptoms: donepezil, rivastigmine, galantamine, and memantine. However, these treatments do not slow down or stop cognitive decline associated with dementia and Alzheimer's disease. Adjunct medications and other non-pharmacological treatments can also be prescribed to alleviate related symptoms (e.g., depression, sleep disturbances, agitation), which may improve general well-being and quality of life.

For the first time since 2003, several new drugs are in the pipeline for future review by regulatory bodies — an exciting prospect after nearly 20 years. Although these new drugs have yet to receive regulatory approval in Canada, CADTH recognizes the importance of proactively assessing the readiness of the Canadian health care system in case the drugs are, indeed, approved. CADTH is an independent, not-for-profit organization responsible for providing health care decision-makers with objective evidence to help make informed decisions about the optimal use of drugs, medical devices, tests, and procedures.

To assess system readiness, CADTH is investigating a number of "implementation factors," including the availability of health care staff, treatment centres, and medical equipment to diagnose, treat, and support people with dementia. CADTH is currently reviewing published literature, health system data, and real-world evidence to better understand which implementation factors would require significant changes if new drugs were to be introduced. As a first step, CADTH assessed the availability of neuroimaging services in Canada should new amyloid-targeted drugs for treating Alzheimer's's disease become available. Findings suggest that, if amyloid-targeted drugs are approved, investment in new imaging equipment may be required. In addition, it may be necessary for decision-makers to seek opportunities to maximize the use of existing capacity.

CADTH recognizes that a fulsome assessment and review of dementia treatments must include the knowledge, perspectives, and experiences of people living with dementia and their caregivers. Therefore, CADTH is collaborating with people with dementia, their families, and communities so they can provide their insight on the diverse, individual needs that currently exist for dementia care and support.

CADTH held an open call (November 2021) for people with lived experience of dementia to share their perspectives, concerns, and any other considerations that may inform CADTH's future work (and prioritization of work) in the dementia space. In December 2021, CADTH hosted a Patient and Caregiver Panel – seven individuals living with dementia were invited to discuss their top treatment goals and support needs related to dementia care. They shared their expectations and hopes for new treatments; concerns about diagnosis, traveling to appointments, covering the cost of treatment, quality-of-life issues, safety, and ethics; and interest in other non-drug treatments for mild cognitive impairment.

The panel fostered an engaging conversation that brought forward many interesting and insightful ideas. For example, some panelists suggested that confusion and distress during hospital visits could be reduced if family members were allowed to accompany a person during a test or scan, key details for the reason of the visit were written down, or a reassuring staff member was made available to guide families through clinic visits. Panelists also emphasized the importance of having access to interventions for keeping people vibrant and active and maintaining overall health. Examples of these interventions include medication patches, technologies to give people freedom to "live at risk," and technologies that can increase a sense of connection with others and reduce isolation, particularly for people living in long-term care.

A full summary of the panel's insights will be published in CADTH's *Canadian Journal of Health Technologies* to ensure they are available to the broader health system and the medical and research community. These insights could be used by CADTH to inform future reviews of medical procedures, devices, diagnostics, and drugs for dementia.

Other examples of CADTH work in the area of Alzheimer's disease and dementia include a recent report on homelike models of long-term care, a report on GPS locator devices, a brief summary of evidence for dementia villages in long-term care, a review of the evidence for patient navigation programs for people with dementia, and an ongoing review of aducanumab for the treatment of Alzheimer's disease. Additional reports can be found in our evidence bundle on aging and health.

Subscribe to News at CADTH (cadth.ca/subscribe) to stay updated on CADTH's latest reports, including those on dementia.

To learn more about CADTH, please visit cadth.ca, follow us on Twitter @CADTH_ACTMS, or speak to a Liaison Officer in your region: cadth.ca/Liaison-Officers. More information about the Patient and Community Engagement program at CADTH can be found at cadth.ca/patient-and-community-engagement. H

Ashley Baddeley (M.Sc.) is a Program Officer at CADTH. Tamara Rader is a Patient Engagement Officer at CADTH. *They would like to thank people with lived experience for joining the panel to comment and share perspectives from the dementia community.*

Medical Affairs

Departments crucial to hospital operations

By Lisa Harper and Dan Edgcumbe

There are many professionals who support Medical Affairs in hospitals across the province yet until now, there have not been good mechanisms for them to share their experience, ideas and resources.

Effective Medical Affairs departments are crucial to the smooth running of hospitals. They have responsibility for managing all matters related to credentialed staff. Credentialed staff are not typically employed, but they are appointed under the Public Hospitals Act and organizational by-laws, and include Physicians, Dentists, Midwives and some Nurses in the extended class.

After spending many years in research I was surprised to find that the interconnectivity and sharing which characterize academia was either missing or not well organized for Medical Affairs. I started reaching out to a few hospitals when I needed information and together, we began to develop a list of contacts across the province. While this was helpful, it still did not meet the needs of the community in coming together and sharing ideas and resources.

OMACOP is a network for professionals working in medical affairs/administration to connect, solve problems, share ideas and collaborate to continue to transform healthcare ensuring credentialed staff are in the best possible position to deliver high quality, safe care to their patients. A web platform has been created for members, allowing for wide-ranging discussion on topics such as credentialing, recruitment, reappointment, stipends, performance reviews, regulatory compliance, performance, and much more.

In November 2021, OMACOP held its inaugural meeting. More than 40 participants attended from small rural single site organizations to specialist academic centres. The featured presentation was provided by Tracy Wrong, Director of Medical Affairs for the Ottawa Hospital, on Medical Human Resource Planning. A number of breakout sessions were facilitated by OMACOP members on Hospital On Call Coverage (HOCC), contract management, disruptive physicians, professional staff resource planning and mandatory education for physicians. Feedback was extremely positive and confirmed the value of developing this community of practice.

OMACOP IS A NETWORK FOR PROFESSIONALS WORKING IN MEDICAL AFFAIRS/ ADMINISTRATION TO CONNECT, SOLVE PROBLEMS, SHARE IDEAS AND COLLABORATE

In early 2020, Dan Edgcumbe, in a new VP Medical Affairs role connected with me while carrying out a Medical Affairs environmental scan of physician leadership development, to support work at Halton Healthcare. He noted that in Ontario, individual hospital organizations were often left to their own devices, and that those working in medical affairs were interested in developing connections with others. After further conversations with interested medical affairs leaders at Providence, Ottawa, Oak Valley Health and Humber, the Ontario Medical Affairs Community of Practice (OMACOP) was born!

Moving forward, we invite all medical affairs professionals across Ontario to join our community, and become active members who share their expertise, collaboratively solution problems and contribute to refining best practices. Our next OMACOP meeting will take place March 1, 2022 from 12:00 – 14:00 hrs.

If you work in medical affairs and would like to become part of the Ontario Medical Affairs Community of Practice you can join at omacop.ca H

Lisa Harper is the Director, Strategy & Transformation at Oak Valley Health. Dan Edgcumbe is VP, Medical Affairs at Halton Healthcare

RC Coffee now at Toronto General Hospital

Canada's first Robotic Cafe, RC Coffee, has made its way to our first Hospital location– serving specialty coffee from Dark Horse and delivering freshly brewed espressos, lattes and more with utmost precision. Now you and your staff can enjoy your well-deserved coffee break with the country's finest self-serve, automated brewed beverages.

Our commitment to serve high quality coffee combined with innovative technology is the foundation of everything we do. We partner with the best local roasters and only serve carefully curated blends, freshly roasted for a fantastic coffee experience.

We offer automated and self-serve coffee solutions for your hospital environment. **Contact us for more details: sales@kiosoft.com**

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