FALL/WINTER 2017 VOLUME 28, ISSUE 2

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LONG TERM CARE TODAY

VOLUME 28 ISSUE 2
FALL/WINTER 2017

Long Term Care Today
is published twice a year for:
Ontario Long Term Care Association
425 University Avenue, Suite 500
Toronto, ON M5G 1T6
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www.oltca.com

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Published by:
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mediaedgepublishing.com

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LONG TERM CARE
TODAY

Please send communications about subscriptions, back issue requests, and changes of address to:
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LONG TERM CARE TODAY is printed on 10% post-consumer FSC certified paper using soya based inks. When necessary to mail an issue in an enclosure, we use an environmentally-friendly, 100% oxo-degradable poly-wrap.

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CALL FOR ARTICLE SUBMISSIONS

Long Term Care Today magazine is looking for submissions from the long-term care community on innovation and best practices. Published quarterly, our articles are educational and provide evidence- and outcome-based materials to a broad range of readers within the sector.

If you want more information or are interested in submitting an article, please contact Judy Irwin at jirwin@oltca.com.

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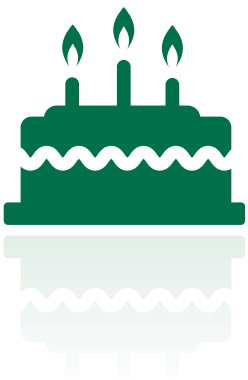

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Over 50 years ago an extensive survey of residential homes in England and Wales found that 44% of men and 49% of women reported loneliness (Townsend, 1962). Today, despite advances in policy and increased therapeutic programming, not only has the problem persisted, but has become worse. In a study conducted in Finland and Sweden for example, loneliness was experienced by 55% of those living in institutional settings (Nyqvist, 2013).

The management and care of the mental health needs of seniors living in residential care is primarily the responsibility of recreation or life enrichment staff. A review of recreational programming in residential homes, however, found no compelling evidence that existing interventions are reducing loneliness (Victor, 2012). Activity calendars offer an abundance of light social events but simply placing residents together in an activity neither reduces loneliness nor promotes a sense of belonging (McLaren, Gomez, Bailey, & Horst, 2007). In fact, it can make it worse. A key factor is not the extent of social contact but the quality of the contact.

The Solution – Residents Helping Residents

Research tells us that there is a psychosocial and psychological need for contact and empathy for others, and if "other regarding" is inhibited, people will wither and die (Kitwood, 1997). What we need are not more activities but an increase of meaningful connections and opportunities to live with purpose.

How do we then, in practical terms, change our focus to improve the quality of resident to resident contact? Rather than trying to engage all residents as often as possible, we instead offer a series of smaller mutually supportive programs - shifting the focus of programs from what we can do for them, to what can they do for each other. This can be done by existing staff and/or volunteers using structured, evidence based peer support programs.

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Kristine Theurer, MA (Gerontology), PhD Candidate, President & Founder, Java Group Programs Inc.

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The digital revolution in long-term care

BY CANDACE CHARTIER

Back in 2008, a small number of long-term care homes in Ontario signed up with the RAI-MDS data system. This computerized tool allowed them to enter their resident assessments on a multitude of different indicators, including restraint use, pain, and antipsychotic use.

By 2012, all Ontario long-term care homes were on board. What happened then was amazing.

The RAI tool made it easier for homes to monitor their performance year-over-year, see how they compared to other homes, and identify areas for improvement. By 2016, restraint use had dropped by more than half. Overall, 50% fewer residents were experiencing pain. And 35% fewer residents were taking potentially inappropriate antipsychotics.

As the saying goes, you can't manage what you can't measure. There were other factors at play as well, but access to a new standardized, computerized tool was crucial to the launch of a phenomenal wave of quality improvement in long-term care, right across the province.

Today, I'm pleased to report that we are on the cusp of the next phase of the digital revolution – connecting homes to invaluable sources of clinical information that will make a significant difference to resident care.

Clinical support tools

What if every long-term care home in Ontario used the same clearly written, evidence-based clinical guidelines and protocols, easily available in their existing point-of-care software? That's the goal of the Clinical Support Tools project. The long-term care sector needs clinical guidelines and protocols that are tailored specifically for the sector, by the sector – practical documents that address the real-world environment of long-term care.

The Clinical Support Tools project launched in June, and the first guidelines have already been identified and are in development. These include guidelines on:

- COPD;
- diabetes;
- dementia;
- end-of-life;
- incontinence;
- wound care; and
- seasonal influenza/respiratory virus prevention.

What if every long-term care home used the same clearly written, evidence-based clinical guidelines and protocols, easily available in their existing point-of-care software?

Ontario's Ministry of Health and Long-Term Care recognized the significance of this initiative to the sector and has provided significant project funding. The project will also support system-level improvements by aggregating previously inaccessible data on resident care.

More on page 12

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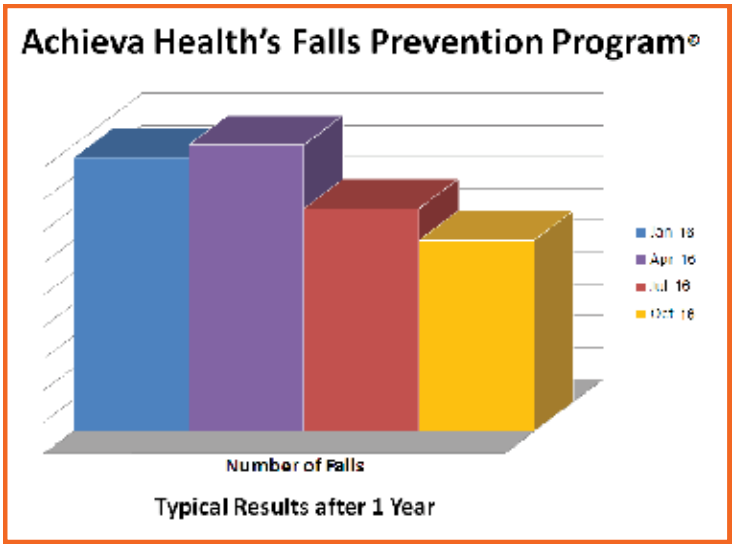

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LTC eConnect

I wrote about Ontario's LTC eConnect last year, when the project was in its infancy, and it is now well under way. The goal of the LTC eConnect project is to connect registered clinical staff (such as doctors, nurses, and physiotherapists) to the province's eHealth database so they can access their residents' provincial electronic health records.

Clinicians will be able to see information in real time on their residents' hospitalizations, lab results, and imaging reports.

This will reduce delays in treatment and ensure that homes have the important information they need to support care before a resident is admitted, or readmitted after a hospitalization.

LTC eConnect is funded by Canada Health Infoway and has been piloted and tested by peopleCare, which operates homes in southwestern Ontario. Their experience with the program has provided us with invaluable feedback and has also allowed them to pursue an innovative pharmacist-led medication reconciliation project (see page 26). Once other homes are connected, we fully expect similar innovations to take off across the province.

The Ontario Long Term Care Association initiated and is leading both these projects. They are being implemented in partnership with AdvantAge Ontario to ensure that all homes across the province have access.

Long-term care homes have been quick to sign on to participate. They are committed to quality improvement, and appreciate tools and support that can help them to improve care for their residents. Once both these initiatives are up and running across the sector, I suspect the changes we see will be nothing short of revolutionary. LTCT

Candace Chartier is CEO of the Ontario Long Term Care Association.

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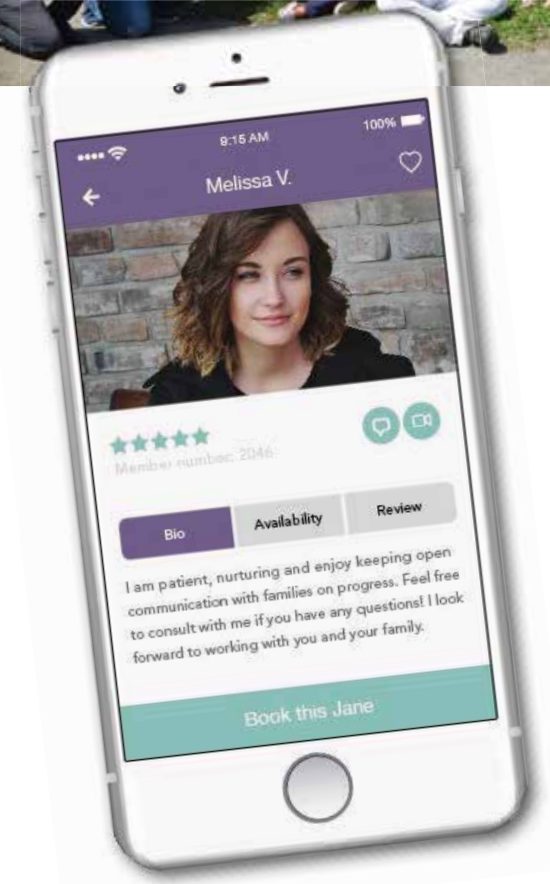

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BookJane also launched a web-based platform, called BookJane ONLINE, to make it easier for clients to book the company's caregivers directly. As a result of the consolidated platform, clients are experiencing faster scheduling, faster confirmations, and higher fulfillment rates than all other competitors' offerings.

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Leaving a legacy

The first medically assisted death in Ontario long-term care

On August 3, 2016, John Stanley Taylor concluded his life the same way he had lived it: on his own terms. With family by his side at his Henley Place home, the 64-year-old husband, father of two, and retired physicist exercised his right to a physician-assisted death, finding reprieve from his condition and becoming the first person in Ontario to receive medical assistance in dying (MAID) in a long-term care environment.

"This was extremely important to him," reflects Wendy Taylor, John's wife. (With their permission, their first names are used throughout this article.)" He was a very independent person by nature, so the fact he could actually call the shots when it came to his own death meant everything to him."

John Taylor was first diagnosed with amyotrophic lateral sclerosis (ALS) in September of 2011. Over the following years, the disease rendered him unable to control his body and it eventually necessitated the use of a power chair. When Canada passed Bill C-14 to allow physician-assisted death in June 2016, John had already made his decision. "By the time they made assisted death legal, he couldn't move any of his body from the neck down and had been dependent on a breathing machine for nearly a year. His mind was there, but his body wasn't – and there was a very real possibility he would die gasping for air," says Wendy. "He was really ready to leave this earth."

That's not to say Henley Place was ready to help him leave. "I remember getting John's email on July 1 saying, 'it's time.' I knew what that meant; John was ready to proceed with MAID, but to be honest, we weren't," recalls Jill Knowlton, Managing Director for Long-Term Care with Henley Place, a Primacare Living Solutions home.

John Stanley Taylor was the first person to receive medical assistance in dying in a long-term care home

"Guidelines around MAID were just being released, there were gaps in the legislation, an absence of regulations, and a clinician referral line wasn't available yet. We just didn't have the training and processes in place for MAID at the time."

Moreover, recalls Knowlton, the passing of MAID legislation introduced an ethical challenge for long-term care staff that needed time to be addressed: "Health care workers are largely socialized around the principal of 'do no harm.' With the introduction of MAID, all of a sudden we had to make a significant paradigm shift in regards to assisted suicide, which is a real shift in terms of one's values and beliefs. Some of our staff weren't willing to do that."

To fulfill John's wishes, Henley Place would need to embed new MAID processes and address both logistical and emotional concerns with staff and residents – and all within the two-week window of time that was considered standard for carrying out MAID after the initial request is made. For these reasons, Knowlton regrettably turned down John's appeal to proceed with MAID in the home.

Nevertheless, he persisted. "John was a strong advocate for dying in long-term care. He was aligned with the Dying with Dignity advocacy group and he was very informed about it and his rights," says Knowlton. "More than that, he was a strong advocate for ending his life at Henley Place. He didn't want to die in a hospital, he wanted to die at a place he had considered his home for nearly three years."

Obstacles and reservations notwithstanding, Knowlton ultimately knew that Henley Place had an obligation to follow John's lead. Over the next week, she consulted with the Ministry of Health, the Office of the Chief Coroner, Primacare's lawyers, and health care representatives to ensure Henley Place had the measures in place to meet its legal responsibilities.

As the time grew near, the home conducted a series of group sessions to educate staff and support them through the process. Knowlton and her leadership team also made themselves available at all hours to discuss staff concerns and questions. Accommodations were made to ensure those who conscientiously objected to MAID could take a personal day off when it came time to perform the process or work in different areas of the home.

Meanwhile, John was also making plans. With no clinician referral line for Henley Place to call, he took the lead in bringing two of his trusted hospital specialists on board to perform the three injections that would be required to carry out MAID. As for his family and friends, his wife Wendy notes, "There's something very strange about preparing for an assisted death. We really didn't have any outside support systems for this, and there was no one we could really talk to who had been through it. A few weeks before the actual date, we just had a meeting with John's specialist and another doctor to talk it all over and make sure we all understood exactly what John wanted."

And so, on August 3, John Taylor united with family and friends at Henley Place's social room to say goodbye and raise a glass to a life well lived. "He was a very happy man that day," recalls Wendy. "He had a glass of scotch and one for anyone who wanted it. After, the home settled him in his room and we all gathered around his bed. Before they started any of the injections, he made a lovely speech about his life, what he enjoyed, and what meant a lot to him. Then, he was ready."

"Within ten minutes or so after the first injection, he was gone."

What came next

It has been over a year since John enjoyed his final toast. Memories of that day, however, still resonate strongly among those who joined him on his final journey. "It was certainly a challenge for us, and one we would have appreciated [having] more time to deal with. Ultimately, though, we feel very satisfied with how it went and the fact we were able to make John's personal wish happen in the way he wanted," says Knowlton.

Wendy Taylor agrees. And while she says it's still difficult to visit Henley Place, she is nonetheless appreciative for the staff's role in helping John realize his end-of-life plan: "I certainly understand why Henley Place feels good about the situation. They were able to give him what he most wanted."

Primacare-managed homes have had two more MAID requests since John's passing. No doubt, it will be a long

time before physician-assisted death feels 'normal' for long-term care caregivers. However, the guidelines, training, and support systems around MAID are starting to take shape.

Still, as long-term care homes approach MAID requests in these early days, Knowlton says it's important to reach out to those who have gone through the process, listen to their stories, and learn from their experiences: "You need to be prepared for this, because it's not something you can say no to. Each case is going to be very individual, so you have to be sensitive to each resident's needs and their family's needs, because all of those will direct you in fulfilling their end-of-life plan."

It's also important to listen to long-term care caregivers and support them throughout the process, notes Wendy, adding, "I didn't appreciate that at the time because I was so consumed with my concern for John, but the personal support workers and the nurses that had gotten close to John knew him so well, it was harder on them than I realized it would be. Some of those people were really heartbroken. They need help, too."

August 3 will forever hold special significance for the Taylor family. For the long-term care community, however, it will mark the first of what will soon become a more common and acceptable process for residents nearing the end of their life.

And for that, says Wendy, John would have been proud: "The fact [that] he made it a little easier for people coming after him who felt the same way, who really needed to be allowed to die, is a legacy he'd be proud of. I think he would feel very good about knowing that he fought to make it work for himself, and that, as a result, there's going to be less suffering for people in the same situation." LTCT

At the 2017 Ontario Long Term Care Association Together We Care Convention, **Primacare Living Solutions** shared their experience with the **first MAID case** in long-term care. Based on the considerable interest in their presentation, the organization has since developed a **MAID toolkit**, available to other long-term care homes by request. Contact Vinita Haroun at vharoun@oltca.com for more information. Ontario Long Term Care Association members can access the toolkit on the oltca.com members' site.

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Cushioning the impact of dementia

A successful effort to redirect one resident's repetitive behaviour

Michele Mackenzie shows one of the cushions she designed

Providing behavioural support to residents with advanced dementia requires understanding what they are communicating with their behaviour, and what personalized strategies will help best.

In some cases, the solutions need extra problem-solving and creativity, as was the case in Sienna's Maple Grove Care Community in Brampton, where a resident with dementia began tinkering with and then removing everything from the walls – including a point-of-care screen, hand sanitizers, and all the wall hangings. "Everything was screwed in place, but he used his hands to jimmy the items left and right until they came off," says the home's Executive Director, Michele Mackenzie. Attempts to distract and redirect Simon's* behaviour worked only for short time periods.

Although the home already had many wall-mounted activity boards specifically designed for people with dementia, these were not of interest to Simon. "Many people with dementia need to be constantly on the move, and the activity boards are too stationary for them," she explains. "In Simon's case, he also fixates on whatever attracts him at eye level, then tries to take it off and carry it somewhere. It's a constant routine. We believe he thinks he is doing a useful task."

One day, Simon went into the dining room during meal service and started pulling down the curtains. The problem escalated further when he began entering other residents' rooms and removing items from their walls. This was very upsetting for residents and their families – and for Simon's wife, who was distressed to learn this was happening. It became a top priority to find something else to attract and engage Simon – both for his sake, and for the privacy and safety of other residents.

Michele Mackenzie came up with the idea of mounting removable cushions to the wall, decorated with textured haberdashery items such as sequins, tassels, and buttons that Simon could touch. She took this on as a personal project, purchasing cushions with bright colours and patterns and sewing on the decorations herself, with the team providing feedback about what Simon might like, and where to place the cushions.

Textured lap mats and cushions can be comforting for people with dementia, but it was not certain that wall-mounted cushions would work for Simon. Four cushions were made and placed at his eye level in parts of the hallway that seemed to be an area of focus.

The experiment has been a success. Simon likes to touch the cushions, then take them off the wall and carry them away with him. The cushions appear to provide purpose, stimulation, and comfort, and Simon no longer pulls other items off the wall or enters other residents' rooms. He is particularly fond of one cushion, which he will take with him for a nap.

"The team has become well practised at collecting the cushions and putting them back on the wall so that he can take them down again," Michele Mackenzie explains. "It has been the right answer for Simon at this stage in the progression of his dementia, and has also helped reduce workload on the team, who had been redirecting Simon continuously to prevent him from entering other residents' rooms." LTCT

**Name has been changed to protect the resident's privacy.*

An example of a wall-mounted removable cushion

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DAY 4

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[1] Brennan, M.R.; Milne, C.T.; Agrell-Kann, M.; Ekholm, B.P. Clinical evaluation of a barrier film for the management of incontinence-associated dermatitis (IAD) in an open label, non-randomized, prospective study. Accepted for publication in Journal of Wound, Ostomy, and Continence Nursing (JWOCN), (n=9).
[2] 3M clinical reference study number EM-05-013236.
[3] 3M clinical reference study number EM-05-013262.

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Right medication, right dose

Pioneering pharmacist-led medication reconciliation at peopleCare

A collaboration between peopleCare Inc. and Hogan Pharmacy Partners has piqued the interest of the Ontario Centres of Excellence for its innovative approach to medication reconciliation. When more than 60% of long-term care residents take 10 or more different prescription medications, it is crucial to make sure they are on the right medication and the right dose, and that there are no dangerous drug interactions.

In 2016, the long-term care organization partnered with Hogan to launch a digital process for medication management, including a digital tool that would help pharmacists and physicians in reviewing, discussing, and making decisions about a resident's medication when he or she is first admitted to the home, or readmitted after a hospitalization. "Medication reconciliation is important for the health and safety of our residents, and it's also a very important accreditation standard we have to meet," says Jennifer Killing, Vice President of Quality and Innovation at peopleCare Inc. "However, it can be a complicated and time-consuming process for nurses who are already very busy during the periods in which residents are being admitted or readmitted to one of our communities."

According to the statistics, Ontario's traditional nurse-led, paper-based medication reconciliation process takes a minimum of 142.7 minutes each time. In a home with 100 beds, this can easily consume 160 hours of a registered staff's focus. Moreover, research shows that this process has led to compliance rates of approximately 57% and discrepancy or error rates as high as 70%. Serious health risks notwithstanding, the cost of preventable, drug-related hospitalizations in Ontario is estimated at $2.6 billion annually.

Long-term care organizations have been taking measures to improve resident medication safety for years through staff education. The evidence for pharmacist-led medication reconciliation versus the traditional nurse-led process, however, prompted peopleCare to pursue a new model and connected technologies to implement it. The journey began nearly two years ago. Hogan Pharmacy approached peopleCare with an idea for a new model of medication management – one that would provide 24/7 tele-pharmacist support and a fully electronic resident health record, allowing pharmacists to access resident information remotely.

Using PointClickCare software, peopleCare joined with Hogan in developing the online tools for a new model that gives pharmacists quick and convenient access to both long-term care resident records and hospital records. Specifically, it involved participation in the LTC eConnect project, which connects homes to clinical information through eHealth Ontario. Once they have this information, pharmacists can complete a thorough medication review and recommendations, which are then discussed with the physician.

According to Jennifer Killing, peopleCare's VP of Quality and Innovation, medical reconciliation is important for the health and safety of residents

peopleCare first piloted its pharmacist-led approach across four of its homes: peopleCare Tavistock, peopleCare Oakcrossing, Delhi Long Term Care, and Golden Years. "We started to see the clinical benefits for residents and time savings for our nursing teams on admissions and re-admissions fairly quickly," says Killing. "That proved to us we had something that worked really well and would be valuable to share with long-term care organizations across Ontario."

The Office of the Chief Health Innovation Strategist and Ontario Centres of Excellence share that enthusiasm. In April 2017, they announced that peopleCare's initiative was among the 15 new projects to receive financial support through the province's Health Technologies Fund. The amount of that support is $476,348, which is now being used by peopleCare to fund research focused on providing evidence that pharmacist-led medication reconciliation is an approach worth replicating. To date, peopleCare's new approach has already reduced medication errors and omissions, given nursing staff more time to focus on direct resident care and, most importantly, improved resident outcomes in its homes. LTCT

Designing for Redevelopment

Four Key Design Approvals for Redevelopment Success

The successful redevelopment of your long-term care home requires a design that meets your needs and the approval requirements of several governing authorities.

Preliminary Plans Approval

Granted by the Ministry of Health and Long-Term Care (MOHLTC), the purpose of this approval is to confirm that your redevelopment will meet the minimum design standards of The Long-Term Care Home Design Manual while maintaining quality day-to-day operations of the home during redevelopment. Submission requirements include a project summary, an operational plan and preliminary drawings.

The development of all submission requirements will be a combined effort between you and your Architect. During a needs assessment your Architect will interview you to identify the spaces required for your operations. This, combined with a detailed review of your existing building, will enable your Architect to prepare preliminary floor plans showing the extent of construction, the need for construction phasing and temporary resident areas required to ensure continued operations. Preliminary Plans Approval allows early consultation with the MOHLTC to ensure that both your needs and their requirements will be met by the redevelopment.

Site Plan Approval

In Ontario municipalities are empowered by the Planning Act to review and approve land development proposals. This includes new construction and the expansion of existing buildings. Due to significant increases in the space required per resident the majority of redevelopment projects will require Site Plan Approval and building expansions.

Submission requirements for Site Plan Approval vary, but typically include building floor plans and elevations, site plans, site servicing and grading designs, landscape plans, and site lighting designs. Additional environmental and engineering studies may also be required. Your Architect will work with the municipality to identify all requirements and to coordinate the work of all engineering consultants. Typically multiple submissions and revisions are required. The Site Plan Approval process can be lengthy and should be started early in the design process.

Working Drawings Approval

The second of two approvals required by the MOHLTC, the Working Drawings Approval, expands on the previous Preliminary Plans Approval. The project summary and the operational plan need to be revised and complete architectural and engineering working drawings need to be prepared and submitted. Your Architect will lead the engineering team in the development of all drawings and specifications required for construction. There are many detailed decisions that need to be made. Your Architect will guide you by providing options and recommendations. Once you are satisfied that the building designs meet your needs, working drawings are submitted to the MOHLTC for review. Receipt of Working Drawing Approval from the MOHLTC allows you to request bids from contractors for construction.

Building Permit

Similar to MOHLTC Working Drawings Approval, fully detailed architectural and engineering drawings are required by the local building department for approval. Municipal building officials will review submitted designs for compliance with the Ontario Building Code. Requirements include: fire and life safety, structural adequacy, energy conservation, and barrier-free accessibility. Interpretations of the Building Code can vary. Your Architect will lead negotiations with the building department to resolve any differences of opinion. Once a Building Permit is issued construction can begin.

Where to Start

Each project is unique. The specific requirements of your redevelopment may necessitate design approvals in addition to the four key approvals described above. In order to meet your redevelopment timelines it is important to identify all required approvals early in the process. The first step is to contact your Architect and arrange a consultation to discuss the unique requirements of your redevelopment.

Carolyn Bilson, OAA, is a principal at James Fryett Architect Inc. For more information visit www.fryettarchitect.com. To schedule a complimentary consultation contact Carolyn directly at (519) 846-2201 ext. 232 or carolyn@fryettarchitect.com.

A positive workplace

Enhancing staff satisfaction at Finlandia Village

It's no secret that a happy staff yields stronger results; and in the field of long-term care, those results can take the shape of stronger teams, enhanced care, and a culture of continuous improvement. Finlandia Village in Sudbury is an example of a long-term care home that understands the benefits of a positive workplace. In recent years, it has witnessed the transformative powers of staff engagement firsthand through a series of workplace surveys and interactive sessions.

For four years and counting, Finlandia has conducted staff satisfaction and resident safety surveys using Accreditation Canada's pre-existing surveys as their template. This has allowed the team to track staff morale and attitudes on a year-over-year basis and compare their findings with previous years to determine areas of improvement.

Based on the results of its 2015 survey, for example, Finlandia discovered several ways in which better communication, frontline staff initiatives, and senior management engagement could contribute to a happier, more productive, and more collaborative workplace culture. In response, senior management used its survey findings to design a staff-training workshop that would bridge the gaps between staff, their colleagues, and senior management. "Staff want to be listened to, respected, and appreciated," says CEO David Munch. "The team workshops fostered an opportunity to strengthen these relationships."

The workshop was trialed with senior leadership before being delivered incrementally to 150 staff members from across all divisions. To ensure it would make an impact, there was a strong focus on making them fun, interactive, and memorable, says Angela Harvey, Administrator at Finlandia. Workshop participants were seated with colleagues from other departments in order to build inter-departmental relationships. Staff were matched with people who fulfilled different types of roles. And the facilitators used activities and motivational YouTube videos to help set the stage for discussions. One popular example was the Wisdom of Geese: staff were given small knitted geese to give to each participant as a reminder of what it meant to "fly in formation" and support each other.

The Koivu Servery: one of several areas that benefited from the addition of decorative elements suggested by staff

To help build relationships and demonstrate their respect for staff, senior leaders in the organization facilitated the workshops. "Staff were happy and excited to see that managers acted on their feedback for improvement," says Munch. "This translated into staff being enthusiastic about their jobs, holding positive attitudes, and staying true to organizational values."

Positive outcomes

The Finlandia journey towards a stronger, more positive workplace isn't over, but results show it's on the right path. According to its latest staff

Example of an improved resident area - the Manty quiet room - that came from staff suggestions

survey, satisfaction rates have increased across the board, including an 18% increase in job satisfaction and a 19% increase in those who feel senior managers were genuinely considering their suggestions for improving resident safety and care. Importantly, 99% of respondents said they believed Finlandia provided access to excellent resident safety, and the same number indicated they would recommend Finlandia to family and friends who required care.

Numbers aren't the only indicator of success. "Staff are more willing to help each other, communication has improved, and more people are coming out to employee parties and appreciation events," says Harvey. There's more laughter in the hallways ... we're becoming more of a family. That's a big cultural change for the better, and as a result staff and residents are a lot happier."

With plans to conduct more staff workshops and to continue the surveys, Harvey adds, "The challenges we face on a regular basis in long-term care can be discouraging, so taking the time out to interact with staff on a personal level, and have some fun, has been hugely important." LTCT

Health & Wellness

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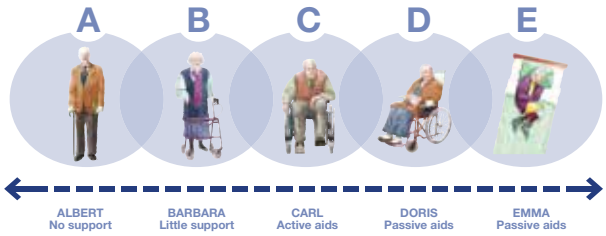
Whether the result of an accident, illness or old age, it is an unfortunate truth that many of us may become dependent on the care of others at some point in our lives.

Caring for individuals with reduced mobility presents certain risks and challenges. From dynamic activities such as bedside transfers, trips to the toilet, bathing and showering, to the passivity of bed care – all require proper support and equipment to improve the quality of life for the resident, reduce risks and improve safety for the caregiver.

The use of appropriate **active or passive lifts** will allow the caregiver to transfer or transport individuals safely to enjoyable and/or necessary activities. Selecting the appropriate product based on the resident's abilities requires optimal guidance.



Bathing and showering are sometimes perceived as two separate choices of hygiene for the resident. The reality is that a combination of both is optimal. ***Showering is approprate for frequent, daily personal hygiene and good skin care maintenance, while the benefits of bathing are hygienic, as well as physical and psychological.***

With an estimated 2/3 of residents in Long Term Care with various levels of dementia, bath or shower time can be a contentious task. Take the battle out of bathing with features like ***Sound & Vision*** – utilizing soft, revolving colored lighting, with the resident's favorite music; or ***Hydrosound*** for optimal hygiene without fear-provoking whirling water to provide a pleasant environment for resident and caregiver; or by matching the bathtime to the resident's sleep patterns to help prevent night-time wandering.

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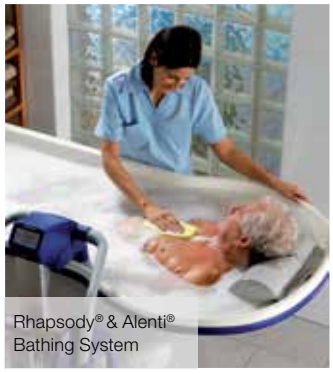
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Sorting fact from fiction

Clearing up misconceptions of end-of-life care

For people with Alzheimer's and other forms of dementia, end-of-life care (or palliative care) is a topic that many are reluctant to broach. Yet, considering the misconceptions and misinformation that often cloud the concept of palliative care, it's one that deserves more conversation.

According to Mary Schulz, Director of Information, Support Services and Education at the Alzheimer Society of Canada, it's human nature to avoid talking about sad and difficult topics such as end-of-life planning, but people impacted by dementia are hungry for practical, reliable information about what to expect at end of life. "Discussing goals and preferences regarding palliative care in advance is important because it will increase the likelihood that a person with dementia will be comfortable at their end of life," says Schulz.

Sorting fact from fiction in palliative care is often an obstacle – especially when outdated perceptions and media stereotypes cloud the conversation. Loved ones will often interpret palliative care to mean that death is close and that caregivers have "given up." While it's true that palliative care is an approach that acknowledges the inevitability of a terminal diagnosis, it is focused on making the absolute most of a person's remaining time by providing team-based care and support for all who are affected. "Palliative care is not just about physical end-of-life care, it's about making sure that

we're really living the days of our lives, and that includes all of the things that make life worth living," explains Schulz.

Palliative care is not about "giving in" to death. It's recognizing that there is plenty of life left and that caregivers, family, friends and the community itself each play a vital role in making sure it's well lived.

Not giving up on the person

It bears repeating that palliative care is not about "giving in" to death. It's recognizing that there is plenty of life left and that caregivers, family, friends, and the community itself each play a vital role in making sure it's well lived. That means helping each other to understand dementia and be aware and react to its symptoms, navigate complex emotions, and support one another throughout the journey of the disease.

Clarifying how the journey for people with dementia differs from others receiving palliative care also helps avoid misconceptions about palliative care. While the symptoms alone can be similar to other conditions, support for someone with Alzheimer's or other dementia can take years. For loved ones, that can feel like a prolonged roller coaster of little losses – each adding to the already protracted grieving process.

The unique nature of dementia can also make it hard for caregivers, since the person with dementia may be reluctant to discuss palliative care in the early stages, even though that is the ideal time to make those difficult decisions.

"When you put all these factors together, you've got a very different kind of challenge to think about [regarding] end-of- life because the journey to that point is quite a different one than it is for other conditions," says Schulz.

Further misconceptions exist around how people with dementia are treated throughout palliative care. Concerns over whether or not loved ones are eating, how they're dealing with pain, or even their use of medication can go unvoiced, leading to unneeded stress and misgivings. Nevertheless, these too can be addressed through honest discussions and education.

Added to these concerns are common questions about where end-of-life care can take place, as many often conjure the image of their loved ones left alone in a dimly lit corner of a long-term care home. Here again, says Schulz, palliative care is about comfort and companionship – making settings like long-term care homes an ideal choice: "Long-term care is an excellent kind of setting for palliative care for people with dementia, while of course understanding that that means people are living life to the fullest. We know from research that if you're able to have the courage and to follow best practices in end-of-life care, you're going to make life a lot easier for the person with dementia, as well as for yourselves as staff, because there are a number of things that can be done in advance."

To learn more about palliative care and free resources available from the Alzheimer Society of Canada, please visit www.alzheimer.ca LTCT

To learn more about **palliative care** and **free resources** available from the Alzheimer Society of Canada, please visit alzheimer.ca

Getting antipsychotics right

Lessons from a provincial prescribing project

Recent years have seen phenomenal efforts across Canada to improve how antipsychotic medications are used appropriately to manage the behavioural and psychological symptoms of dementia, ensuring they are used for the right symptoms, at the right time and at the right dose.

A recent Ontario project to support appropriate prescribing of antipsychotic medications in long-term care homes has contributed to these achievements, and the team's experience has provided valuable insight and tools to support for ongoing efforts.

A team approach

In 2014, Ontario's Ministry of Health and Long-Term Care and the Ontario Medical Association launched a project to support appropriate prescribing in long-term care, in collaboration with the Centre for Effective Practice (CEP) and Health Quality Ontario.

As part of this project, the CEP provided academic detailing services in 41 long-term care homes that volunteered to participate. The academic detailing service involved one-on-one educational outreach from a pharmacist to prescribing physicians or nurse practitioners and staff in the long-term care home.

With thousands of new research studies published on medications and dementia care every year, long-term care physicians appreciated having comprehensive information brought to their attention. "Prescribers often had pieces of information about these medications, but not the whole picture," says Pharmacist and Academic Detailer Kristin Ferguson.

What started out as individual relationship building soon had a much broader reach."Long-term care is a very different practice environment than other health care settings," says Ferguson. "Prescribing is not just an individual activity, it's supported by the whole staff. Everyone who interacts with the resident plays a role – they notice how the residents are interacting and any changes in their behaviour. These are key pieces of information that the prescriber needs in order to determine whether medication is necessary, how it's working, and whether there are side effects. It's important to involve everyone and let them know they are part of the team."

Some long-term care homes asked the academic detailers to have group meetings with all staff, from physicians to housekeeping, because they wanted help to clarify the role of medications in treating behavioural symptoms with their whole team. The CEP team also met with Family and Residents' Councils in many of the participating homes. "There are lots of misconceptions on the use of antipsychotics," says Ferguson. "When staff and families understand what the medications can and can't do, and what behavioural management strategies can be tried, it creates a team approach with everyone speaking a common language."

The CEP produced a guide for health care providers with evidence-based information and practical recommendations to help summarize these conversations. Residents, families and caregivers requested a similar guide to help explain the role antipsychotics play in behaviour management.

Discussion guides for providers and families

The antipsychotic discussion guides have been very well received, says Ferguson. Both are available for free online at the CEP's website, thewellhealth.ca/dementia. Some of the highlights:

1. Antipsychotics can be helpful for delusions and psychosis, but rarely for exit-seeking behaviour, resistance to care, verbalizing, or wandering (see graphic).
2. Antipsychotics can be effective, but unfortunately they don't work for everyone – they will be effective only in about one out of every five patients. Other options are provided in the discussion guide.
3. Look to non-pharmacological options first, such as Behavioural Supports Ontario or PIECES.
4. Dementia is a progressive disease and even severe symptoms may change or even disappear over time. Evaluate every three to six months and try tapering the resident down to the lowest effective dose or even off the drug.

"Look for champions and change agents in your home," Ferguson adds. "It does not necessarily always have to be the QI person or the director of care. Find someone passionate about the cause, interested in leading the change, and give them some resources to spread the word." LTCT

Symptom Likelihood to Respond to Antipsychotic Therapy

Cluster	Likely	Unlikely
 **Psychosis**	• Delusions • Hallucinations • Misidentification • Suspicious	
 **Aggression**	• Defensive • Physical	• Verbal • Resistance to care
 **Agitation**	• Restless/anxious	• Dressing/undressing • Pacing • Exit seeking • Repetitive actions
 **Depression**	• see below*, **	• see below*, **
 **Mania**	• see below*	• Euphoria • Irritable • Pressured speech
 **Apathy**		• Amotivation • Lack of interest • Withdrawn
 **Other**		• Hiding or hoarding • Wandering without aggression • Disinhibition (e.g., sexual)

* The role of antipsychotics in those with dementia and depression is beyond the scope of this evidence review.

** In cases where depression treatment may be indicated, consider psychiatric consultation to determine appropriate pharmacotherapy options.

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Minimizing discomfort

Improving pain management at Tilbury Manor

Pain management is more than a mandate in long-term care. As caregivers well know, managing and minimizing discomfort is the cornerstone of a home's promise to deliver high-quality care to its residents. This is especially true today given the fact that many of those living in a long-term care environment experience persistent pain due to debilitating and chronic illness.

This reality has prompted many in the long-term care field to seek improvements to the way resident pain is identified, tracked, and addressed. That includes Tilbury Manor, where the pursuit of a more collaborative, staff-driven, and data-rich approach to pain management is seeing definitive results. "Pain management is obviously one of the biggest focuses we have in long-term care," says Sara Le, Tilbury's Director of Resident Care. "So once we started seeing a rise in the pain symptoms that our residents were having, that's when we knew we had to find a better way."

The home reached out to Beverly Faubert, Tilbury's Registered Nurses Association of Ontario (RNAO) Long-Term Care Best Practice Coordinator, for guidance in creating an enhanced and sustainable pain management program. It began by assigning management champions from Tilbury's frontline staff, who then conducted a gap analysis review of the home's current pain management approach to compare their practices against evidence-based practices documented in RNAO's Assessment and Management of Pain Best Practice Guideline.

Next, Tilbury's pain management champions leveraged insights from their gap analysis review to inform new pain management strategies, including capacity building, data collection, and program monitoring techniques outlined in the RNAO's implementation toolkit. "Educating long-term care staff is important, but research shows it doesn't always result in sustainable improvements," explains Faubert. "Our implementation process marries education with a proven implementation process for sustainable outcomes. Staff became better at communicating, supporting, and coaching, which are all skills that need to be developed in order to be a champion of any initiative."

Tilbury residents like Marie Anne Levesque - seen here in her room with two staff members - have benefited tremendously from the home's enhanced pain management program

That implementation included regular meetings with Tilbury's pain management champions, training and coaching across all departments, changes to point-of-care charting, and advanced tools to assist staff in monitoring, reporting, and assessing their pain management actions. Revised processes were also put in play to guide staff through varying degrees of treatment, be it therapeutic, medicinal, or physician-led. Further to this, brochures and educational resources were developed for residents' family members to help them in identifying and reacting to symptoms of pain.

Le believes the strength of these initiatives depended on Tilbury's team: "That staff buy-in has been critical, and having the frontline staff responsible for really driving that change – coaching their teammates and providing education – has been a huge contributor to our success." Buy-in has also been essential to sustaining Tilbury's new approach. Pain champion leaders are consistently monitoring staff progress, ensuring program audits are being done, and processes are being followed. "We are always monitoring pain levels by talking with residents and using our systems to track whether or not our responses are working. Not only does this keep staff engaged, but if we start seeing increases in pain levels, we can suggest new therapies, medication, or another way forward," says Le.

Proof of Tilbury's success is in the numbers. As of August 2017, Tilbury Manor has reduced the percentage of residents experiencing daily pain to 1% from 4% (well below the provincial average of 5.80) and the indicator for worsened pain to 0% from 18%. Le says she is pleased with these numbers, but recognizes how important it is to continue building on the program, noting, "In long-term care environments we are often caring for individuals that are at end-of-life and who have a chronic illness that come with a lot of pain. Our goal is to help the residents achieve a level of comfort that allows them to continue to participate in the activities that make them happy for as long as they can and to assist residents going through the end-of-life stages with dignity and comfort." LTCT

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Together We Care 2017

Together We Care, the joint annual convention of the Ontario Long Term Care Association (OLTCA) and the Ontario Retirement Communities Association (ORCA), was held April 3-5, 2017, at Toronto's spectacular Congress Centre.

The conference featured an outstanding program – just scan the photos and list of conference themes. And for the first time ever, the Premier of Ontario attended the event for an informal conversation with the CEOs of OLTCA and ORCA.

Mark your calendars now for the 2018 conference, to be held April 9-11 at the Toronto Congress Centre. Beloved Canadian singer Jann Arden is confirmed as keynote speaker; you won't want to miss Jann's story of caring for her mother with Alzheimer's disease. Registration opens in December.

THEMES AND SESSIONS: SOME HIGHLIGHTS

- Leading in times of calm and crisis
- The first MAID case in Ontario long-term care
- Advance care planning
- End-of-life care for people with dementia and their families
- Digital innovation: LTC eConnect
- Building up your employees
- Inspection program update – a presentation by the Ministry
- Navigating today's employment environment
- Wish of a Lifetime for seniors
- Changing the world of senior living
- Building a culture of innovation
- Collaborating more effectively with your Family Council
- Culture change through resident-led programming and events
- Helping residents to be active
- Opening Minds Through Art
- Capital renewal: Challenging conventions and discovering new opportunities
- Risk management during construction and procurement
- Culinary and nutrition summit

For the first time ever, the Premier of Ontario took the stage at the Together We Care conference. Kathleen Wynne joined OLTCA CEO Candace Chartier and ORCA CEO Laurie Johnston (not pictured) for an informal discussion

David Kent told the inspiring story of his adjustment to life in a long-term care home, and how he became an active and engaged volunteer

A vibrant trade show provided information, demos, and seasoned advice on products and services

Chartwell's Taking Flight program, with its stories of culture change, inspired the crowd

By outfitting participants to alter the way they experienced the world, the virtual dementia tour gave participants an opportunity to step into the shoes of someone with dementia

Engaged crowds packed the sessions looking for advice, information, and inspiration

Long-term care's biggest networking night of the year took participants back in time to the roaring twenties

The Canadian Centre for Aging & Brain Health Innovation, the Association's Strategic Alliance Partner, taught participants an innovative "design thinking" approach to tackle some challenges in capital renewal

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The Associations' Corporate Alliance Partners, Arjohuntleigh, Cardinal Health, and Essity, as well as the Strategic Alliance Partner, the Centre for Aging & Brain Health Innovation, provide invaluable support to the work of the Association and its membership

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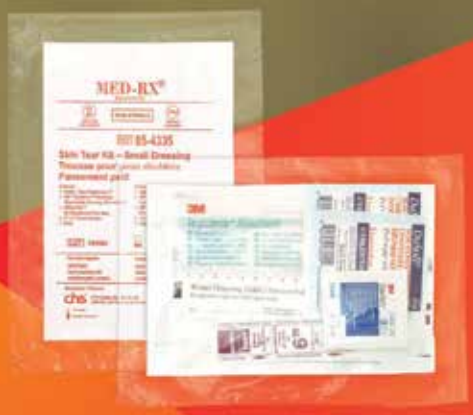

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*Leblanc et al. The Art of Dressing Selection: *A Consensus Statement on Skin Tears and Best Practice. Advances in Skin and Wound Care.* Vol. 29, No. 1, 2016. Leblanc et al. *Best Practice Recommendations for the Prevention and Treatment of Skin Tears. Wound Care Canada.* Vol. 6, No. 1, 2008.

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