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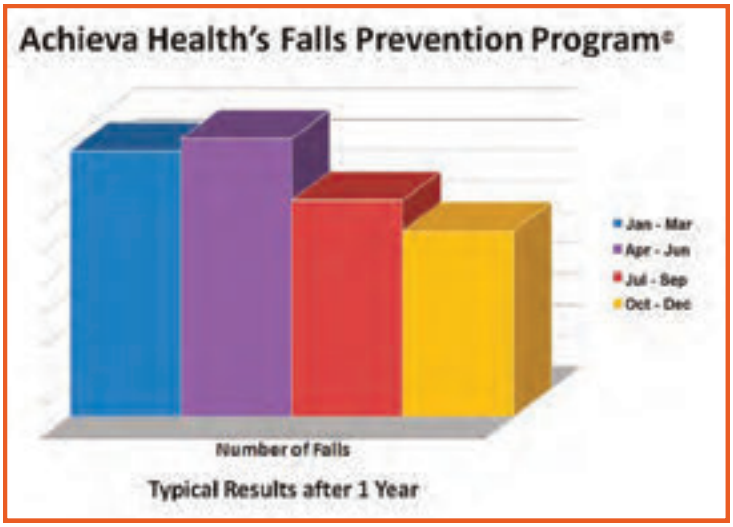

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Transforming care to serve people better

The Ottawa Hospital and Extendicare partner on an innovative transitional care unit for alternate level of care patients

In 2021, The Ottawa Hospital and Extendicare began to collaborate on plans for an innovative transitional care unit that is now serving as a model for tackling one of the health system's most persistent challenges. Their partnership, built on a relationship forged during the COVID-19 pandemic, is leading to better hospital access for people in the community and better rehabilitative care for seniors with complex care needs, and others who need support.

Like many Canadian hospitals, The Ottawa Hospital has been facing capacity challenges. Across Canada, an increasing number of beds are occupied by people who no longer need the level of care provided by hospitals, but who are unable to live independently and are waiting for additional supports or another community-based care setting such as long-term care.

With wait lists for many health services under pressure, it is not uncommon for these patients, designated "alternate level of care" or "ALC," to wait in hospital for weeks or months before moving to the care destination most suited to their needs. The majority are seniors. Prolonged hospitalizations, which offer limited opportunities for social stimulation and physical mobility, can negatively impact a patient's well-being, lead to a significant loss of muscle tone, and accelerate symptoms of dementia.

Transitional care approaches provide a missing link in the health care system and are becoming more common across Canada, through a variety of different models of care and governance. The Ottawa Hospital/Extendicare unit, located in Extendicare's West End Villa long-term care home, features an integrated team of staff from both organizations. Extendicare staff provide support with meals, activities, well-being supports and housekeeping, while hospital physicians and nurses provide care and clinical oversight, beyond what would normally exist in a traditional long-term care home.

The unit began with the ability to care for 55 patients departing hospital, and after a year of successful operations

on a single floor, has since expanded to a total of 100 beds on two floors. It has freed up hospital spaces for those who need them, offers a more suitable and comfortable environment for seniors with ongoing and complex care needs, and provides care to former ALC patients in the community, at a lower cost to the health care system.

Dr. Michael Guerriere, President and CEO of Extendicare, and Cameron Love, President and CEO of The Ottawa Hospital, were recently interviewed for OLTCA's podcast, *Coming of Age*, where they discussed the need for greater partnership between hospitals and the long-term care sector, like the transitional care unit in Ottawa. Read on for excerpts from their inspiring discussion.

In conversation with Cameron Love, President and CEO of the Ottawa Hospital, and Dr. Michael Guerriere, President and CEO of Extendicare

On the impetus for the unit:

Cameron Love: One of the big challenges that all health care organizations face is just growing demands of health care. When you look at the Ottawa area and across Ontario, even pre-pandemic, we were starting to see significant growth in population, and particularly in the adult population, for those that required care after a hospital stay. We do not have enough capacity within the system. I think first and foremost, what you really want to do is to have mechanisms by which you can provide safe and high-quality care regardless of where patients are in the system.

During earlier waves of the pandemic in Ottawa, Michael and I and our teams really started to work closely together in terms of how we as a system managed care for patients who have COVID, whether they're in the hospital or long-term care. And that was really the first foray into these discussions. The government has done a very good job of really setting forth a path to truly build capacity for long-term care, and there is no question we need that capacity in this province. But the challenge we have is until that capacity is built, how do you create capacity within a system to transition from now until then?

Michael and I started to talk about how we create environments where we can use existing capacity, improve the care that we're doing collectively together, and provide different environments where we can get patients to move to while they wait, whether it's for placement in long-term care, for home care, or other services.

In the case of West End Villa, we had the opportunity collectively around some potential beds that could be used to create this integrated model of care where our teams are over with Michael's, both medically and clinically, providing a seamless transition from their acute care environment.

It wasn't a discussion about what are we going to do differently in the hospital versus what are we going to do differently in long-term care. It was all about recognizing that we don't have enough in the system as a whole and we have to find a different way of putting in that capacity together.

I think one of the biggest gaps we have in our health care system is the risks of transferring patients between environments. The more we can integrate care, both medically and clinically between organizations, the better we can support patients through any type of transition.

On the right care in the right place:

Dr. Michael Guerriere: People and their function are heavily influenced by their environment. I remember in my internal medicine practice years ago how rapidly seniors can deteriorate when they're in an acute care hospital environment and when they have an acute event. The lack of mobilization, the lack of socialization can be a real problem.

We tend to look at a patient who is stuck in a hospital as also being stuck with a certain level of function and ability to function independently, when, in fact, we know that rehabilitation, socialization, more activity and stimulation can lead to a significant improvement. Basically, people are stuck because the system doesn't have enough capacity.

Our unit helps people to bridge that gap. We get them into a long-term care environment, but still with the supports of an acute care hospital team. The Ottawa Hospital physicians and nurses are still taking care of the residents in the transitional care unit, and the long-term care team gets involved with socialization and programing and bringing families more in touch.

We've seen with our program a good level of improvement where people then graduate to a point where their function and their needs make them perfect candidates for traditional long-term care, and even in some cases for returning home with home care.

On teamwork and government support:

Cameron Love: The two teams have a genuine, willing drive to help patients and people. I think what really gelled the two groups right off the bat is a real willingness to realize we have to change, and we've got to do it to the benefit of what patients and families experience.

It wasn't a discussion about what are we going to do differently in the hospital versus what are we going to do differently in long-term care. It was all about recognizing that we don't have enough in the system as a whole and we have to find a different way of putting in that capacity together.

Dr. Michael Guerriere: The teams on the ground at both The Ottawa Hospital and Extendicare hit it off right out of the gate. And they were passionate about the unit. They made it happen; Cam and I just played a supporting role.

That chemistry, that trust that occurred in those early days was critically important because when we started, we didn't know if we'd get government support, or if we would be successful.

We stepped off the curb on this one – but you need to venture out and try something and see what you can make happen. I give a huge amount of credit to our frontline teams for making it happen. But I also have to give huge credit to the people in the Ministry of Long-Term Care and the people in the Ministry of Health, because these two ministries really worked together to make this happen and they moved quickly.

On the importance of integrated care:

Dr. Michael Guerriere: I think there's a need for a more integrated kind of planning construct that focuses on populations and their needs. With health services separately funded and separately governed, it leaves it up to the individual citizen and patient to navigate those services and boundaries. I think there are things that we could be doing to make sure that we're focused on the needs of the individual and setting up our structures to be able to achieve that.

A key part of that is ensuring that integration is supported by information technology. That is currently a huge barrier to cooperation and collaboration because we have patients moving through the system with remarkably poor ability to communicate between provider organizations.

To resolve this for our transitional care unit, The Ottawa Hospital's information systems were installed on the floors so that there's a completely common record between the unit and the hospital.

Cameron Love: You hear a lot of people talk about integration. Where it really starts to show benefit and make a lot of sense is when you get teams that are managing a patient population and not working from an organizationally based approach.

You can't try to boil the ocean and just say, "We're going to make a big systemic change." You've got to look for opportunities, much like we've done here as a starting point, that you can build upon. You take that expertise and infrastructure, and you start wrapping it around a patient population.

What you get is a system approach, not just a hospital versus the long-term care home versus a home care approach. You just have people caring for people across a continuum. LTCT

Excerpted from Cameron Love and Dr. Michael Guerriere's discussion with OLTCA CEO Donna Duncan on Coming of Age, *the Ontario Long Term Care Association's podcast.*

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Improving care and reducing hospitalizations for responsive behaviours

Baycrest virtual consultation program is available across Ontario

By Baycrest

A virtual program to assess and treat people with challenging behaviours caused by dementia and related cognitive disorders is helping long-term care homes, as well as hospitals and family caregivers, to provide better care for people living with dementia.

Launched in April 2020, the Virtual Behavioural Medicine (VBM) Program is a collaboration between the Sam and Ida Ross Memory Clinic at Baycrest and the Toronto Central Behavioural Support for Seniors Program housed at Baycrest, which sees patients through virtual visits over the secure Ontario Telemedicine Network rather than in person.

Individuals with challenging responsive behaviours, such as physical and verbal aggression, agitation, hallucinations and paranoia, receive pharmacological and non-pharmacological interventions to mitigate their behaviours.

Among the benefits of the VBM Program is that its team of specialists – including neurologists, a nurse, a social worker, a pharmacist and the BSO team – can provide a rapid response where and when they are needed. They work with care teams in long-term care homes, as well as with acute care hospitals and family members in the community, to help them develop and implement care plans, access behavioural and social supports, and provide follow-up.

Analysis shows that before a consult with the VBM program, 96% of people were in clear need of admission to a specialized neurobehavioural unit. After implementing the program, only 38% needed inpatient care.

Two stories from long-term care homes show the significant impact of the program.

The Apotex Centre, Jewish Home for the Aged, had a new admission with behavioural symptoms of extreme aggression, both verbal and physical. The individual needed security and extra staff 24 hours a day. A referral was made to Dr. Morris Freedman, Head, Division of Neurology, Baycrest, who explained that he could assess the resident without seeing them in person. There was no need to transfer them to an in-patient unit.

Behaviours improved with the VBM's two-pronged intervention approach. "Dr. Freedman came on board along with the Long-Term Care Behavioural Support Outreach Team," said Shitu Wang, the Behavioural Supports Resources Team Lead at the home. "It took two months of sustained work with our team using medications and non-pharmacological interventions identified by the Behaviour Support Team. The results were especially positive with conversations and activities all done virtually."

When the Downsview Long-Term Care Centre in Toronto referred a resident with physical aggression to the VBM Program, there were similar results. The resident was quickly assessed, and the program worked collaboratively with their interdisciplinary team to develop and implement effective strategies to stabilize their condition. Following this, the resident no longer required one-to-one monitoring. "It's like having a virtual Behavioural Neurology in-patient unit in each location," says Dr. Freedman. "And just like on an in-patient unit, we have weekly rounds to review patients as a team."

The VBM program has also implemented bi-weekly case review rounds involving the whole team to look at each case and ensure that any gaps are filled, all available resources are optimized, and a transitional plan and supports are in place for a person's discharge from the program.

A physician referral is necessary to access the VBM program. Referrals are processed through the TC-LHIN Behaviour Support Hotline at Baycrest. Health care practitioners requiring support can contact the BSO Hotline seven days a week, from 8:30 a.m. to 4:30 p.m., including weekends and holidays, to be connected to support as well as to the VBM program as needed. LTCT

To refer a resident to the VBM Program, please contact the Behaviour Supports Coordinating Office at 416-785-2500, ext. 2005 or toll-free at 1-844-785-2500 or behavioursupport@baycrest.org. This story was adapted from an article previously published on Baycrest's website in 2021.

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Using the "fairness triangle" to resolve concerns

Perspectives from Ontario's Patient Ombudsman

By Craig Thompson

A long-term care home is a unique and special space. It is a workplace, it is a setting that delivers health care while also offering emotional and personal support, but most importantly it is a resident's home.

Though long-term care homes strive to provide all the comforts of home, there are situations that arise where residents or their loved ones have concerns about their experiences. The Patient Ombudsman's role is to help address those concerns.

In Ontario, Patient Ombudsman was established as an independent, impartial office whose role is to receive, respond to and help resolve complaints from current or former patients/residents and caregivers about experiences in Ontario's long-term care homes, as well as public hospitals and Home and Community Care Support Services.

Patient Ombudsman works with both sides (resident/caregivers and long-term care homes) to reach a fair resolution.

What do we mean by fair?

When working to resolve a complaint, Patient Ombudsman uses its 'Fairness Triangle' as a framework for its review. The Fairness Triangle outlines a set of principles that can be used when analyzing a complaint and test if a resolution is fair – it looks at what the health sector organization (HSO) decided, how was it decided, and how people were treated.

What is fairness by design?

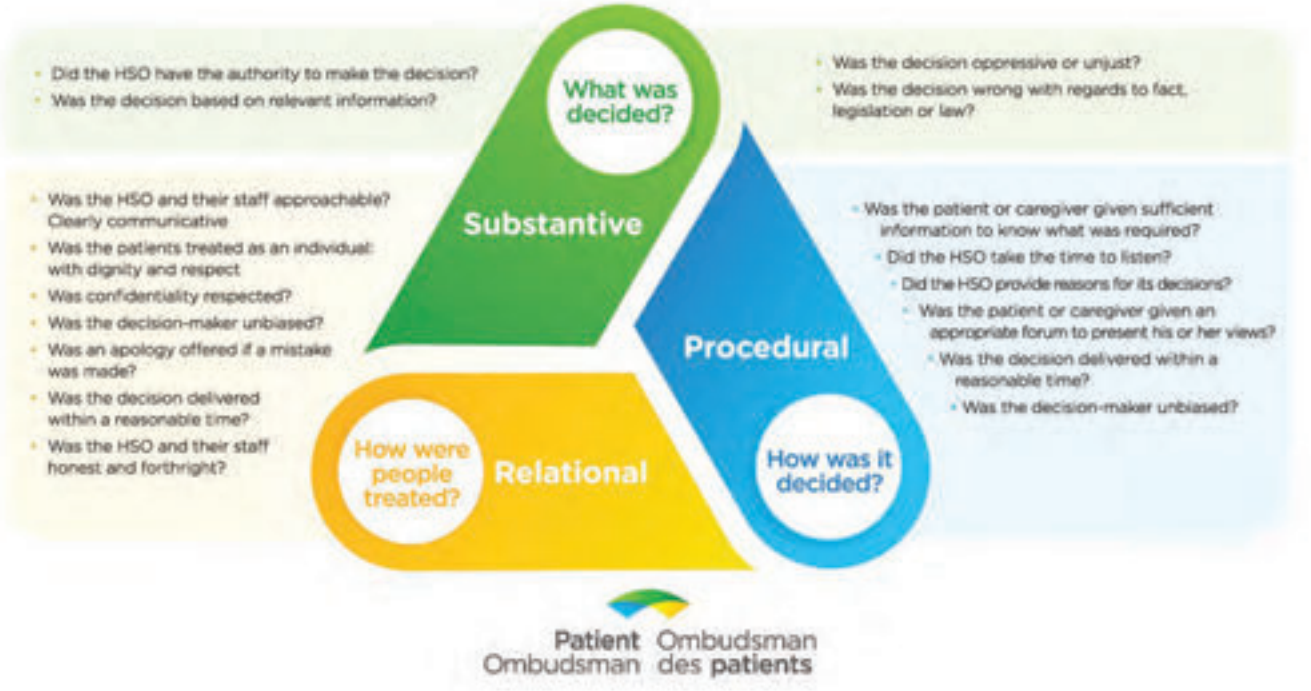
The concept of fairness doesn't only have to come into play when resolving complaints or conflicts. Long-term care homes and other health organizations can incorporate fairness into their planning to ensure fairness in policies and procedures and can review their own work to ensure decision-making is also done in a fair manner. The concept of using fairness standards to inform and validate your work at the outset is "fairness by design."

Incorporating fairness by design

How can long-term care homes make use of fairness by design to proactively address common concerns from residents and caregivers?

When developing a new policy, or making an important decision that affects residents, long-term care homes should ask themselves three key questions: what was decided, how was it decided, and how were people treated?

This includes ensuring residents and caregivers can meaningfully participate in decision-making and



their concerns are heard; ensuring decisions are based on rules and standards; and ensuring processes, policies and decisions are responsive to residents' individual needs.

Addressing common complaint issues

In recent years, restriction to visitation has been one of the top complaints Patient Ombudsman received from long-term care home residents and caregivers.

How are these kinds of complaints reviewed and how could long-term care homes use fairness to proactively address these concerns?

When Patient Ombudsman receives a complaint about restrictions to visitation, some of the key questions asked are:

- For restrictions that affect one specific family:
  - Was the decision based on evidence of behaviour or safety risk?
  - Did the home document the reasoning in a clear way that highlights the need for the restriction?
  - Did the home clearly communicate the risk of having visitation restricted due to behaviour?
  - Was the decision-making process clearly communicated?
  - Are there ways visitation could be facilitated, for example, in a private room or with supervision?
- For restrictions that affect a larger group of residents (for example, due to an outbreak):
  - Is the restriction based on evidence and proportional to the risk a visitor may pose?
  - Has the home considered how the restriction will affect resident mental health/well-being and ways to mitigate these effects?
  - Is the restriction time limited and only in place for as long as needed?
  - Have the reasons for the restrictions and the plan to remove them been communicated to residents and caregivers?
  - Are there exceptions on compassionate grounds?

Before implementing restrictions to visitation, long-term care homes can ask themselves these and other questions to gauge whether the approach taken is fair.

By taking proactive steps to ensure resident and caregiver participation, as well as clear communication, many top complaint issues may be mitigated at the outset. LTCT

Craig Thompson is Ontario's Patient Ombudsman. He has more than 25 years of experience working for public and private organizations in the health care, design sciences and communications sectors. For more information, visit patientombudsman.ca.

Relationship-building with Family Councils

Top 10 tips for long-term care staff

By Cathleen Edwards & Tiffany Fearon

Family Councils, autonomous groups composed of family and friends of residents, have been intrinsic in quality improvement efforts through advocacy, education, peer support and much more. While each Council across Ontario will be different in their makeup, they all seek to create safe, vibrant and supportive long-term care communities for residents, families and staff.

Numerous Councils have undergone their fair share of change over the last two years in response to the COVID-19 pandemic. As some saw growth in their membership, others experienced challenges connected to their inability to meet safely in person, the decrease in engagement, and home communication breakdowns due to transitions in leadership and widespread staffing shortages in the sector. As the provincial conduit for Family Councils, we know how important it is for interpersonal relationships to be nurtured for healthy collaboration, especially in the current climate. With that being said, here are 10 tips for home administrations to consider in order to rebuild relationships with their respective Family Councils:

1 Understand the new legislation & powers of a Family Council

Family Councils are recognized and included in the laws governing long-term care in Ontario. The legislation provides important information about Family Councils, including formation, membership and powers. It is a best practice for home administration and Council members to review and understand what is outlined in legislation and their scope of practice to be able to effectively and appropriately collaborate and fulfil goals.

2 Get to know each other

It is important for administrators and families to take the time to get to know each other beyond formalities outlined in legislation. Putting effort into building rapport through informal friendly greetings and showing interest in the other party helps to develop mutual understanding and fosters trust.

3 Discuss and set expectations for communication

Home administration and Family Council members should prioritize streamlining communication modes and discussing expectations. This may include determining which communication mediums will be used, frequency and response timelines. Some families and Councils prefer in-person dialogue, written memos, emails with updated policy or robocalls for updates about outbreaks. It is great to try various processes and evaluate what works best for staff and families.

4 Move beyond "Us vs. Them" dynamic

Family caregivers are motivated by love and their desire to ensure the highest quality of life for residents. While there might not be full agreement on various topics, all parties should be working together towards the same goal of making home communities thrive. To do this, it is important to move past an "Us vs. Them" outlook heading into interactions. It is crucial to recognize everyone's stake in their home community to enable positive partnership.

5 Embrace a solution-oriented mindset

Family Councils are encouraged to adopt a solution-oriented mindset when discussing concerns and complaints. When Councils have identified an issue, it is helpful for members to brainstorm potential solutions that they can suggest to management. It is best practice for Councils to come up with a few realistic ideas to share with home administration that all parties will find suitable.

6 Be transparent about decisions

Transparency is key to avoid misunderstandings that may arise when it comes to decisions being made that will impact residents, families and staff. Administration should try their best to explain why a specific path was taken and what factors were considered when making this decision. While some decisions may not be ideal, being forthcoming and candid when updating families and Councils of major changes or updates promotes trust, inclusion and healthy conversations.

7

Involve Councils in decision-making

Sharing of information and opportunities for families to provide input when it comes to decision-making is a great way for administration to support their home's Council in exercising their legislated powers. Administrators can engage councils to provide feedback on drafts of new policies and procedures that will be implemented in the home. Many family members have an artillery of knowledge and experience that can be utilized in decisions in areas such as nutrition, recreation and event planning.

8

Let go of the "Old Ways"

While Family Councils and home management may have developed strategies from relationships prior to COVID, now is a time to let go of "old ways" that are no longer efficient or operational. Take the time to evaluate existing processes and be creative in how systems can be enhanced for the betterment of a home.

9

Utilize communication tools

Interpersonal breakdowns often occur between families and care teams within a home because of miscommunication or lack of information exchange. Many communication tools that have been developed for health care professionals can be utilized to support Council to staff dialogue. "Non-violent communication" and SBAR are examples of tools that can be adapted to support healthy dialogue.

10

Recognize and celebrate success

As homes rebuild relationships, it is imperative to recognize and celebrate successes. Doing this not only shows appreciation for individual and group contributions, it reinforces the idea that working together can bring about positive outcomes. Homes and Family Councils can consider planning events to bring attention to extraordinary actions or dedicating a space within the home to show off Family Council achievements.

Rebuilding relationships takes time and commitment but is definitely worthwhile. Being effective partners in care is an amazing feat when those living, working and caregiving in long-term care homes can come together for the purpose of enhancing the delivery and access to care for residents. LTCT

Cathleen Edwards is an Education Manager at Family Councils Ontario (FCO) and Tiffany Fearon is an FCO Policy & Research Manager.

ABOUT FAMILY COUNCILS ONTARIO

Family Councils Ontario works with long-term care home residents' families, Family Councils and home staff across Ontario to enable them to cultivate positive relationships, build effective Family Councils and improve the long-term care experience.

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Hazards Associated with Branch Circuit Overloading Due to Portable Air Conditioning Units

Background:

Portable Air Conditioning (AC) units (example Photo F1), including plug-in, wheel-in and window types are sometimes used in older buildings during the hot summer season as a quick solution to manage the elevated temperatures. Some portable AC units are required to be plugged into a receptacle fed by a dedicated branch circuit (a circuit that does not feed any other receptacles or loads). If these are connected to existing circuits that feed other loads, there is a risk of overloading that circuit. Continuous overloading for a circuit may lead to overheating, deterioration of wiring/devices, and a potential fire hazard or loss of power.

Photo F2 shows an example of a nameplate of portable AC unit.

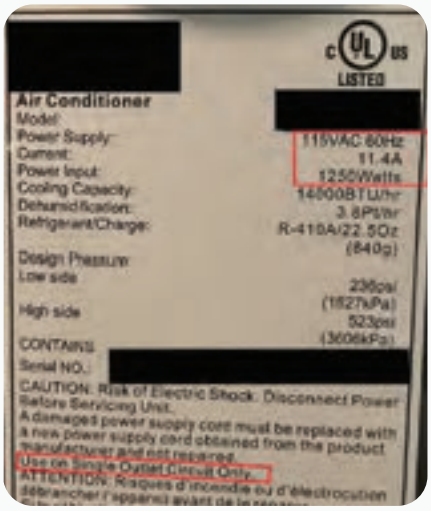
It is clearly stating "Use on Single Outlet Circuit Only," which means that the unit is required to be plugged into a receptacle fed by a dedicated branch circuit.

Photo F1 - Example of Portable AC

Recommendation:

- Always read the appliance label and manufacturer instructions and adhere to it.
- If the portable AC unit requires a dedicated receptacle circuit, it should not be connected to an existing branch circuit feeding other loads or general purpose receptacles.
- If a breaker is tripping when a portable AC unit is connected, do not attempt to plug it again and consult with a Licensed Electrical Contractor.
- For existing circuits that are shared between rooms, before plugging in portable AC units in each room, assessment is required to avoid connecting the AC units on the same circuit and to determine if additional dedicated circuits are needed.
- Where multiple portable AC units will be connected to an existing installation in a building, the assessment must also take into consideration the loading of the distribution panels and main electrical service.

Photo F2 - Example of Nameplate of Portable AC



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Bill and Walter are two of the 2SLGBTQI+ seniors who were interviewed for the Tool Kit video.

How to better support 2SLGBTQI+ seniors

A new Tool Kit from the City of Toronto can help long-term care homes create more inclusive environments

By Joseph Friedman Burley

"2SLGBTQI+ seniors often have to choose to return to the closet as we age or else face homophobia, biphobia and transphobia in long-term care and other support settings."

"No 2SLGBTQI+ individual should experience re-closeting – they should live their lives authentically, with dignity, pride and respect, for they have earned it."

Quoted above are Heather Hay and Pink Angel, both of whom are 2SLGBTQI+ seniors and members of the Seniors Services and Long-Term Care (SSLTC) Tool Kit working group at the City of Toronto. Hay and Angel describe a harsh reality facing many Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and gender- and sexually diverse (2SLGBTQI+) seniors as they enter long-term care: to remain 'out' or risk discrimination from staff and other residents.

2SLGBTQI+ seniors are a diverse and vibrant group who fought hard to advance rights for their communities and endured decades of prejudice, but their needs are routinely overlooked in long-term care settings. Those entering long-term care today came of age during the 1969 Stonewall Uprising and the infamous Toronto Bathhouse Raids in 1981. Some were left jobless during the Canadian federal purge of 2SLGBTQI+ employees. Many lost partners, friends, chosen family and entire communities during the AIDS crisis in the 1980s.

Cumulative exposure to this kind of homophobia, biphobia and transphobia across the life-course shapes the needs of 2SLGBTQI+ seniors. Social isolation and mental health issues, discriminatory policies in care settings, providers who lack the knowledge to deliver affirming support – these are just a few of the challenges that 2SLGBTQI+ people face as they age. Additionally, 2SLGBTQI+ seniors are an incredibly diverse group who may simultaneously experience intersecting forms of oppression based on other aspects of their identity such as race, religion, ability and socioeconomic status.

The combination of these factors can make it feel all but impossible to receive respectful, inclusive and affirming care, which is why many 2SLGBTQI+ seniors make the

difficult decision to conceal their identities and "go back into the closet."

Working group

To address these needs, SSLTC collaborated closely with a working group of community members, long-term care staff, and allied service providers to develop *Leading & Learning with Pride: A revitalized Tool Kit on Supporting 2SLGBTQI+ Seniors*. The Tool Kit is a freely-accessible, comprehensive resource for long-term care and seniors-service providers, featuring new resources, best practices and examples that build knowledge, skills and organizational capacity to support 2SLGBTQI+ seniors. Importantly, it was also co-created with the community.

"2SLGBTQI+ seniors have long been excluded in long-term care settings, left out of key decisions about their care, and rendered invisible by the very systems designed to support them," says Jennifer Dockery, General Manager of SSLTC. "That's why it was so critical that we engaged a working group of lived experience advisors, service providers, advocates and allies to redevelop, launch and implement this Tool Kit. We needed to bring awareness to these needs, collaborate and amplify the voices of 2SLGBTQI+ seniors."

With guidance from the working group, the Tool Kit was designed with new content on terminology, current research, allyship, and a cycle of 10 recommendations to foster respectful, inclusive and affirming care environments.

Rick Gourlie, also a member of the Tool Kit working group and a former Long-Term Care Administrator, believes the resource could transform the culture of long-term care: "When I worked in a long-term care home, there were very few practical tools that I and my staff team could implement to create a real culture of inclusivity. This Tool Kit uses a 2SLGBTQI+ lens to spark conversations and new processes that challenge status-quo care practices and foster nonjudgmental environments. I firmly believe it will enhance everyone's understanding of what it really means to provide the best care for all residents, while showing staff that being better allies can be easy – you just have to try."

Comprehensive campaign

After a successful release on June 23, 2022, SSLTC has undertaken a comprehensive Pride and Education campaign to advance training on the Tool Kit and promote 2SLGBTQI+ inclusion across the city's 10 long-term care homes and community programs. Components of the campaign include a mandatory video-learning module called *Understanding Gender and Sexual Orientation*, a series of interactive workshops delivered in partnership with The 519 and Senior Pride Network Toronto, and leading the 2022 Toronto Pride Parade's seniors' contingent. Most recently, SSLTC released a promotional video for the Tool Kit in honour of International Day of Older Persons, featuring interviews with 2SLGBTQI+ seniors and long-term care residents.

"There's no question that the road ahead is long and that the Tool Kit represents just the beginning of a much broader process of transformation," says Dockery, "but with ongoing support from our working group and community partners, we are taking an initial and important step towards truly inclusive long-term care homes and seniors services. I implore sector partners across the province to follow suit."

The 2SLGBTQI+ Tool Kit working group, featuring community members, long-term care staff, and allied providers, co-created the resource and continue to guide its implementation. Pictured left to right: Pink Angel, Shoshana Pellman, leZlie lee kam, Christine Chan, Margaret Rodrigues, Tom Warner, Tanya Neumeyer, Joseph Friedman Burley.

As for Heather Hay, the Tool Kit suggests the promise of a brighter future for her community: "We are so excited to see long-term care homes and seniors services begin to implement this Tool Kit so that we can continue to shine, no longer hiding in a closet." LTCT

For questions on the Leading & Learning with Pride Tool Kit, please contact seniors@toronto.ca.

Joseph Friedman Burley is a management consultant at City of Toronto Seniors Services and Long-Term Care and the lead on the 2SLGBTQI+ Tool Kit.

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If you build it, they will come

Foundations for engaging residents in Residents' Councils and beyond

By Stephanie Ventura

"Residents' Councils are the lifeblood of the home." This is how one resident leader described the importance and purpose of the Residents' Council in his long-term care home, and we at the Ontario Association of Residents' Councils (OARC) wholeheartedly agree.

Residents' Councils provide a formal, legislated way for people living in long-term care homes to help shape the place they call home. In Ontario, the legislation governing long-term care homes, the *Fixing Long-Term Care Act, 2021* mirrors its predecessor, the *Long-Term Care Homes Act, 2007* by continuing to mandate that every long-term care home in the province have a Residents' Council.

The new act also magnifies the importance of including residents in decision-making and consultation, by requiring resident participation in various home committees and by requiring that information sharing occurs between long-term care home operators and residents.

While the act does outline the scope, powers and functions of Residents' Councils, the long-term care home's duty and obligation to meet with, respond to and support Councils, and the specific information that homes must share with Councils, it says very little about *how* Residents' Councils should operate and how long-term care home operators can best support their Residents' Council. Residents in every long-term care home, with the support of their home team members, are tasked with building and sustaining effective Residents' Councils that meet all the requirements identified in the act, but with very little guidance on exactly how to do so. This is where OARC comes in.

OARC is a non-profit association providing a network to strengthen the voice of residents living in long-term care through their respective Residents' Councils by empowering residents to understand their rights, share their lived experience, and inspire a better tomorrow. We do this by working together with our partners to educate stakeholders, build a collective voice, and create positive culture change.

Recently, we had the opportunity to do just that by contributing a breakout session to the Ontario Long Term Care Association's This is Long-Term Care virtual conference. Our session, entitled *If You Build It, They Will Come: Foundations for Engaging Residents in Residents' Councils and Beyond*, reminded participants of the importance of Residents' Councils, acknowledged the current state of Residents' Councils after two and a half years of the Covid-19 pandemic, and encouraged residents and their supportive team members to let go of any preconceived ideas of what an effective Council should look like, and instead focus on building a Council that celebrates the strengths and abilities of residents who live in the home.

The session was informed and inspired by what we have heard from residents across the province, Residents' Council staff assistants, and long-term care home administrators through direct interactions with OARC and through results from a June 2022 environmental scan survey conducted by our association.

The message was clear – Residents' Councils (and overall resident

engagement) have taken a hit due to pandemic-related restrictions and human resources challenges facing the sector, while at the same time, new legislation requires more resident involvement and engagement in home committees and operational decision-making. Residents' Council leaders and their supportive team members need simple, easy-to-implement strategies and approaches for engaging residents who, for whatever reason, have lost, or have never had the opportunity to establish, the connection to their Council and to their long-term care home community.

There are barriers to resident engagement – we hear this from residents and team members all the time. Residents tell us that participation in Residents' Councils is low because "nothing ever changes, so why attend meetings?" or that meetings are not taking place because meeting spaces have been repurposed for pandemic-related storage and testing. We hear from team members that "there are few residents capable of, or interested in, participating" due to increasing resident acuity and decreasing ability, or that there simply isn't enough time to provide the kind of tailored support needed to allow residents to participate meaningfully in Residents' Councils and other home committees.

Yet, in spite of the barriers, we know how important it is for residents to be involved in the life of their home, to have a seat at the table when decisions are being made that affect their day-to-day lives, and to share their lived experiences, including how home policies and procedures affect them.

In our session, we invited participants to go back to basics and build a Council (and home committees) that residents want to attend, and can attend, because they feel welcomed, well supported, and know that their voice matters because of the response they receive from their home's leadership. The foundation for this is to know the residents and how to best support their participation (using a strengths-based approach), and to build a Council for the people who live in the home, instead of trying to find residents who "fit" into an existing, and sometimes outdated, Council structure.

In other words, we need to adapt meeting and Council styles for the people we have and let go of the idea that residents (and team members) should conform to existing structures that may not work for them. This is resident-directed engagement. It is residents shaping the place they call home; their indispensable influence builds a sense of community and vitality in the home for residents and team members. Residents' Councils are the lifeblood of the home. LTCT

Stephanie Ventura is the Education and Community Engagement Manager at the Ontario Association of Residents' Councils (OARC).

Menu planning... one bite at a time

Addressing concerns about recent regulatory changes to menu planning and meal service in long-term care homes

By Carol Donovan

What is big and gray and scary and constantly in your face? Change! Change is the proverbial "elephant in the room" these days. In these changing times... change is the only constant. In long-term care we have been in the constant state of change long before COVID-19 blew our way. The legislation related to menu planning has recently changed and has many of you wondering what to do. The good news is you do not have to do anything to comply.

The following regulations related to menu planning and meal service went into effect on July 12, 2022 (paraphrased):

77(1) Menu Planning

- The homes no longer have to offer two full choices of all meal items, rather they must provide one main choice meal (including entrée, sides and desserts) and have alternate options available.

77(7) Mealtimes

- The homes no longer must serve meals during very specific time windows; you may now serve meals at preferred times agreed upon by the Residents.

77(1) Snack Menus

- There must a choice of food items for snack at PM and HS.

77(2) Menu Evaluation

- The evaluation of the menu is to be conducted by both the Registered Dietitian and the Nutrition Manager and is based on the DRIs. Dietary reference intakes (DRIs) are a set of scientifically developed reference values for nutrients. These tables provide dietary reference intakes for vitamins, elements (minerals) and macronutrients.

This is each home's opportunity to rethink food service. The new regulations give you autonomy to set up a food service system that works for your population. Each home will be different based on residents' preferences, size, staffing and complexity of diet types and budget. For example, a smaller rural Home might select one popular menu choice for entrée and sides and have alternates available if needed. Homes with a larger population and cross-section of needs and preferences may want to offer two choices or more.

Do I have to make changes?

You do not have to make any changes. Your previous menus still meet the regulation. You have time to decide whether changes would benefit your residents and your home or not. The best way to do this is to talk to the valuable resources you already have in your home. Ask the residents, their families, the food service workers, cooks, Nutrition Managers, Registered Dietitians and Health Care Staff the simple question: *"What is working and what is not?"*

If resident meal satisfaction is an issue, you can make changes that will allow the dietary staff to spend more time and effort producing the

residents' favourite classic comfort dishes, offering prime cuts of meat, making more items from scratch and enhancing special events (such as holiday/themed meals). If staff shortages are an issue, going to one entrée choice with options available for a second choice if needed may help decrease workload. If budget is a concern, one choice of entrée, vegetables and starch may help decrease food waste and save money overall. The new regulations allow you to have the opportunity to use your time and your money – and offer choice – in a way that works for your unique home. You can now focus on quality instead of quantity.

You can also consider different mealtimes to better utilize the precious staff resources you have. You may want to implement the occasional cold continental breakfast and serve brunch instead of lunch on the weekends. You and your team can work on ways to ensure that the Health Care Staff have time to focus on assisting the residents in the dining room versus making sure regulations are being met. This is a great opportunity to slow things down and to get to know your residents better.

So how do you eat an elephant? Just one bite at a time!

Here are some tips on options you have within these new regulations:

- Continue with past practice if that is working for you.
- Go with two entrees but just one starchy choice and one vegetable.
- Go with one popular entrée and offer alternate items for those that don't like the main choice.
- Serve soup and sandwich together.
- Focus on residents' food preference to determine if an alternative is needed for that meal.
- Share the main entrée choice with the residents the day prior and have them order an alternate if they don't like the main choice.
- Your second choice could be:
  - A vegetarian entrée – this way you would always have something for those residents that prefer a vegetarian way of eating;
  - An "Of the Day" choice, e.g., sandwich, salad plate, omelette or casserole of the day; and
  - Or have "always available" food in the serveries, e.g., bread, PNB, cheese, yogurt, boiled eggs, soup, etc.
- Serve one dessert and have fruit (all textures) or ice cream or a pudding cup as the alternate – the residents would love to be able to get ice cream anytime they want!
- For your snack cart, have one choice (all textures) and have a fruit (all textures) available as your second choice. Use prepackaged shelf stable fruit cups to reduce waste.
- Some timing changes you could make may be:
  - Sunday brunch;
  - Continental style breakfast on certain days;
  - Serve your big meal at lunch, small meal dinner;
  - Consider open meal service hours such as breakfast from 7:30 to 9:30 a.m.; or
  - Set up a breakfast cart by nursing station for early risers or late risers.

Change is never easy. There will be bumps or even more elephants along the way. Your ultimate goal may look different after several adaptations, but remember the changes to the legislation are there to give you the autonomy to create a meal service that works best for your residents and your home. So, think elephant big but start small, just one bite at time. LTCT

Carol Donovan RD, is President of Seasons Care Dietitian Network. Visit Seasons Care at www.seasonscare.com or follow them on social media for updates. Other sources to follow are the Ontario Seniors Nutrition & Advocacy Committee and the Food and Nutrition Advisory Team. Follow them on Instagram and Facebook and check out their new website www.osnac.com for all their timely free resources.

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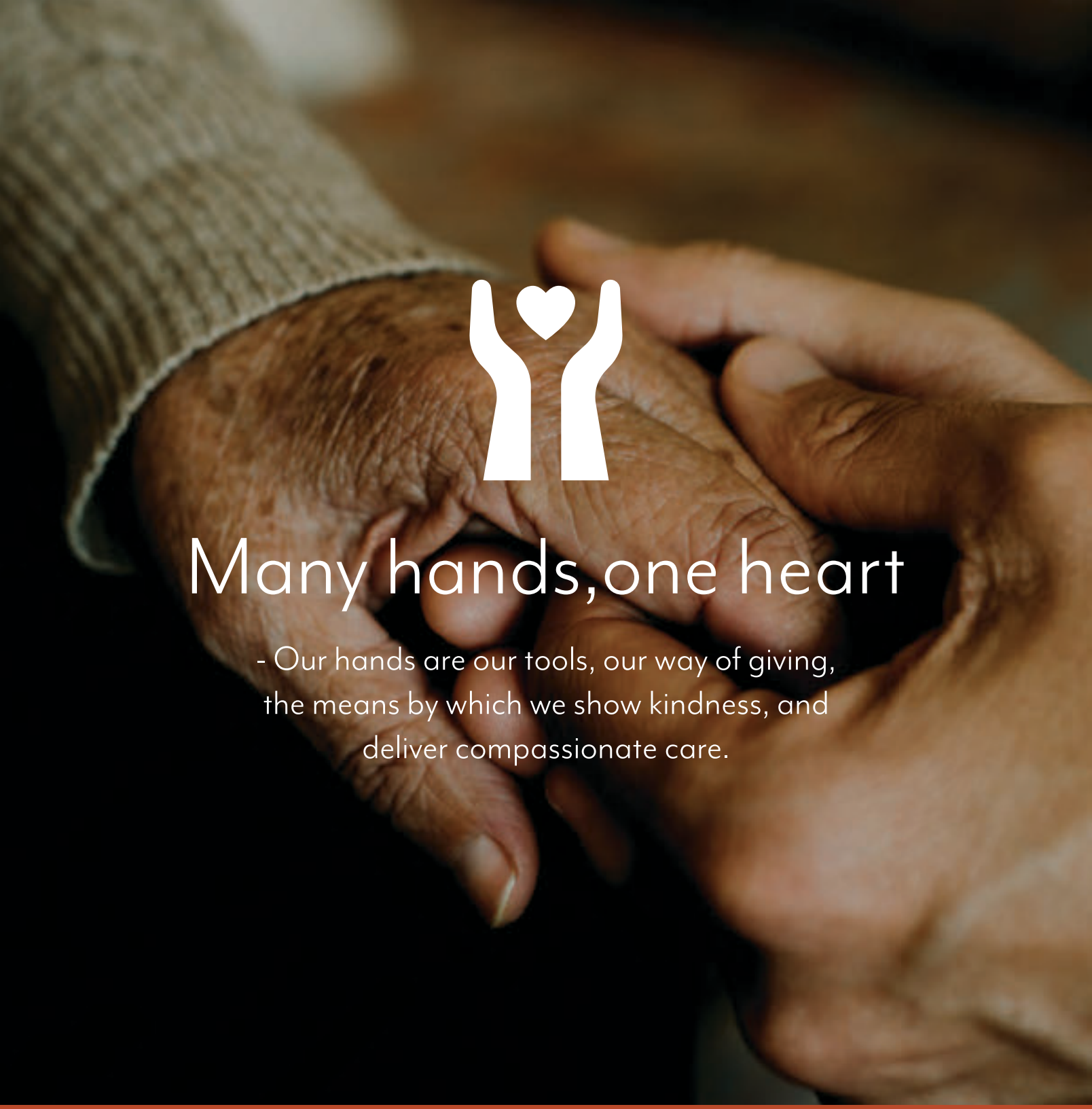

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Who would you be willing to die for? Would you die for your sibling? For a principle or a cause? How would you like to die: in your sleep or quickly but not violently?

These are some of the not-easy but truly thought-provoking questions that participants discuss to explore their own values and ideas around dying and death during the *All-In Palliative Care: The Team Approach to LTC* virtual training (*All-In training*).

Palliative care offers a quality of life that aligns with a person's needs and wishes, better controls symptoms, and decreases stress for families and team members.

In the winter of 2021, 634 learners from 67 homes across Ontario completed the *All-In Palliative Care: The Team Approach to LTC* training. The training empowers teams to apply a palliative approach in their care, and to feel confident in having difficult conversations. It also offers a space to share reflections:

- Homes have started revamping their palliative care programs and are changing the narrative around palliative care:
  - More than half of the participants already have been following leading practices. Some discuss palliative care when the resident/family tours homes or during the initial assessments. Others discuss this at their first care conference or within three months of moving in. Still, 47% of the participants did not know when palliative care conversations happened or reported starting too late.
  - The primary reason for delayed palliative care conversations is confusion between palliative and end-of-life care. This makes team members resistant to start. *"[We delay] often out of fear of upsetting the client/family."* Plus, *"The misconception and the comfort level of staff have resulted in delayed palliation."*
- Most teams have not considered the interprofessional or cultural aspect of palliative care.
- There is an immeasurable need for grief support in the sector:
  - More than two in three participants said that they never or rarely talk openly about their grief. These team members are missing a powerful tool because sharing your grief is vital to healing from the loss.
  - The pace of the work environment, lack of comfort with grief conversations, and the desire to not appear vulnerable prevented most from processing and talking about their personal grief: *"More residents need help so no time to pause. The bed needs to be filled"* or *"Making yourself vulnerable, showing weakness."*

How to cope better with grief at work? Implement designated times and space to discuss grief: *"A death cafe or death talk group where fears, ideals, experience, etc. could be expressed,"* or *"team meeting after someone passes to discuss grief,"* or *"management support providing space and time."*

Making this a regular event may lead to team members *"feeling secure enough with others to share the grief."* Learners expressed that being able to talk about grief anonymously would make it easier for them, especially if there is a *"dedicated person and a private space to talk about grief"* and *"confidentiality, [to] not [be] judged."*

Participants expressed a desire for *"having education and training like this [All-In session]"* to support team members in expressing grief. Implementing some of

these suggestions can help build psychological safety, prevent burnout and increase retention.

Continuing along the path from learning to action, we know that on its own, training for team members is insufficient to change the practice and organizational culture. The *Collaborative Project to Sustain a Palliative Approach to Care in LTC* through multifaceted capacity-building activities helps teams to support continuing education and quality improvement to consistently deliver holistic high-quality care. The project:

- Creates and offers customized education to build knowledge;
- Uses coaching to support knowledge mobilization;
- Offers an LTC-specific palliative resource library of tools and resources already available for Ontario homes; resources are grouped by region and by long-term sustainability themes (Lennox et al. 2017); and
- Combines and leverages all our partners' expertise and resources to avoid duplication, strengthens homes' relationship and encourages ongoing collaboration with key stakeholders.

Between October 2021 and June 2022, 43 homes engaged in a quality improvement journey. They started with a comprehensive self-assessment of their palliative care program. Then they identified up to three priorities and picked feasible activities achievable during the pandemic. Activities were of varying intensity with the *All-In Palliative Care* training (10 hours/participant) requiring a significant effort compared to "smaller bite" but still keenly needed activities, such as short training sessions for families and friends.

Join your colleagues in the sector and strengthen your homes' palliative care programs this year. Fall sessions of *All-In for Palliative Care* are full. Stay tuned for the monthly Ontario CLRI newsletter (https://clri-ltc.ca/subscribe/) or contact us at ceol@bruyere.org about signing up for January-February. In preparation or as a refresher, access CEoL e-learning courses (one hour in total) on the CLRI's website or through Surge Learning (aussi disponible en français). Contact us at ceol@bruyere.org to find out more about the Collaborative Project. LTCT

Since 2018, the objective of the Communication at End-of-Life Education Fund for Long-Term Care (CEoL Fund) has been to enhance long-term care team members' and students' competencies in providing high-quality palliative care. Funded by the MLTC and led by the Ontario CLRI at Bruyère, the CEoL Fund fosters an environment of organizational culture change and enhances collaboration among key stakeholders. This is in line with the guidance of the Ontario Palliative Care Network's Palliative Care Health Services Delivery Framework and with the Ontario Palliative Care Competency Framework and helps homes meet the requirements of Fixing Long-Term Care Act (2021).

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An example of a Reflection Room at Sheridan Villa Long-Term Care Centre

The Reflection Room project

How storytelling supports processing pandemic-related grief

By Neeliya Paripooranam, Celina Carter, Hana Irving, Justine Giosa & Paul Holyoke

Throughout the pandemic, everyone in long-term care experienced some form of pandemic-related loss ranging from the loss of in-person social activities to the death of loved ones. However, due to numerous disruptions from the pandemic, many people have not had access to resources and support to process their emotions. Physical distancing has interrupted traditional grieving rituals, in-person social gatherings have been limited, and access to support networks and health and social care professionals has been challenging. The Reflection Room® project is one resource that is being offered to attend to this growing need in long-term care homes in Ontario.

The Reflection Room project was first developed in 2016 to support people in community and health care settings to talk about dying and death. Reflection Rooms are evidence-based, participatory art installations that provide a space for visitors to read reflections about others' experiences and post their own. Researchers from the SE Research Centre and Memorial University of Newfoundland (MUN) were inspired by the death awareness movement and installation artist Candy Chang's work (beforeidieproject.com) to provide a space for people to pause, reflect, and be present with one's feelings and thoughts related to dying and death.

The Reflection Room project is currently in Phase 3 of its adaptation and evaluation. The first two phases of the project focused on supporting health care and community settings to transition from death-denying to death-discussing. In the current phase, the Reflection Room was adapted by a team of representatives from SE Health, Family Councils Ontario, the Ontario Association of Residents' Councils, and others to attend to pandemic-related grief in long-term care homes. It was decided that long-term care homes would be provided with an easy-to-set-up 'kit' (free of cost) incorporating instructions and materials (e.g., Reflection Cards, a red curtain to display Reflection Cards, candles, etc.) that enable them to adapt the Reflection Room to any available space within their homes. The Reflection Room installations are supported by the Saint Elizabeth Foundation as part of its commitment to improving end-of-life care journeys.

To evaluate Phase 3 of the project, we wanted to know if people who experience Reflection Room installations perceive it to be helpful in addressing grief in the time of COVID-19. Preliminary findings based on 68 surveys completed by visitors to the Reflection Room (e.g., long-term care staff, residents, caregivers) suggest that the Reflection Room is helpful in working through grief because it offers an opportunity to engage in grief work such as looking inwards, experiencing calm and peace, and connecting with the experience of others.

Most people who completed surveys recommend that other long-term care homes have a Reflection Room. Many said the installations are important because they provide a place of respite and space for

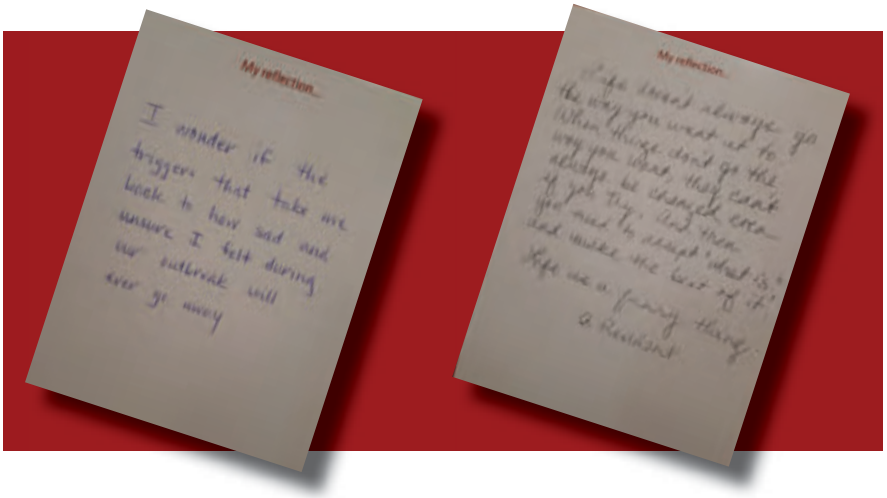
self-reflection. Others also believe Reflection Rooms have the potential to support those who are grieving as well as the holistic well-being of individuals and communities. We believe these findings support the idea that storytelling can be an important part of grieving.

Since June 2021, 48 long-term care homes have chosen the Reflection Room as a resource to help their communities reflect on their grief and heal from the pandemic together. Feedback from long-term care home staff is that the installations often align with other existing initiatives in their homes, such as palliative care committees and spiritual programs.

Phase 3 of this project will continue to recruit interested long-term care homes across Ontario this year. We will continue to build knowledge about the impact of the Reflection Room and how the Reflection Room can be scaled and spread to other settings and sectors across the continuum (e.g., hospitals) to address pandemic-related grief. LTCT

If you know a long-term care home that might be interested in hosting a Reflection Room, please contact Project Manager Neeliya Paripooranam at NeeliyaParipooranam@sehc.com.

Neeliya Paripooranam, MSc, is a Project Manager at the SE Research Centre SE Health. **Celina Carter**, RN PhD, is a Senior Research Associate at the SE Research Centre SE Health. **Hana Irving**, MA, is Director, Philanthropic Programs, at the Saint Elizabeth Foundation. **Justine Giosa**, PhD, is an Adjunct Assistant Professor in the School of Public Health Sciences at the University of Waterloo and the Managing Director of the SE Research Centre SE Health. **Paul Holyoke**, PhD, is the Executive Director of the SE Research Centre SE Health.



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1. Gefen A. The future of pressure ulcer prevention is here: Detecting and targeting inflammation early. EWMA Journal 2018, 19(2):7-13.

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Tackling ageism

It starts with you

By Ashton Applewhite

A recent presentation at OLTCA's conference by ageism expert ***Ashton Applewhite*** *was a popular session with attendees. Below are some tips on what individuals can do to address ageism, taken from her book,* This Chair Rocks: A Manifesto Against Ageism.

Acknowledging bias is an uncomfortable task and an ongoing one. The critical starting point is to acknowledge our own prejudices. Make the effort, and the rewards are real. Educating others, kindly and tactfully, also sends change outward like ripples across a pond.

With that, here are some tips:

- If you're not sure whether something is ageist or not, think about whether the same language or image would be appropriate if the situation involved someone significantly older or younger. When does an amorously entwined couple get downgraded from "hot" to "adorable," for example? (If your dentist spots a lot of cavities "for someone your age," on the other hand, it's probably all about the floss.)
- Don't compliment an older person by telling her she's "different" – fitter, stronger, more stylish – from other people her age. Saying "I can't believe you're 75" implies that 75-year-olds look a certain way. She can only accept the compliment at the expense of other women her age. And it implies that you'll stop admiring this attribute or capacity when it stops being exceptional. Instead, compliment her purse or her power lift.
- Instead of telling people they look great for their age, tell them they look great.
- Don't use "still" when describing a routine activity, because it suggests that the activity makes the person an outlier. It's a hard habit to break, but leave it out.

- Don't use adjectives for older people that you wouldn't apply to younger ones, like "spry," "feisty," or "kindly." Try "active," "opinionated," or "kind."

- Avoid youth-centric language like "young at heart," "youthful," or "young for your years." Instead, use specific descriptors like "playful" or "full of energy" or "charismatic" or "enthusiastic" – attributes that are age-independent.

- Have you ever heard anyone describe themselves as elderly? Avoid the word. Skip "the elderly" too: it implies infirmity and suggests that advanced age lumps people into some kind of uniform category, when nothing could be further from the case.

- Nix "grandmotherly" unless the topic is grandmotherhood. It reduces women to their reproductive status, leaves out the child-free, and is desexualizing.

- Look for beauty in older faces and bodies. It is there.

- Don't assume someone is too old – or too young – to weigh in on a topic or take on a responsibility.

- Talk to people significantly older and younger than you and listen carefully. If you don't know many of them, seek them out.

- Assume capacity, not incapacity. Speak to an older person the way you would a younger one. Offer help if it seems appropriate and listen to and respect the answer.

- The next time you wonder whether an outfit, or an attitude, or an outing is age-appropriate, reconsider the question. For adults, there's no such thing.

- A good, all-purpose response to an ageist comment is simply, "What do you mean by that?" Let the uncomfortable silence sit there, and remember: the goal is to change, not to blame.

Be on the lookout for ways you are ageist, instead of looking for evidence that you aren't. You can't challenge the bias unless you're aware of it, and everyone is biased some of the time. Ageism is woven into the fabric of life, reinforced by the media and popular culture at every turn, and seldom challenged. "Why can't we stop ageism?" asks ethicist and gerontologist Harry R. Moody. "For some answers, start by looking in the mirror – and look around you." LTCT

Ashton Applewhite, a writer and activist, is an internationally recognized expert on ageism who was recently named one of The Healthy Ageing 50 by the Decade of Healthy Ageing platform, a collaboration between the United Nations and the World Health Organization. Learn more on her website, thischairrocks.com.

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Creating a safe space to talk about mental health

By Scott Mitchell

When workers in long-term care experience mental distress, they need to feel safe enough to talk about their mental health with their manager and with their team. They need to know they are supported, what resources are available to them, and how to access those resources.

To create a psychologically safe and healthy workplace in long-term care where everyone feels supported, we need to reduce the stigma associated with mental illness.

Negative attitudes and beliefs toward people who have a mental health condition are rooted in fear and misunderstanding. Stigma is widespread and often leads to discrimination. For someone who is struggling to cope with a mental health condition, stigma can make them reluctant to seek support.

"In any given year, one in five people in Canada will personally experience a mental health problem or illness," reports the Canadian Mental Health Association. Unfortunately, research shows that stigma prevents 40% of people with anxiety or depression from seeking medical help.

Reducing stigma starts with education. When long-term care leaders and team members are trained to understand mental health, recognize signs and symptoms of mental distress, and know how to offer support to a colleague, they can create a safer space at work that enables everyone to talk about their mental health and to ask for help when needed.

To tackle this stigma, the Schlegel-UW Research Institute for Aging (RIA) has partnered with the Mental Health Commission of Canada (MHCC) to provide free mental health education for long-term care homes in Ontario. Enter *The Working Mind (TWM) Healthcare*: an interactive, facilitator-led training program that provides tools to promote mental health in the workplace while also reducing the stigma of mental illness.

Developed by MHCC in collaboration with mental health experts and health care professionals, TWM is an evidence-based program that includes three core modules for all team members to increase their self-awareness and take care of their own mental health. For leaders and managers, a fourth module offers practical tools to support the mental health of individual employees and teams.

"We have heard time and time again from participants that the training and coping strategies taught in *The Working Mind* were invaluable and they wished they had access to this information years ago," says Micheal Pietrus, Director of Opening Minds, MHCC's award winning anti-stigma initiative. "We're very pleased to partner with the Research Institute for Aging to bring forward this program to long-term care workers across Ontario."

Liz Horvath, Manager of Workplace Mental Health at MHCC, says, "The need to protect the psychological health and safety of workers in the long-term care sector is essential. As noted in our newly released policy brief, *Examining Two Psychosocial Factors in Long-Term Care During the COVID-19 Pandemic*, research has shown that the mental health of health care workers has been exacerbated by exposure to COVID-19, with 77% reporting worsening mental health – and the long-term care sector has been the most strongly affected."

All long-term care homes in Ontario are encouraged to sign up for free mental health training, supported by the PSW Education Fund. The fund provides tuition and backfill reimbursement for all participants, including your leadership team. For details, visit https://pswfundltc.ca/the-working-mind-healthcare/ LTCT

Scott Mitchell is a Knowledge Broker at the Ontario Centre for Learning, Research and Innovation in Long-Term Care, hosted at the Schlegel-UW Research Institute for Aging.

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