STROKE STRATEGY of Southeastern Ontario

Ontario Stroke System
Fewer strokes. Better outcomes.

STROKE STRATEGY OF SOUTHEASTERN ONTARIO

AN ENVIRONMENTAL SCAN OF LTC HOMES IN THE SOUTHEAST REGION

September 2009
Gwen Brown
Regional Stroke Community & LTC Coordinator
Stroke Strategy of Southeastern Ontario

A sincere thank you to the Long Term Care Homes in the southeast region, all of whom participated in this scan. Your consideration in setting aside time to share your thoughts, recommendations and experiences was most appreciated. There was universal evidence of concern and compassion for staff, residents and families and a shared vision for the highest quality of care.

EXECUTIVE SUMMARY

> *"In 2001, 3.92 million Canadians were estimated to be over 65 yr old, and by 2021 the senior population is expected to reach 6.7 million and 9.2 million by 2041 (Statistics Canada 2004a). The oldest seniors (those over 85) are the fastest growing age group (expected to total close to 1.6 million by 2041) (Health Canada, 2002) and these most "senior" seniors have the greatest likelihood of living in a LTCF (Statistics Canada 2004b)."*[1]

The results of this scan provide the picture of a health care sector that is struggling to provide the highest quality of care to a growing population of elderly residents with increasingly complex care needs. The provision of this care is challenged by a lack of human resources and funding; multiple expectations (from government agencies, partners, families, residents and staff); the need for increased education to reflect expanding or changing scopes of practice; and a shifting demographic.

The Stroke Strategy of Southeastern Ontario (SSSEO) initiated this scan to determine how they might best support the long-term care (LTC) homes in their region to implement and sustain best practice stroke care. The recommendations arising from the results of this scan can be found in Section V and are aligned with the six focus areas of the scan, namely:

1. Educational Supports
2. Learning Approaches
3. Best Practice and Interprofessional Care
4. Assessment Processes (therapy)
5. Records and Referral Information
6. Key Challenges

Broadly speaking, the scan results recommend changes to the SSSEO methodologies of education and associated tools and supports; enhanced marketing of available resources; sustained and enhanced partnerships and linkages and continued advocacy and support for best practice.

The findings suggest that it is time to review current educational approaches in recognition of the changing environment of the LTC sector – to work with the homes to determine how to best take advantage of the limited time and funds available for education and to consider innovative approaches to sustaining best practice.

There is also a need to re-evaluate the role of stroke rehabilitation in the LTC setting subsequent to some relatively recent changes. LTC homes are now independently contracting physiotherapy (PT) services (rather than accessing them through the Southeast Community Care Access Centre or SE CCAC) and there has also been increasing emphasis on the roles of physiotherapy assistants (PTAs), restorative care and activation. As well, in February of 2009 the SE CCAC ceased to provide ADP (assistive devices program) assessments via Occupational Therapy to the LTC homes. The results of this scan also point to untapped potential roles for speech language pathology (SLP) and social work and an expanded role for OT (i.e. beyond ADP assessments).

A recent LHIN-funded partnership initiative (SSSEO & the SE CCAC) includes a component where enhanced rehabilitation services are provided to LTC residents who have experienced a recent stroke. The findings of this project may better define the critical role that stroke rehab could play in the LTC setting

As a pivotal player in the care cycle, the LTC sector will continue to expand in response to a shifting population pyramid. LTC Homes must be supported at all levels if their vision of high quality care to residents is to be sustained.

Table of Contents

SECTION I

BACKGROUND

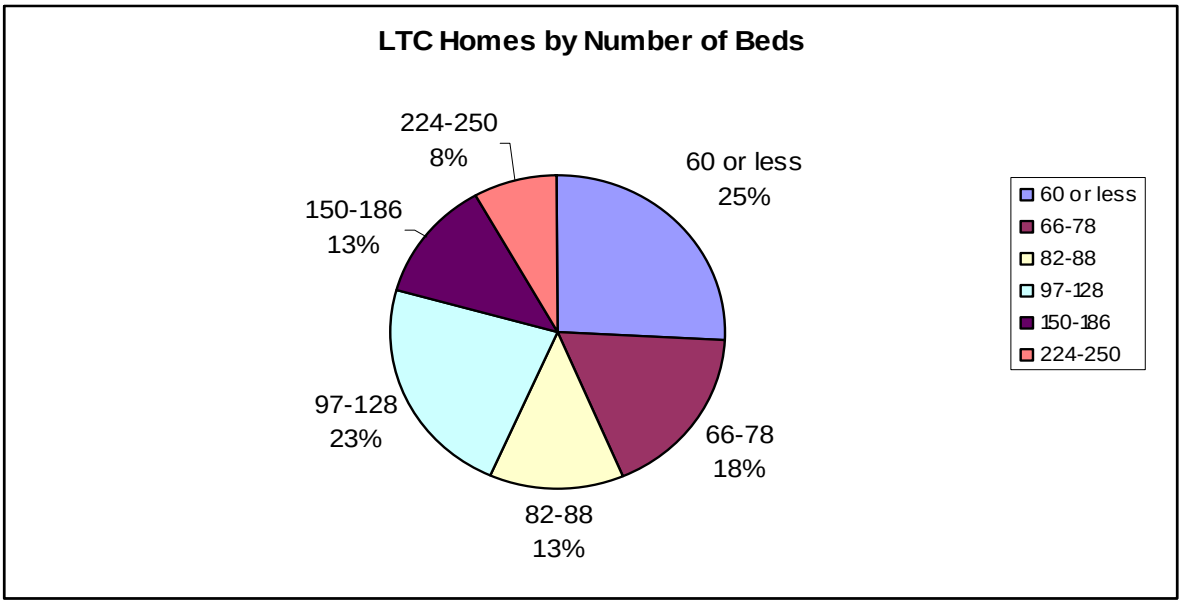
The Stroke Strategy of Southeastern Ontario is one of eleven regional systems established across the province with a responsibility to implement the vision of the Ontario Stroke System*., 'Fewer Strokes. Better Outcomes*.' The mission of the Strategy is '*To continuously improve stroke prevention, care, recovery and integration*.' This is accomplished through the re-organization of stroke care delivery across the care continuum, promotion of system change, health provider education and public awareness. The values of the SSSEO are:

- Regional integration
- Equitable access
- Effective patient-centred care
- Evidence-based practices
- Timely access to the continuum of care

The southeast region covers a large geographic area of approximately 20,000 square kilometers and in 2007 had a resident population of close to 481,000.[2]). Interestingly, of all the stroke regions within Ontario, the southeast has the largest proportion of rural residents at 46% (MOHLTC 2003 estimate urban/rural radius based on Statistics Canada 2001Census). The southeast region corresponds with the boundaries of the Southeast LHIN and includes the counties of Kingston, Frontenac, Lennox, Addington, Hastings, Prince Edward, Lanark, Leeds and Grenville. The three major metropolitan areas are Belleville, Brockville and Kingston. There is one regional stroke centre (Kingston General Hospital) and one district stroke centre (Quinte Healthcare in Belleville). There are ten other hospital sites in the southeast region including four rehabilitation centres/units. The Southeast Community Care Access Centre serves the region.

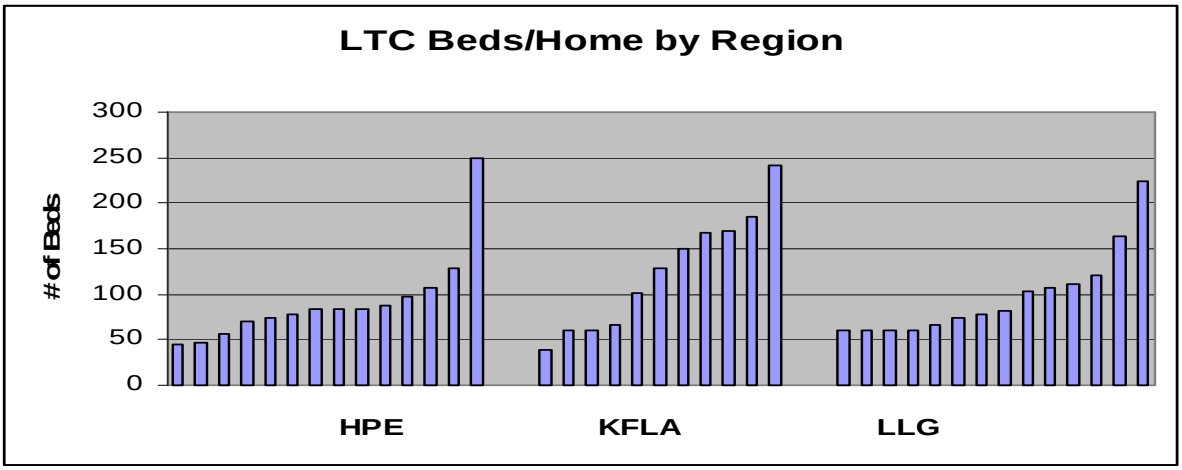
The health professionals involved in implementing the Stroke Strategy of Southeastern Ontario work across the continuum of stroke care - prevention, emergency, acute care, rehabilitation, LTC and community re-engagement. The Regional Steering Committee provides oversight to the program.

There are a total of 39 LTC Homes in the southeast region (one facility houses interim beds). The smallest home has a total of 38 (interim) beds and the largest has 250 beds.



Hastings Prince Edward (HPE) has 14 LTC Homes ranging from 45 beds to the largest at 250 beds. Kingston, Frontenac, Lennox & Addington (KFLA) has 11 LTC Homes ranging from 60 beds to 241 beds and includes the interim 38-bed facility. Lanark, Leeds & Grenville (LLG) has 14 homes ranging from 60 beds to the largest at 224 beds.

As illustrated in the graph below, KFLA has a higher proportion of larger homes and LLG a higher proportion of smaller homes. KFLA also has a higher number of homes that could be defined as urban relative to HPE and LLG.



There is a growing proportion of seniors in the population generally and the "…South East LHIN has a higher percentage of elderly individuals than the rest of the province (17.1 % vs. 13.2% for persons 65+ in 2007)." [2] Hence, it is reasonable to expect that the requirement for LTC beds will continue to increase in this region and it is also reasonable to question if the system will have the capacity to meet the rapidly growing demand. It is of interest to note that the MOHLTC recently approved an additional 192 new long-term care beds in the Quinte area (primarily in response to the number of ALC patients in hospitals) during the course of this scan.

As the general population ages, so does the population residing in LTC Homes and with the increased average age, many LTC homes are finding they need to care for a much more dependent resident. "The population in non-acute settings is now mostly over 80 years old, with a much lower capacity to care for themselves and with many more needs for support than in the past. Residents typically require assistance with many aspects of daily living and have increasingly heavy and complex care continuing care needs. Over the last decade in Ontario, 78% of LTC clients have been classified in the mid-to-heavy care categories; 63% possess some form of cognitive or psychiatric disorder (Alzheimer's disease, related dementias, psychoses and mental disorders); 72% are incontinent, up from 51% in 1992; 37% require constant encouragement or total feeding, up from 28% in 1992; and 72% require one or two staff to assist with toileting, up from 48% in 1992."[3]

As the complexity of care increases so does the demand for staff, however, the pool of healthcare human resources is a shrinking one and has definitely become a 'seller's market'. Unfortunately, research indicates that LTC homes do not always do well in the competition for these scarce resources. "A great challenge in LTC is finding qualified and committed professional staff…Professionals appear to choose LTC either because they 'love it': or they have no choice due to abilities, training, job opportunities or geography. Those who love it are very important; those who 'learn to like it' are key to successful programs, and those that have no choice end up resenting LTC and causing problems. The challenge for the LTC field is to nurture those who love it and turn them into role models and leaders and to find those who learn to like it and build on their discovery. The challenges in LTC include the enormous and complex demands for

individualized care, and general understaffing, including physicians who are only periodically available, few full-time nurses and limited rehabilitation and recreational staff. There are multifaceted medical problems, complex pharmacotherapy with a tendency to therapeutic nihilism and severe behavior issues that result in psychotropic medication therapy with its associated benefits and problems."[4]

It will become evident through the findings in this report that southeastern Ontario LTC Homes are experiencing these challenges first-hand.

SECTION II

SCAN METHODOLOGY

In order to better understand how the SSSEO could best support LTC Homes in our region to implement and sustain best practice stroke care, a decision was made to conduct an environmental scan. The goals of the scan were to:

- Initiate or renew contact with the Homes (through the Regional Stroke Community & LTC Coordinator);
- Introduce or re-introduce the available educational supports offered by the SSSEO and obtain feedback on their value;
- Enhance our understanding of the challenges currently faced by LTC Homes and how the SSSEO might help to address these challenges to achieve mutually beneficial outcomes and
- Inform SSSEO Workplans.

The environmental scan was initiated in July 2008 and the final home was surveyed in May 2009. The participants were given the option to complete the scan by phone or in person. The majority of the scans were completed by phone (85%). Most respondents were Directors of Nursing, Directors of Care or Assistant Directors of Care/Nursing. One respondent was an RN and two scans included several supervisory/management staff. Completed scans were shared with the relevant respondent(s) as an opportunity to make any corrections and/or add any further information as they deemed appropriate.

All homes participated in the scan and respondents were universally transparent in the dialogue and willing to share the challenges and successes of their individual homes. The difficulty experienced in setting interview dates is likely reflective of the current LTC workload.

The scan essentially had six focus areas:

- Educational supports provided by the SSSEO (and partners)
- Learning approaches (successes & challenges)
- Best practice & interprofessional care
- Assessment processes (e.g. rehabilitation therapy)
- Records & referral information
- Key challenges

There were significant commonalities in the responses received and many responses supported the literature both in Canada and internationally. There were no significant differences across the region, however there were some differences noted with respect to urban versus rural homes; small versus large homes and older versus newer homes.

These differences are evident in the comments contained within this report. Broadly stated, small homes may have had increased issues with staffing capacity in some cases; rural homes with travel-related challenges and older homes with space and other infrastructure issues.

SECTION III

FINDINGS

Educational Supports

> *"The quality of life for long term care residents is the result of a participative effort. It requires the participation of the resident, the family and the institution's staff. The high quality of care that is necessary to the resident's life quality can become a reality when inservice training is an integral part of facility staff development. (There is a) continued lack of involvement and commitment of the health professions schools in establishing long term care curricula for new professionals and for continuing education. As long as the providers must take major responsibility for orientation and training in long term care, the field will continue in a "catch-up" mode rather than being able to utilize inservice training as a vehicle for continuing competency and honing the leading edge in long term care practice."*[5]

The SSSEO offers several educational supports including the *Field Training* and *Shared Work Experience* programs, the *Brain, Body & You* continuing education program (in partnership with St. Lawrence College [SLC]), bursaries and posters as well as resource materials such as the *Tips & Tools for Everyday Living: A Guide for Stroke Caregivers* manual (Heart & Stroke Foundation of Ontario, 2002) and DVD/video set.

Field Training Program

The SSSEO *Field Training Program* is designed to support an educational event for a group of health care providers working in stroke care to develop their knowledge and skills related to stroke. The instructor receives a financial incentive of up to a maximum of $200. The scan asked if the respondent was aware of this support, if they had accessed it in the past, did they find it valuable and would they recommend any changes.

Fifteen (or 38%) of the respondents were aware of this support and of those, twelve had accessed it in the past. For those respondents not aware of this support, an explanation was provided. All respondents were asked if they thought this support was of value and if they would recommend any changes (as per their experience or as it was described).

All, but one respondent saw value in the Field Training program and none of the respondents recommended changes.

Some of the comments from respondents related to reasons why the support had not been used and typically spoke to staffing capacity or other resource issues:

- Staffing capacity is always a challenge in smaller home
- Some challenges - due to limited human resources it is difficult to pull staff from the floor to attend education sessions - this is particularly problematic for registered staff
- Have not used recently due to priority of several other educational initiatives.

There were several positive comments on past experiences including:

- Worked very well and provided a positive experience for staff. Provided an opportunity to obtain a better understanding through working with PT/OT. Information was then shared with co-workers.
- Activities staff as well as health care workers (HCWs) have participated; physio provided session and staff found this approach to be excellent. There was good staff attendance and feedback and the format was seen to be effective.
- Past presentations on mobility/transfers and dysphagia/diet/feeding. Found these sessions to be excellent with good staff attendance and feedback.
- PT presentation in past. Staff was highly impressed with the session and the presenter; session was well presented and set up with good staff feedback.
- PT offered several shorter sessions on same subject over the course of a full day - this approach allowed more staff to attend.
- Had brief presentations on each floor and was very well-received. Approach may work better with unregulated staff in LTC although registered staff also attended. LTC Homes need to know that sessions/approaches can be customized to meet the needs and opportunities in each Home. They also need to know that the approach does not need to be structured or formal in duration of session or in content (could be case-specific or generic).

Several respondents indicated an interest in a presentation by a SLP (e.g. on dysphagia) and, with respect to formatting, it was suggested that it "would be particularly meaningful for personal support worker (PSW) staff if sessions were practical and incorporated hands-on component" and "this support would be particularly advantageous in situations where the learning would address an identified resident issue and promote client-centred care".

Two respondents suggested that further marketing be done to ensure that LTC Homes are aware of the support and how to access it.

Shared Work Experience Program

The *Shared Work Experience Program* offered by the SSSEO supports one or more learners, to spend time with a health care provider(s) working in stroke care to share expertise, knowledge and develop hands-on skills. The organization or independent participant will receive a financial incentive of up to $200.

A slightly lower percentage of homes were aware of this support (31% or 12 homes) as compared to the *Field Experience Program*. Of those 12 homes, only half had accessed the support in the past. As with the *Field Experience Program*, respondents who were not aware of this support were provided with a description. All respondents were asked if they thought this support was of value and if they would recommend any changes (as per their experience or as it was described). Two homes did not see this support as being valuable. No changes were recommended by any of the respondents.

Reasons for not accessing the support typically centred on staffing capacity and potential need to travel as illustrated by the following comments:

- Challenges to accessing support due to difficulties in freeing staff to go to another facility and/or spend time with another professional/care provider.
- Has shared the information re this support with staff, but no interest expressed. This may be attributable to staffing limitations.
- May access in future as very supportive of education and enhanced expertise; challenge is that it would typically involve travel which adds to length of day and costs; additionally, not all staff are comfortable with driving longer distances to urban areas.
- May not be as valuable as Field Experience as may involve travel to another facility - if staff required to travel then increased need for backfill.
- Concept is very good, but there are inherent challenges in freeing staff to participate in this activity. (name of Home) is not located in an urban centre, the travel required for a staff member would result in a half day of travel and a half day of actual practical experience.

**Note that it was not clear to all participants that expertise may be brought to the Home thereby negating the need for travel.*

Comments in support of the program included references to various staff disciplines obtaining benefits from such a learning exchange and three comments spoke directly to staff spending time with rehab staff at Providence Care, St. Mary's of the Lake Hospital site (SMOL):

- Found it to be very beneficial when restorative care aides attended SMOL; Used in past for shared learning between an RN at SMOL and RPN in the Home; Staff member spent some time at SMOL and found this approach to be of great benefit.
- May be less problematic to free up one staff to attend training off site than several to attend training on site (e.g. field training).
- This initiative also supports increased communication between organizations and enhances understanding of the roles and capacities of organizations.
- Interested in this support for personal learning.
- Support would be particularly valuable if it was all inclusive (i.e. included all staff - RNs, RPNs, PSWs, therapy, etc.). Would be beneficial to promote this support through presentations and other strategies. **Note that this support is available to all health care workers.*
- May be a potential for registered staff to take advantage of this incentive.
- Always interested in educational opportunities both on site and externally particularly if support is offered.
- Potential to use this support to increase skills of PSWs.

Bursaries

The SSSEO provides bursaries in the southeast region to support staff attendance at Collaborative Learning Network meetings. The current Learning Collaborative planning partnership includes Psychogeriatric Resource Consultants, the Palliative Pain & Symptom Management Consultation Service, the RNAO Best Practice Coordinator for LTC Homes in the East Region and the SSSEO. A bursary application is completed and, following approval and attendance at a Collaborative Learning Network meeting, $75 will go to the employer to support staff attendance. There are three Collaborative Learning Networks in the southeast – KFLA, LLG and HPE. The Collaboratives evolved out of a recognition that there would be value-added in the partnering of several organizations that, at the time, were providing education to LTC and community healthcare providers independent of each other. This resulted not only in duplication, but also in unnecessarily taxing the staffing resources of the healthcare organizations (i.e. attempting to have staff attend several events rather than one). Further, it was evident that hosting isolated education sessions did not support the concept of a continuum or cycle of care or the reality of co-morbidities. Each region has an average of four events per year all of which are half-day sessions and are free of charge. The sessions often take advantage of expertise in the region and topics are universally relevant to the participants (selection of topics is typically based on participant feedback and/or anecdotal information from involved homes and organizations). Topics may be similar across the three Collaboratives or may be different depending on the needs and requests of each area. Recent topics have included oral care, MDS RAI, transition of

developmentally challenged persons into LTC, challenging resident behaviours, rehab in LTC, inter-organizational communication and the 4 'Ds' (death, dying, depression and delirium).

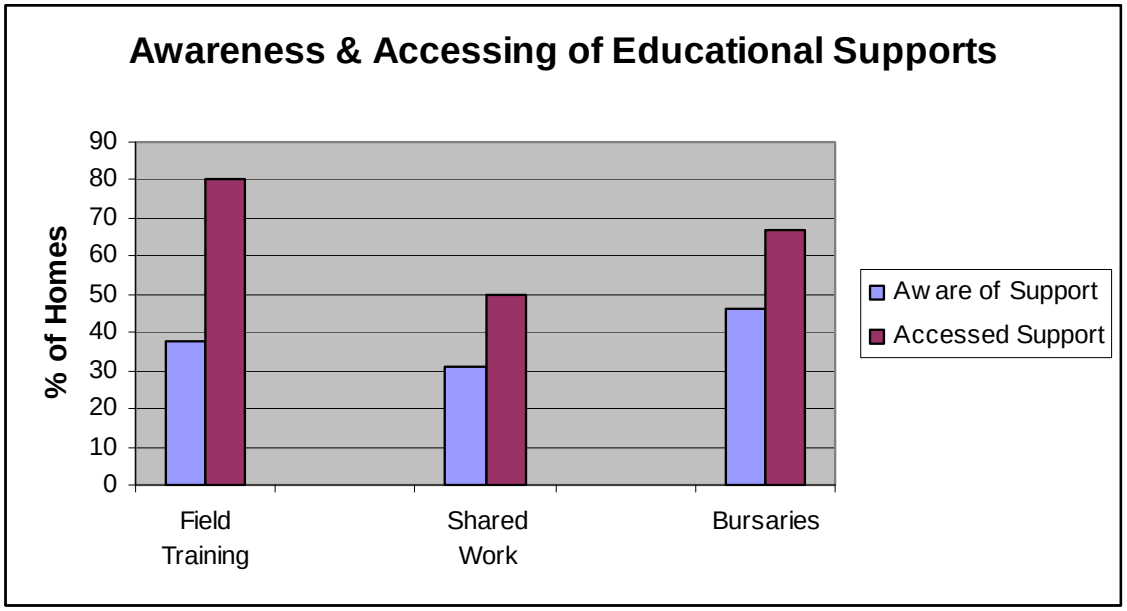
Of the 39 homes surveyed, 18 or 46% were aware of the bursary and, of those, 12 (or 67%) had accessed this support. Although not formally tracked, there were several respondents who were not aware of the Learning Collaboratives and an explanation was provided. One respondent did not see this support of value and one suggested a change to the process to inform applicants when the bursary application had been approved.

Thirty-one per cent of the respondents stated that the bursary was not accessed due to challenges related to finding adequate staff coverage especially if there was travel involved. There were also three respondents who indicated that lack of staff motivation is a factor. Comments illustrating these concerns included:

- Support is of help from a financial perspective, but challenge of backfilling for staff attending an event remains.
- Due to staffing issues it is very challenging to have front line staff attend (travel tends to make attendance a full day commitment).
- Has not been able to attend recent sessions due to staffing challenges particularly with registered staff.
- Attendance tends to be a challenge when travel is involved. The bursary may help to offset some of the cost, but if travel then may result in a full day absence.
- Not sure that bursary would provide an incentive and/or increase participation as staff (HCAs in particular) is not motivated to attend education sessions even mandated ones; Challenges with getting non-registered staff to participate in education.

Other respondents did see the bursary support as a decision factor in staff attendance:

- Valuable incentive for participation; any assistance that supports and encourages education and provides information on best practice is welcome.
- Amount of bursary is close to repaying RPN salary; Bursary does provide an incentive for attendance and the current amount would essentially cover the cost for a PSW to attend a 3-hour session.
- Finds it valuable given the limited nursing funding available; does act as an incentive as budget is typically tight.



The above graph illustrates the percentage of Homes that were aware of the support (field training, shared work experience and bursaries) and of those that were aware of the support, the percentage of Homes that actually accessed that support.

Brain, Body & You

The *Brain, Body & You* program (provided by St. Lawrence College in partnership with the SSSEO) is intended for front line care providers (e.g. PSWs, RNs, RPNs, Rehab Assistants & Restorative Care Aides) caring for stroke survivors in long-term care, community, acute, rehabilitation, complex continuing care and other related areas. It provides an opportunity to learn, perform, practice and enhance care and support techniques to promote safety, comfort and dignity for stroke survivors and other client populations. The program currently offers four separate half-day modules (which can be taken independently) – stroke care prevention to life after stoke and continence care; communication and behaviour; nutrition, hydration and feeding; and mobility. Educators are those who have an expertise in stroke care including a speech language pathologist (SLP), a physiotherapist (PT) and a registered nurse. Program registration fees are supported by the SSSEO regional annual education budget (i.e. there is no registration fee for participants).

Of the participants surveyed, 30 or 77% were aware of the *Brain, Body & You* program. Of those, 10 or 30% had accessed the program. One home indicated that a program similar to *Brain, Body & You* was offered corporately.

Of those participants who indicated a preference for the timing of the module sessions, 9 recommended that the modules be offered during a weekday, 3 suggested evenings during the week and 16 indicated that either days or evenings would promote participation provided it was during the week. Weekends were effectively discounted as a viable alternative as many front line staff work every other weekend and so are understandably reluctant to give up their time with family etc. during a weekend off. From the perspective of staffing, weekend attendance was also problematic as there are increased challenges in finding backfill. Homes also noted that they were typically unable to 'support' staff attendance due to financial constraints and/or inability to backfill.

- Staff interest is negatively impacted by program being offered on weekend as staff is booked to work every other weekend so are reluctant to take that time away from family & personal activities.
- Barriers to attending are financial (funding to replace staff who are attending course) and HR challenges (availability of staff to backfill). Also, staff are reluctant to use vacation time for education - are willing to attend if compensated for time.
- Backfilling to support staff attendance can be challenging especially if it results in overtime.
- Education budget is limited so not able to financially support staff attendance.
- Some staff did express an interest in attending, but it was problematic to send them with respect to distance and backfill.
- The timing of course offerings is also significant and best times would likely be spring and early fall as this avoids high vacation times and poor weather.

When asked, location was cited as a potential disincentive for 27 or 69% of the participants (particularly rural homes). Twelve suggested that offering the program on-site (i.e. in the home) would be a great incentive although there was also recognition that this might restrict the number of attendees. Offering the program outside of the home and at a distance (distance was not defined) was seen as problematic for several reasons including length of time required to reach location, availability of transportation, cost of transportation/travel and the comfort level with the location and the driving.

Comments included:

- Generally speaking, external inservices are more of a challenge with respect to staff participation especially when travel is involved.
- Would be benefit to offering course on site as staff would be more comfortable in their own location. In addition, PSWs in particular do not always have personal cars for transportation or may find it difficult to pay for transportation.
- Distance for staff to travel is a definite disincentive and it would be prohibitive for the Home to financially support the travel costs. Extent of travel time required would also negatively impact on the success of an evening course as staff would arrive home quite late. Offering modules closer to home would likely increase participation.
- Benefits to offering education on site although numbers would be limited (due to size of Home).
- Distance required to attend the program can be a disincentive with cost of transportation and time involved which converts a half-day program to a full day commitment.
- Extent of travel time required would also negatively impact on the success of an evening course as staff would arrive home quite late.
- Location of course may have impact on attendance - HCAs would probably feel more comfortable attending the program if it were held in a LTC Home rather than on campus.
- Presenting the modules in a location that is distant for staff would be a deterrent. If program is not close then there are challenges in providing transportation and reimbursement for travel.
- Some staff did express an interest in attending, but it was problematic to send them with respect to distance and backfill.
- There would be tremendous benefit in presenting on site. Bringing the presentation to a Home also encourages partnerships with other Homes in area who can also take advantage of a course closer to home. Sense is that there is a higher degree of comfort in attending education sessions in another Home rather than the formality of a college setting.

The Program itself was seen to be of value and certainly relevant to the LTC setting:

- Staff member who attended found modules to be informative and enjoyable.
- Several staff have taken course and remarked that they got a lot out of it.
- Have sent staff in the past and they were thrilled with the program and it is likely that other staff will attend in the future.
- Staff has expressed interest in attending. Format of offering different modules with no requirement to attend all modules is a good approach as it supports staff attending sessions that they are interested in or have a need for. Three hour session duration is good.
- Have had staff attend. Feedback has been very positive - staff found sessions to be informative and brought information back to share with team.
- Staff has participated and has been very enthusiastic about the experience. Subsequent changes in practice tend to be subtle, but what is more evident is a change in perspective particularly with PSWs. PSW tends to be somewhat limited with respect to physiology and the BBY sessions provide the PSW with this valuable knowledge which then enables them to see the stroke survivor in a different context. There is increased understanding of behaviours and how they may be linked to a brain injury.

There were some suggestions for change put forward in addition to the timing and location of the program:

- Offering session on site would promote participation as would shorter sessions such as 1 hour.
- May be a benefit in offering flexibility in times that modules are offered.
- Would be valuable to offer a bursary in support of attendance at this program (although registration is paid, there are other costs such as travel and backfill).
- Ideally offering two 3-hour sessions in one day, on site during the week would likely result in the greatest attendance.
- Attending these kinds of programs can be problematic - full time staff are often very busy juggling work and family obligations while part time staff may be trying to manage two jobs at two different employers. Correspondence course may be an effective strategy especially if paired with a contact or mentor who would be available as a resource.

Tips & Tools for Everyday Living: A Guide for Stroke Caregivers

In 2002, the *Tips & Tools for Everyday Living: A Guide for Stroke Caregivers* resource was distributed to LTC homes across the province. This resource was developed provincially and consists of separate modules (e.g., communication, meals & hydration, cognition, etc.) addressing various care needs and strategies for the stroke caregiver. In 2004, the SSSEO developed an accompanying DVD/video set to complement the resource binder and, at the same time supported the formation of Stroke Care Resource Teams within the LTC Homes. Homes were encouraged and supported by the SSSEO to send three staff for training who would then act as the in-house Resource Team for stroke care based on the *Tips & Tools* resources. The SSSEO recommended that the three representatives from each Home include administration, a regulated staff member and an unregulated staff member. All but one of the LTC Homes in the southeast region participated in the initiative. For the purposes of this scan, homes were asked if the Resource Teams were still in place and functioning and if the *Tips & Tools* resources were still in place and being accessed by staff.

Of the original Resource Teams, none were currently functioning. Participants provided several reasons for this including staff turnover, too many (competing) teams with overlapping mandates and many of the same members, lack of staffing capacity, and a global decision to not use the approach of in-house resource teams.

- No teams currently in place. Not due to lack of desire or interest, but rather due to limited staffing and associated time constraints. Health human resources staffing shortage is particularly acute in LTC and, as a result, Resource Teams would not be the best approach.
- Use of resource teams in smaller Homes not always effective as typically there are a few staff members who populate all the teams. This results in burn out as well as overlap between the teams and team mandates. Teams are also negatively impacted by staff turnover and reliance on the dedication of the team members. Having several resource teams results in a multitude of meetings and with workload of staff it is difficult to elicit interest in becoming a team member. Use of 'blanket' education (i.e. education of all staff) is a more effective approach for a smaller home.
- Teams are not typically used due to staffing efficiencies. Individual staff with a specific interest in a best practice area may act as a champion or resource and would be provided with educational support as required and as (name of Home) is able.
- Staff turnover and other roles & responsibilities (leaving limited available time) have (negatively) impacted on the Resource Team. Additionally, (name of Home) is a smaller Home so that staffing is limited and it is more efficient to integrate many teams/specialties into one overall team which is the current approach.
- It is a challenge to dedicate an entire team to a specific diagnosis/issue as there are so many competing priorities (e.g. pain, infection control, stroke, etc.) some of which are mandated. Also, there is often redundancy in having various teams as there is frequently overlapping knowledge/expertise as different diagnoses may share similar care needs (e.g. pain, mobility, etc.). It is very challenging to find staff resources and time to address so much incoming information.
- Staff tend to change adding an additional challenge to the sustainability of teams. Rather than create various teams to address various care needs/diagnoses, strategy is now to incorporate new needs into current teams.
- Challenge is that LTC is such a busy field that it is difficult to support a team for every need/diagnosis.
- Recently implemented a new team that amalgamates five previous free standing teams. This is more effective approach as the stand alone committees often had overlapping mandates and issues and working in isolation was not a value-added approach.
- Sometimes teams will be depopulated due to staff changes or at the request of the participants who have been on a team for an extended period of time.
- Not sure if resource teams are best approach as have so many teams for so many different things that people are 'teamed out'.
- It can be a challenge to maintain a level of expertise if there are few opportunities for practical application.
- Current approach is to ensure that a wider range of staff have expertise/education - this supports a core group and an 'expert' for each shift.
- Approach is to streamline process and reduce meetings. Recognition that many care issues/best practices overlap many areas (e.g. grief or dementias may result from stroke).

- This may not be the best approach due to increased need to allocate resources (i.e. team rather than individual necessitates a greater dedication of resources for initial training).
- Approach is to educate many staff then move the expertise to smaller groups. This addresses previous issues where there may have been some resentment due to the perspective of some staff that having an identified 'expert' implied that they did not possess the knowledge. This modified approach is more inclusive, increases available on-site 'expert' resources and does not undermine the self-confidence of front line staff.

Many homes did have resource teams in place other than for stroke including teams for best practice, continence, palliative care, wound & skin care, falls, infection control and health & safety. Some of these teams are mandated or Ministry-driven.

While participants were not specifically asked about the use of ‘champions’ within their homes, several participants did comment on this approach:

- Have also used 'champions' but finds that individual champions are less effective at supporting implementation. Sustainability is an ongoing challenge for champions and teams due to being so busy.
- There are some resident 'experts' for certain practice areas/activities.
- Having an expert on staff does promote consistency of approach. Development of experts through education/practice is reflective of needs within (name of Home).
- Those that do participate on resource teams tend to become more aware of best practice in their particular area and become 'champions'.
- Do not use 'champions' per se but do have identified experts for some functions. Then use train-the-trainer approach which works very well for a larger facility. Selection of trainers is done so that all staff on all shifts can receive the training (i.e. 2 part time staff who work evenings & nights to address those shifts and 2 full time staff to educate employees who work days and evenings).

To the best of their knowledge, the *Tips & Tools* resource binder was still present in 33 of the respondents’ homes and the DVD or video set in 20 of the homes. (DVDs were re-sent to six homes subsequent to their scans and a binder/DVD set was re-sent to five). The resource continues to be accessed in 14 of the homes although typically only on an infrequent basis (i.e. to address specific resident care needs). Some homes also continue to use the binder and/or DVD/video set during orientation and/or as ongoing education and review during evening/night shifts, on weekends and during scheduled inservices. Other homes have also posted excerpts from the binder for education or have provided excerpts to front line staff when asked about a stroke-specific care need. In one situation, the binder is also placed so that residents and families could also access it.

- *Tips & Tools* is an education topic at staff meeting on an annual basis.
- Have copied information from *Tips & Tools* to display.
- An annual inservice is offered to all care staff using the video to re-introduce staff to the resource. Additionally, there is an annual orientation where the *Tips & Tools* resources are used. The video has also been set up in a central location for staff to watch as they are able.
- Videos work particularly well for orientation as they are brief and provide pertinent information.

One home stated that these resources were used frequently and were seen as a "valuable ongoing resource as the Charge Nurse is able to use it for inservices and at the bedside". However, the majority of homes did indicate that while the resource was used frequently following its introduction in 2002, use is now sporadic or infrequent and typically in response to a particular care need. This was seen to be due to staff familiarity with the contents (including the care strategies) and due to the overshadowing of this care component/resource by other priorities.

- Binders are located throughout the Home; accessing is variable and typically occurs in response to a resident-specific need or change in condition. Particular pages may be cited to staff as a reference or certain pages pulled from binder and posted. Binder and videos may also be used during an education blitz that includes stroke and stroke-related conditions.
- When resource was first received, it was used quite frequently by staff. Staff who are familiar with this resource initially do not use it often now; however it is used as a resource for the orientation of new employees.
- Other priorities and initiatives have taken precedence.
- Had one particular situation where the communication section was used as a primary resource in care planning for a resident with a communication issue.
- These resources had greater use initially as staff were familiarizing themselves with new practices and knowledge and have now likely found a place on the shelf although they are pulled out for reference for specific cases.
- Used quite frequently when first introduced however not as much recently. There has been little change in staff so many familiar with contents and have not had the need to refer to it. Staff will consult binder if there are unusual concerns or situations.
- Would be of benefit to re-introduce these to staff as have had significant turnover since their initial introduction.

One participant noted that "Offering *Brain, Body and You"* as initial education (theory & practice) would provide substantial background which could then be sustained through the use of *Tips & Tools*. It is recognized as a benefit that much of *Brain, Body & You* (and *Tips and Tools*) content/approaches are applicable to diagnoses other than stroke."

Posters

The SSSEO has produced several posters intended for table displays with topics related to stroke. These posters were developed several years ago and have been made available to the LTC Homes in the region. Poster topics include dysphagia & diet, hypertension & medications, signs & symptoms/management of stroke and falls prevention. Participants were asked if they were aware of these posters, if they had accessed them in the past, if they saw them as a valuable learning tool and if they had suggestions for additional poster topics.

Thirteen of the homes indicated that they were aware of the posters and all thirteen had accessed at least one of the posters. There was widespread interest in the falls prevention poster as this is a current MOHLTC focus.

> *"Falls are a major problem in community residing elderly persons and even more in frail elderly residing in institutions. Falls are a frequent occurrence in nursing homes, with approximately two falls per bed per year. They may have considerable consequences for the health status, the autonomy and the quality of life of the patients involved."*[6] *In addition to the trauma experienced by the resident, falls also result in increased emergency visits and, frequently, hospitalization. The hospitalization, in turn, may end up in an ALC designation if the original LTC bed was not held for the resident. "Falls are a major safety issue in long-term care. The rate of falls among seniors (aged 65+) resulting in an emergency department visit or inpatient hospitalization per 100 resident-years in long term care homes in Ontario is 11.6. There has been no significant change in the previous five years.*[6]

Respondents also provided suggestions for other poster topics:

- Aphasia/communication (communication tools & strategies; types of aphasia, physiology of aphasia) (4)
- Feeding (2)
- Pain management (2)
- Stroke physiology (1)
- Behaviours/emotions (why they occur and how to manage them) (2)
- Positioning/seating (2)
- TIAs (1)
- Osteoporosis (1)
- Mobility (1)
- Care of resident with one-sided paralysis (assisting resident with ADLs) (1)

Most respondents supported the use of posters as a good educational strategy. One barrier identified by four respondents was the lack of space for a table display in the home (usually an older home), but these homes were interested in displaying wall posters.

- Challenge would be finding a location where space would support a table display and where display would be highly visible. Wall posters would be a more feasible alternative.
- Have used two posters in the past, but there is a challenge in placement of poster display. (name of Home) is an older facility with narrow hallways so it is difficult to find a location that has high traffic, but where the display does not act as an obstruction/barrier.

Another concern expressed by two of the homes was the use of posters in what is intended to be a home-like environment:

- Not sure how they might be utilized given that (name of Home) is a home and so setting should support a home-like environment. Posters may be seen as distracters in an environment that is meant to be a home for residents.
- Would need to investigate how such displays could best be placed to support the greatest audience value (e.g. staff, resident, family) while not interfering with the current home-like setting.

> *"A recent Ministry-led consultation with long-term care residents found they are more concerned about their quality of life and issues such as maintaining their autonomy, having meaningful activities and living in an environment that feels like home not an institution, than they are about the objective quality of care."*[7]

Generally, the respondents saw posters as an effective method of reaching the majority of staff without having to schedule time away from resident care or arrange for backfill. Posters were also seen to be amenable to various topics and audiences – staff, residents and families. It was seen as advantageous if the poster topic was coordinated with another event such as Heart & Stroke month, an internal inservice or a current resident care need. With respect to including quizzes with the poster displays, there was little consensus – some homes saw the addition of a quiz as confirming and reinforcing the learning while others believed that they may act as a disincentive to staff reading the posters.

- Most effective would be to use posters in combination with a learning session (e.g. poster could provoke pre-session interest and support post-session practice).
- Useful approach as everyone is working to capacity so dedicated education time is often problematic. Posters in high traffic areas would allow staff to have some quick hits of education.
- Especially effective when the topic reflects personal health as well as resident care (e.g. signs & symptoms of stroke).

- Displays work well as do not require structured time away from the unit. Topics work well especially if they are connected to a current challenge within the facility. For instance, currently have a resident who is cognitively impaired and has communication & behaviour issues. A poster that would assist in understanding the resident's needs and solution finding would be very well received.
- Very popular and a good education tool. Typically displayed in foyer area where they can be accessed by staff, families and residents. In some situations, aids and other visuals are added to the display (e.g. for the swallowing poster, nutrition aids were included such as a lip cup). Handouts may also be available.
- Posters are a good learning strategy with added benefit that families and residents may also learn from them.
- Use of posters in high traffic areas is an effective strategy as staff tends to learn without intention. Posters receive attention by virtue of their location and learning happens visually.
- Best strategy would be to coordinate posters with relevant in-house or external presentations and with current in-house initiatives. For example dysphagia and diet poster could be linked with Nutrition Month. May link posters with coffee break learning sessions with placement of posters in high traffic areas. Recommend that posters include practical, day-to-day applications, tips and strategies.
- Poster on dysphagia was particularly well-received and captured a lot of staff interest. There was a visit by Compliance Advisor during this time and they were very impressed with display.
- Have used in past particularly the one on dysphagia and diet. Found that tips included on posters were valuable (e.g. use of a teaspoon) and that staff did take the time to read the posters.
- Good learning strategy as it capitalizes on the visual which will capture staff attention. Posters provide opportunity for quick reviews and learning of salient points - even if staff is only reviewing briefly, some content will likely be retained.

Learning Approaches

The SSSEO was interested in learning what approaches to education were seen to be effective in the LTC setting. In particular, the concept of ‘learning blitzes’ – sessions of short duration presented throughout day which would support staff attendance without requiring backfill.

One hundred per cent of the respondents saw this approach as potentially effective and many had already implemented this strategy for other learning. The duration of the sessions was typically suggested to be from 15 minutes to 45 minutes (average of 15 – 20 minutes) and the timing of the sessions would ideally be such that two shifts (days and evenings) could be accommodated.

While providing education and motivating staff to attend were seen to be challenges, the importance of ongoing learning was also recognized especially in the context of increasing resident complexity. "There is a growing need for professional development for healthcare providers in gerontology because of the complexity of health problems in the clientele. Client groups and family members are better informed about their health concerns resulting in higher expectations. (However) with increasing fiscal and human resource restraint in the current healthcare system, it is becoming a luxury to attend half- or full-day workshops on continuing education (CE) topics through institutional sponsorship."[8]

- Shorter sessions more likely to get staff interest as usually working to capacity and are also reluctant to take time from a day off to attend a longer presentation. The idea of 'hit and run' information accompanied by a handout would be effective. Funding rarely allows for mandatory education sessions.
- Funding may be in place to present the sessions, but barrier is typically related to difficulties in backfilling for those attending.
- Worked in the past - staff are more motivated to attend when sessions are abbreviated, where there is rapid learning and where there is flexibility in when staff may attend. Having longer sessions tends to decrease participation and staff has increased difficulty focusing as they are needed on the floor.
- Blitzes work well as workload tends to be quite heavy and staff is reluctant to be away from the floor for an extended period of time. It is also difficult to request/expect staff to give up breaks to attend education sessions.
- Experience has also been that staff have a better focus if the session is limited to about 30 minutes.
- It also provides a quick learning opportunity for staff who may be reluctant to commit to longer programs.
- Time factor is a significant barrier to training/education. A full or half day comprised of repeated 20 minutes sessions would be a better approach. Spectacular idea.
- Works well and (name of Home) has moved a lot of education to this type of approach. This may require the modification of some information (i.e. may not be as comprehensive), but it is an approach that succeeds in getting the information to the staff. Have found that producing a longer and more in depth session may not be effective in that few staff attend.
- Very effective strategy. Have used in past and it has been well-received. If sessions are extended to 45 minutes or an hour or more, staff often feels that they should be doing something else. Additionally staff is reluctant to come in on their day off, so short sessions integrated into a work day are best. Blitz approach could work well. Best approach would be to schedule multiple sessions that would accommodate more than one shift (i.e. early a.m. to capture both night and day shifts or early p.m. to capture day and evening shifts). Would also be effective to offer sessions on different days to reach the greatest audience.

There were also suggestions as to how attendance might be maximized such as:

- Making the presentation relevant to a familiar case (presenter collects information prior to presentation to ensure that specific in-house challenges are addressed - this approach follows a logical progression from what staff are seeing to why they are seeing it [physiology] to the strategies that may be implemented); use hands-on demonstrations (use residents as 'volunteers' [this has the additional benefit of a therapeutic interaction with residents and provides them with an opportunity to contribute], demonstrate an activity and then allow time for staff to implement the learned strategy in the workplace and then report back on how well it worked, what barriers or challenges they encountered (this opportunity to practice what has been learned and the report back could all be in one day)
- It is very successful when sessions are interactive and use actual cases to apply learning. Similar sessions in the past have resulted in changes to how care is provided and the resulting successes support implementation and sustainability
- Having a resource person visit on occasion who simply makes him/herself available to staff using a very practical approach for such care issues as seating and feeding. This has been an effective approach.

Respondents were also asked to share other educational strategies they have found to be effective. These ranged from newsletters and payroll inserts to 'in the moment' opportunities seized at the nursing station or during reports. It was suggested that bringing the education directly to the units allowed the educator to take advantage of teachable moments even if the audience may be small. Shift change was seen as a venue for information sharing (for instance if there is a particular initiative that is about to be implemented or a change in practice) as the educator is able to include a greater number of staff. However, there was a limit to this approach in that with the increase in acuity of residents more time needed to be allocated to communicate specific resident care information at shift change thus restricting the opportunity for other information sharing. Other educational approaches mentioned included the use of crosswords, quizzes, fact sheets, payroll attachments, newsletters for staff, residents, families, use of videos/DVDs and education bulletin boards/posters. Lunch & learns were also mentioned and of interest were comments from two homes where "lunch and learns are well received by registered staff, but not popular with PSWs which may be due to timing of PSW lunches which occur earlier in the day" and "registered staff tend to participate in lunch and learns, but this approach has not been as successful with PSWs - this may be due to the timing of their lunches."

The use of computer-based learning was only mentioned by three homes – two saw it as a valuable learning strategy as "many staff are computer literate so use of teleconferences, webcasts and self-learning modules also tend to be successful" and "it would be valuable to have on-line educational offerings or expertise specific to hypertension and stroke that could be accessed by staff" while the third home stated that "not all staff are comfortable with computers at this point so on-line and self-learning modules would likely be unsuccessful."

One respondent identified the need to continue with some extended education sessions "It would also be beneficial to have the same approach as PIECES where there is a commitment by staff to attend a full day resulting in a certificate. This approach may be initially focused on professional staff, but then extended to unregulated staff. Focus on rehab, behaviours, family interventions, assessment (e.g. warning bells), etc. Acute care has benefited from an educational focus provided to them so moving to LTC will be well-received."

It was evident that there was a diversity of need within and between the LTC homes necessitating a flexible approach in the provision of education. There was emphasis placed on the need for a practical time-limited approach, one that reflected the realities of care and the resident population.

> *"Use of a variety of learning approaches including narrative, video, reflection and lecture. Recognition of the expertise already present in nursing homes is an important part of developing educational experiences" (Froggatt, 2001).*
>
> *"Development and changes in practice do not come from the rational application of formal abstract knowledge and information but rather from new experiences (Kennedy, 1983; Stake, 1986). People react directly to vicarious experiences. They need stories of people in a plight like their own. Those who miss an experience first hand can, through the detailed narrative account of others, transport knowledge from setting to a new context (Abma, 1998)."*[8]

Best Practice & Interprofessional Care

The LTC Homes in the southeast region were asked about processes they used to move best practices forward within their facilities and were also asked how the concept of interprofessional care was operationalized within their homes. All of the homes surveyed used a care planning process reflective of the individual resident's needs and incorporated a risk assessment into the process.

In the majority of homes, the decision to implement a new best practice within the home setting typically rested with upper management often in collaboration with the management team, the registered staff, Professional Advisory Committee or Best Practices Committee. In four of the homes, the decision originated with the corporate office (with input from the home), in one with the Nursing Practice Committee, in one with a multidisciplinary committee and in another the decision rested with the committee most relevant to the practice under consideration. The decision was influenced by such factors as Ministry mandates, staff input, compliance issues, quality assurance initiatives and identified gaps. At one home, management staff would "review best practices for applicability and establish what would need to be implemented to support any required changes in practice. It would also be determined how the new best practice could best be integrated into care planning and care plans".

In the majority of homes, the strategy or process for the 'roll out' of the best practice was dependent on the practice – who would be impacted, what were the anticipated changes, where was the expertise, etc. There were some homes who indicated that roll out would be managed by the Best Practices, Professional Advisory or Multidisciplinary Committee, the DOC or the corporate office in collaboration with the home team(s). In one situation "the interprofessional team on each unit would facilitate implementation of (and hold accountability for) a new best practice." Generally, the homes would "identify top issues and then explore the processes that are currently in place. Once this has been done, the next step is to ask if best practice is in place or if it needs to be implemented." Implementation was generally supported through education, communication and the drafting of relevant policies and procedures. Education might entail broad-audience inservices, train-the-trainer approaches or, in some situations, champions. The registered staff might initially be apprised of the best practice and then participate in bringing the practice to the front line healthcare providers.

The RNAO (Registered Nurses Association of Ontario) has a library of best practices, many applicable to the LTC home setting. In addition, the RNAO also supports Best Practice Coordinators for LTC throughout Ontario. In a recent study conducted by the RNAO, "Seventy-three per cent of responding long-term care homes in Ontario have had past experience with implementing a (RNAO) best practice guideline with most focused on falls, continence and pressure ulcers. Those homes not implementing BPGs cited conflicting demands, lack of staff, new role responsibilities, lack of information or lack of resources as reasons for not focusing on these areas of practice. Pain, falls prevention and management and client-centred care were the top three clinical areas of interest expressed by LTC homes. Both LTC homes that are implementing guidelines and those not currently implementing consistently identified staff shortages, lack of time, limited financial resources and non-receptive staff as challenges to implementation. In addition, non-implementers also shared interpretation of BPGs and computer literacy as issues. (Eleven per cent of LTFC homes in the East region [includes Renfrew, Ottawa and Eastern Counties as well as the SE LHIN region] have implemented a BPG). This is about average for the province. Top five reasons provincially for not implementing a BPG – conflicting demands (64%), lack of human resources (57%), new to the job (26%), insufficient information (19%) and lack of material resources (9%). LTC homes that have implemented a BPG identified the following top five challenges to successful implementation – lack of staff, time constraints, limited financial resources, staff not receptive to change and negative staff attitudes."[9]

Strategies that facilitated the implementation of BPGs included "incorporating BPGs into their policies and procedures; in-services; presentations; audit and feedback; developing learning packages and fact sheets; use of committees; consultation with LTC BPC (Best Practice Coordinator); creation of tools; work groups; reminders; and audiovisual aids." The top five strategies used to support sustainability include: quality monitoring; revision of policies; continued education; educational materials; and availability of equipment and supplies."[9]

The value of interprofessional care conferences was recognized by the respondents and all homes used this approach in initiating and updating resident care plans. "The team philosophy of treatment is particularly important in long-term care simply because it *is* long-term care and services are sustained, not intermittent. A genuine and firm

commitment to an interdisciplinary or team approach to care will open the way for a blending of essential services "synthesizing life-sustaining function with life-enriching programs and services"[10]

Interprofessional care conferences are regularly scheduled for all residents in all homes. The frequency of the conferences had some variation, but, at minimum there would be a care conference for each resident within 6 weeks after admission, annually and as needed. Some homes also held quarterly conferences. It was also evident that discussions re resident care were not restricted to the formally scheduled care conferences. Ad hoc discussions were the norm especially at the front line. Literature supports this as an effective and efficient strategy for care planning. "Perhaps one of the most important interdisciplinary efforts affecting the quality of care and satisfaction of the residents is the "hallway conference". More formal, structured and consistent team meetings are vital, but persistent, informal exchanges regarding resident care that naturally occur among team members as they routinely perform their duties often anticipate problems before they arise. What comes through in such relaxed exchanges is a filtration process that leaves only those issues requiring multidisciplinary intervention for the formal system of conferences. The more structured team meetings can clearly focus on problems necessitating multi-level interventions thus eliminating time-consuming discussions of matters that demand less intense review."[10]

Ideally, participants in the conferences included anyone involved in the care of the resident ("the care team"), but in reality this was not always possible due to staffing considerations. However, input from all staff members was encouraged and they could contribute prior to the meeting either verbally or in writing. Participants frequently mentioned included:

- Nursing
- Activation/recreation
- Resident and family
- Dietary
- PSWs
- Physio

Other identified participants included the Director of Nursing, pharmacy, environmental supervisor, physician, housekeeping, business office and external experts. "Essential to include all roles including PSWs and HCAs and those most overlooked such as service & maintenance personnel. These individuals are most intimately involved in the day-today care regime and, consequently, have an enormous impact on the resident's quality of life. Without their support and involvement, the array of services offered by professional staff will fall far short."[10]

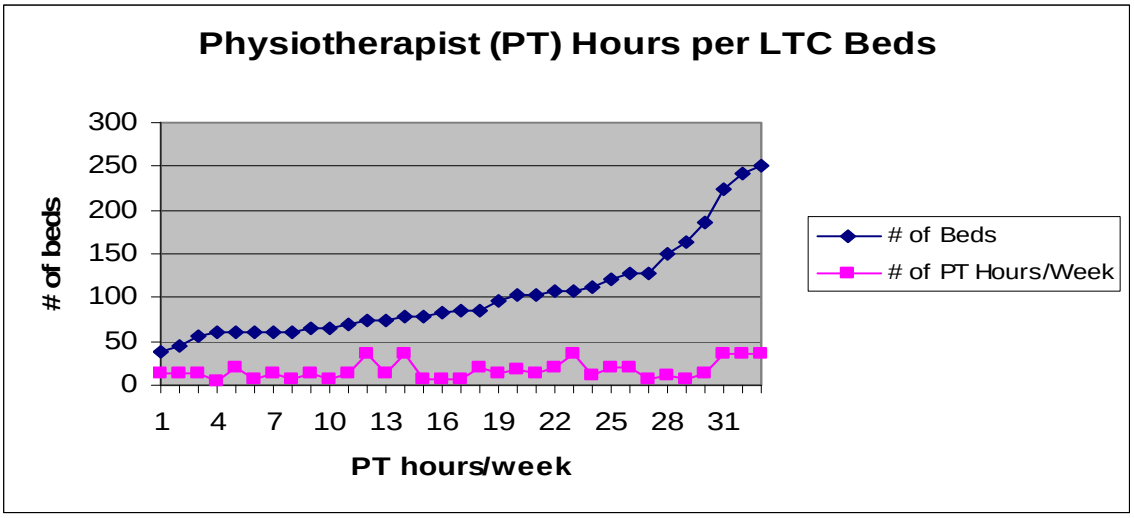
Participants were also asked about other expertise or supports they would access for care planning and/or educational support. Those most frequently mentioned included the Psychogeriatric Resource Consultants/PIECES, the Palliative Pain and Symptom Management Consultation Service, SSSEO contacts, contracted or in-house therapists and corporate resources. Others identified were pharmacist, community partners, diabetes expert, wound expert, Regional Infection Control Network (RICN) and the Local Health Integration Network (LHIN).

Assessment Processes

> *"In general the availability of rehabilitation in LTC, for any condition, is limited. PriceWaterhouseCoopers estimated that the percentage of persons living in LTC in Ontario with rehabilitation potential is 14%. They also found that 68% of all LTC residents did not receive nursing rehabilitation; 24% received only one nursing rehabilitation intervention over a 7-day period. Only 0.2% of residents in LTC received any occupational therapy. Only 10% of those with rehabilitation potential received physical therapy."*[11]

All of the homes had independently contracted physiotherapists providing services to their residents. The physiotherapist (PT) in thirty-six of the homes (92%) assessed each new admission. In two of the remaining homes the PT assessed the majority and in the last home the decision to have a PT assessment rested with the RN. Reassessment was most often on an as needed basis (e.g. after a fall, return from hospital, change in mobility, etc.), although in eight homes a reassessment occurred quarterly and in one home on a monthly basis. A reassessment could be triggered by any staff member or by the resident/family.

With the exception of one home that had PT services for a half-day every three weeks, the minimum on-site time was once a week and the maximum was five days per week. The number of PT hours per week did not show a consistent correlation with the size of the home (i.e. number of beds), however many homes also had physiotherapy assistants (PTAs) on staff as well as restorative care, activation or similar services who would carry out the programming designed by the PT.



Most homes also had a dietician on staff or contracted although the time in-house was quite variable (from once a month to twice a week) and not captured in this scan for all homes. Typically, the dietician would assess all new residents or, at minimum, follow all residents who were identified with a nutrition need (e.g. weight loss, obesity, diabetes, etc.) especially those designated as high risk.

Other therapies were typically accessed through the CCAC. During the course of this scan (on February 1, 2009), the CCAC ceased to provide ADP (assistive devices program) assessments via Occupational Therapy to the LTC homes. Many homes were still in the process of determining an alternate process for ADP assessments. In most cases, funding for this service would likely fall to the resident or family. Five of the homes did have their own OT and one home had a PT who was an ADP authorizer. It appeared that other OT services were not usually accessed by the LTC homes and it was not clear if the LTC homes fully understood the role of the OT. Speech language pathology was universally accessed through the CCAC. Wait times for both OT and SLP ranged from 1 week to 8 weeks to “lengthy”. Some homes did indicate that private therapy might be arranged if wait times were prolonged and the resident/family was able to pay.

When asked who provided social work services, eighteen respondents stated that it was rarely or infrequently used, eleven did not reference SW at all, two that SW was provided by an in-house staff member and one that services were on-site twice a week. In a few situations it was stated that social work would typically be used (if at all) by the family not the resident.

Records & Referral Information

All of the homes used a patient/resident software system. Of the 39 homes surveyed, 20 used MED-e-Care™ software, 16 used PointClickCare™, 2 used GoldCare™ and one did not specify.

The homes were at various stages of the MDS RAI implementation. The MDS RAI is a care planning, data collection tool that all homes are required to implement. The tool produces Resident Assessment Profiles (RAPs). The RAPs are identified problems or conditions that might require further assessment/reassessment and intervention and include delirium, cognitive loss/dementia, visual function, communication, nutrition, falls and many others. There are also embedded scales that can be used to evaluate a resident's current clinical status as well as changes over time. Scales include those used to measure cognition, depression, social engagement, decline, aggressive behaviour, pain and ADL function. While the implementation of the MDS RAI was seen to be very labour intensive by the homes, it was also seen to be a value-added exercise. Implementation was particularly hard on smaller homes with less staffing capacity.

Participants were asked about the quality of the information received with a resident referral. Forty-five per cent stated the information they received was generally good and twenty-one per cent said it was variable. Thirty-eight per cent had found the information to be incomplete, 31% felt it was outdated, 21% said it was not always practical and 18% found it to be inaccurate. Some respondents indicated that the quality of the referral information was dependent on the person completing that information. A particular area of omission was around behavioural issues. It was also acknowledged that the current referral (i.e. placement) system tended to compound the problem (i.e. information was provided up front for residents awaiting placement, however the actual placement may not take place for several months or not at all).

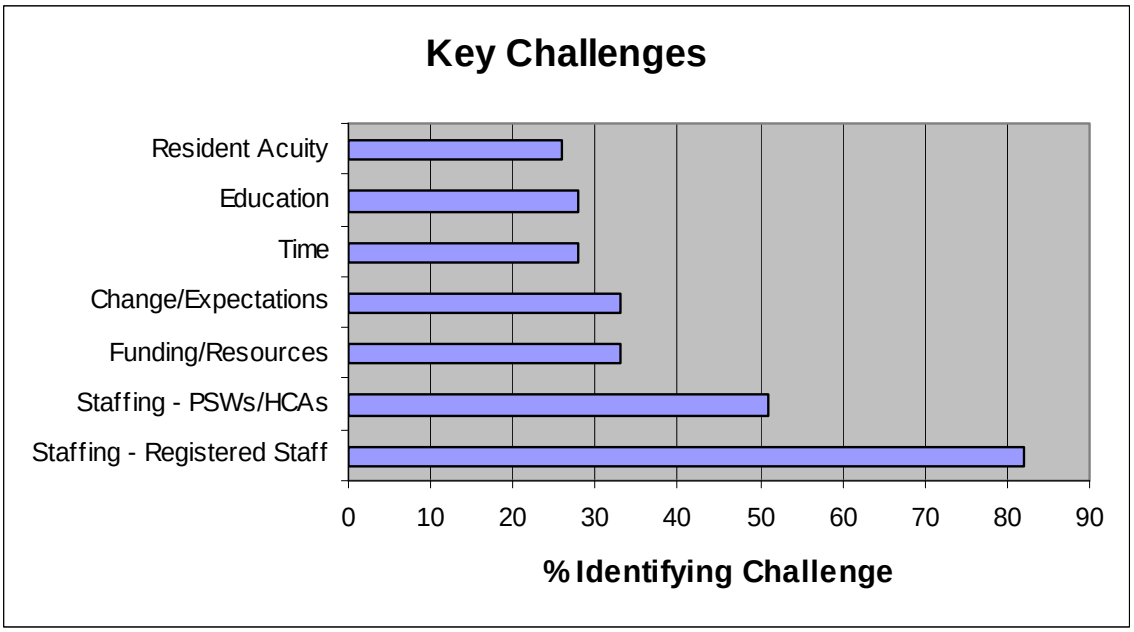
- RAI notes are usually very valuable. May receive an admission and only have old chart as guide - update missing or not completed. Also, sometimes lack of understanding by referral source of the LTC Home (what profile of resident can be accommodated)
- In about fifty percent of situations, the referral information is not current and/or relevant. In these cases, the resident's status (care needs, behaviours, etc.) is discovered only after admission to the home.
- Information when resident is initially admitted is usually good however when a resident is returned to (name of Home) following transfer to an acute care facility, the information which comes back is often sparse or almost non-existent.
- Referral information received from the CCAC is generally fairly good (resident may be on the wait list for 6 months or so after initial assessment, but updates are provided). Information received when residents is coming from the hospital or home tends to be less comprehensive.
- Information received is variable. Often the information is neither current nor relevant to the current status of the resident. (name of Home) will accept an admission based on the received information, but when the patient arrives find him/her to be quite different. This can be frustrating as plans/arrangements have been put in place based on the information received.
- Referral information received from hospitals/CCAC tends to have gaps. Information may not be current and may not accurately reflect the resident's status. This is particularly problematic with respect to behaviours (e.g. aggression). Information that may be lacking with respect to nursing care needs can usually be accommodated post-admission, but there is a requirement to have up front current information on behaviours to ensure appropriate placement and care.
- Quality of referral information is typically dependent on the origin of the information. Transfer information from other LTC Homes is usually very good. Conversely information received form a hospital is often incomplete and seems to reflect a lack of understanding of what LTC Homes can and can't provide.
- Tends to be dependent on the person sending the information - sometimes very good and other times may receive nothing at all. Information that may be lacking is often quite significant such as MRSA positive status, c-diff positive status, dressings, wounds, smoking, etc. Also need to ensure that system recognizes what information is necessary and what is not (both information received and information sent). Current bed offer system results in a significant volume of information - will receive huge volume of charts for review on applicants that will never be placed at (name of Home) as applicants may die or be placed in another facility. May be a significant delay between when chart is reviewed and when placement occurs so update needs to be reflective of applicant's current status and needs. Question if system could be amended such that information is forwarded at time of individual bed offer. This would reduce volume of information received; increase timeliness of information received; protect confidentiality of applicants who do not receive bed offer from (name of Home).
- There are challenges with the information received from referring organizations (i.e. may be insufficient). What has changed recently is that organizations are acknowledging that this is an issue. For example, CCAC has recently introduced a feedback form for all admissions. Staff of LTC Homes is also adept at identifying when information is missing and will follow up with a phone call.

- Referral information received from hospitals/CCAC tends to be very good. Residents now tend to be very complex and there is a responsibility of the LTC Home to ask questions of the referral source if information is missing. Some information is critical to receive such as behaviours (e.g. wandering, use of restraints).
- It is challenging to ensure that information is current given that the population is relatively unstable (i.e. elderly complex population may experience changes rapidly thereby invalidating the referral information).

Key Challenges

Finally, the long term care homes were asked to identify the key challenges they are currently facing.

Several themes recurred including staffing issues, funding, education of staff, rising acuity/complexity of residents, ongoing change/increasing expectations and lack of time.



As the following supporting comments illustrate, no challenge can be viewed in isolation. For example, lack of funding and human resource issues both impact on the capacity to provide staff education; staffing issues lead to time challenges which can be further compounded by increasing resident acuity and multiple demands from external organizations; staff experiencing heavy workloads have little time or energy for education.

Time

- Lack of time (residents are requiring heavier care but staffing ratio has not kept pace so there is very little time for any activities other than hands-on care).
- Everything is moving faster with many competing priorities and initiatives (many of which are mandated).
- Time is a scarce resource as there are an ever increasing number of requirements and expectations being placed on LTC. Mandated process changes often result in increased workload and there are increasing requests for reports.
- Daily crises – time required to 'put out fires' reduces time available to be more proactive, move initiatives forward, etc.

In a study published in the International Journal Of Nursing Studies, residents were found to be very aware of the workload pressures experienced by the staff and were often reluctant to 'bother' the staff with personal requests and care needs. This impacted directly on their concept of 'personhood'. "The more residents internalized their identity as largely formed by waiting for staff to attend to them (rather than residents feeling they had some sense of personal agency) the more they voiced a sense of loss of personhood. Such findings were echoed in previous research by Jacelon (2002) who found that when staff did not have time to interact with residents, residents failed to perceive a relationship with staff and consequently, felt a loss of dignity. Many residents felt as if they have become "non-persons", not because of their inability to do things they once took for granted, but because they are dependent on waiting for staff to take their concerns seriously…They were torn between the need for attention and feeling guilty in increasing work pressures on staff. Residents will often not want to call attention to their needs for care and attention if they perceived the staff were overworked."[1]

Resident Acuity

- Difficulties integrating residents with psychiatric disorders.
- Caring for residents with challenging behaviours and residents who are at risk of falls.
- Younger residents - Increasing numbers of younger residents being admitted. LTC Home staff doesn't typically have expertise in caring for younger residents and the services and set up of the Home is not geared to this population.
- Continually need to upgrade staff to new skills not previously required in LTC such as VAC dressings, IV pumps, PICC lines, etc.

"Many nursing home residents have mental health problems that affect the nursing care they require. Different data report up to "70% to 80% of nursing home residents suffer from some kind of mental illness but most receive no active treatment. …Depression, a

highly treatable condition in this population ranked second among mental health problems in long-term care settings. Other data suggests than in addition to those already suffering from mental health problems, a significant percentage of unaffected nursing home residents may be at risk for developing behavioral problems or mental illness because of high physical co-morbidity and the non-supportive milieu of most long-tern care settings. Thus the treatment of mental health problems looms as a growing concern in caring for the elderly. One of the major roadblocks to addressing this problem is that nursing home staff do not receive sufficient training about mental health issues, the aging process and assessment and management of psychiatric symptoms in the elderly."[12]

Change/Expectations

- Multiple priorities all occurring at the same time.
- Increased requirements for paperwork from various entities including Ministry of Labour and Ministry of Health and Long Term Care.
- Competing priorities but limited resources.
- Expectations continue to increase and LTC Homes are often under the scrutiny of the press and the MOHLTC. 'Bad' press stories put additional stress on LTC Homes.
- Average length of employment at (name of Home) is 18 years which can result in challenges when new changes are introduced and there have been a significant number of changes initiated particularly over the last 5 - 6 years.
- Implementation of change - staff who are long term employees need ++ support and education with new changes.
- Staff resistance to change as it requires a shift in habits and practices.
- Incredibly high (unrealistic) expectations and demands from families & residents.
- Lack of understanding by acute care, CCAC and other partners that LTC can be everything to all people (i.e. expected to be a home for residents, but also function as an acute care when needed).

In one study by McGillis Hall et al, "Both staff and managers described a climate in which funding for long-term care has been decreased dramatically but needs have increased sharply. Personnel at all levels are struggling with widely expanded roles and highly demanding residents. Where once residents were typically high-functioning elderly adults, today they are more often than not in need of intense palliative or chronic care. Still, higher levels of management and government fail to appreciate the time-consuming and draining nature of the care provided and set contradictory expectations of what needs to be accomplished without providing the necessary levels of funding to meet the objectives.

When asked what the biggest challenges or barriers are to seeing supportive behaviors emerge in the workplace, virtually all care givers pointed to the overwhelming "scope of the role" imposed upon staff and managers alike. This was particularly recognized as a challenge for managers, whose duties range from basic management to very complex decision making, but all of which are regarded as crucial to the smooth running of the department."[13]

Education

- With respect to education, backfill is not typically the primary issue; rather it is motivating staff to attend the sessions.
- Staffing to support education (backfill for HCAs who are being upgraded to PSWs).
- Providing education to staff - funding for education is very limited as there many competing priorities for the available dollars.
- Education to manage these situations (frontal lobe injuries) cannot be abbreviated so there is a challenge in providing longer more in depth sessions given the limited staffing resources and dollars available for back fill.
- Participation of HCAs in education sessions is an ongoing challenge. There tends to be very little motivation and there is some expectation that attendance at education sessions should be reflected in increased compensation.
- There are some challenges with staff attendance - finances required to back fill, motivating staff to attend especially if not on work time; changing skills requirements.
- Changing scopes of practice - tend to be continually raising the bar with subsequent need to provide ongoing support to staff and staff may also not have the required educational grounding to move forward (e.g. may have received training years ago and course curriculum may have undergone dramatic changes).
- Educating the PSW and finding time to educate families.

The rate of low acuity emergency visits by residents in long-term care in the south east region is 9.6 per 100 person years which is slightly above the provincial average of 9.1. Why are there so many unnecessary visits to emergency? (One of the reasons is) "lack of training – residents from long-term care facilities may be sent to emergency for something minor because their home doesn't have enough staff trained to handle the problem or there's no physician available to assess how sick the resident is. "[7]

Funding

- Restricted budgeting - decision to implement new process/equipment etc. may involve additional costs which then results in the need to cut back in another area such as education.
- Challenge to meet regulatory standards for both front line and administration.
- Program sustainability due to lack of resources (time, staff and dollars).
- Funding is also an ongoing challenge as it does not support the hiring of more PSWs and thus impacts on care and the implementation of best practices.

The impact of funding constraints has a domino effect – decreased (or stable) funding results in decreased staffing which leads to greater challenges in providing education which can then have a negative impact on care. Ineffective care can lead to increased costs and the cycle persists.

> "In 2007/08 7.3% of long-term care residents surveyed had a stage 2 or higher pressure ulcer. The per cent for high-risk patients was 11.2%. There are 3.3% of long-term care residents who don't; have an ulcer in their previous assessment who develop one. Preventing pressure ulcers takes training and *enough staff* to do all the steps involved. *Reluctance to pay for equipment*, like special mattresses is also a problem."[7] (italics mine)

Staffing

- Staffing to meet resident need. Many staff have worked at (name of Home) for 20 years and longer so it is a challenge when one of these staff retire and the position must be filled and the new employee trained. This tends to happen more with PSWs than with registered staff.
- Greatest challenge is the dramatic changeover in staff. For many years there seemed to be established relatively stable staffing. Now hiring is ongoing and many end up leaving. Part time in particular leave to get more stability in hours (hospitals hiring so often go there). Currently, unable to offer benefits to part time so this is also a reason for their leaving. As a result, facility is constantly dealing with new staff members that do not have the training. This is hard on other staff and on the residents who must continually meet new people. Have never seen this degree of change before.
- Staffing levels are challenging - residents have increased acuity and complexity but there is no funding for increased staffing levels in recognition of this changing profile.
- Recruitment and retention of staff particularly registered staff especially given the current system-wide shortage which results in a very competitive market and LTC Homes cannot always compete with the salaries in other health care sectors
- Staffing is an ongoing issue particularly with registered staff and impacts on the staff/resident ratio.
- Adequate staffing, in particular RNs and RPNs. It is often a challenge just to find adequate staffing for resident care so attendance at education/training sessions can become quite problematic.
- Limited management staff.
- Change in values of younger staff - tend to have less initiative or willingness to 'go that extra mile' than those more senior staff.
- Working with two unions.

LTC often finds itself at a disadvantage as it competes for the ever decreasing pool of health care workers. Once recruited, retention becomes an issue as workers may

choose to migrate out of the sector, out of the region, out of the country or, in some case, out of the health care field. "The dramatic pay differential for nurses working in hospitals versus those working in the long-term care facilities, combined with incredible draining work load, makes the latter facilities less attractive to professionals seeking employment."[14]

Other challenges identified by the participants included:

- Location/structure of home - problematic for smaller (rural) homes to send staff to meetings in larger centres due to staffing issues, travel time and associated costs; limited space in hallways and residents' rooms (3); age of the home (3)
- Scrutiny of press; LTC generally has a bad reputation in the community even thought the standards are very high and compliance is very closely monitored. Much of the public have preconceived (erroneous) ideas and expectations about LTC. The standards applied to LTC Homes are also very different from those applied to hospitals (e.g. use of chemical and physical restraints, therapeutic surfaces) and not well understood by the general public, residents and family members. (2)
- Referral wait times especially OT for seating issues; accessibility of services (long waits for such services as OT, SLP, SW which impacts the provision of support to families who are grieving, experiencing transition, etc.) (2)
- Role of Board - turnover of Board members results in members who lack knowledge of and insight into LTC. There tends to be micromanagement by the Board as they are not knowledgeable of Board functions and mandate. (1)
- Communication – how to reach all staff and use methods that reflect diverse learning needs (1)
- Knowing what is available and to how to access supports (1)
- Family dynamics (1)
- Lack of volunteers (1)

SECTION IV

DISCUSSION

The results of the environmental scan provide a snapshot of the LTC homes in the southeast region. There is a sense that this sector is experiencing a dramatic transformation in the resident population and are consistently challenged to find the staffing resources required to care for these residents. Many of these residents will have experienced a stroke either recently or in the past. All will still be dealing with the impacts of that stroke from a physical, emotional and psychosocial perspective.

The resident population is increasing in age and complexity and many staff are having to learn new skills as they care for residents with complex medical issues and co-morbidities as well as residents with significant mental health diagnoses while trying to preserve a home-like environment. Stroke survivors present with a complexity of needs and require individualized care planning that reflects a holistic approach. The lack of comprehensive rehabilitation services within LTC Homes can be particularly problematic to stroke survivors achieving and maintaining their optimal functional level. It is imperative that staff within LTC Homes are cognizant of the role of all rehabilitation therapy providers and receive the education and support to implement and sustain best practice stroke care. According to 2002 data, the average percent of residents in LTC Homes in the southeast region of Ontario who had experienced some form of cerebrovascular accident was 25.2% (highest percentage at 31.54% and lowest at 22.11%) - a significant proportion of the LTC Home population (Levels of Care Classification, District Health Council, 2002). Although residents with a primary or secondary diagnosis of stroke comprise about one-quarter of the LTC Home population, many programs within the home are designed for and directed to residents with dementia-related illnesses. As well, the behaviours related to dementia often require increasing amounts of staff time, perhaps disadvantaging other diagnoses such as stroke.

How can ongoing education for best practice stroke care (and other diagnoses) be provided in a milieu of rising resident need with stable or decreasing staffing numbers? Respondents spoke to challenges with providing backfill so that staff could participate in education; reluctance of staff to attend inservices due to motivational factors and/or a

reluctance to leave their colleagues short-staffed on the unit; lack of funding to support educational initiatives; and factors related to distance if education was offered externally.

A literature review of continuing education in LTC by Aylward et al found that "The uniqueness of the long-term care setting may present additional or different barriers or facilitators to the effective implementation of continuing education. The culture of long-term care is different from, for example, acute care in that there is less emphasis and value on training and few incentives are present to encourage staff change or motivation."[15]

In the midst of what can be a very task-oriented day, staff are also recognizing the critical role of emotional and psychosocial support (quality of life versus quality of care), but their efforts may be confounded by staffing issues. For the stroke survivor and family, the effects of the stroke combined with the transition to a LTC Home can be devastating. The need for ongoing emotional and psychosocial support in such situations is critical. In the Coughlan/Ward study (2007), the relations with staff appeared to be the most central to (the residents) quality of care and life in the LTCF. "The impact of … brief conversations were immediate, and attitudes and mood improved immediately. Two factors appeared to impinge on building staff-resident relationships – one was the lack of staff and, therefore, the lack of time staff can spend with residents and the other concerned continuity of care. Many residents reported that, with so few staff, they spent a lot of time waiting. They did not want to upset the staff because their quality of care and quality of life depended so much on them. They also knew how over-worked they were."[1]

The majority of participants in this scan spoke to a lack of staff and ongoing recruitment initiatives. LTC is not typically rated very high in the 'pecking order' of employment seekers. "Nurses in LTC and CCC facilities are considered to be less skilled and motivated, and of a lower professional status than those working in acute care settings. Similarly, direct care workers are frequently cynical about the institution, bored by the repetitive and routine nature of their work and distressed by the deterioration of those in their care. Often, they feel underappreciated for their capacity to cope with the difficulties of their work. At times, they become overwhelmed and exhausted by it."[3]

Further, nurses "who work in long-term care are more likely than others to feel they don't have enough time for their job (31.5%) and feel little control over their environment (24.9%)."[7]

Staffing may also be impacted by illness and injury. The LTC sector is noted to have the highest injury rates (one injury for every 11 full time workers per year which is double that of hospitals).[7] For those staff caring for stroke survivors with limited mobility, it is essential that training be in place to support safe care including education on lifts, transfers and assistance with walking. This same education ensures the safety of the stroke survivor resident.

A 2008 report also noted that PSWs in LTC in Canada are seven times more likely to experience daily violence at work than those in Nordic countries – an astounding 43% will experience violence on a daily basis. The study also establishes a correlation between levels of violence and heavy workloads placed on staff (the main difference between Canada and the Nordic countries was level of staffing).[16] As with other health care sectors, LTC homes are also faced with an aging workforce (in Canada, nearly one-third of RNs in the workforce are aged 50 years or older) and with part time employees who tend to have higher turnover rates, less commitment and greater intention to quit that full time employees.[17] This high turnover presents challenges to ensuring that all staff providing care to stroke survivors are aware of and experienced in best practice stroke care.

In the *2009 Report on Ontario's Health System* two of the questions asked are of particular relevance to this scan - why are some people unhappy with long-term care and why are there challenges in keeping long-term care residents healthy? The answers to these questions, as stated in the Ontario report, mirror the findings of this scan in many respects and can have a significant impact on the capacity of LTC Homes to provide best practice stroke care:

- Lack of protocols and training – chronic conditions require regular monitoring and consistent delivery of care. If a home doesn't have standard protocols for each condition, or staff don't have the skills and training to meet standards of care, frail residents can go downhill quickly.
- Too few staff – many people worry staff don't have enough time to provide all the care residents need.
- Inefficient use of staff time – long-term care staff commented on the huge amount of mandatory paperwork and said streamlining charts and simplifying documentation could increase the quality of time spent caring for residents

- Quality of the home environment – residents expressed a strong belief that creating a "home-like environment" was critical to their quality of life. Residents may feel increased depression or not be motivated to keep themselves healthy fit they are unhappy with their physical environment.
- Staff availability – resident satisfaction may be related to how much time staff has to provide personal attention
- Staff morale – good staff satisfaction can have a direct impact on resident satisfaction, but staff in long-term care homes tend to feel they have little control at work and they also have higher injury rates than other healthcare settings
- Activities – providing enough activities for residents is difficult because of their different interests and abilities. They can also take a lot of staff time to organize and run.
- Environment – physical design such as plenty of space, light, private areas and decor – contributes to home-like environment. Newer facilities tend to have more amenities than older ones[7]

It is evident that system changes need to be made to support LTC Homes in the provision of best practice care to a changing demographic of residents in the face of diminishing resources. This scan provides the opportunity, at a regional level, for the SSSEO to evaluate the effectiveness of our current supports and to implement changes that will enhance the implementation and sustainability of best practice stroke care in LTC Homes in southeast Ontario.

SECTION V

RECOMMENDATIONS

Given what seems like overwhelming and system-wide issues, how can the SSSEO make a difference? At a high level, we need to recognize the challenges that the LTC homes are experiencing and be responsive to the suggestions and recommendations they have put forward. There is an obvious desire for education and a clear vision for high quality, compassionate resident care. Our role is to support that vision particularly with respect to the care provided to stroke survivors in the southeast region LTC homes while being sensitive to the competing demands, limited resources and staffing challenges being experienced by the homes.

At a more practical level, the SSSEO must assess what changes to current supports can be made and what new supports/strategies can be implemented. Many of the recommendations as outlined below have been or are in the process of being implemented. These are indicated with an asterisk (*).

Educational Supports

Shared Work Experience & Field Training

- Market these supports through flyers, email distribution lists, monthly focus newsletters*
- Capitalize on in-house initiatives/projects and offer educational sessions in support
- Link sessions to the reality of daily resident situations; consider case scenarios and those care needs that are proving to be the most challenging*
- Incorporate hands-on, practical demonstrations*
- Offer sessions of shorter duration and repeat during the day (bridging shifts) to capture the greatest audience and respect the staffing concerns*
- Ensure sessions are interactive and support collaborative solution-finding*
- Bring the expertise to the home for Shared Work Experience when possible if travel/distance is a barrier*
- Reinforce that both supports can be used for all team members
- Track the use of supports and follow up with those Homes who are not accessing to determine reasons and how supports may be adapted to their needs

Bursaries

- Continue to promote the Learning Collaboratives and attendance bursaries* *Note that since the completion of the scan the actual number of Homes accessing the bursary has increased from 12 to 20 out of 39 Homes)*
- Bring forward topics highlighted in the scan to the Collaborative planning process*
- Capitalize on the partnerships within the Learning Collaboratives to enrich the education for LTC homes*

- Ensure a process is in place to advise homes when bursary application has been approved*
- Track the use of supports and follow up with those Homes who are not accessing to determine reasons and how supports may be adapted to their needs

Brain, Body & You Program

- Continue to market the program and emphasize the applicability to other complex resident conditions*
- Offer program at varied locations throughout the region to mitigate challenges related to transportation/distance*
- Offer program during the week rather than on weekends and avoid those times when staffing capacity is at its most vulnerable due to high vacation or poor weather*
- Consider option of on-site program if participant numbers can be confirmed*
- Consider option of modifying modules for in-house presentations*

Tips & Tools

- Ensure reference to Tips & Tools by educators at Brain, Body & You and other inservice presentations/workshops*
- Develop strategies to 'refresh' this resource subsequent to the release of the new version (possible fall 09). Consider potential of in-home 'champions' during refresh.
- Reference resource in posters and potentially use excerpts*
- Offer as a tool for LTC resource teams (e.g. best practice, continence)

Posters

- Consider topics that are of interest to a varied audience - staff, residents, families*
- Link posters to in-house presentations/initiatives or monthly focus (e.g. Heart & Stroke month, nutrition month)
- Provide posters that incorporate practical, hands-on tips and strategies*
- Include optional self-quizzes, crosswords, sign-in sheets
- Ensure posters are available as table displays and as wall-mounted posters*
- Expand the current library of posters to include such topics as emotional/behavioral aspects of stroke, physiology of stroke, feedings techniques, pain management, seating, TIAs, positioning, communication and assisting the hemiplegic resident*
- Promote the posters to the LTC homes and use as reinforcement for other educational sessions
- Include applicable aids, handouts, tools when possible
- Consider how poster design might compliment a home-like environment

Learning Approaches

- Base approaches on understanding of limited staffing resources, increasing workloads and increasing resident complexity*
- Incorporate the 'learning blitz' and 'quick bites' approach into education*
- Bring learning to the homes and to the units*
- Capitalize on current strategies within homes such as newsletter articles, payroll inserts, videos, education boards, lunch & learns, crosswords, fact sheets

- Consider developing self-learning modules and toolkits for educators*
- Include practical, realistic, hands-on information*
- Recognize the changing and expanding scopes of practice*
- Tailor presentations to audiences and to various learner needs (e.g., visual, tactile, auditory)*

Best Practice & Interprofessional Care

- Continue to partner with other individuals and organizations to promote both concepts (e.g., RNAO, PRCs, Palliative Pain and Symptom Management Consultation Service, in-home resource teams)*
- Incorporate concepts into various educational strategies (e.g., posters, information sheets, Learning Collaboratives)*
- Capitalize on implementation of MDS RAI and potential for linkages with best practice stroke care recommendations*
- Promote revised Tips & Tools resources as stroke care guides

Assessment Processes

- Continue to advocate for the benefits of therapy in the LTC setting (build on findings of current Enhanced Therapy Project)*
- Provide education on rehabilitation in LTC and on the roles of the therapists including social work and occupational therapy*
- Incorporate therapy concepts into all educational tools such as posters and information sheets*

Records & Referral Information

- Capitalize on MDS RAI implementation to gather data with respect to residents who have experienced a stroke, their care needs and outcomes
- Promote the sharing of current, relevant, practical and comprehensive information across the continuum of care*

Key Challenges

- Adjust and modify educational supports and processes to reflect the reality of LTC homes today*
- Advocate for best practice and the necessary infrastructure to support implementation and sustainability*
- Link with new and pilot programs such as the LTC Nurse-Led Outreach Teams*
-

The SSSEO is committed to moving forward with the implementation of these changes in partnership with LTC homes to support the ongoing implementation and sustainability of best practice stroke care.

REFERENCES

1. *Experiences of recently relocated residents of a long-term care facility in Ontario: Assessing quality qualitatively, Coughlan R., Ward L., International Journal of Nursing Studies, 44(1):47-57, 2007Jan.*

2. *Regional Capacity and Assessment Projections: ReCAP Findings, South East LHIN, 2009*

3. *Reconnecting to Care: A Nursing Initiative at the Baycrest Geriatric Health System, Glouberman, S., Richards J., El Bestawi M., Seidman-Carlson R., Teperman L., Nursing Leadership, 2007, 20(2): 39-49*

4. *Humanity in long-term care. Ethical, clinical and social challenges, Gordon M., Canadian Family Physician, December 2004, 50:1629-35*

5. *Inservice Training: Quality Ingredient to Care, Provider Improvement Branch, Division of Long Term Care, American Health Care Association Journal, Spetember1997, 3(5): 38-43*

6. *A multifactorial intervention for the prevention of falls in psychogeriatric nursing home patients, a randomized control trail (RCT), Neyens J., Dijcks B., Twisk J., Schols J., Van Haastregt J., Van Den Heuvel W., Witte L., Age and Ageing 2009 38:194-199*

7. *2009 Report on Ontario's Health System, Ontario Health Quality Council in Partnership with ICES.*

8. *Providing Meaningful Continuing Education in a Changing Long-Term Care Environment, Tryssenaar J., Gray H., Journal for Nurses in Staff Development, 20(1):1-5, 2004 Jan-Feb.*

9. *Uptake of Best Practice Guidelines in Ontario Long-Term Care Homes. An Analysis of the Provincial Survey, Santos J., RNAO, November 2008*

10. *Team Approach Brings Better Care, Kenneth Lewis, Contemporary Administrator, April 1983 6(4): 27-32*

11. *Stroke Care in Long-Term Care Facilities in Southwestern Ontario, Stolee P., Hillier L., Webster F., O'Callaghan C., Top Stroke Rehabilitation 2006; 13(4), 97-108*

12. *Geropsychiatric Education Programs; Providing Skills and Understanding, Smith M., Buckwalter K., Albanese M., Journal of Psychosocial Nursing December 1990 28(12):8-12*

13. *Enhancing the Quality of Supportive Supervisory Behaviour in Long-term Care Facilities, McGillis Hall L., McGilton K., Krejci J., Pringle D., Johnston E., Fairley L., Brown M., Journal of Nursing Administration, 2005 Apr., 35(4):181-7*

14. *Enhancing the Quality of Supportive Supervisory Behaviour in Long-term Care Facilities, McGillis Hall L., McGilton K., Krejci J., Pringle D., Johnston E., Fairley L., Brown M., Journal of Nursing Administration, 2005 Apr., 35(4):181-7*

15. *Effectiveness of Continuing Education in Long-Term Care: A Literature Review, Aylward S., Stolee P., Keat N., Jonhcox V., The Gerontologist, Vol. 43, No. 2, 259-271*

16. *Canadian long-term care workers risk violence at work, Banerjee A., Daly T., Armstrong H., Armstrong P., Larance S., Szebehely M., NUPGE, March 2008*

17. *Human Resource Management Strategies and the Retention of Older RNs, Armstrong-Stassen, M. Canadian Journal of Nursing Leadership, 2005, 18(1), 50-65*