ia BPG International Affairs & Best Practice Guidelines

Best Practices in Long-Term Care

Working together towards excellence in resident care.

Fall 2009

IN THIS ISSUE

Host Agencies Share BPG Implementation Stories

By Josephine Santos, RN, MN, Project Manager, LTC Best Practices Initiative

Josephine Santos

The Long-Term Care Best Practices Initiative is very grateful to the eight Host Agencies that have opened their doors and welcomed the LTC Best Practice Coordinators to their homes. In this issue of our newsletter, we feature our current host agencies and their best practice implementation activities that are enhancing quality resident care in their homes. The stories allow us to get a glimpse of their implementation strategies and how they overcame challenges. Ultimately, the LTC sector can learn from their experiences and discover that we are similar in many ways as we work to improve quality care and resident safety. Sharing these stories will hopefully assist other homes similarly engaged in BPG implementation and provide some direction as well as inspiration.

In this issue, we learn from two of St. Joseph's Care Group's homes in Thunder Bay (Hogarth-Riverview Manor and Bethammi Nursing Home) how quality improvement methodology using a collaborative approach, combined with BPG implementation, can improve resident outcomes. Of course, teamwork, as mentioned by Algoma Manor, is one of the essential components for creating an organizational culture that facilitates successful collaboration. Teamwork is not only confined to the team within an organization. The John Noble Home describes their collaborative approach with external partners in implementing the Pain BPG.

Other host agencies such as Vision 74 created knowledge transfer strategies that are interactive, humorous, fun, and most of all compelled staff to share information with others. This allowed increased retention of best practice information that they can now apply to practice. We also share the story of Specialty Care Mississauga Rd. and how the involvement of their corporation helped to facilitate the implementation of several BPGs. Another host agency, Hillsdale Estates, has embraced opportunities by building capacity through participation in the RNAO Advanced Clinical/Practice Fellowship and the Best Practice Champions workshops. Implementation will not be complete without evaluation, and that's exactly what Miramichi Lodge did – they evaluated a bathing intervention as part of implementing the delirium, dementia and depression (3Ds) BPGs. Lastly, we say goodbye to the North York General Hospital's Seniors Health Centre as the host for the Toronto LTC Best Practice Coordinator and we welcome Ukrainian

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Residents at the Heart of St. Joseph's Care Group

By Heather Woodbeck, RN, HBScN, MHSA
Long-Term Care Best Practice Coordinator,
North West Region

John had dementia when he was admitted at Hogarth-Riverview Manor (HRM) in Thunder Bay. Soon he began falling frequently, particularly at night when getting up to the bathroom. The Clinical Care Coordinator and the Continence Team assessed his falls carefully using Best Practice Guidelines (BPGs). First they noticed he was catching his feet in the bed sheets. Removing the top sheet and using only a duvet helped a bit. Next, the staff rearranged his room to mirror the layout of his bedroom at home. That helped some more. Finally, a men's room sign was put onto his bathroom door. Together these interventions dramatically decreased John's falls. This is an example of how HRM and Bethammi Nursing Home, St. Joseph Care Group's two LTC homes, have improved resident care by implementing Client Centred Care, Continence and Falls BPGs.

Both Bethammi and HRM attribute their success to their involvement with the Improving Continence Care Collaborative (IC3) and the Northwest LHIN-Wide Falls Coalition. These two projects use the Rapid Cycle Method of Improvement (RCMI) and Plan-Do-Study-Act (PDSA) cycles to improve care in steps. With the RCMI, each home formed a team of a manager, RN, RPN and health care aide/personal support worker (PSW). This team worked together with teams from other LTC Homes over several months. In four day-long learning sessions that took place over a year, teams met to learn the improvement approach, get expert information on best practices and most importantly to share strategies and accomplishments.

The success of the collaborative approach is summed up by one RN from Bethammi, *"When you are toileting someone, you are looking at their face, and you are talking to them. When you are cleaning them up, you are looking at their backside, and you are not talking to them. IC3 absolutely changed the quality of interactions between PSWs and residents*." She also said, *"If you don't give up on a toileting program, it will get done. And it is worth it."*

Teamwork As A Collaborative Process At Algoma Manor

By Heather Thompson, RN
Long-Term Care Best Practice Coordinator, North East Region

The development of teamwork is a process of creating a culture that places a high value on collaboration. The environment of teamwork is one of respect, joint planning and decision making. The members of the team respect each other's positions and opinions. They discuss and agree on decisions and plans of action that everyone shares in implementing.

Last year, Barb Harten, RN, BSCN, Administrator of Algoma Manor, attended the Healthy Work Environment Summer Institute. When the idea of a Continence Best Practice Guideline (BPG) team was brought to her, she embraced the idea with enthusiasm. Her knowledge of the possible outcomes of a BPG team gave encouragement and support to the members.

The Continence BPG team at Algoma Manor in Thessalon, a municipal home with 108 residents, brings together registered and non-registered health care providers, as well as support staff, family members and residents who work collaboratively on the team. How is this done with such a diverse group? It's done by recognizing the varied and rich background and experiences that each person brings to the team.

The collaborative process of team building is hard work and takes dedication and commitment of all members. Teamwork is a change from the hierarchical culture where decisions are made by management and staff follow the direction given to them. With the Continence BPG team, decisions are made cooperatively, assimilating the input from each member to achieve the goal through collaborative planning and decision making.

The process of creating an implementation team began with communication. The improvement idea was presented and the team members shared their knowledge in discussing the vision and goal. Communication among the team members is a skill that is developing as they progress, and involves team members sharing their various points of view during meetings.

See "Teamwork" on page 3…

Vision 74 Creating Strategies For Knowledge Transfer

By Beverly Ann Faubert, RN, BScN
Long-Term Care Best Practice Coordinator, South West Region

Dana Horton, RN, nurse manager and Cheryl Beauvais, RPN are Best Practice Champion leaders at Vision 74 Nursing Home, which is a non-profit 110 resident home in Sarnia. With the implementation of 15 Best Practice Guidelines in the last two years and a high participation rate from all departments (management, nursing, housekeeping, dietary, maintenance, residents and families) in educational sessions, it is evident they have the key to creative strategies for knowledge transfer and uptake.

What is the secret of their success? Cheryl and Dana make these sessions interactive, humorous and fun. Their strategy incorporates presenting the key ideas so they are memorable. This supports retention of information. It also compels staff to share the information with others, which in turn brings more staff to the next session because the word gets out about the key learnings and fun experienced from the last session.

Some of their creative in-services included the following strategies. For wound prevention, they created the game *Family Feud No Pressure* along with a cake shaped like buttocks with a pressure ulcer. The winning team was awarded a gift and all participants received certificates, lunch and cake. Another huge success was a role play for fall prevention. The cast consisted of staff members dressed up like a resident who was a high fall risk, a family member, and a nurse who dressed as Sherlock Holmes investigating risks and prevention. Staff members were placed into groups to identify and discuss the risk factors. The team with the most factors received prizes. Falls prevention was marketed with a display at the home's front entrance which included samples of hip protectors and non-skid socks for families and residents to view. Quizzes for staff were placed in their lounge to promote discussion. Articles are also featured monthly in the staff newsletter called *The Visionary* to update staff on Best Practice Guidelines (BPGs).

Another key element of their knowledge transfer/uptake strategy is the support of their senior management team. The Administrator, Heather Martin and Director of Care, Sue Farren recognize that dedicated time away from the floor is required to accomplish this work and allow for one paid day per month for Dana and Cheryl to dedicate time to the implementation of BPGs. Reward and acknowledgment for success are another important action. Staff are given ballots for in-services attended throughout the year; at the Christmas party, these ballots can be entered into draws for significant prizes.

Heather and Sue also supported the first annual BPG Open House during Nurses' Week. It highlighted all of the home's work related to BPGs. Booths for each BPG featured posters, videos, and pamphlets. A barbeque for staff, family and residents was held and there was a special draw for staff who attended.

Their enthusiasm is contagious and the number of Champions increased last November. Four more staff became Best Practice Champions after attending a workshop in London. New Champions are enhancing resident care by participating on the Transfer and Lift Team and rolling out pain assessment tools including the ESAS (Edmonton Symptom Assessment Scale) and PPS (Palliative Performance Scale) interventions based on the BPG *Prevention of Falls and Fall Injuries in the Older Adult* and *Assessment and Management of Pain.*

Vision 74 is already planning for next year's events to be bigger and better. Their formula is EDUCATION+FUN+FOOD+PRIZES= INTEREST+BUY-IN+ SUSTAINABILITY.

Ideas and participation from other BPG homes are always welcomed by the Vision 74 staff who reported, *"Let's educate and be the best together!"*

Corporate Involvement Helps Implement Pain BPG at Specialty Care Mississauga Road.

Champions at Specialty Care Mississauga Road

By Saima Shaikh, RN
Long-Term Care Best Practice Coordinator, Central West Region

Specialty Care Mississauga Road, the host agency for the Best Practice Coordinator for Central West, is a 160 resident home within the Specialty Care Corporation. The corporation lives its philosophy "Creating Communities of Caring" through an approach they call "Enabling Choices". It supports client centered care values and beliefs by creating policy and supportive environments for the implementation of clinical Best Practice Guidelines (BPGs) in its homes. Specialty Care has integrated 11 BPGs including the six BPGs in the Best Practices Toolkit into the nursing and resident care policies and procedures that guide professional practice.

At Specialty Care Mississauga Road, there are nine Best Practice Champions who implement best practice through focused committees that meet monthly. These committees include Falls Management, Wound Care, Continence and Pain Rounds. Teresa Quintos, ADOC and Best Practice Champion comments, *"I find enjoyment in my role as being the person who will encourage staff to work using the Best Practices."*

Specialty Care Mississauga Road is currently reviewing and implementing the Assessment and Management of Pain BPG because measures indicate an increase in challenging resident behaviours over the past year, with pain being a suspected cause. *"Currently, our best practice focus is on pain management in partnership with the Halton Peel Palliative Network. Monthly pain rounds are held with front line registered staff, the Pharmacist, the Clinical Pain Consultant, the Psychogeriatric Resource Consultant (PRC) and the attending physician either pre- or pos-conference,"* Ilona Turczyn DOC/Best Practice Champion notes. Many of the 79 recommendations in the Pain BPG have been integrated into policy design and development. Pain management has been enhanced through collaborative practice, in which evidence-based tools and processes were linked to activities already occurring in the home, in consultation with professionals and staff from sister homes. Turczyn notes: "*Many of our tools such as the Pain and Symptom monitoring tool have been created through staff input. Our work is derived from feedback from front line staff, it is staff driven."* This has resulted in the current documentation system reflecting guideline recommendations around the ongoing monitoring and reassessment of pain. Recommendations regarding care planning for residents experiencing pain were also enhanced by consultation with the clinical pain consultant and the PRC who helped expand knowledge on selecting appropriate pharmacological and nursing interventions for different types of pain and for differing levels of cognitive awareness. The improvements to the documentation and care planning process allow for evaluation of the effectiveness of the pain plan for individual residents.

Formal and informal mentorship by the Champions has resulted in interactive learning in professional practice. Surveys conducted by the Pain Consultant indicated the need for engaging all unregulated health care providers. Formal education programs have supported change in practice through workshops, in-services and educational rounds with the clinical pain consultant. Informal mentorship encourages all unregulated health care providers to report and/or communicate situations of unrelieved pain as an ethical responsibility.

Specialty Care Mississauga Road strives for excellence and demonstrates commitment to Best Practices. Their innovative and progressive work continues to improve the quality of care and enhance resident outcomes.

Teamwork

Continued from page 2...

Ideas are discussed and although not all ideas are adopted, everyone respects the participation and contributions made by all members of the team. To sustain and maintain the momentum of the team, routine meetings take place and minutes are circulated throughout the home. Algoma Manor acknowledged the need for improved communication and management is creating an environment of respect to encourage creativity and innovation among the team members, and other staff. Georgia Katajamaki, RN, DOC at Algoma Manor has noticed a difference in staff attitude over the past few months; she says, "*There is notably less negative talk, more positive attitudes, and sticking to the facts by staff. The staff are more focused on the problem rather than the person, when a situation arises*." When asked how monitoring and evaluating the impact of the strategies implemented affects the quality of care provided to the resident, Georgia says, "*It is noted by resident satisfaction, consistency of care being delivered as well as a decrease in the incontinent products being used.*" Georgia also stated, *"Staff recognition and rewards contributes to improved care. This gives staff encouragement and motivates them to do even more."* Recognition of the smallest success helps create a sense of accomplishment that is so critical to the sustainability of practice change. *"Acknowledgments of jobs well done are sometimes all that is required,"* Georgia adds. During the education process of the BPG implementation, the team distributed quizzes to the staff and used it as a tool to communicate with the staff. Once a week for three weeks the Continence BPG quizzes were given to staff, they were completed and returned to be entered into a draw for a prize from a local merchant. Everyone was very enthusiastic and this approach was a great success. Knowledge was brought to the front line workers and they were rewarded for their positive participation. Most importantly, the care for the residents improved.

Evaluating an Intervention at Miramichi Lodge

By Janet Evans, RN, BScN
Long-Term Care Best Practice Coordinator, East Region

Miramichi Lodge in Pembroke is the host agency for RNAO's Long-Term Care Best Practice Coordinator in the East Region. Recently, Miramichi Lodge completed an evaluation of the program entitled *Bathing Without a Battle*. This program is designed to help care providers move to a person-centered approach when providing personal care to persons with dementia. For further information, visit the website at www.bathingwithoutabattle.unc.edu.

This project was conducted by University of Ottawa RN students Josh Brazeau and Nicole Lafrance, who evaluated this program as a result of a well established collaborative relationship between Miramichi Lodge, Algonquin College and the University of Ottawa. As a result of this collaboration between stakeholders, Miramichi provided a firsthand opportunity for students to experience and participate in data collection and evaluation, which are aspects of research and evidence-based care. Under the guidance of their preceptor, Jean Benton, RN(EC), the students conducted a critical comparison between traditional bathing practices and an approach known as *Bathing Without a Battle*. The goal of the approach is to deliver personal care that is adjusted to the retained abilities/lost abilities of persons with dementia. It also recognizes that environmental modifications can go a long way to preventing responsive behaviours. This program is also in line with the RNAO BPG *Caregiving Strategies in Older Adults with Delirium, Dementia, and Depression* which states that nurses should know their clients, recognize their retained abilities, understand the impact of the environment, and relate effectively when tailoring and implementing caregiver strategies.

A "windshield survey" was conducted using quantitative data supported by qualitative direct observations. The survey revealed that 98% of staff experienced resident behaviour issues during the tub bath such as resistance, and physical or verbal aggression. Three common themes emerged: confusion, fear, and cold/privacy. The survey also noted that 56% of staff believed they could make positive changes in caring for residents with dementia.

The *Bathing Without a Battle* approach in its most basic form consists of bathing the resident in bed with rinse-less soap, using pre-warmed washcloths, under cover of a bath blanket. Residents bathed using these approaches were observed to be relaxed and comfortable, with some falling asleep during the procedure. Overall, use of the *Bathing Without a Battle* approach realized a marked decrease in behaviours such as aggression, resistance and anxiety that the same residents had experienced when a tub bath was given.

Implementation of the *Bathing Without a Battle* program at the Lodge starts with early identification of residents who are exhibiting responsive behaviours to the traditional bathing process. Assessment findings are then used to trigger a trial of the *Bathing Without a Battle* method. The program has undergone review and acceptance by the Miramichi Lodge Enhancing Care Committee.

Evaluation of various programs in long-term care, as demonstrated by Miramichi Lodge, has a big impact on the program's success and sustainability for the future. Actions as simple as performing a windshield survey provide valuable information regarding staff and resident needs such as revealing common causes of responsive behaviour during bath time in residents with dementia. As a result of this evaluation, Miramichi has continued to build on their evidence-based programming to keep quality resident care in the forefront.

Changing Host Agencies in Toronto ~ Best Practice at the Centre of Both!

By Maryanne D'Arpino RN, BScN
Long-Term Care Best Practice Coordinator, Toronto Region


NYGH Seniors Health Centre

Congratulations to North York General Hospital, Seniors Health Centre (SHC). Growth within the organization has meant they are moving on and giving up their role as host of the Toronto Long-Term Care Best Practice Coordinator, which they have been since 2005. SHC is a leader in best practice implementation with the aim of promoting positive resident outcomes within the home and collaborating with other regional homes. They have participated in the Toronto Best Practice Steering Committee and have helped in developing resources such as policies and procedure on skin care, pressure ulcer management and hydration management. Best practice resources they participated in developing can be found at www.rgp.toronto.on.ca. Some of their staff have also participated in the LTC Best Practice Implementation Community of Practice (CoP) by networking with other LTC homes in Toronto and sharing resources to support the implementation of best practice guidelines on Falls, Pain, and the 3Ds (Depression, Delirium, Dementia). The LTC Best Practice Initiative wishes them all the best as they continue to promote a culture of evidence-based care and a healthy work environment.

In July 2009, the Ukrainian Canadian Care Centre (UCCC) became the new host agency for the Toronto LTC Best Practice Coordinator through an application process open to all homes in the region. The UCCC is an ethno specific charitable non-profit long-term care home with specialized care services and is home to 152 residents. The UCCC has been instrumental in implementing various BPGs, including: prevention and treatment of pressure ulcers, pain, falls, crisis intervention, and infection control practices. The UCCC is also committed to many government initiatives that support positive resident outcomes. These include U-First and Gentle Persuasion core programs to increase staff knowledge, skill, and competencies in dementia and dementia care, and participation in the implementation of the Ministry's Mental Health Framework.

The UCCC is expanding their BPG focus to include elements and recommendations from the Healthy Work Environment guidelines. *"Staff development at the front-line and management levels is an essential step towards making the Ukrainian Canadian Care Centre a centre of excellence,"* says Sandy Lomaszewz, Administrator. Staff are enthusiastic about beginning their journey with the Toronto LTC Best Practice Coordinator – a journey comprised of collaboration in enhancing a culture of evidence-based resident care.

Collaboration and Partnerships Enhance Implementation of Pain BPG at John Noble Home

By Gina De Souza, RN, BScN
Long-Term Care Best Practice Coordinator, Central South Region

The John Noble Home (JNH), a municipal home with 156 residents, believes that their front-line care giving staff is where success begins. They are the key to building partnerships to enhance the resident care. The engagement and participation of these key stakeholders and partnerships by the JNH team provides a solid foundation that will sustain future growth and development.

The home identified a need to change their care delivery model in order to develop nursing leadership skills. As part of this work, they are using *Developing and Sustaining Nursing Leadership* Healthy Work Environment BPG. This has enhanced their ability to support clinical BPG implementation specifically the Pain BPG. This has positively impacted other areas of care and service.

The launch of the pain guideline took place in July 2008. This work benefited from the home's exemplary ability to engage stakeholders. This has been done by:

- being involved in a Community of Practice that created the *Best Practices Approach to Persistent Pain in LTC Homes Resource Kit*;
- using a case management approach that two staff learned from the Hamilton Regional Stroke Strategy and shared with others in the home. Using this methodology, the pain implementation team now invites staff to bring specific resident cases where pain needs to be better managed. The team is also looking at Minimum Data Set (MDS) outcome scores to assist in the selection of resident case studies;
- launching the guideline during 'National Pain Week' where members of the team presented on Palliative Care, a Physiotherapist spoke about positioning for comfort and a Registered Massage Therapist spoke to alternative methods of relieving pain;
- forming a Best Practice Pain Implementation Committee that meets regularly;
- asking the consulting pharmacist to provide education sessions to the staff on different types of pain and effective medication;
- hosting the RNAO LTC Best Practice Coordinator who is a resource to the team;
- using existing resources such as the Regional Geriatric Program Central/ BP Bloggers, RNAO pain education e-Learning module and SHRTN resources;
- sharing their experience in a panel discussion at a Best Practice Champion workshop. The panel were team members that included a HCA, RPN, RAI Coordinator and ADOC;
- partnering with researchers to implement policy and procedure. JNH is involved in a study of the Transformational Model of Pain Management in LTC through McMaster/Regina University (Phase 1). Phase 2 participation has been extended that will assist in developing the team;
- consulting with experts: the Brant County Pain and Symptom Management Consultant provide consultation on specific resident cases and provides general education sessions;
- collaborating within the home: for example, the pain team collaborates with the Palliative Care Team and several team members are enrolled in the "Fundamentals of Palliative Care Course"; and,
- involving inter-professional staff: recreational staff are asked to join the team to look at alternative interventions for pain and encourage participation and understanding.

Although the journey of any quality improvement project is an unending one, the gains from engagement of stakeholders are evident. This engagement has brought objectivity and fresh perspectives to problem solving. The openness to culture change has been a benefit of this engagement which brings the energy, excitement and momentum to continue to improve quality care to their residents.

Hillsdale Estates Embraces Opportunities – Champions Supporting Best Practice Implementation

By Natalie Warner, RN, MN, BFA
Long-Term Care Best Practice Coordinator, Central East Region

"When I started with best practice it was either sink or swim," says Pamela Rowe, Best Practice Champion since 2006 at Hillsdale Estates, a 300 bed municipal home in Oshawa, Ontario. Pamela's sentiments are not unique and this is the story of the opportunities Pamela and Hillsdale Estates used to successfully implement the RNAO clinical guideline *Prevention of Falls and Falls Injuries in the Older Adult.*

Opportunity was created by the Director of Care, who had a vision for best practice in the home. She encouraged Pamela and a colleague to become BP Champions and arranged for them to have two days per month to work on guideline implementation. Internal support was furthered by the choice of guideline; Pamela notes, "*Falls were disturbing to residents, families and the staff because of the trauma and consequences of falls".* Staff's concern were addressed by enhancing their knowledge of falls prevention on strategies and by offering falls information activities such as quizzes, word searches, posters and PowerPoint presentations during Nursing Week 2007.

Existing best practice resources were used and efforts went to customizing these for their home. For example, Pamela and her colleague developed a Falls policy and procedure with assistance of the falls policy from the Toronto Best Practice Initiative. Three forms on falls risk and post fall evaluation were changed into two more user-friendly forms with input from staff and the medical director. Also, one of the recommendations in the guideline is that Tai Chi helps to prevent falls. The home partnered with a regional Tai Chi program to have volunteers offer Tai Chi to residents.

Additional human resources were devoted to the program when Pamela successfully applied for RNAO's Advanced Clinical Practice Fellowship. The Fellowship provided reimbursement to the home for part of Pamela's time, and connected her with a mentor, Myrna Mason, RN, MN, from the Rekai Centre to continue to build her skills and develop resources to assist the home in sustaining practice change.

Embracing opportunity also involves sharing experience. Hillsdale Estates hosted last October's regional Best Practice Champion workshop and participated in the panel discussion. Pamela also shared her experiences with others by being a speaker on a recent Champions teleconference on falls.

Announcements

Welcome to the Team!

RNAO is delighted to introduce Saima Shaikh as the new LTC Best Practice Coordinator in the Central West Region. Saima joined RNAO in June 2009.

Mark Your Calendar!

December 2-4, 2009
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Our Newest Resource: E-Learning On Client Centred Care

By The CCC e-Learning Development Team

Client Centred Care is "*an approach in which clients are viewed as whole; it is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making*" (RNAO, Client Centred Care Supplement, 2006).

Client centred care (CCC) is at the centre of all best practice and it is of interest to many – it was identified by a provincial survey conducted in 2008 as one of five best practice guidelines (BPGs) homes are interested in implementing. The Client Centred Care BPG differs from many of the other clinical guidelines in that it only has four recommendations that have broad implications touching on individual practice, education and organizational structure and policy.

In order to assist in making Client Centred Care come to life for everyone in long-term care (LTC), from front-line staff to those in management, the LTC Best Practices Initiative has developed a new e-Learning course. The e-Learning course brings the concepts of client centred care to life, making them memorable by integrating stories and dialogues that Ria Spée, an Advance Practice Nurse at Sunnybrook Veteran's Health Centre, has collected from their staff, and videos that Pia Kontos, a research scientist from the Toronto Rehabilitation Institute and career scientist with the Ministry of Health and Long-Term Care (MOHLTC), developed based on observation in a home as part of an arts based strategy to educating health care providers on understanding personhood. Each module builds on the prior; there is an introduction and then learners are exposed to values and beliefs of client centred care, after which comes "Core processes living the values and beliefs"; finally, it is rounded out with the module "Creating a supportive environment" that helps individuals understand client centred care recommendations applicability to the home.

The free e-Learning course is web-based and allows users to complete the four modules at a time convenient for them. A certificate is provided at completion for use in the learner's portfolio or for submission to employers who may choose to use this as part of education programming within the home.

The e-Learning course is set to be launched at RNAO's 8th International Elder Care Conference *Older People Deserve the Best* in October and can be found at: http://clientcentredcare.rnao.ca.

Stories

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Canadian Care Centre (UCCC) as the new Toronto host agency. Seniors Health Centre may have ended their role as a host agency but their journey to BPG implementation continues. While UCCC may not be new to BPG implementation, their journey with the Toronto LTC Best Practice Coordinator is just beginning.

Just as the host agencies have shared their BPG implementation stories, the LTC Best Practices Initiative is delighted to share with you our latest addition to our collection of implementation resources, an e-Learning course on client centred care.

This e-Learning course is designed to facilitate reflection on your knowledge, experience, values, and beliefs regarding client centred care. Video and audio clips are included in the modules to enhance this process.

There is so much to learn from one another and we welcome story submissions from other LTC homes. Story telling is an opportunity to participate in reflective practice and provides the opportunity to learn about the similarities and challenges that connect us all in the LTC sector. The Long-Term Care Best Practice Coordinators and I continue to invite LTC homes to share their stories as there is so much to learn from each other.