#1	*Assessment of a pre-admission protocol to identify and maximize safety for persons with disruptive high risk behaviours (DHRBs) in long-term care homes*

Contacts	**LHIN**
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Partners	**Funding**
St. Joseph's Health System Research Network, St. Joseph's Health System, St. Joseph's Health Centre, Guelph St. Joseph's Lifecare Centre, Brantford St. Joseph's Villa, Dundas Waterloo Wellington Community Care Access Centre Canadian Patient Safety Institute	Jointly funded by the Canadian Patient Safety Institute and St. Joseph's Health System **Status** Currently underway 10/01/2009 01/01/2011

Abstract

Overview Disruptive high risk behaviours (DHRBs) (see footnote below) are an aspect of care that long-term care facility (LTCF) staff must increasingly contend with on a daily basis. DHRBs have been associated with a number of safety issues including injuries and assaults to self and others, property damage, overmedication, reduced quality of life, accelerated decline, and increased costs for care provision. Forewarning and appropriate care planning can significantly reduce the impact that these behaviours have in the long-term care setting.

In response to some high profile cases (e.g., Casa Verde case) where DHRBs of newly admitted clients to LTC facilities have led to injurious results, St. Joseph's Health System (SJHS) formed a committee to identify and develop a protocol to circumvent some of the risks associated with clients who demonstrate these behaviours. Over a two-year period, this committee has investigated the issue and has developed a protocol/decision tree for staff to guide identification of clients with DHRBs and to effectively plan for their care in order to minimize the risks to staff, clients, and others.

The protocol consists of two parts:
1. Pre-admission (to guide admit decision-making and appropriate care planning)
2. Newly admitted or current residents/patients (to ensure a consistent process and translation into appropriate care planning for already admitted residents/patients)

<u>Part 1: The Pre-Admission Protocol</u> The LTC admission process is a high risk time for individuals and other residents when DHRBs are present and no standardized admission process across LTCFs exists to ensure that DHRBs are identified and appropriately managed. The Pre-Admission Protocol developed by SJHS is a comprehensive protocol to assist LTCFs in identifying persons with DHRBs prior to admission in order to make more informed admission decisions and to develop care plans to safely manage the risks associated with DHRBs. It covers: identifying contributing factors through review of the RAI-MDS and other sources, determining sufficiency of available information, requesting additional information (e.g., Cohen-Mansfield, MoCA, MMSE) if needed, admission decision-making, and pre-admission care planning.

<u>Part II: The Post Admission Protocol</u> The Post-Admission Protocol covers processes involved in identifying and documenting concerns related to DHRBs, charting, individualized care plan approaches and reviews, team meetings, and community resources.

#1	*Assessment of a pre-admission protocol to identify and maximize safety for persons with disruptive high risk behaviours (DHRBs) in long-term care homes*

Evaluation A Research Team recently submitted an application to the Canadian Patient Safety Institute (CPSI) to obtain funding to conduct an evaluation of the effectiveness of Part 1: Pre-admission process of the protocol. The Pre-Admission Protocol will be implemented across the three LTCFs that are part of the SJHS: •St. Joseph's Health Centre, Guelph •St. Joseph's Lifecare Centre, Brantford •St. Joseph's Villa, Dundas

The specific aims of this demonstration project are to:

•Determine the effectiveness of the protocol to accurately identify persons with DHRBs prior to admission decisions

•Obtain provider feedback on the strengths of the protocol as well as barriers to its use

•Evaluate the ability of LTCFs to provide support for care planning for persons with DHRBs

Staff from the LTCFs (DOCs, social work, and nursing), regional CCACs (placement coordinators), and hospitals (discharge planners) will participate in applying the protocol and providing feedback to the research team. Training on the protocol use and care planning strategies will be provided prior to the protocol implementation for those staff who would normally have input or be responsible for admission decisions or for those who would be responsible for developing initial care plans for clients identified with high risk behaviours. Feedback on the process will be collected employing a concurrent mixed method design using both qualitative feedback (i.e., surveys, focus groups) and quantitative data collection (i.e., chart audits) to assess the protocol's effectiveness.

As per the defined CPSI timeline, the evaluation begins in June of 2009 and will be conducted over a 20 month period.

Deliverables Upon completion of the demonstration project, a 12-month profile of the prevalence and types of DHRBs referred to SJHS LTCFs and the types of interventions used to reduce adverse events related to DHRBs will be available for consideration by SJHS, our two regional associated LHINs, the MOHLTC, and other community partners. A report will be written detailing the utility of the DHRB Pre-Admission Protocol in terms of its strengths and limitations, recommendations for improvements, implications for admission and care planning practice and recommendations for policy changes.

Key Learnings

As with any demonstration project, it is necessary to closely monitor and record compliance with the protocol in order to document strengths and barriers to the change in practice.

Papers and Presentations

Maitland, J., Brazil, K., Walker, M., Tettman, M., Curtis, A., & Krueger, P. (2009). A New Pre-Admission Protocol to Identify and Maximize Safety for Persons with Disruptive High Risk Behaviours in Long-Term Care Homes. Paper presented at Long-Term Care Research Education Day, Toronto, ON.

#2	*Mindfulness-based meditation for persons with acquired brain injuries*

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Partners	**Funding**
St. Joseph's Health Centre Guelph, St. Joseph's Health System Research Network, St. Joseph's Health Centre Foundation, Trellis Mental Health and Developmental Services	St. Joseph's Health Centre Foundation provided the funds to complete this project. In-kind support was also provided by St. Joseph's Health Centre Guelph and St. Joseph's Health System Research Network.
	Status
	Recently completed 09/01/2008 07/01/2009

Abstract

TITLE: A MINDFULNESS-BASED INTERVENTION (MBI) TO IMPROVE QUALITY OF LIFE FOR ADULTS WITH MILD TO MODERATE ACQUIRED BRAIN INJURY

STUDY PURPOSE AND RATIONALE Mindfulness-Based Stress Reduction (MBSR) is a well-defined patient–centred approach that systematically teaches patients purposeful moment-to-moment awareness of their thoughts, feelings, and behaviours. This non-judgmental awareness enhances the patient's inner capacities for relaxation, focus, awareness, and insight. Patients have reported increased ability to problem solve, and enhanced feelings of personal responsibility, control, compassion, and even happiness (Kabat-Zinn, 1990). This approach has been used successfully to treat persons suffering from chronic pain (Kabat-Zinn, 1982; Kabat-Zinn, Lipworth, & Burney, 1985), cancer (e.g., breast, prostate; Massion, Teas, Herbert, Wertheime, & Kabat-Zinn, 1995), cardiovascular disease (Moustgaard, Bédard, & Felteau, 2004; Tacon, McComb, Caldera, & Randolph, 2003), dermatological conditions (e.g., psoriasis: Kabat-Zinn et al., 1998), fibromyalgia, and stress related disorders (Kabat-Zinn, 1990) such as anxiety, depression (Segal, Williams, & Teasdale, 2002) and irritability (Kabat-Zinn et al., 1992; Miller, Fletcher, & Kabat-Zinn, 1995).

Mindfulness-Based Cognitive Therapy (MBCT) is a relatively newer therapeutic approach based on MBSR which combines aspects of cognitive therapy and mindfulness meditation. MBCT seeks to teach patients greater awareness of their thoughts and feelings and to view them as mental events rather than as truthful reflections of reality. Greater awareness of a given moment increases the likelihood for recognizing the triggers of problematic habitual thinking and feeling. Recognizing triggers or warning signs is a major focus of MBCT which was developed as an intervention to prevent the relapse of depression and like MBSR has been shown to be effective in a wide range of clinical populations. A few research studies (e.g., Bédard et al., 2003, 2005) have demonstrated that both MBSR and MBCT hold significant potential for enhancing the quality of life for persons with acquired brain injuries (ABIs). Client feedback from the Bédard et al. (2003) study indicated that participants experienced improvements in attention, concentration, memory and mood. They additionally reported feeling calmer and less likely to overreact in stressful situations. They expressed increased insight and clarity with old problems, more confidence and a general sense of individual acceptance (Felteau & Marshall,

#2	*Mindfulness-based meditation for persons with acquired brain injuries*

2007). Considering the time-limited nature and cost effectiveness of mindfulness-based interventions (MBI) , the demonstrated value of MBI for improving quality of life makes it an appealing alternative to more traditional approaches to recovery. Persons with ABI often suffer from multiple executive functioning deficits in awareness, insight, judgment, planning, organization, problem solving, multitasking, and working memory as well as many physical impairments including headaches, dizziness, balance deficits, and blurred vision (Mezirow, 1991; Segal, Williams, & Teasdale, 2002). Persons with ABI are also at greater risk for psychological disorders such as anxiety and depression (Linn & Willer, 1992) which can hinder their ability to recover. The ability to integrate into a community (e.g., achieve certain levels of independence as well as meaningful employment) is highly related to the quality of executive functioning (e.g., understanding of social appropriateness) and is an area that poses great challenges for individuals with ABI. All of these deficits severely limit daily living and greatly reduce the quality of life for individuals living with ABI. The good news is that there is no limit to the extent to which individuals who have sustained head injuries can be rehabilitated (Falconer, 2000). Learning of more effective coping strategies to deal with these multiple deficits has the potential for greatly benefiting persons with ABI.

Our study sought to explore the effectiveness of an adapted mindfulness-based intervention on improving key aspects of quality of life for adults with mild to moderate severity of ABI. Given the success of MBSR and MBCT therapies with the previously noted range of populations including those suffering from health-related conditions, chronic pain, and stress-related disorders such as anxiety and depression, we specifically hypothesized that individuals participating in our 10 week MBI program would improve their ability to attend to the moment and consequently would: •improve their ability to manage pain • experience decreased anxiety •experience an increase in self-esteem and •report improved overall health-related quality of life

Our study is currently in the analysis phase. Results will be available in the near future.

Key Learnings

1. In order to consider conducting a project of this nature, be prepared to provide a large degree of support on many levels to the program participants. For example, it was necessary to provide transportation, many reminders, and emotional support.
2. An aspect that also needed to be considered was the preparation of participants for the termination of the 10 week program. The program quickly became a source of community, networking, and purpose that represented a loss once it was completed.

Presentations and Papers

Maitland, J. E., Devitt, A., & Rogers, P. (2009). Research Evidence for Mindfulness: Impact on Quality of Life for ABI Survivors. Paper presented at the Acquired Brain Injury Provincial Conference 2009, Niagara Falls, ON. Devitt, A., Richmond, R., & Maitland, J. E. (2008). Living in the moment: A mindfulness-based intervention for survivors of ABI. Paper presented at the 15th Annual Conference on Neurobehavioural Rehabilitation in Acquired Brain Injury: Advances in ABI Research and Practice, Hamilton, ON. Audrey Devitt, A, Maitland, J. E., Rogers, P., & Richmond, R. (2007). Mindfulness-Based Meditation for Individuals with Acquired Brain Injuries. Invited talk for Lawson Imaging, Lawson Health Research Institute, London, ON

#3	*Behavioural Support Team*

Contacts	**LHIN**
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Partners	**Funding**
St Joseph's Health Centre, Guelph Waterloo Wellington CCAC Trellis Mental Health & Developmental Services Other agencies will be involved in finalizing the proposal Homewood Health Centre Grand River Hospital (Specialized Mental Health) Long Term Care Home	It was intended to seek Aging at Home dollars but this in now on hold **Status** Not Implemented

Abstract

Background

Beyond 2006 (2006, pg 7) indicated that it is "…the elderly consumer population which is growing rapidly and putting the most pressure on the long-term care service system." The recently released "Rising Tide: The Impact of Dementia on Canadian Society" indicates that this pressure will continue to increase as the number of new cases of dementia among Canadians age 65+ in 2038 is expected to be 25 times that of 2008. Beyond 2006 further stated that "Recent research has identified high-risk behaviour as the most significant factor working against placement in LTC homes." (pg 26)

WWLHIN sponsored planning sessions held in December, 2007 (one in each of Waterloo and Wellington), which had participation of the Community Care Access Centre (CCAC), acute care hospitals and LTC homes, identified that the biggest challenge was managing residents with high risk behaviours. Person centered care plans for seniors exhibiting high risk behaviours can be developed through specialized assessment and treatment services within a home environment similar to that in a LTC home.

Deliverables and Monitoring Implementation of the proposed Behavioural Support Team will:

- Decrease the use of ALC beds for seniors with dementia and responsive behaviours;
- Decrease the use of ALC beds for seniors without dementia but with responsive behaviours;
- Decrease presentations to the Emergency Department for seniors with responsive behaviours
- Shorten the wait times to access a LTC bed for individuals with dementia and responsive behaviours;
- Facilitate the flow of individuals across the continuum of care;
- Increase system capacity in LTC homes through transfer of knowledge and support for skill development;
- Increase resident and family satisfaction with care; and
- Increase satisfaction of LTC home with the management of residents with dementia and responsive behaviours.

The following ***measures can be used to evaluate the impact of the program***:

- Resident and family satisfaction rate
- Average wait time for LTC bed for individuals with dementia and responsive behaviours
- Number of ALC days for individuals with dementia and responsive behaviours requiring admission to

#3	*Behavioural Support Team*

LTC bed
• Number of ED presentations for LTC residents related to severe behaviours
• Satisfaction rate of LTC homes with outreach support

The Behavioural Support Team will: assess individual and their environment including detailed observation and evaluation of problem behaviours; assist caregivers in stabilizing behaviours; collaborate with caregivers to develop a care plan and risk management plan ; support caregivers in implementing the plan including education and coaching/mentoring in collaboration with caregivers including PRCs; follow-up while plan is being implemented and stabilized; and consult with LTC homes to better manage behaviours.

This service is provided in partnership with LTC homes and/or other caregivers and requires the following from LTC home/caregiver: commitment to collaborate commitment to accommodate the individual with high risk behaviours The service is intended to be available 7 days a week from 9-9 (only 8 hours on weekends).
The team will include: Registered Nurses PRCs (Psychogeriatric Resource Consultants) Recreation Therapists Nurse Practitioner and/or Geriatrician (PT) Geriatric Psychiatrist (PT)

Target Population This service will focus on meeting the needs of seniors in the WWLHIN who: have a pattern of behaviours that are escalating and/or are persistent; whose behaviours are not responsive to other interventions to date after use of PIECES and PRC involvement; and present a significant risk. It is anticipated that the majority of the seniors referred will have a diagnosis of dementia, however seniors with other diagnoses such as mental illness may also be appropriate for the service.

Key Learnings

Project has not been implemented but preparing the proposal identified several things: * need to look closely at how new service would integrate and link with existing services * need to look beyond patient with dementia to other populations with responsive behaviours ie other mental health issues, developmental delay * importance of having an evening and weekend response capability

Presentations and Papers

#4	*Behavioral Health Program in LTC*

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Partners	**Funding**
St. Joseph's Health Centre Guelph WWCCAC Acute Care Hospital (Guelph General) Mental Health Hospital (Homewood) LTC Homes Psychogeriatric Resource Consultant Community Mental Health Agency (Trellis) WWLHIN	It has not received funding and there is no potential for funding at this time **Status** Not Implemented

Abstract

With high risk behavior a most significant factor working against placement in LTC homes in Waterloo-Wellington, St. Joseph's Health Centre developed an Aging at Home Business Case proposal in April 2009 for a 32 bed specialized Behavioral Health Program as part of 96 new LTC beds that it is building to be opened in the fall of 2010. The program would serve the needs of individuals in the Waterloo Wellington LHIN who have a diagnosis of dementia and exhibit behavioral or psychological symptoms including verbally or physically responsive behaviors. St. Joseph's would provide a familiar home-like setting for time limited assessment and treatment rather than an institutional environment.

Seniors with these behaviors would be admitted from home, LTC, acute care or Specialized mental Health to the time limited assessment and treatment program and then discharged back to an appropriate community setting after treatment. All phases of care including intake, assessment, development of a management plan and discharge would be coordinated and built upon an interdisciplinary model of care and would link with existing community resources. The program would also create new linkages and partnerships across the continuum of care to support coordinated and holistic care for seniors across the system.

The proposal was developed through a multi-agency steering committee and involved a literature search, site visits and phone interviews with peer programs and consultation with community partners and stakeholders across the continuum of care.

The expected outcomes of the proposed program were: * decrease in the use of Alternate Level of Care beds for individuals with dementia and responsive behaviors; * shortened wait times to access a LTC bed for individuals with dementia and responsive behaviors; * facilitate the flow of individuals across the continuum of care; * increase the system capacity through knowledge transfer; and * increase the satisfaction of families and LTC homes with the management of residents with dementia and responsive behaviors.

Key Learnings

Our key learnings in developing this proposal and in not achieving the ability to secure funding to implement it are: The significant impact of Ministry of Health policy barriers for LTC placement: 1) The Ministry cannot provide funding to one LTC home that exceeds the current funding methodology. 2) The CCAC placement process is set according to the LTC home choices for LTC placement that have been

made by individuals/Power of Attorney. In order to be admitted to a behavioral program, the program LTC home would have to be on the list of choices for that individual. 3) The LTC environmental standards currently do not allow for the modifications that are required for the security of a behavioral unit/program. 4) The bed holding policy does not allow for the time period that may be required for a LTC resident to be admitted to this program (up to 90 days).
Presentations and Papers
It has been presented at the Behavioral Assessment Units Information Exchange on April 27, 2009 and the proposal has been shared with the Behavioral Support Systems Project.

#5	*Services Needed for the Dementia Journey*

Contacts	**LHIN**
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Partners	**Funding**
1.Public Education Coordinator Alzheimer Society of Cambridge (author) 2.System Plan Committee of the Hospice and Palliative Care Network of LHIN3 3.Geriatrician 4. Waterloo Wellington Dementia Network Co-Chair 5. Case Manager, Waterloo Wellington CCAC 6. Former Family Care Partner 7. Person with Dementia 8. Director of Care, Saint Luke's Place, Cambridge 9. Nurse Clinician, Seniors' Health Clinic, Cambridge Memorial Hospital 10. Geriatric Clinical Resource Consultant, Trellis 11 Psychogeriatric Resource Consultant 12 Geriatric Clinical Nurse Specialist CCAC	No funding was used. We met on work time as paid by our various agencies. Alzheimer Society resources were used for production and distribution of the finished product. **Status** recently completed 01/01/2009 10/01/2009

Abstract

A plan for the inclusion of persons with a dementia in the Waterloo Wellington Palliative System was required as part of the work of the System Plan Committee, a subcommittee of the Hospice Palliative Care Network of the Waterloo Wellington LHIN. A Working Group was struck composed of one member of the System Planning Committee who recruited the other members for this project. The Working Group began with a document entitled "The Continuum of Services for People with Alzheimer Disease and Family Caregivers: A Vision" published by the Alzheimer Society for Metropolitan Toronto in April 1994. To the twelve service areas identified in Toronto in 1994, we have added pre diagnosis, elder abuse and neglect, crisis recovery and end-of-life care. Following a logic model of analysis as requested, we have established an overall objective, service areas (each with one or more main components), and their accompanying outcome objectives, implementation objectives, potential output measures for evaluation, resources available and current or best practices (if available). We view this service plan for the Dementia Journey as a means to evaluate the care offered to individuals and their families in our area throughout their experience with dementia.

Key Learnings

The breadth and depth of education and support for the person with dementia and their families from before diagnosis until after death. Families who are well supported and educated have been found to maintain their own health better, have been able to keep the person with dementia at home longer, and the person with dementia is less likely to have responsive behaviours when they are suitably psychologically supported.

Presentations and Papers

Presented to the System Plan Committee and the Hospice Palliative Care Network of the Waterloo Wellington LHIN, as well as the Alzheimer Society Chapters.

#6	*Homewood Health Center Program for Older Adults*

Contacts	**LHIN**
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Partners	**Funding**
Homewood Health Centre linkages with Trellis, Senior's Services Network, GeroPsychiatry Community Education Program. CCAC Emergency Depts Long term care homes and retirement homes	Homewood Health Centre Operating Budget **Status** Recently completed 01/01/2008-ongoing

Abstract

Program for Older Adults has been 2 inpatient units at the Homewood Health Center in the Community Division since 1996. There have been 51 beds for older adults with [depression, anxiety, psychosis], [difficult to manage behaviours related to dementias] and also [acute crisis beds].

A Program Review has been completed and as of April 2010 there will be 30 beds for each of these specialized streams, [10], [18], and [2] respectively. Typically >55 yrs, we are a Schedule 1 facililty and are not a long term care placement option. Dementia [18 beds, elective program, <90 day LOS] risk assessments, behavioural disturbance within the context of behavioural impairment, long hx of mental illness now with cognitive impairments and behavioural issues Mood Anxiety and Psychosis [10 beds, elective, approx 8 weeks LOS] - Axis I with risks associated that prevents safe management elsewhere, relapsed, can participate in cognitive behavioural activities, no acute substance abuse impairment Crisis [2 beds, Schedule 1 Form 1, <14 day LOS] - emergency admissions for evaluation of mental health behavioural issues, medically assessed and stabilized.

Program Deliverables recurrence/relapse prevention including ED visits, reduce risk, decrease family burden, enhance community networks reduced recidivism, optimize function, mental and physical health and quality of life,

Key Learnings

The re-design of the POA programs is to be implemented April 1st for bed changes and service delivery will be going through the development for June 1st. Related to next question, a marketing approach is under development, some information shared to key stakeholders.

Presentations and Papers

#7	*Hush - No Rush: The Preferred Journey Through Dementia*

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Partners	**Funding**
Preferred Health Care Services Leisureworld Caregiving Centres	The education component of this program is paid for by the consumer. The implementation and sustainability is at no additional cost to the home. **Status** currently underway 01/01/2008-ongoing

Abstract

Hush - No Rush is an educational program for people working primarily in the community and LTC homes. Ideally it is suitable for anyone who works with people with dementia in any setting. Through our program, Hush - No Rush: The Preferred Journey Through Dementia, we have learned that staff behaviours and the environment are most often responsible for triggering client behaviours. We know all behaviour has meaning and once investigated, analyzed and a plan is put into place, behaviour can be positively affected. Further to this, we have discovered that education of staff working with clients with dementia is the most effective method for sustaining positive change and creating a calm and quiet environment for these people with dementia. This program has already been successfully delivered in 14 Leisureworld LTC homes within several LHINS, including North Simcoe Muskoka, and Preferred Health Care Services home care agency. We propose that the Hush - No Rush education program be implemented in all long-term care homes and for staff working in the community. Beyond initial education costs, dementia care units can quite often be modified with little or no expenditures. Additionally, we have designed this program using current staffing deployment. However, once a client is transitioned from a BSS unit back to his/her original LTC environment, behaviours can be expected to re-occur unless staff are educated in this specialized area of care. All staff in all departments need to know what dementia is and how best to respond to and look after these clients with respect and dignity. In our holistic model, Hush - No Rush is delivered at the staff workplace, where everyone can be educated to care for people with dementia. In LTC this fosters a team problem-solving approach critical to managing behaviours due to dementia. In the community, when health care providers are educated, aging at home is improved, therefore caregiver stress is decreased. The person with dementia is able to stay home longer before admission to LTC becomes necessary.

Key Learnings

-staff behaviours are the key to maintaining a quiet and calm atmosphere for the resident/client -education and the desire to have an excellent dementia care unit must be driven by all staff at all levels of the organization -policies and procedures related to staff education are required
-staff need to attend mandatory ongoing education to promote quality dementia care if they wish to

#7	*Hush - No Rush: The Preferred Journey Through Dementia*
work on a dementia care unit -staff need to be selected to work on a dementia care unit, as opposed to being sent there due to seniority -family education needs to be offered on a regular schedule -a multidisciplinary model of care is necessary with a blurring of boundaries i.e. PSW's need to assume responsibility to engage the resident in an activity and program staff need to be involved in feeding and personal care	
Presentations and Papers	
-Helpful Hints, BPG Implementation in LTC 2007 -Hospital News January 2008 -Presentation OLTCA April 2008 -Presentation Central LHINS Breakfast of Champions May 2008 -Presentation RNAO Elder Care Conference Sept 2008 -Presentation PSNO Nov 2008 -Paving the Way: Understanding the Path to Dementia Care, organized by the Alzheimer Society of North East Simcoe and the Dementia Education Planning Committee May 2009 -Poster display OACCAC May 2009 -Presentation OHCA June 2009 -Axiom News Multiple articles 2008, 2009 2010	

#8	*Behavioural Intervention Response Team*

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Partners	**Funding**
Mental Health Centre Penetanguishene Community Mental Health, Collingwood	Aging at Home year 2
	Status
	Currently Underway June, 2009 – March 2011

Abstract

The Behavioural Intervention Response Team (BIRT) is a specialized geriatric psychiatry response team for long-term care (LTC) residents with severe behaviours (SB) related to dementia. BIRT is an collaborative, interdisciplinary team comprised of RPN's, 2 Behavioural Support Specialists, a Social Worker and two Psychogeriatric Resource Consultants. The program was designed based on the premise that with the right mix of service (assessment, education, collaborative care planning and, support trialing behavioural modification strategies) LTC facilities can improve quality of life for residents with SB, and prevent unnecessary transfers to the emergency department.

Residents are referred to BIRT by MHCP's Geriatric Psychiatry Outreach Team or, by the facility the resident resides in. Referrals are screened by the Clinical Intake Coordinator for Geriatric Services Program at MHCP. Criteria for admission to BIRT are strict and the resident must meet each prerequisite: cognitive impairment; escalation of persistent behaviours; aggressive behaviours; high risk behaviours. BIRT staff complete an initial assessment within 24 hours of a resident being admitted to the program.

The intended outcomes of this program include: •Enhancing existing confidence and capacity related to SB in LTC. •Averting unnecessary transfers to the emergency department for residents with SB related to dementia. •Development of an aggression risk-assessment tool for seniors living in LTC.

Successful implementation of this program in the North-Simcoe Muskoka LHIN will provide evidence of the need and efficacy for this type of service across Ontario's 14 LHINS. This service is provides specialized, intensive support while simultaneously building the facility's capacity for providing appropriate person-centered care to residents with SB. Through capacity building, BIRT will enhance quality of life for all LTC residents especially those with cognitive impairments, who are among the most vulnerable of all.

Results: The BIRT team has served 16 residents since September, 2009 and has kept 14 residents out of general hospitals. Facility referrals have come from across the North-Simcoe Muskoka LHIN. Directors of Care report satisfaction with the degree of support and guidance provided by BIRT. A formalized

#8	*Behavioural Intervention Response Team*
evaluation tool for LTC facilities is being developed.	
Key Learnings	
1) Facilities are looking for support. There is an observed decrease in the facility's level of distress which occurs at the first visit by BIRT. Many DOC's report relief just from knowing that they are no longer "in it alone". 2) Staff need permission to let go of time and tasks. Frontline staff need to be directed and supported by management to share information about the resident, debrief after critical incidents and take the time to implement strategies recommended by BIRT. 3) Commitment to the process. Modifying severe behaviours takes time and requires commitment by the facility and its staff to stay the course and deny the impulse to send the resident to hospital when an incident occurs. 4) Managing violence and risk requires creativity, willingness, and a high level of communication from all those involved.	
Presentations and Papers	
MacKenzie, S & Scott, G. (2009, November). Behavioural Intervention Response Team: A new approach to a persistent dilemma. Poster session presented at Leading Outside the Box: how Research & Innovation Can Improve LTC Quality & Sustainability, Toronto, ON. Ma Kenzie, S & Scott, G. (2010, January). Behavioural Intervention Response Team: A collaborative approach to managing severe behaviours in the long-term care setting. Webinar presented via Alzheimer Knowledge Exchange, Online.	

<table>
<tr><td>#9</td><td colspan="2">Wendat Psychogeriatric Program - Transition Service and Social Work service</td></tr>
<tr><th colspan="2">Contacts</th><th>LHIN</th></tr>
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Lorna Tomlinson, Executive Director
705-526-1305 or Lorna@wendatprograms.com</td><td>North Simcoe Muskoka</td></tr>
<tr><th colspan="2">Partners</th><th>Funding</th></tr>
<tr><td colspan="2" rowspan="3">Mental Health Centre, Penetanguishene -in-patient and Outreach programs (Geriatric Services, Psychosocial Rehabilitation, Admission and Assessment Unit) Psychogeriatric Resource Consultants - Simcoe and Muskoka NSM CCAC - Placement and Client Care Coordinators NSM CCAC - Severe Behaviours Care Coordinator Long Term Care Homes in NSM LHIN (27) Hospitals (Acute Care Centres) in NSM LHIN (6)</td><td>In 2006 the need was identified at many levels and New funding was identified for a community Psychogeriatric program. In August 2006 the MOHLTC awarded Wendat the funding with their proposal to develop a model for transitioning clients from inpatient psychiatric care to Long Term Care (LTC) Homes. Wendat proposed a two-pronged approach for their service to Psychogeriatric clients: transition service as well as social work assessment/intervention for those families and individuals living in their homes. Program Supervisor hired in January 2007 to develop model - first pilot September 2007 - full FTE capacity December 2007. Funding continued upon entry of LHIN structure and meeting of indicators.</td></tr>
<tr><th>Status</th></tr>
<tr><td>Currently Underway
2/1/2007- now ongoing</td></tr>
<tr><th colspan="3">Abstract</th></tr>
<tr><td colspan="3">The Wendat Psychogeriatric program is composed of : Registered Practical Nurses with both long term care and psychiatric nursing experience, a registered Social Worker and a Program Supervisor/Registered Social Worker. The program functions in close collaboration with specialized psychogeriatric service teams, Hospitals, Long Term Care facilities, and Psychogeriatric Resource Consultants in addition to many other community based partners This service is available for residents within the North Simcoe and Muskoka Local Health Integration Network catchment area who are: Seniors aged 65 years and over with a dementia and/or complex mental health needs OR Persons under age 65 suffering from a neurodegenerative disease process affecting cognition such as Alzheimer Disease, Acquired Brain Injury, Substance related disorders. And are experiencing behavioural disturbances that interfere with their ability to function, or, be managed in their present environment. Transition Service Acts as a bridge in the transition of client specific care needs and behaviour management strategies across systems of care. This service is particularly targeted to those persons who have undergone specialized assessments moving from any in-patient hospital setting (psychiatric hospital or Acute Care Centre) to a Long Term Care Home. The Transition Behaviour Nurse works</td></tr>
</table>

#9	*Wendat Psychogeriatric Program - Transition Service and Social Work service*

collaboratively with the Hospital Doctors, Nurses and multidisciplinary staff in the preparation of a comprehensive Transition Plan of Care. This Transition Plan of Care identifies, in concrete terms, the risk behaviours, what they are related to (Diagnoses – neurological, psychiatric, physical, emotional), the triggers and the interventions in a PIECES format. Once the person is offered a bed in LTC collaboration begins with the LTCH staff in preparation for the transition of their new resident. Review and modification of the Transition Plan of Care occurs with potential internal environmental risks identified. The resident is then admitted to the LTC Home with the Transition Behaviour Nurse spending and additional 3 to 6 weeks offering intensive, sometimes hands-on support and peer coaching to the Long Term Care Home staff post admission of the resident. The Transition Plan of Care is a dynamic record and available for all staff to input successful and unsuccessful interventions as well as concerns expressed. A 3-week Care Conference is mandatory with all care partners invited so as to assess how the transition of care and management of behaviours is progressing. The Transition Behaviour Nurse decreases the number of visits based on LTCH staff comfort level and ability to manage the risk behaviours presented by the resident. Social Work Service Provides psychosocial assessments, therapeutic interventions, health teaching and support service integration for seniors with complex mental health needs who are experiencing difficulty and for their family members. The goal is to help the senior/family access all the supports necessary to assist the person to remain in their choice of environment. Mostly service is provided to those marginalized in our communities who fall through the cracks of service mandates.

Our initial goals/indicators being monitored:
1. To facilitate the successful transition from in-patient care to living in a Long Term Care facility.
The criteria for Outcome was: 1) the person remains in the LTC facility at the conclusion of the Transitional workers involvement (target is 40% initially increasing to 65% of cases after18 months of program implementation) - We have been able to exceed this indicator experiencing 1 return to hospital for medical reasons and 1 return to psychiatric in-patient care mid transition. 2) persons are supported in the transition from in-patient care to living in a LTC facility (annual target is 16-20 clients for whole program) - Again we have met or exceeded this indicator with 32 completed transitions in this past fiscal year
2. To improve the quality of life for persons newly admitted to Long Term Care facilities from hospital care. The criteria Outcome was: 1) client satisfaction with current living situation (target is 65% are satisfied). 2) the LTC facility is satisfied with person remaining in their home (target is 65% of cases). In both of the above Satisfaction surveys are sent to the LTC Home as well as the client/family/POA - This is done in combination with the Case Conference questions and face to face contact with DOC and Administrators. Satisfaction level exceeds the target of 65% Our next goal is to access the referring facilities and their satisfaction level with the service. Another goal/desire is to have the service expanded to accommodate the "Wait at Home" clients as there is a strong need being expressed by our service providers. The patients are being sent home to wait for LTC and the family as well as the receiving facilities are now experiencing behaviours and management of such. Safe and proactive transitioning works.

Key Learnings

Key learnings; You need the buy in from the referring facility as well as the receiving facility as it takes everyone working together for the transition to work. It is best to be a neutral party i.e. not belonging to LTC or Hospital/Psych facility therefore minimizing political issues, perceptions, etc Understanding that

#9	*Wendat Psychogeriatric Program - Transition Service and Social Work service*

the LTCH staff are managing a very difficult and demanding population and working with fewer staff and greater restrictions re: management interventions (restraint) Really understanding the different Legislative acts the different facilities are working under and how to create care plans that accommodate these differences effectively That the first time in to a new facility - hospital or LTC Home - you will be met with some resistance and hesitation to collaborate but employing "capacity building techniques and peer coaching" as well as acknowledging the staff strengths is very important. Even though scope of practice has not been overstepped you will be quoted as "ordering" a certain medication or procedure. Staff especially in acute care hospital settings are looking for any help with these very challenging behaviours and once familiar with the service look to you for guidance and expertise.

Presentations and Papers

Presentations provided with MHCP and NSM CCAC to the MHCP Tertiary care Conference 2008 Geriatric Rounds - Tele-education 2007 with MHCP OACCAC - Conference in Toronto Harbourfront - 2009 Videoconference to Baycrest - 2008 Alzheimer Society of East Simcoe County - conference 2009 Presentations to local health fairs and conferences in the form of Poster Board Presentations to Hospital teams. CCAC community teams, Community Mental Health Teams in Muskoka and Simcoe Information shared with McMaster Geriatric Program, Tamarra Sussman in 2007, SHRTN and AKE. Information about the Program is on a link with the MHC Penetang - this is not an interactive link.

<table>
<tr><td>#10</td><td colspan="2">St. Joseph's Care Group-Centre of Excellence for Senior Integrated Services (CEISS), Regional Behavioural Health Program</td></tr>
<tr><td colspan="2">Contacts</td><td>LHIN</td></tr>
<tr><td colspan="2">Paulina Chow Chowp@tbh.net
Meaghan Sharp sharpm@tbh.net</td><td>North West</td></tr>
<tr><td colspan="2">Partners</td><td>Funding</td></tr>
<tr><td colspan="2" rowspan="3">Senior Mental Health Out Reach Team, Lakehead Psychiatric Hospital, St. Joseph's Care Group (SJCG) Hogarth Riverview Manor, SJCG Psychogeriatric Resource Consultant, SJCG Complex Continuing Care and Rehabilitation Admission Facilitator, SJCG Northwest CCAC Lakehead Psychiatric Hospital, SJCG Revera Living Inc. Consumer Representatives (3) City of Thunder Bay Homes for the Aged Utilization Management, Thunder Bay Regional Health Science Centre Alzheimer Society, Thunder Bay Chapter Master of Public Health/Research, Lakehead University Manitouwadge General Hospital McCausland Hospital Canadian Mental Health Association (CMHA), Fort Frances District of Kenora Home for the Aged, Kenora St. Joseph's Care Group North West LHIN Ad hoc: Dr. George Morrison, Dr. Trevor Bon, Dr. Patricia Lepage</td><td>This project was made possible by the announcement of the previous Minister of Health and Long Term Care, George Smitherman in providing funding to develop a Centre of Excellence for Senior Integrated Services which includes: 336 Long Term Care Beds which includes 64 beds Regional Behavioural Health Program and 132 Supportive Housing Units on Hogarth Riverview Manor site.</td></tr>
<tr><td>Status</td></tr>
<tr><td>Currently Underway
10/01/2008 12/01/2012</td></tr>
<tr><td colspan="3">Abstract</td></tr>
</table>

SJCG and NWLHIN Steering Committee has established the Regional Behavioural Health Program Working Group to provide advice to the Center of excellence for Integrated Senior Services (CEISS) Steering Committee regarding:
1. An integrated system-of-care model for clients with responsive behaviours in the North West LHIN
2. Process that support quality of care and safe environments
3. Indicators that measure quality care for clients with responsive behaviours
4. Key strategies to address clients (eligible for long-term-care with responsive behaviours and map care along the continuum
5. Policy issues, and
6. Relationship of regional Health Service Providers (HSPs) with the Regional Behavioural Health Program.

Objectives: 1. Identify best practices for care delivery
2. Define the standardized tools to be used across the system for assessment of clients with responsive behaviours
3. Develop criteria for admission, transfer and discharge of clients to the Behavioural Health program
4. Develop process map for the continuum of care(urgent referrals, physician consultation and access to the program or other resources)
5. Develop various case scenarios to clearly articulate the client's journey through the system
6. Develop the mechanisms to respond as a regional outreach resource
7. Identify how to access additional resources/hours of care for clients transitioning back to long-term-

#10	*St. Joseph's Care Group-Centre of Excellence for Senior Integrated Services (CEISS), Regional Behavioural Health Program*
care setting 8. identify communication strategies, and Make recommendations and present findings to the CEISS Steering Committee.	
Key Learnings	
Below is the summary provided from Dr. Ken LeClair after our consultation with him last summer as: 1. Defining the population: from diagnosis to a broader identification which includes diagnosis but also considers needs, risks, stability, mobility and social need; 2. Vehicle for transformation; from a unit concept to a service that provides a vehicle for transformational change to meet the present and future priorities of the MOHLTC and is aligned with the emerging values, principles of overall health care direction and related Ministry planning and development; 3. Service unit to a system resource; sitiate the Behavioural Support Service Unit in a Behavioural Support System context; 4. Human resources; (a) practitioner and human resource planning driven from the provider professional's focus to increased emphasis on functional-based human resource planning model; and (b) a shift of emphasis of emphasis from direct care provision to collaborative evidence-informed practitioners; 5. Environment; from an architectural design based on common present practices to one aligned with the realities, perceptions, needs and functions of the target population; 6. From a unit concept or place to an integrated System Resource; which include a consideration of evolutionary system design that considers specific elements in the development at the (a) systems organizational; (b) systems performance and (c) point of care levels with emphasis on quality and a population health perspective; 7. From "building it and they will come" perspective to developing an incremental staged strategy; to foster intersectional collaboration and accessibility through the region.	
Presentations and Papers	
Not sure about the Link, it was presented at April, 2009 with the first AKE/MOHLTC initiative bringing the interested group together to discuss the Behavioural Support Unit Development	

#11	*COPA COLLEGE (C)*

Contacts	**LHIN**
Marilyn White-Campbell COPA 416 516 2982 ext 22 Liz Birchal 416 516 2982 ext 224	Toronto Central
Partners	**Funding**
CAMH Elmgrove Living Center White Eagle Long Term Care Center Leisure World St George Fudger House YorkView Life Center Toronto Community Housing	No funding **Status** recently completed 02/01/2007 06/01/2010

Abstract

COPA COLLEGE is a psychoeducational group therapy model which was developed to provide therapeutic support groups for older adults with problem substance use and mental health problems. The focus of the group is support and education on issues relating to substance use concurrent disorders in the context of late life learning.

Sessions are held once a week in a host long term care facility or in the community for 8 weeks. Topics include relapse prevention, alcohol and its effects on the body in later life, mental health and the impact of substance use, bereavement, healthy sexuality, effective communications etc.

The group was evaluated in 2008 in collaboration with University of Toronto School of Medicine determinants of health. Method: One-on-one semi-structured interviews of ten clients were conducted. Clients were asked to rate the importance of different aspects of the program and discuss alcohol intake following participation in the program. Evaluation results included increased self esteem of participants, improved mood, memory, sleep and social connections. Participants from long term care homes who were in the evaluation group were identified as residents with behaviours and those who the homes were considering moves to other facilities. The homes and their support staff identified a trickle down effect to the other residents who shared rooms with these residents whereby the residents' who attended COPA college decreased their behaviours significantly and the room mates behaviours were minimized. Staff also reported that the resident's behaviours were greatly improved. This study set out to both evaluate participant reactions to the program and to determine if clients decreased substance use following the program's completion.

Key Learnings

1. Residents with substance use and mental health problems can make changes and improve behaviours.
2. Concurrent disordered Older adults are interested in learning.
3. Concurrent disordered Older adults left untreated can decompensate physically and cognitively
4. Concurrent disordered older adults can and do learn from the sessions
5. The model encourages late life learning and is delivered within an antiopressive framework.

#11	*COPA COLLEGE (C)*

Presentations and Papers
Canadian Association on Gerontology Annual Scientific Meeting Oct 2008 Jarvee Colloquium http://www.jarvie.org/colloquium13.htm EVALUATING THE COPA COLLEGE PROGRAM: An Innovative group based psychosocial approach for Dually Diagnosed Older Adults who have problem substance use and mental health issues. Submitted to Journal of Dual Diagnosis UK Dec 2009 presented at OPHMAN conference May 2008, presented to Geriatric Psychiatry Dept at CAMH Fall of 2008, Baycrest Geriatric Psychiatry Rounds Dec 2008 Accepted Abstract TITLE: A Model of Care for working with Older concurrent disordered Older adults; The COPA College Program to be presented at the ONNAHS conference in June of 2010. Accepted abstracts for Canadian Coalition For Seniors Mental Health Nova Scotia Sept 2010

<table>
<tr><td>#12</td><td colspan="2">Building Collaborative Interprofessional Capacity within Long Term Care or Bridges to Care Project</td></tr>
<tr><th colspan="2">Contacts</th><th>LHIN</th></tr>
<tr><td colspan="2">Sally Munroe sallymunroe@maxvillemanor.ca
Sue MacDonald suemacdonald@maxvillemanor.ca</td><td>Champlain</td></tr>
<tr><th colspan="2">Partners</th><th>Funding</th></tr>
<tr><td colspan="2" rowspan="3">Providence Care and The Centre of Studies in Aging and Health in collaboration with: - Alzheimer Society - Kingston Chapter - Elisabeth Bruyere Research Institute - Lakehead University - Centre for Education and Research in Aging and Health - Provincial Task Group of Promoting Productive Partnerships among Long Term Care Homes, Colleges and Universities in Ontario - Regional Geriatric Program of Ottawa - St. Lawrence College The LTCH participating include: - Maxville Manor - Residence Saint- Louis - Helen Henderson Care Centre - Rideaucrest Home for the Aged - Providence Care - Providence Manor - Pinewood Court -</td><td>Health Force Ontario</td></tr>
<tr><th>Status</th></tr>
<tr><td>currently underway

started 11/01/2009</td></tr>
<tr><th colspan="3">Abstract</th></tr>
<tr><td colspan="3">At Maxville Manor our project has focused on how to use existing knowledge in PIECES and U First to develop a process to have a discussion around BSPDs. We are experimenting with the use of a 3-question template that prompts interaction between care providers. Our primary objective is to find a ways to improve communication between registered and non-registered staff around BPSDs using tools from PIECES and U First.

Quality problems/Background Discussion around BPSDs were done sporadically as major issues came up. Registered staff were not making use of the training with PIECES to engage front line staff. Front line staff trained in U First were not using the training to full advantage in group discussions about BPSDs. Front line staff not feeling validated for the knowledge they had about residents. We are now in process of collecting results from use of new tools.</td></tr>
<tr><th colspan="3">Key Learnings</th></tr>
<tr><td colspan="3">Have education on quality improvement methodologies was very helpful. Have funding to assemble a QI team and define and establish an AIM and complete PDSA cycles was critical. Leadership and peer - group discussions has proven successful in promoting an interprofessional approach to care.</td></tr>
<tr><th colspan="3">Presentations and Papers</th></tr>
<tr><td colspan="3"></td></tr>
</table>

#13	*Proxemics Plus +*
Contacts	**LHIN**
Gail Grant ggrant@prhc.on.ca Margaret Schell mschell@prhc.on.ca	Central East
Partners	**Funding**
LTC homes x 8 Community Agencies x 3	Project monies were found out of the PRC and Geriatric Mental Health Outreach Program budget, One staff (PRC) worked on the project while doing regular duties, one staff was hired for the six month project to support the project out of staffing dollars freed up due to staff changeover. **Status** recently completed 10/01/2007 03/01/2008

Abstract

The goal of worker safety, confidence and competence in using verbal and physical interventions when aggressive responsive behaviours occurred resulted in the development of a pilot training project : Proxemics Plus +. The program was developed by PASE. A number of workshops involving 249 participants were held over a three-month period in the PASE catchments areas of Peterborough, Northumberland, Haliburton and City Of Kawartha Lakes counties within the province of Ontario. Eight long-term care homes and agencies participated in having their staff attend the training, totaling 114 from the community and 135 from long-term care.

The staff groups were asked to record their perceptions of increases to their knowledge and confidence after attending the workshop. In addition, participants were asked to comment on what they would do differently as planned future practice changes. Pre and post-test questions were asked of those participants to determine prior knowledge and learning, and to demonstrate knowledge transfer of key concepts presented during training. Data collected included the perceptions of participants of the frequency of occurrence of responsive behaviours by type, and by work setting. Previous training in dementia and responsive behaviours was identified by participants and utilized in the evaluations. Community participants were primarily Personal Support Workers (PSW's) and home care aides, with just a small number of registered staff present. Long-term care home participants were just over 50% PSW's with a larger percentage of registered staff, and a few representatives of other departments including: administration, activity workers, and support staff. Data collected included participants' measures of occurrence of responsive behaviours by type and by work setting, and identification of any related training previously attended by participants.

PASE pilot project Proxemics Plus+ goals for the participants were that staff would: •Gain confidence through a better understanding of aggressive responsive behaviours. •Learn strategies to prevent or minimize the emergence of these behaviours. • Develop skills in personal safety through self-protection techniques. •Identify some debriefing strategies to use after an incident. •Gain confidence through a better understanding of aggressive responsive behaviours.

#13	*Proxemics Plus +*

The goals of the pilot project Proxemics Plus + were met. Participants reported new learning and appreciation for the materials and techniques they learned and practiced.

A. Participants were asked to indicate if they had been exposed to one or more responsive behaviours in the 7 days prior to attending the workshop. Only 17% of community participants reported experiencing responsive behaviours, as compared to 83.5% of long term care home staff.

B. Participants were asked if they had attended previous related training. 31% of community staff and 60% of long-term care staff had attended programs such as P.I.E.C.E.S, Non-Violent Crisis Intervention (NVCI), U-First, or Gentle Persuasive Approaches (GPA). The responses to the questions regarding perceived increases in knowledge and in confidence as a result of the attending the workshop were analyzed for those participants, and confirmed that those participants also experienced new learning and increased confidence.)

C. Having some representation from professional and managerial staff was found to be very helpful when policy questions arose, and was important as a demonstration of administration's support of staff and buy- in of the concepts taught.

D. 63% of community participants and 64% of long-term care staff reported that they would provide care differently based on their new learning in the following areas: 1.Use of some or all of the physical self-protection techniques. 2. Increased awareness of the participants' own proxemics and approach. 3. More knowledge of the resident and the residents needs.

Some of the findings came from the experience of the Proxemics Plus + leaders and from surveying the staff through the pre- and post-test questionnaires and included the following data:
The need for organized policies and procedures to guide the staff involved, and around them, in how to response when an incident occurs, The need to improve our ability to support staff and learn through the use of debriefing after an episode of responsive behaviour. The majority of participants reported increased knowledge and confidence in the way they plan their care. Participants reported that they will better anticipate and more safely work with residents who have aggressive responsive behaviours. The participants' identified that their confidence in care giving would also be increased.

Key Learnings

We found the course more applicable for staff in LTC homes than in community - main reasons that in the community the behaviours are not as frequent and part of the PSW's daily interactions.
Community people were thought to have fewer reactive behaviours due to the "home environment" which supported the person with cognitive issues better than in LTC. More study on this is required.
We would like to share the course with other PRCs... There is a demand for self protection techniques and this type of work is important. We hear that people use the information they gleaned from the sessions. We have been told by staff that they are fearful of being injured while helping the person with cognitive impairment. These interventions have been found to improve thier confidence in working with these individuals.

Presentations and Papers

Proxemics Plus+: A Pilot Training Initiative to Enhance Staff Confidence and Competence in Managing Aggressive Responsive Behaviours. Long Term Care, Volume 18, Number 4 December 2008
ENHANCING CARE WORKERS CONFIDENCE AND COMPTETENCE IN WORKING WITH CLIENTS EXHIBITING AGGRESSIVE BEHAVIOURS, Presentation to Ontario Gerontology Association May 30th ,2008 Annual Conference, Toronto by Margaret Schell and Marian Swiebert, PASE Proxemics Plus+ , Personal Support Network Ontario (PSNO) Annual Conference, October 20 2008 and October 19th 2009, Toronto, Margaret Schell

#14	*Sheridan Villa - Special Behaviour Support Unit (SBSU)*

Contacts	**LHIN**
Darlene Pidzamecky, Project Specialist, SBSU905-791-8668, x.2967 or darlene.pidzamecky@peelregion.ca Inga Mazuryk - Administrator, Sheridan Villa 905-791-8668, x.2906 or inga.mazuryk@peelregion.ca	Mississauga Halton
Partners	**Funding**
Sheridan Villa LTCH Credit Valley Hospital Trillium Health Centre (Seniors Mental Health Services and Psychogeriatric Outreach Team) Halton Health Centre MH CCAC St. Josephs Health Care (Halton Geriatric Mental Health Outreach) Peel Halton Acquired Brain Injury Service (PHABIS) Nurse Practitioner	SBSU receives base funding from the MOHLTC as a long term care home, client fees for accommodation, Aging at Home funding (LHIN 2010/2011),and shared resources in partnership with community agencies. **Status** currently underway 11/01/2009 08/01/2010

Abstract

LTC home setting after their behaviours have been successfully managed or the disease has progressed to a stage where they can be managed in a normalized long term care setting. A SBSU Steering Committee comprised of intersectorial stakeholders provided the data to confirm the need for this unit, proposed the unit model, identified the target group, linkages and partnerships, established a decision matrix to guide eligibility determination and will develop an evaluation plan to assess the effectiveness of the unit. The Steering Committee will continue to be involved in the development of the unit.

Access to the SBSU will be coordinated through the Mississauga Halton Community Care Access Centre (MH CCAC) who will determine LTCH eligibility and maintain a waitlist. CCAC case managers in partnership with community health service providers and partners will use evidence based psychogeriatric tools to determine appropriateness for placement into the SBSU. Working groups will be established to address and prepare for: the proposed staffing model, training requirements, environmental and infrastructure requirements, policies and procedures, communication plan, budget and treatment process etc. An admission/discharge committee will be developed with community partners along with an evaluation framework designed to measure outcomes.

Key Learnings

The SBSU project will: • Develop a centre of excellence for the management of challenging behaviours within the target population • Provide leadership and build capacity among LTC providers by sharing “lessons learned” • Provide the cornerstone for an evidenced based framework and practice for the future

Presentations and Papers

#15	*Services Needed for the Dementia Journey*
Contacts	**LHIN**
Jennifer Ghent-Fuller 519 650 1628, jennifer@alzheimercambridge.on.ca Tricia Stiles 519-823-2550 ext 2206	Waterloo Wellington
Partners	**Funding**
Alzheimer Society Public Education Coordinator (Author) Seniors' Health Clinic, Cambridge Memorial Hospital Geriatrician Case Manager, CCAC Geriatric Clinical Resource Consultant, Trellis Person with a Dementia Former family care partner Psychogeriatric Resource Consultant Geriatric Clinical Nurse Specialist CCAC LTC Director of Care Waterloo Wellington Dementia Network Co-Chair	No funding was used. We met on work time as paid by our various agencies. Alzheimer Society resources were used for production and distribution of the finished product. **Status** Recently Completed

Abstract

A plan for the inclusion of persons with a dementia in the Waterloo Wellington Palliative System was required as part of the work of the System Plan Committee, a subcommittee of the Hospice Palliative Care Network of the Waterloo Wellington LHIN. A Working Group was struck composed of one member of the System Plan Committee who recruited the other members for this project. The Working Group began with a document entitled "The Continuum of Services for People with Alzheimer Disease and Family Caregivers: A Vision" published by the Alzheimer Society for Metropolitan Toronto in April 1994. To the twelve service areas identified in Toronto in 1994, we have added prediagnosis, elder abuse and neglect, crisis recovery and end-of-life care. Following a logic model of analysis as requested, we have established an overall objective, service areas (each with one or more main components), and their accompanying outcome objectives, implementation objectives, potential output measures for evaluation, resources available and current or best practices (if available). We view this service plan for the Dementia Journey as a means to evaluate the care offered to individuals and their families in our area throughout their experience with dementia.

Key Learnings

The breadth and depth of education and support for the person with dementia and their families from before diagnosis until after death. Families who are well supported and educated have been found to maintain their own health better, have been able to keep the person with dementia at home longer, and the person with dementia is less likely to have responsive behaviours when they are suitably psychologically supported.

Presentations and Papers

Presented to the System Plan Committee and the Hospice Palliative Care Network of the Waterloo Wellington LHIN, as well as the Alzheimer Society Chapters.

<table>
<tr><td>#16</td><td colspan="2">Crisis Outreach Service For Seniors</td></tr>
<tr><td colspan="2">Contacts</td><td>LHIN</td></tr>
<tr><td colspan="2">Laura Pearson 416-645-6000 ext 1366
Rima Zavys 416-645-6000 ext 1165</td><td>Toronto Central</td></tr>
<tr><td colspan="2">Partners</td><td>Funding</td></tr>
<tr><td colspan="2" rowspan="3">COPA (Community Outreach Programs for Addictions) Streethealth WoodGreen Community Services Good Neighbour's Club South Riverdale CHC</td><td>Phase 2 Aging at Home</td></tr>
<tr><td>Status</td></tr>
<tr><td>Currently underway
7/1/2009-present</td></tr>
<tr><td colspan="3">Abstract</td></tr>
<tr><td colspan="3">The Crisis Outreach Service for Seniors (COSS) is a 7 day a week mobile crisis intervention and outreach service focused on seniors who have a mental illness and or addiction. The population served will include frail, marginalized and at risk seniors many of whom are homeless or underhoused, living in poverty and or are new immigrants. Referrals can be made by clients, family members or friends or by health care providers. The services are delivered by multi disciplinary outreach teams which will provide comprehensive care in the community as well as in client's homes, supportive housing sites, drop-in and community centres. Outreach will focus on individual clients who have been identified to them as well as providing specific outreach in high priority neighbourhoods, targeting clients who are hard to serve and hard to reach. The teams will: 1. Assess clients' need and develop and implement a care plan with short and long term goals 2. Provide specialized psychogeriatric crisis support/client stabilization 3. Provide addiction and harm reduction interventions 4. Provide intensive short term case management 5. Provide Nursing and community supports as needed The team has served over 350 older adults in the community. The team has linked clients to appropriate community services and decreased inappropriate use of Emergency Departments and 911 calls by ensuring other resources are in place to support the client.</td></tr>
<tr><td colspan="3">Key Learnings</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Presentations and Papers</td></tr>
<tr><td colspan="3"></td></tr>
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<table>
<tr><td>#17</td><td colspan="2">Gentle Persuasive Approaches in Dementia Care</td></tr>
<tr><td colspan="2">Contacts</td><td>LHIN</td></tr>
<tr><td colspan="2">Barbara McCoy bmccoy@alzheimerhamiltonhalton.org
Paula Di Loreto diloretop@hhsc.ca</td><td>Hamilton Niagara Haldimand Brant</td></tr>
<tr><td colspan="2">Partners</td><td>Funding</td></tr>
<tr><td colspan="2" rowspan="3">Alzheimer Societies: South Central area Regional Geriatric Program Central Hamilton Health Sciences</td><td>Seed funding by Regional Geriatric Program Central. Now self sustaining and funding other local Gerontological education initiatives</td></tr>
<tr><td>Status</td></tr>
<tr><td>Currently underway
Started Sept 2005</td></tr>
<tr><td colspan="3">Abstract</td></tr>
<tr><td colspan="3">The GPA curriculum was developed as a result of the recognition that all practitioners need to learn compassionate and effective ways to help persons with dementia when they are upset and frustrated. For example, in some instances a staff person might be left feeling quite helpless, vulnerable and ineffective when they don't know exactly what to do if two residents with dementia are involved in an altercation. This curriculum has been developed to help formal caregivers intervene in a manner that is non punitive, respectful and self protective. Goal: To use a person-centred, compassionate and gentle persuasive approach, respond respectfully and with confidence and skill to responsive behaviours of a more escalated nature associated with dementia. Evaluation Methods: Mixed Methods Approach Quantitative Measure: Demographic, Satisfaction with curriculum, Self perceived Competency Attitudes & Values Qualitative Measures: Focus Groups with participants, Semi-Structured interviews with key informants, Open-ended tools with participants and Master Trainers) Evaluation Results Demographics: 205 participants, majority (51%) PSW's, also nursing, recreation, housekeeping, pastoral care & administration. Most were women, 54% had worked in LTC for more than 10 years. 48% stated they had previous training in responding to behaviours. Satisfaction with Curriculum: 5 point Likert scale. good length (Mean =4.23), materials clear & well organized(Mean=4.67), materials easy to understand (Mean = 4.63), appropriate exercises (Mean = 4.65), small class size (Mean= 4.67), facilitator's knowledge and preparation (Mean = 4.65), application in the workplace (Mean = 4.50) Immediate Impact: Statistical significant increase in self-perceived competency in all but one instance, felt significantly more competent to identify triggers of responsive behaviours, in their ability to communicate effectively, to identify appropriate and respectful responses to behaviour, in knowing how to de-escalate a situation and respond appropriately after a situation. Continuous evaluation of the workshops continue with consistent evaluation results similar to above.</td></tr>
<tr><td colspan="3">Key Learnings</td></tr>
<tr><td colspan="3">Evidence based Practice in Dementia Education in LTC is essential. Support of administrative staff to allow their staff to keep current in Dementia practice is essential. Aministrative staff need to support their PRP's in being identified as a "go to" person for assistance in dementia care strategies. Having a point person trained in LTC, if supported by administration for time to assist others, is key to knowledge uptake and transfer. Recognizing education and continuous support is essential to support the staff in the delivery of quality services to our older population with dementia</td></tr>
</table>

#17	*Gentle Persuasive Approaches in Dementia Care*
Presentations and Papers	
3rd party evaluation of the GPA program: The Gerontologist. Vol 4.No4, 570-576: Mobving Forward: Evaluating a Curriculum for Managing Responsive Behaviours in a Geriatric Psychiatry Inpatient Population; Spezialoe, Black et al. Conculsion demonstrated a reduction in aggressive behaviour on the Geriatric Psychiatry unit Links: www.rgpc.ca Click on GPA	

#18	*LTC Nursing Outreach Project*

Contacts	**LHIN**
Hellen Jarman St. Mary's General Hospital 519-749-6578 ext. 1132 Sandra Hett- Chief Nursing Officer St. Mary's General Hospital 519-149-6578 ext. 1905	Waterloo Wellington
Partners	**Funding**
St. Mary's General Hospital Grand River Hospital Cambridge Memorial Hospital Guelph General Hospital All LTC homes in the Waterloo Wellington LHIN Waterloo Wellington CCAC	This project is funded through the Aging at Home Initiative. **Status** Currently underway 06/01/2009 - 06/01/2011

Abstract

The Nurse Led Outreach programs goals are to: decrease transfers from LTC facilities to local Emergency Departments and to decrease length of stay of LTC residents in hospital by 20%. The strategies include: data collection, promoting community programs, educational programming support, collaboration with stakeholders, enhancing utilization of LTC expertise and partnering with acute care hospitals to facilitate LTC admission. IV therapy access for LTC facilities has been implemented. We are currently exploring a fast track radiology program for LTC residents. Clinical consultation and collaboration with care partners is ongoing and available at the request of LTC facilities to assist with Emergency Department diversion and timely return to the LTC facility after admission to hospital. Data regarding ER transfers and admission to hospital is collected from LTC facilities monthly and reported on quarterly. Evaluation of this program is pending.

Key Learnings

Presentations and Papers

<table>
<tr><td>#19</td><td colspan="2">Emergency Department geriatric Mental Health Program</td></tr>
<tr><th colspan="2">Contacts</th><th>LHIN</th></tr>
<tr><td colspan="2"></td><td>Toronto Central</td></tr>
<tr><th colspan="2">Partners</th><th>Funding</th></tr>
<tr><td colspan="2" rowspan="3">TC-LHIN, Mt Sinai Hospital St. Michael's Hospital UHN Sunnybrook Health Sciences Center St. Joseph Health Center, Toronto Toronto East General Hospital, TC-CCAC</td><td>TC-LHIN</td></tr>
<tr><th>Status</th></tr>
<tr><td>Currently underway
08/01/2008- 12/01/2010</td></tr>
</table>

Abstract

The SMHAS Project was a multi-phase project initiated by the Ministry of Health and Long-term Care (MOHLTC), Toronto Office in response to the Casa Verde Coroner Inquest Report in 2006. This is the third phase of the project funded by the TC-LHIN. To continue the success of previous phases that include the development of the Long-term Care Mental Health (LTC-MH) Framework and the implementation of the Framework to Long Term Care Homes (LTCHs), this phase of the project focused on the implementation of the LTC-MH Framework to the hospital sector, mainly the Emergency Department (ED) and the Specialty Hospital.

The Project was mandated with three initiatives with specific targets: 1.To develop and pilot ED geriatric mental health tools and education program to two ED pilot sites in the TC-LHIN; 2.To develop and pilot a centralized access process for Specialty Hospital geriatric MH&A beds; 3.To support LTCHs within TC-LHIN to further collaborate with key partners and sustain the LTC-MH framework implementation efforts.

An intersectoral Executive Committee was formed to provide guidance on strategic planning, execution decisions and performance accountability. Seven various Work Groups and Teams were formed with over eighty highly committed and knowledge individuals involved working diligently to deliver results.

All three initiatives achieved their goals and targets with good results within the project timelines.

Deliverables

1.Development of an Emergency Department Geriatric Mental Health (ED-GMH) Program that is composed of:

a. A geriatric mental health (GMH) protocol to guide ED medical and professional staff to apply newly introduced standardized assessment tools following a newly defined process in managing seniors with mental health and addiction (MH&SA) issues presenting to the ED.

b. An online e-Learning modular GMH Education Program with voice over- a 2-hour professional staff version, and a 20-minute physician version

c. Culturally sensitive elements and their practical applications to a clinical setting for a diverse population woven into the ED-GMH Protocol and Education Program.

2. Pilot of the ED-GMH Program at two ED sites. The ED-GMH Education Program was completed by over seventy-five percent (75%) of ED staff (about 140 medical and professional staff). Both pilot sites have started to use the ED-GMH protocol with enthusiasm.

#19	*Emergency Department geriatric Mental Health Program*

3.Development of the Centralized Access to Specialty Hospital Beds System (CASS) using a newly designed single, common intake and referral form and process coordinated by a centralized office to access specialized geriatric MH beds at CAMH, TRI and Baycrest.
4. Pilot of the CASS for over two months processed 28 cases through the CIR Office with successful coordinated admission of 40% of cases to date. In addition, good relationships and collaborations were built between the three specialty hospitals and the CIRO.
5. Enhancement of collaboration between LTCHs in TC-LHIN and Key Partners that lead to a detailed action plan; several action items have already begun to produce results.
6. Comprehensive evaluation measures of processes and outcomes for all three initiatives.

Evaluation 1. ED Tools and Education Initiative:

- Over 75% of ED medical and professional staff of both pilot sites completed the e-Learning ED-GMH Education Program, and among those who responded to an evaluation survey, 85% expressed overall satisfaction to the ED-GMH Education Program in terms of the program's content, clarity and practical usefulness.
- The preliminary survey of impact of the ED-GMH Program post implementation revealed increased ability and confidence of ED staff in identifying MH&A issues of seniors and applying their knowledge to manage these problems. The long-term performance outcome remains to be evaluated in a few months.

Key Learnings

Presentations and Papers

#20	*Seniors' Mental Health Integrated Service SMHIS*
Contacts	**LHIN**
Natalie Bellehumeur Regional Outreach Manager, Northeast Mental Health Centre, Seniors' Mental Health Program - Regional Consultation Service nbellehumeur@nemhc.on.ca (705) 494-3062 Dr. Grant McKercher, Medical Director - Northeast Mental Health Centre - Seniors' Mental Health Program gmckercher@nemhc.on.ca (705) 494-3054	North East
Partners	**Funding**
North Bay General Hospital - Mental Health & Addictions Care Centre Northeast Mental Health Centre - Seniors' Mental Health Program - Regional Consultation Service	Funded via Health Accord (Nursing Component) NEMHC (Physician component)
	Status
	Currently Underway 07/01/2009- ongoing

Abstract

The Seniors' Mental Health Integrated Service (SMHIS) is a new service provided by the Addiction & Mental Health Care Centre of the North Bay General Hospital with the clinical support and leadership of the Northeast Mental Health Centre- Seniors' Mental Health Program - Regional Consultation Service. Its main focus is to assist seniors with age-related mental health problems/illness and support health care staff in care planning. This service includes assessment by a Seniors' Mental Health Nurse Clinician and Geriatric Psychiatrist or Physician specializing in care of the elderly. Individuals exhibiting any of a broad range of emotional, cognitive or behavioural symptoms can be referred. The target population is seniors (usually over the age of 65 or younger persons who have an age-related illness) whose problems meet one or more of the following criteria: Medical illness (including confusional state) complicated by mental health problems (e.g. individuals with neurological disorder and Depression) Severe Mental Illness with age-related complications (e.g. individual with mood disorder and cognitive problems) Comorbid problems associated with late-onset cognitive disorders(e.g. behavioural disturbance, psychosis, Depression). Severe late-onset mental illness (e.g. an 85 year old person who develops Depression or psychosis) The Seniors' Mental Health Nurse Clincians (1.6 FTE) are engaged in consultative, educative and liaison processes in order to share specialized knowledge with members of the healthcare team, and to enhance effective and efficient interventions for patients with mental health problems. To refer to the Seniors' Mental Health Integrated Service Team The patient will have been evaluated by the most responsible physician (MRP) or their designate, and the treatment team. Their assessment will conclude the patient requires further specialty consultation by the Seniors' Mental Health Integrated Service (SMHIS) Team. An order written by the MRP or designate, must be written on the patient chart, and a Request for Consultation form is completed and ordered-entered through the meditech system. These referrals are received (Monday-Friday, except holidays) by the SMHIS Nurse Clinicians. The Nurse Clinicians respond within 48 hours by contacting the in-patient unit to clarify the nature of the referral. The SMHIS nursing assessment of the patient at the hospital is

#20	*Seniors' Mental Health Integrated Service SMHIS*

provided based on demand and nurses' availability. Following the initial assessment, a Medical/Psychiatric consultation is arranged within half/day week clinical block.

SMHIS Demographic Stats from April 2009-March 2010
Number of Referrals to Program - 72 referrals
Patients admitted to SMHIS - 66 patients (50% male and 50% female)
Age of patients - less 65 yrs = 2 (3%) 65-74 yrs = 19 (29%) 75-84 yrs = 26 (39%) 85 yrs + = 19 (29%)
Reasons for Referrals: Assessment of Cognition = 22% ,Assessment of Delirium = 19%, Assessment of behaviours = 43% Assessment of Mood = 11% Other (e.g. safe to go home?) = 5%

Key Learnings

Even in collaborative initiatives, it is important to clearly define the roles and lines of communication of individual services/personnel

Presentations and Papers

GiiC Workshop - North Bay May 12, 2010

#21	*Hamilton Brant Behaviour Services*
Contacts	**LHIN**
Keith Anderson, Manager 905 574 5151 ext 231 or 519 753 4174 ext 246 or kanderson@hbbs.ca	Hamilton Niagara Haldimand Brant
Partners	**Funding**
Our home sponsoring agency is the Family Counseling Centre of Brant	April 1, 2007 - ongoing Annualized funding from MCSS - Hamilton Regional Office We have sites in Brantford and Hamilton
	Status
	My project is in the implementation phase (currently underway).

Abstract

Hamilton Brant Behaviour Services was formed in April, 2007. Our mandate is to provide behaviour consultation services to individuals with a developmental disabilities residing in the Brantford-Hamilton Region. We receive referrals through the local single-access agency CONTACT, where a confirmation of eligibility is determined. In Brantford we accept referrals from all age groups (children, youth, adults), whereas in Hamilton we are strictly an adult (18ys+) service provider. Clinical supervision is provided by a registered Psychologist and manager (MSW). We provide behaviour services to individuals, families, and community agencies, spanning several sectors as necessary (Education, Mental Health, Justice, Health and Long Term Care). We use an intradisciplinary approach, incorporating wholistic and diverse best practices (positive applied behaviour principles, cognitive behaviour therapy, dialectical behaviour therapy, mediation etc.). We also offer a variety of groups and training opportunities for staff, community and care providers. We are actively involved in supporting people with a developmental disability and behaviour challenges related to aging, whether that be with their family, in their home or in a retirement/long term care setting. We assist in developing transition plans and provide support and training to staff. We are actively involved in local committees (OPADD, Dementia Network) and have acquired specialized training in PIECES, U-FIRST, GENTLE PERSUASION APPROACH, numerous AKE training events. We collaborate in training and consultation with local agencies, Alzheimer Society, CCAC.

Key Learnings

Collaboration, respect and flexibility are essential for creating the best outcomes for people. Through adversity and necessity people create workable solutions. Increased coordination between Ministries and sectors is required. Mutual transfer of resources, knowledge and experiences need further improvement. Opportunities for co-location, job shadowing, secondments are beneficial.

Presentations and Papers