The Integration of Stroke Best Practices into LTC Resident Care Planning

Gayle Campbell
Administrator
Seven Oaks

Theo Lancee
Director of Care
Carefree Lodge

Leona Bryan
Nurse Manager
Seven Oaks

Gwen Brown
Regional Community & LTC Coordinator
SEO Stroke Network

All images Microsoft Office Clipart 2003
DISCLOSURE

"In the last two years, we have not had a financial interest, arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation."
AGENDA

- Background
- Pilot Project Description
- Implementation – Two Case Studies
- Evaluation Findings
- Next Steps
22% of residents in LTC age 65 or older have had a stroke (Heart and Stroke Foundation of Ontario, 2000) and stroke is the third most common diagnosis in long-term care (Price Waterhouse Cooper 2001).
ADDING IT UP

RAI MDS
+ Tips and Tools for Everyday Living™

= Best Practice Stroke Care Plans
THE RAI MDS

- RAI – Resident Assessment Instrument
- MDS – Minimum Data Set
Focus is more on what the resident can do with the right support. It focuses on resident’s strength, abilities and preferences. It recognizes the additional elements of care that can improve the resident’s quality of life and enables measurement of all care activities as often as an assessment is undertaken.
TIPS AND TOOLS FOR EVERYDAY LIVING – A GUIDE FOR CAREGIVERS

- Heart & Stroke Foundation of Ontario
- Health professionals
- Best practice stroke care at the bedside
Objective
Support best practice stroke care through the integration of the *Tips and Tools for Everyday Living* resource into LTC care plan libraries. Link RAI-MDS assessment findings with relevant stroke care plans.
THE STEPS

Phase 1
- Steering Committee and Working Groups

Phase 2
- Working groups translate the Tips and Tools for Everyday Living modules into care plans

Phase 3
- Input care plans into care plan libraries of participating Homes and implement at frontline.

Phase 4
- Evaluation & dissemination

Phase 5
- Translation of care plan interventions into ‘job aids’
THE MODULES

- Communication
- Pain
- Cognition
- Perception
- Depression
- Behaviour
- Mobility, positioning, transfers
- Bowel and bladder control
- Hydration, meal assistance & special diets
- Activities of daily living
- Skin care & hygiene
- Leisure

(stroke, interprofessional team, caregiver stress)
CARE PLAN GUIDELINES

Language must be clear, simple and action-oriented - no vague words/phrases that allow for interpretation (e.g. encourage, emotional support)

FIVE STANDARD CARE PLAN COMPONENTS

Focus
- Use PESS (problem, etiology, signs, symptoms) methodology.

Goal
- SMART format (Specific, Attainable, Realistic/Relevant, Measurable, Time-framed), written from the resident’s perspective (i.e. what resident will do, look like, accomplish, etc.) and reflect the RAI-MDS Outcome Scales.
CARE PLAN GUIDELINES

Interventions
○ Restorative, interdisciplinary approach. The number of interventions should optimally range from 5 to 10 per goal.

Accountability
○ Specific team members must be identified for each intervention which may include resident or SDM.

Timelines
○ Timelines should not automatically coincide with reassessments (i.e. q3months). Timelines are to be related to resident’s goal or goal assessment.
PILOT PROJECT

- Four Ontario Homes:
  - Carefree Lodge (Willowdale)
  - Fairhaven (Peterborough)
  - Pine Meadow (Northbrook)
  - Seven Oaks (Scarborough)

- Staggered entry into pilot
- Time frame ≈ 6 months
TELLING THE STORY

- Carefree Lodge
- Seven Oaks
**Objective**

- To evaluate the impact of the Tips and Tools care plan templates on the integration of Stroke Best Practices into LTC resident care planning in the following domains:
  - awareness
  - accessibility
  - effectiveness
- Pre- and post-surveys
- On-line versus hard copy
**EVALUATION**

- An increase in the number of respondents accessing *Tips and Tools for Everyday Living* as a best practice stroke resource in the post- as compared to the pre-survey.

- 95.8% of post survey respondents indicated that stroke care plans enhanced their ability to care for stroke residents to varying degrees.

- Care plans identified as being more useful were transfers and mobility, perception, cognition, pain and communication.
EVALUATION

- Care plans identified as being less useful due to more detailed and/or similar existing care plans were continence, bowel and bladder, skin care.

- 73% of respondents to the post pilot survey combined the content of the Stroke Care Plans with other existing care plans.

- An increase in the development of strategies to facilitate stroke-related education such as a stroke best practice resource team/champions, collaboration with Stroke Networks, procurement of further stroke resources and additional stroke-related tools.
DISCUSSION

- Evaluation results show an enhanced awareness and increased uptake of best practice stroke care in the 4 pilot LTC Homes using the stroke care plans.

- As care plans are triggered by resident care needs, not by diagnosis, it is more difficult to access stroke only information.

- The inability to target the same pre and post pilot respondents made gathering data more difficult.
DISCUSSION

- Survey respondents indicate that there would be benefit to creating job aids such as pocket cards and pictorial aids targeting auxiliary staff (housekeeping, nutrition).

- Stroke-related webinars for use in Long Term Care settings would be a valuable learning strategy.

- Future exploration into the possibility of integrating stroke care plans into the current software platforms is recommended.
DISSEMINATION

Beyond project partners
- Ontario Long Term Care Association
- Health Quality Ontario
- Ontario Association Non-Profit Homes & Services for Seniors
- Long Term Care Expert Panel
- Ministry of Health & Long-Term Care
- Registered Nurses’ Association of Ontario Best Practice Champions
- Heart & Stroke Foundation of Ontario
- Community & Long Term Care Specialists/Coordinators (Ontario Stroke Network)
- Stroke Collaborative 2011/2012
- Canadian Stroke Congress 2012
- LTC Magazine
CONTACTS

- Theo Lancee
tlancee@toronto.ca
416-397-1521
- Gayle Campbell
gcambe@toronto.ca
416-392-3502
- Leona Bryan
lbryan@toronto.ca
416-392-3546
- Gwen Brown
browng2@kgh.kari.net
613-549-6666 X 6867
## CONTRIBUTORS

### LTC Home Representatives

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrea DeNeire</td>
<td>RAI MDS Coordinator</td>
<td>Terrace Lodge, Aylmer, ON</td>
</tr>
<tr>
<td>Phillippa Welch</td>
<td>LTC Consultant</td>
<td>Woods Park, Barrie, ON</td>
</tr>
<tr>
<td>Natalie Cameron</td>
<td>Registered Nurse</td>
<td>St. Joseph’s Villa, Dundas, ON</td>
</tr>
<tr>
<td>Sylvia Masters</td>
<td>RAI Coordinator</td>
<td>Leisureworld, Brampton, ON</td>
</tr>
<tr>
<td>Erin Cunningham</td>
<td>Administrator</td>
<td>Muskoka Landing, Huntsville, ON</td>
</tr>
<tr>
<td>Alice Jyu</td>
<td>Patient Care Manager</td>
<td>Veterans Centre, Toronto, ON</td>
</tr>
<tr>
<td>Cecilia Yeung</td>
<td>APN</td>
<td>Veterans Centre, Toronto, ON</td>
</tr>
<tr>
<td>Razane Diab</td>
<td>Acting DON</td>
<td>Cedarvale Terrace, Toronto, ON</td>
</tr>
</tbody>
</table>

### LTC Home Representatives

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denyse Duke</td>
<td>Director of Care, LTC</td>
<td>Residence St. Louis, Ottawa, ON</td>
</tr>
<tr>
<td>Manon Simard</td>
<td>RAI Coordinator</td>
<td>Residence St. Louis, Ottawa, ON</td>
</tr>
<tr>
<td>Darlene Lawlor</td>
<td>RAO MDS Coordinator</td>
<td>Perth Community Care Centre, Perth, ON</td>
</tr>
<tr>
<td>Jackie Maxwell</td>
<td>DOC</td>
<td>Village Green, Selby, ON</td>
</tr>
<tr>
<td>Pam Brown</td>
<td>Corporate RAI-MDS Coordinator</td>
<td>Extendicare (Canada) Inc. Eastern Operations</td>
</tr>
<tr>
<td>Wendy Campbell</td>
<td>Assistant Administrator</td>
<td>Stayner Nursing Home</td>
</tr>
<tr>
<td>Marsha Nicolson</td>
<td>City of Toronto Resident Care Director, LTC Homes and Services</td>
<td></td>
</tr>
<tr>
<td>Theresa Savard-Maki</td>
<td>RAI Coordinator</td>
<td>Bethammi Nursing Home, Thunder Bay, ON</td>
</tr>
</tbody>
</table>

### MOHLTC

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandra Schmidt</td>
<td>Project Lead</td>
<td>Implementation and Support</td>
</tr>
<tr>
<td>Soo Ching Kikuta</td>
<td>LTCHCAO Program Manager</td>
<td></td>
</tr>
</tbody>
</table>

### OSN Community & LTC Coordinators/Specialists

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Gilmore</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vicky Smith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donna Cheung</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharon Trottman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alda Tee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jessica Comay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gwen Brown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pauline Bodnar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sue Verrilli</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jocelyne McKellar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Morris</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
QUESTIONS