RAI-MDS & TIPS & TOOLS
Connecting to Best Practices in LTC

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All images Microsoft Office Clipart 2003
"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
- Project Description
- Care Plans
- Implementation
- Evaluation
- Dissemination
RAI–MDS

Due to its holistic design, it provides a framework for care providers to complete a comprehensive assessment of resident care needs in a number of areas, including psychosocial status, communication, activity levels, cognition and physical condition (Rantz et al, 1999)
WHAT

- RAI – Resident Assessment Instrument
- MDS – Minimum Data Set
WHERE

- RAI–MDS 2.0 has been implemented in more than 30 countries including the United States, UK, Germany, Italy, France, Japan and Australia as well as several provinces and territories in Canada.
- In Ontario – June 2005
ROLL OUT

- 2005 – small sample of Homes (first two phases involved 10 Homes each)
- 8 phases of implementation with increasing expansions in each Phase and application of lessons learned
- All Homes to have implemented by September 2010
- Every Home had to have a RAI Coordinator who was a Regulated Health Professional (typically an RN or RPN)
STAGED IMPLEMENTATION IN EACH HOME

- Home prep
- Coding
- Data submission
- RAI outputs & reports and data quality management
- RAPS and Care Planning
- 100% data submission to CIHI
WHO

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.
WHEN

- On admission
- Quarterly
- Annually
- Significant Change in Status
- Significant Change – Can be with deterioration and with improvement of status (resident improves and required fewer supports)
Assessment a standardized process
Assessment triggers RAPs
RAPS trigger care planning
Embedded scales (Depression, ADL, CHESS, Social Engagement, Cognitive Performance, Pain, Pressure Ulcer and Aggressive Behaviour)
Quality Indicators (36)
Data sent and reports received from CIHI (Canadian Institute of Health Information)
Over 400 Indicators in MDS tool
Fewer Strokes. Better Outcomes.

- Stroke is the third leading cause of death and long term disability in Canada – each year more than 50,000 Canadians experience a stroke and over 14,000 Canadians die as a result. There are about 300,000 Canadians living with the effects of stroke. Of those, 25% recover with a minor impairment and 40% are left with a moderate to severe disability (Heart and Stroke Foundation of Ontario 2010).

- 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).
The Regional Community and Long Term Care Coordinators/Specialists of the Ontario Stroke Network (OSN) work closely with LTC stakeholders to increase awareness and facilitate the uptake of stroke care best practices. *Tips and Tools for Everyday Living* is a best practice resource available to assist providers to care for those living with stroke.
TIPS AND TOOLS FOR EVERYDAY LIVING – A GUIDE FOR CAREGIVERS

- Heart & Stroke Foundation of Ontario
- Health professionals
- Best practice stroke care at the bedside
THE SEED

- Project Implementation Lead previous DOC at Laurier Home in Ottawa
- Translation of Tips & Tool content into care plan format
- Partnered with the Ottawa Stroke Network
- Working group that included a resident, family member and care team
- Gap analysis
- Stroke Network provided education in support of the initiative to the residents, families and care teams.
- Care plans initially paper-based
RAI MDS and TIPS & TOOLS
Connecting to Best Practices in LTC

- Community & LTC Regional Stroke Coordinators
- Project Implementation Lead – LCAP
- LTC Home Representatives
**LTC HOME REPRESENTATIVES**

- Corporate and municipal Homes
- Rural and urban Homes
- Differing software systems
- ‘Niche’ Homes (i.e. Homes that have identified stroke as a particular focus and/or have a specific interest in best practice stroke care).
Objective
Integrate the Tips and Tools for Everyday Living resource into LTC care plan libraries. As a result, the RAI–MDS assessment findings would then link with relevant care plan(s) for stroke survivors.
OTHER CONSIDERATIONS

- RAI–MDS includes 450 data items and 18 RAPs which complement the Tips & Tools methodology.
- Care plan may be triggered either by a data item or by a RAP.
- Care plans developed in project must be both usable and modifiable so that they can be adapted to the software format of individual Homes or corporations (e.g. word documents that support ‘cut and paste’).
ANITICIPATED BENEFITS

Supporting compliance with:

- Best practice and research-based standards of accreditation organizations (e.g. Accreditation Canada and Commission on Accreditation of Rehabilitation Facilities [CARF])
- The July 2010 LTC Act (including an integrated care planning approach); and
- MOHLTC Inspector expectations
THE STEPS

Phase 1
- Steering Committee and Working Groups

Phase 2
- Working groups translate the Tips and Tools for Everyday Living resource information into a care planning format.

Phase 3
-Translation of care plan interventions into ‘job aids’

Phase 4
- Input care plans into care plan libraries of participating Homes.

Phase 5
- Evaluation & support for sustainability
Integration of Stroke Best Practices into Long Term Care Resident Care Planning – The Timeline

- Template Designed
- Working Group Progress Checkpoint
- Job Aid Template
- Review of Care Plans
- Review of Job Aids
- Debrief with Working Groups

- June 2011
- July 2011
- August 2011
- September 2011
- October 2011

Evaluation of Initiative and Tools Developed
THE MATH

- Thirteen Tips & Tools modules
- Four Working Groups
- One Steering Committee
- Four months
THE PROCESS

- Teleconferences
- Working Groups
  - draft care plans
  - LTC & OSN reps
- Steering Committee
  - review care plans
  - FAQs
  - implementation
  - dissemination
  - LTC & OSN reps and Project Implementation Lead, LCAP
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.
# CARE PLANS – PERCEPTION

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>GOAL(S)</th>
<th>TIMELINES</th>
<th>INTERVENTIONS</th>
<th>ACCOUNTABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visual Neglect</strong></td>
<td>Resident will increase attention to his/her affected side</td>
<td></td>
<td>Arrange the environment to provide stimulation on the stroke-affected side</td>
<td>HCA/PSW/Restorative Care/Therapy Assistants</td>
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<tr>
<td></td>
<td>Resident will decrease the episodes of bumping into objects on his/her affected side</td>
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<td>Approach the resident from the unaffected side then gradually move to the affected side</td>
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<td></td>
<td>Resident will decrease the episodes of his or her arm/hand dangling off the wheelchair or chair armrest</td>
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<td>Instruct and reinforce scanning of the environment using the Lighthouse Strategy (Ask the resident to imagine their eyes as beams of light sweeping from side to side)</td>
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<td></td>
<td>Resident will decrease the episodes of his/her leg/foot dragging off the wheelchair footrest</td>
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<td>Position the affected arm and/or leg so the resident can see it</td>
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<td></td>
<td>Resident will increase independence in finding all food items during meals</td>
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<td>Gently rub the affected arm</td>
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<td></td>
<td>Resident will require less cueing to find necessary objects/items in cupboards/drawers</td>
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<td>Assist resident to position the affected limb correctly</td>
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<td></td>
<td>Resident will need less assistance to find his/her way around Home</td>
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<td>Use cues to draw attention to the affected side</td>
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<td>Keep hallways and rooms well lit and clear of clutter</td>
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<td>Ensure positioning aids are in place</td>
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<td></td>
<td>Instruct family on interventions to increase resident’s attention to neglected side.</td>
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<td></td>
<td>Report to the RN/RPN any improvements or deterioration in participation level.</td>
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- **FOCUS**: Resident ignoring left/right side of body due to stroke as evidenced by bumping into things, missing food on left/right side of meal tray, losing way to room.

- **GOAL(S)**: Increase attention to affected side, decrease episodes of bumping into objects, decrease episodes of arm/hand dangling, decrease episodes of leg/foot dragging, increase independence in finding food items during meals.

- **TIMELINES**: Arrange the environment to provide stimulation on the stroke-affected side, approach the resident from the unaffected side then gradually move to the affected side.

- **INTERVENTIONS**: Instruct and reinforce scanning of the environment using the Lighthouse Strategy, position the affected arm and/or leg so the resident can see it, gently rub the affected arm, assist resident to position the affected limb correctly, use cues to draw attention to the affected side, keep hallways and rooms well lit and clear of clutter, ensure positioning aids are in place, instruct family on interventions to increase resident’s attention to neglected side.

- **ACCOUNTABILITY**: HCA/PSW/Restorative Care/Therapy Assistants, report to the RN/RPN any improvements or deterioration in participation level.
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<td>Apraxia</td>
<td>Impaired perception related to stroke as evidenced by the resident being confused over proper sequence of steps for eating, grooming, etc.</td>
<td>Resident will require decreased cueing when dressing</td>
<td>Use short and simple instructions while performing tasks</td>
<td>HCA/PSW/Restorative Care/Therapy Assistants</td>
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<tr>
<td></td>
<td>Impaired perception related to stroke as evidenced by the resident having difficulty using common objects even though he/she is aware of what the object is (e.g. combs hair with a fork)</td>
<td>Resident will require decreased cueing for grooming</td>
<td>Plan steps of the task with the resident</td>
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<td></td>
<td></td>
<td>Resident will require decreased cueing for eating</td>
<td>Assist in starting the next step</td>
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<td>Break the task into simple steps and reminders for the proper sequencing of task</td>
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<td>Instruct resident to practice activities</td>
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<td>Provide hand-over-hand guidance</td>
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<td>Instruct family on interventions to increase resident's task performance.</td>
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<td>Resident will require decreased cueing for eating</td>
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<td>Break the task into simple steps and reminders for the proper sequencing of task</td>
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<tr>
<td>Perseveration</td>
<td>Resident will be able to engage in appropriate social interaction up to 10, 15, 20 minute duration ____/week.(selection)</td>
<td></td>
<td>Plan steps of the task with the resident</td>
<td>HCA/PSW/Restorative Care/ Therapy Assistants</td>
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<td></td>
<td>Resident will require decreased cueing with self care tasks</td>
<td></td>
<td>Use clear, step-by-step instructions</td>
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<td>Give resident time to practice sequences</td>
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<td>Help resident stop if they get “stuck” repeating a word, phrase or action and by moving on to next step</td>
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<td></td>
<td>Assist in starting the next step of a task</td>
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<td></td>
<td>Provide hand-over-hand guidance</td>
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<td></td>
<td>Instruct family on interventions to decrease resident’s perseveration.</td>
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<td>Report to the RN/RPN any improvements or deterioration in awareness level.</td>
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<tr>
<td><strong>Spatial Relations</strong></td>
<td>Impaired perception related to a stroke as evidenced by misjudging distances, heights, space available (e.g., missing a chair when sitting down, misjudging where an item is when reaching for it)</td>
<td></td>
<td>Use short and simple instructions when assisting with care</td>
<td>HCA/PSW/Restorative Care/ Therapy Assistants</td>
</tr>
<tr>
<td></td>
<td>Resident will require decreased cueing with dressing</td>
<td></td>
<td>Encourage repetition and practice of activities</td>
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<td></td>
<td>Resident will have improved ADL score</td>
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<td>Provide hand-over-hand guidance</td>
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<tr>
<td></td>
<td>Resident will require decreased cueing with grooming</td>
<td></td>
<td>Encourage resident to practice and repeat actions</td>
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</tr>
<tr>
<td></td>
<td>Resident will require decreased cueing with eating</td>
<td></td>
<td>Instruct family on interventions to increase resident’s task performance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resident will require decreased assistance/cueing to obtain all food items during meals</td>
<td></td>
<td>Report to the RN/RPN any improvements or deterioration in awareness level.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resident will be able to obtain necessary objects/items in cupboards/ drawers with decreased assistance/cueing.</td>
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<tr>
<td></td>
<td>Resident will need less assistance to find his/her way around the Home</td>
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</tbody>
</table>
**FOCUS**

Impaired communication related to stroke as evidenced by slurring of speech, difficulty word finding, problems producing words and sentences, difficulty reading and writing, problems understanding and forming thoughts, physical impairments (inability to access communication devices (phone, computer, paper & pen))

**GOAL(S)**

Resident’s communication will improve as measured on the RAI-MDS Change in Communication (C7)

**TIMELINES**

Conduct communication assessment

Resident will participate in restorative communication program.

Provide time and opportunity for the resident to speak and to respond.

Be patient and persistent in communication. Do not change the topic.

Be creative in the ways you communicate with the resident. Try drawing or printing, use objects, pictures or use different words.

Tell the resident that you understand that they know what they want to say.

Make sure there are few distractions.

Introduce changes of topics clearly

Supply the word they are looking for only when the resident is too frustrated.

Approach the resident slowly and from the front. If needed, gently touch a hand or arm to help get their attention. Introduce yourself. Make sure name tag is visible.

**INTERVENTIONS**

**ACCOUNTABILITY**

Speech Language Pathologist

All staff in contact with resident
<table>
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<tr>
<td>Impaired communication related to stroke as evidenced by slurring of speech, difficulty word finding, problems producing words and sentences, difficulty reading and writing, problems understanding and forming thoughts, physical impairments (inability to access communication devices (phone, computer, paper &amp; pen) (cont’d)</td>
<td>Resident's communication will improve as measured on the RAI-MDS Change in Communication (C7)</td>
<td>Address resident by preferred name. Make eye contact at level of resident when possible. Always include the resident in a conversation. Give one message at a time. Ask one question at a time. Keep choices limited and use ‘yes’ or ‘no’ questions if resident has trouble expressing preferences. Repeat important information using the same words if you are not sure that your message was understood. Ask the resident to speak more slowly and loudly than normally. Speak slowly in a normal voice. Repeat what you have understood. Ask the resident to explain anything you have not understood. Place communication aids within easy reach and on unaffected side. Use an alphabet board/communication board</td>
<td>All staff in contact with resident</td>
<td></td>
</tr>
</tbody>
</table>
### CARE PLANS – COMMUNICATION

<table>
<thead>
<tr>
<th>FOCUS</th>
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<tr>
<td>Impaired communication related to stroke as evidenced by slurring of speech, difficulty word finding, problems producing words and sentences, difficulty reading and writing, problems understanding and forming thoughts, physical impairments (inability to access communication devices (phone, computer, paper &amp; pen) (cont'd)</td>
<td>Resident’s communication will improve as measured on the RAI-MDS Change in Communication (C7)</td>
<td>Provide resident with paper and pen or white board and marker so they can write their message. Break down longer questions into yes or no questions Communicate about important issues when the resident is rested. Ask the resident where they want to go and provide mobility aids if needed. Talk face to face in a quiet room with good lighting on your face. Ensure resident is wearing working hearing aid where needed. Speak at a normal tone/volume or your speech may be distorted and can overload hearing aids, which can be painful. Position yourself where you will be heard easily and ask if the resident can hear you. Ask questions to verify that your messages have been heard accurately. Check if resident is wearing glasses, if they are needed. Make sure the lighting is not too dark or too bright. Educate family members on interventions to improve communication.</td>
<td>All staff in contact with resident</td>
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</table>
### CARE PLANS – COMMUNICATION

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<tr>
<td>Resident has specify - (blurred vision, double vision, right/left sided neglect) related to stroke evidenced by difficulty communicating.</td>
<td>Resident will be able to compensate for a vision impairment.</td>
<td>Cue resident to scan environment right to left or right to left.</td>
<td>For a visual field loss, move yourself and any materials so they are easily seen in the remaining visual field.</td>
<td>All staff in contact with resident</td>
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<td>Resident will have assistive visual device(s) in place.</td>
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<tr>
<td>Impaired communication related to stroke as evidenced by inability to change facial expression</td>
<td>Resident will be aware of and be able to compensate for lack of expression when communicating with others.</td>
<td>Verify that resident's facial expression is reflecting their emotion by asking the resident.</td>
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<td>All staff in contact with resident</td>
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<td>Identify and record triggers for inappropriate emotional responses and avoid triggers where possible.</td>
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<td>Remember that the resident is not being rude on purpose.</td>
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<td></td>
<td>Help the resident change communication that appears rude by telling them how you feel about this behaviour and what would work better.</td>
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<tr>
<td>Impaired communication related to stroke as evidenced by inability to respond with appropriate emotional reaction</td>
<td>Resident will be able to limit number of inappropriate emotional responses.</td>
<td></td>
<td></td>
<td>All staff in contact with resident</td>
</tr>
</tbody>
</table>
IMPLEMENTATION

- Various software systems
- RAI–MDS Coordinators
- Integration with current library
- Staff training
**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
PRE-SURVEY

- Demographics
- Focus on *Tips & Tools for Everyday Living* resource
  - format
  - help with providing care
  - help with formatting care plans for residents who have experienced a stroke
Demographics

Focus on Stroke Care Plans
- improve your provision of stroke care
- user-friendly (accessible, easy to read and understand)
- interventions used in care

Strategies related to implementing/sustaining best practice stroke care (care plans)

Job aids?
DISSEMINATION

Beyond project partners
- Ontario Long Term Care Association
- 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
- LTC Magazine
THE CHALLENGES

- Time
- Competing priorities
- Coordination (distance)
- Lack of common knowledge base (RAI–MDS & Tips & Tools)
- LTC Home variances (software, practices, staff designations)
THE SUCCESSES

- Engaged, committed group
- Interest in and support for best practices
- Collaborative process
- Mutual learning
- Focus on the resident
- Potential framework for others
CONTACTS

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Tel: (613) 549–6666 X 6867  
browng2@kgh.kari.net
## CONTRIBUTORS

### LTC Home Representatives

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrea DeNeire</td>
<td>RAI MDS Coordinator</td>
<td>Terrace Lodge, Aylmer, ON</td>
</tr>
<tr>
<td>Phillipa 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>
<tr>
<td>Denyse Duke</td>
<td>Director of Care, LTC</td>
<td>Residence St. Louis, Ottawa, ON</td>
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<tr>
<td>Manon Simard</td>
<td>RAI Coordinator</td>
<td>Residence St. Louis, Ottawa, ON</td>
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<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.</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>
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</tbody>
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QUESTIONS