Leadership  Patient Centered  Now

“Will you be ready to care for me?”

Isabel Henderson
Nancy Guebert
Co-Leads Continuing Care Resolution Team
Thursday October 23, 2014
Why this is now the time to act

A True Story...
What we can learn from this story
Our Mandate

• To provide a high level scan of the current state of Home Care, Supportive Living, Long Term Care

• To review the Continuing Care Concerns Line and Email

• To connect with clients, families, the public and stakeholders

• To identify strengths and opportunities in all sectors including educational opportunities
Why the burning platform

• Largest growth area; older adult growth to 880,000 by 2030
• Highest number of early dementia cases in Canada
• Complex Chronic disease
• Continuing care is more than seniors
What we have heard

Access

Quality

Facilities

Communication

Other

Transition
What we have heard

Access

• How to navigate the system
  - who do I call
• Waiting for information
• Waiting for a bed
What we have heard

Quality of Care

• Responsiveness to call bells
• Activities of daily living
• Psychosocial/emotional support
• Goals of care
• Wound management
• Complex chronic conditions (eg: Dementia care)
What we have heard

Communication

• Start the conversation early
• Lack of delay in response to concerns
• Reluctance to share concerns
• Use of teleconference, Skype
• Conflicting or lack of information
What we have heard

Transitions

• Delays in referrals
• Transfers between facilities
• Too many moves
• Right place, right care, right provider
What we have heard

Facility

- Temperature
- Food
- Cleanliness
- Home-like vs. Institutional
What we have heard

Other

• Way-finding
• What is CCRT?
• How does long term care work?
• Some interesting inquiries: noise in the back alley
Our Workplan is built around
Workplan

Patients/Families/Clients Public

• Navigation/Hub
• Streamline case coordination
• Expand family/caregiver/volunteer support
• Relationships
• Optimize the client’s potential
Workplan

Staff/Providers

• Listen, engage, value
• “Leadership” at the frontline
• Orientation, education, knowledge translation
• Team work
Workplan

The System

- Clear vision - Care at home/Care in community
- It is broader than seniors
- Strong partnerships/relationships
- Clarify roles, responsibilities, accountability
- Staff model to support acuity
- Technology & Innovation
- Restorative Care
- Person-Centred Care

A Foundation of Stability
Continuing Care in Alberta: Clients/Families/Public

Based on: 195/485 interviews/people, 350 documents reviewed, 320 concerns received

**Quality and Safety**

**Home Living**
- Current waiting for ALC placement in community (all levels) as of Aug 31/14 = 748
- Current Home Care client
- Not enrolled

**Supportive Living**
- **Level 3**
  - (unscheduled 24/7 personal care)
  - HCA’s assist residents with ADLs
  - 24/7
  - RN on call 24/7

**Supportive Living**
- **Level 4/4D***
  - (hours of care are slightly less than LTC – about 3.0 hours of care per resident)
  - (*Dementia Care in a secure environment)
  - HCA/LPN 24/7
  - RN available 24/7 but not necessarily on site

**Long Term Care**
- Alberta currently funds 4.02 hours of direct care per resident per day
  - RN/LPN/HCA 24/7

**Acute Care**
- # ALC waiting in Acute care (all levels) as of Aug 31/14 =740
- Return Home

**Options**

**Client and Family Centred Care/Caregiver Resources and Support**

**GOAL:** LPNs supporting care in place

- **Client education**
- **Caregiver/family education**
- **Respite**
- **Day programs**
- **Client education**
- **Caregiver/family education**
- **Family councils**
- **Client education**
- **Caregiver/family education**
- **Family councils**
- **Client education**
- **Caregiver/family education**
- **Patient and family centred care**
- **Don’t give up too early; care at home**

www.albertahealthservices.ca
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Return Home Facility Living

Client and Family Centred Care/Caregiver Resources and Support
GOAL: LPN’s supporting Care in Place

- Care coordination
- Care Coordination
- Care Coordination
- Care Coordination
- Care Coordination

- Collaborative Teams
- Collaborative Teams
- Collaborative Teams
- Collaborative Teams
- Collaborative Teams

- Care at home
- Collaboration/Teams
- Education/knowledge mobilization
- Education/knowledge mobilization
- Education/knowledge mobilization

- Education/knowledge mobilization
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- Education/knowledge mobilization

- Keep moving
- Education/knowledge mobilization
- Start the conversation early on admission; home
- Start the conversation early on admission; home
- Start the conversation early on admission; home

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Options

Client and Family Centred Care/Caregiver Resources and Support

GOAL: LPN’s supporting care in place

• Early enrolment in Home Care
• Restorative/Rehab Care Model
• Goals of Care

• Restorative/Rehab Care Model
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• Goals of Care

• Restorative/Rehab Care Model
• Goals of Care

• Avoid lengthy admissions
• Keep moving
• Admission Avoidance

www.albertahealthservices.ca
The LPN’s contribution to the plan...

- Assessment and reporting skills
- Lead and encourage a team
- Can practice independently and/or as a collaborative team member working to full scope of practice
- Has knowledge and skills to assist clients with complex needs
- Be part of the quality and safety agenda
- Be a voice
Client and Family Education/Information

- Early enrolment in Home Care
- Equipping the home environment
- Advanced Care Planning
- How to manage the diagnosis
Restorative Care

- Functional Decline
- Recuperate and rehabilitate
- Improve/optimize mobility/physical function
- Quicker recovery - reduce falls, depression, improved sleep, dependency
- Can be done anywhere!

If you don’t use it, you lose it
Collaborative Practice/Care Coordination

Front Line Directly Impacts

- Care planning
- Care delivery
- Shared decision-making
- Outcomes

“Leadership is not about titles, positions or flowcharts; it is about one life influencing another”.

John Maxwell, American Author
Education/Knowledge Mobilization

- Using the education and knowledge that you have
- Coach and mentor
- Specialized knowledge/education
Patient & Family Centred Care

• Caring NOT managing

• Knowing the patient/family stories before we judge or label

• Seeing ourselves and our work through the patient’s/family’s eyes

• Partnership; what we do WITH patients rather than what we do TO them and FOR them

• Inclusion

“Please respect me.”
“Please listen to me.”
“Please involve me.”
“Please don’t confuse me.”
“We have the opportunity to heal the mind, soul, heart, and body of our patients, their families and ourselves. They may forget your name. But they will never forget how you made them feel.” (Maya Angelou)
“A test of a people is how it behaves toward the old. It is easy to love children. But the affection and care of the old, the incurable, the helpless, are the true gold mines of a culture.”

(Abraham Joshua Heschel, Rabbi and Civil Rights Activist)
“We work in the Resident’s home: They do not live in our Workplaces”

Iris Neumann – Capital Care
What are we being told

- Have the right capacity to support the care needs
- Strategies to reduce transfers to Emergency or Acute Care admissions
- **Ask** for our ideas & opinions
- The time is **NOW**
- We need **everyone**
Leadership

True leaders don’t create followers, they create more leaders.
Leadership

“Leaders think and talk about the solutions. Followers think and talk about the problems.” (B. Tracy)
# Leadership

## OLD PARADIGM

- Have a Leader
- Follow “Best Practices”
- Play the Game
- Start with “What”
- Quick to say “No”
- Set boundaries
- Train

## NEW PARADIGM

- Create culture of Leadership
- Develop “Next Practices”
- Change the Game
- Start with “Why”
- Quick to find a way to say “Yes”
- Close gaps
- Develop
We have a window of opportunity

- We need to streamline and simplify
- We need to be proactive rather than reactive
- We need to ensure that Continuing Care is on everyone’s agenda
- We need to give Continuing Care the attention that it deserves.
- We need to keep the conversation “alive”
- We need everyone involved!
If we all live to be 100 we have a lot of work to do!!

The onward march of the century makers (BBC News, Sept 26/14)

“Austerity may be gripping Whitehall but one department is increasing staff numbers - the Department for Work and Pensions. The new employees are needed to organise the growing number of congratulatory cards for centenarians. The increasingly long lists are dispatched to Buckingham Palace so officials can get the Queen's birthday messages in the post. Figures from the Office for National Statistics, noted by the DWP, show there are now 13,780 people aged 100 or more in the UK, an increase of 70% over the last decade.”
We will be ready

Hope

Optimism