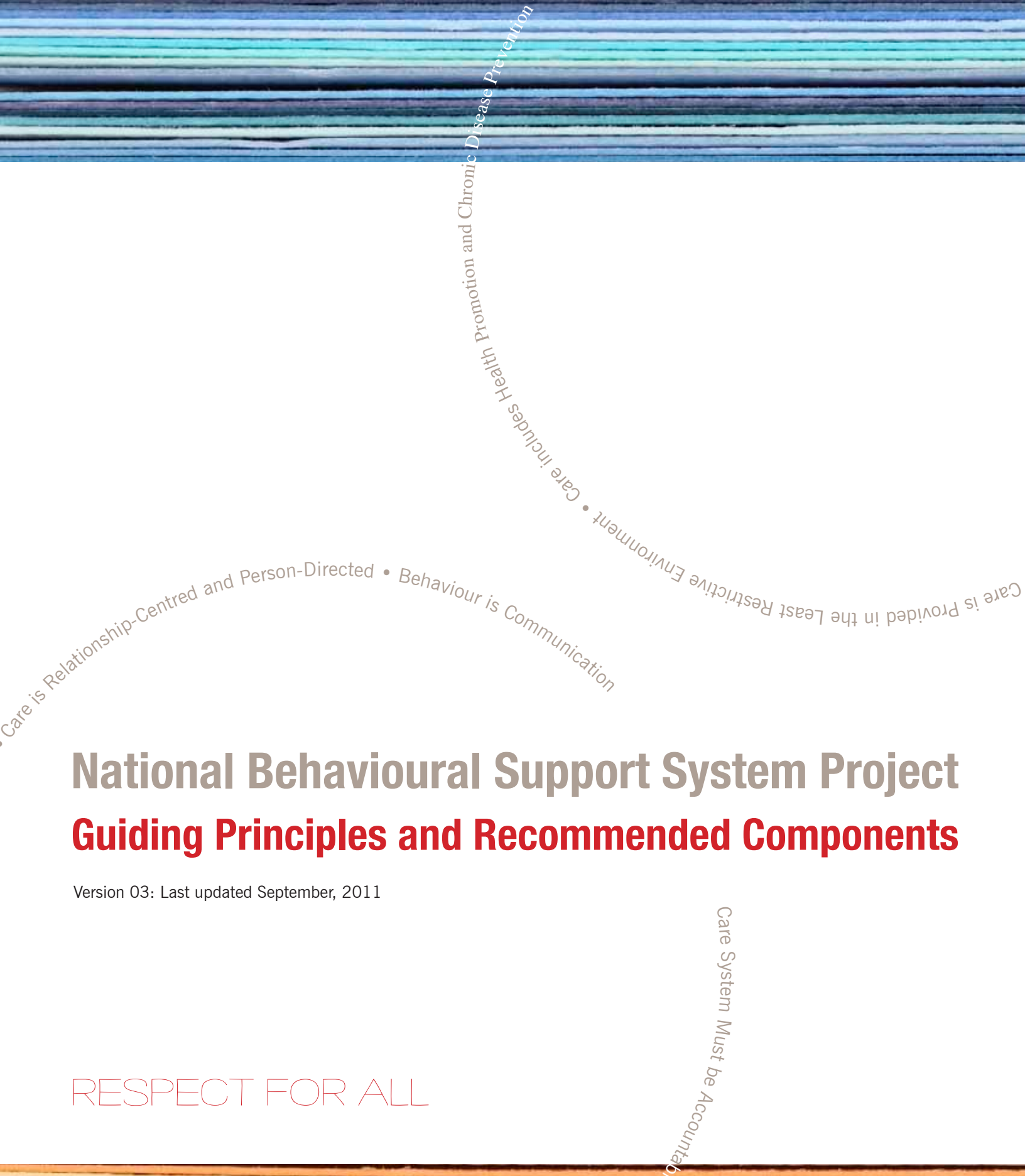


National Behavioural Support System Project

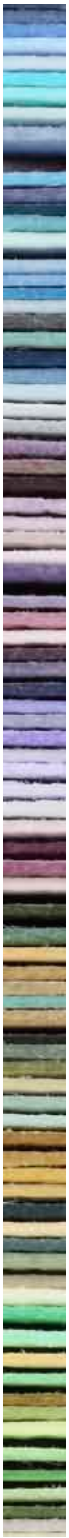
Guiding Principles and Recommended Components

Version 03: Last updated September, 2011

RESPECT FOR ALL

THANK YOU

to those listed below for your tremendous contribution to the National Behavioural Support Systems project. Your effort and expertise has made the creation of this **BSS Guiding Principles and Recommended Components** document possible.



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Purpose of the Behavioural Support System Guidelines

Stakeholders from 11 provinces and territories across Canada have contributed to these guidelines in order to provide a framework to support **a quality, integrated system of care for older persons with cognitive impairment and changes in behaviour, and his or her caregiver.** This includes but is not limited to, older adults with complex and responsive behaviours associated with cognitive impairments due to complex mental health, addictions, dementia, or other neurological conditions.

This document will provide the planner, policy maker, provider and caregiver with recommended guidelines, and targeted areas to focus improvement strategies and measures of success that can be applied at national, provincial / territorial, regional, local or organizational levels.

Within this context, and throughout the rest of this document, the "system of care" refers to all points, people and partners across the continuum of care including, but not limited to, community, acute, primary, long-term, rehabilitative, and specialized care services.

Examples of other populations that may benefit from these guidelines include those with acquired brain injuries or adults with developmental disabilities and dementia; however, these guidelines were not developed specifically with these additional populations in mind.

INDEX

Guiding Principles for a Behavioural Support System

The six guiding principles set the foundation for the remainder of these guidelines. These principles represent a set of values that should underlie a behavioural support system of any size and scope.

PRINCIPLE 01

Care is Relationship-Centred and Person-Directed

The development of meaningful relationships with persons, caregivers and service providers is required to incorporate the broadest range of information and expertise into personal care and life goals. The health system must be informed by the values, needs and self determination of the individual and their family and embed these concepts into the processes and services associated with care delivery. This principle, **which is foundational to all other principles and components of a national BSS**, must be reflected in the assessment, care planning, case review, communication, access to service, staff support and development, policy, and evaluation or quality improvement activities.

PRINCIPLE 02

Behaviour is Communication

A foundational underlying assumption is that behaviours are an attempt to express positive emotions, such as joy, as well as to communicate distress or unmet needs. As such, all responsive behaviours have meaning. Deciphering and responding to behaviours may require a team effort and multiple care adaptations over a period of time. Disruptive behaviours may be minimized by understanding the person, identifying the pattern of behaviours and the triggers leading to the behaviour, and adapting the environment or care to satisfy the individual needs, emotional distress or problem.

PRINCIPLE 03

Respect is Given for All

Respect and trust should characterize the relationships among clients, caregivers and staff, and between providers across systems. To create an environment of respect and trust, care practices must value and incorporate the language, ethnicity, race, religion, gender, beliefs / traditions, and life experiences of the person in a way that is culturally safe to be relevant to the individual being served. With a comprehensive appreciation of the person's individuality, practitioners are better able to understand the presenting behaviours and the contextual factors contributing to that behaviour.

PRINCIPLE 04

Care System Must be Accountable and Provide Leadership

Collectively, the points (i.e. individuals, teams, organizations, etc.) in the system of care are accountable to each other and exist to provide the leadership required to support communication and collaboration with respect to care. This leadership and accountability must be reflected across the care continuum within and between health and social service providers, funding agencies, policy makers, point-of-care practitioners, family caregivers, researchers and educators.

PRINCIPLE 05

Care is Provided in the Least Restrictive Environment

Care approaches will create safe physical and social environments that adapt in response to changing needs of the individual by focusing on preventative and supportive interventions to achieve and sustain a sense of well-being and quality of life. A 'least restrictive' environment should minimize risk and be home-like with adequate resources to assist the person to achieve a sense of security and safety and promote independence, autonomy, and sense of well-being, while also supporting caregivers. These environments must promote choice and control in how care is delivered, respect the individuals' rights and dignity and increase safety without denying freedom and independence.

PRINCIPLE 06

Care includes Health Promotion and Chronic Disease Prevention

Health promotion and prevention activities must be valued and implemented throughout a person's journey. This includes promoting health and wellness, early diagnosis and treatment, preventing excess disability, crisis prevention and management, enabling persons and caregivers with the knowledge, tools and resources to assist with their own self-management as able, and supporting them where needed to promote a sense of wellness. Efforts to promote health and prevent excess disability must be rewarded by the health system and represented in subsequent funding models.

The following components represent what might make up an 'ideal' **behavioural support system (BSS).** These components were identified by combining the knowledge from those with lived experience as health system consumers, those with practice-based experience, and knowledge from literature.

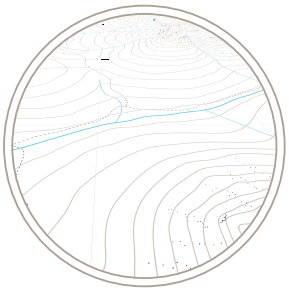
A successful BSS of any scope (organizational, local, regional, provincial/territorial, national, etc.) should include these components; however, not all components may need to be in place in order to achieve incremental successes. The combination of components, and the start points, will depend heavily on the context and culture within which the BSS is to be developed.

In the pages that follow, you will find that each component has a recommendation, rationale and practical examples of what implementation of that component might look like at several levels. These practical examples could also be considered as possible success indicators for evaluation purposes.

LEVELS

SYSTEM

what those working in or observing at a systems level, across all points of care, see and experience



ORGANIZATION

what an organization would see and experience

what the combination of care providers working together for the person and their caregiver see and experience

TEAM

what the person and his / her caregiver see and experience

PERSON

The components in this section include:

An Integrated Care System

Comprehensive Health Services

Collaborative Care

Culturally Appropriate Services

Continuous Quality Improvement

Supportive Access to Resources

Supportive Environments

Caregiver Support

Education and Training

Health Technology

C1 An Integrated Care System

RECOMMENDATION

A successful behavioural support system should be part of a broader integrated health system which relies on a collaborative approach in order to provide services that are the most appropriate and least restrictive for older adults with behavioural changes.

RATIONALE

Integration involves organizing sustainable consistency, over time, between a system of values, an organizational structure and a clinical system so as to create a space in which stakeholders (individuals and organizations concerned) find it meaningful and beneficial to coordinate their actions within a specific context.

Integration can be considered at different types, levels and forms. Quality care delivery is accomplished through interdisciplinary intersectoral teams with integrated communication, leadership and front line efforts. Achieving this requires an understanding that people are always transitioning rather than a focus on admission / discharge processes. Furthermore, integration requires that services and supports are available throughout the lifespan, as an individual's needs and circumstances are constantly changing over time. Several studies have demonstrated that relatively simple interventions designed to improve the strength of the care system yield significant improvements in quality of life and patient outcomes, e.g. through better coordination among providers. While additional resources may be of value, systems can also be better built upon existing resources and initiatives if the provision of supports is flexible and based on need. To best provide for this particular population, health organizations and agencies should implement common systems of care and documentation, encouraging further collaboration and information exchange while still maintaining confidentiality.

Contrandripoulos et al. (2003)
Contrandripoulos et al. (2003)
The Standing Senate Committee on Social Affairs, Science and Technology (2006)
Bartels et al. (2002)
Canadian Coalition for Seniors' Mental Health (2006)

MAKING IT REAL * What would an integrated system of care look like in the context of your environment? How would things change? What can you do to encourage integration? What would your "first steps" be?

SYSTEM

The system supports cross-sector partnerships, collaboration and information sharing to enable smooth transitions and quality care

Governments employ long-term integrated planning and policies based on a convergence of multiple intersectoral mandates

To ensure a common vision, common language and a common approach between partners the system has multiple entry points and uses consistent integration models

ORGANIZATION

A collaborative, shared-care model is used across services and includes formal agreements between organizations to enable inclusive admission criteria, cross-sector information sharing and cross-sector consultation and education

Policies and processes are flexible to enable services to be provided based on individual needs, as opposed to, for example, location or age

The most appropriate organization self-identifies as the "most responsible agency" to take the lead in coordinating shared-care across organizations

TEAM

Staff demonstrate an understanding of other roles within their team, organization and system

Staff provide inter-professional collaborative consultation across teams and / or organizations

Education is linked to service delivery to enable a coordinated, best-practice response to needs

PERSON

Technology enables accessible health information between sectors

The person and caregiver receives consistent service and support from the "most responsible agency" (as identified by the organizations involved in the person's care)

The person and caregiver is engaged early in dialogue to proactively facilitate best use of services and supports, helping to mitigate crisis events

Transitions between health organizations / sectors are supportive

C2 Comprehensive Clinical and Social Services

RECOMMENDATION

In order to effectively meet the needs of the person and caregiver(s) within the local and regional contexts a health service system should be comprised of appropriate clinical and social services. These services must build on the strengths of the person and caregiver(s) as well as a variety of professionals, resources and other care personnel to provide a comprehensive range of services in and across settings, with an appreciation for inclusion of clinical, social, and support services.

These services should be accessible and broadly available regardless of location or socio-economic status. To achieve comprehensive service delivery, the models associated with clinical and social services must be well integrated.

RATIONALE

The majority of individuals requiring a BSS have multiple complex needs that change over the continuum of health for older persons with cognitive impairment and changes in behaviour and require a wide variety of services and programs during the course of their health care experience. Many individuals also have co-morbid conditions that further complicate care. Comprehensive care should include effective case management, patient and family support services, general medical care, caregiver training, 24-hour crisis intervention, and psychosocial rehabilitation. This requires programs to be built around the needs of the person and caregiver(s), not disorders and/or isolated services. Through continual monitoring and evaluation of a patient's, clinical, behavioural, social, and psychological measures, providers are able to better understand behaviours and their triggers and develop the most appropriate care plan.

Bartels et al. (2002)
The Standing Senate Committee on Social Affairs, Science and Technology (2006)
Sambrook et al. (2004)
Bartels, Levine & Shea (1999)
Callahan Boustani Weiner M, et al (2011)
Canadian Coalition for Seniors' Mental Health (2006)

MAKING IT REAL * What would need to be included to create comprehensive clinical services in the context of your environment? Who would need to be included? How might you close service gaps? What would be your starting point?

SYSTEM

Health organizations are recognized and held accountable for their ability to provide collaborative, person-directed care for persons with responsive behaviours

Services are accessible and broadly available regardless of location, culture or socio-economic status

A measurable decrease of inappropriate use of clinical or social service is observed

A measurable decrease of number of transfers between a care facility and acute care settings is observed

ORGANIZATION

A balance of organizational services exist across the continuum of care including preventative services, responsive community services and specialized services which is determined by the local context and culture

Specialized inpatient geriatric mental health units (which provide acute, short stay evaluation, treatment and stabilization) are an integral component of the system for those with long standing behavioural issues

Staffing and equipment accessibility within care units reflect the unique needs of the person with responsive behaviour

TEAM

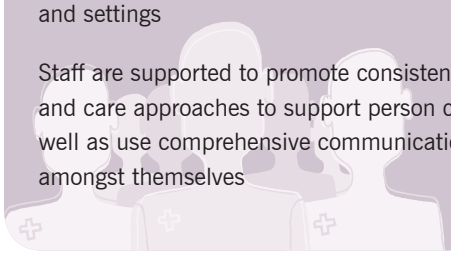
Teams engage in care planning, collaborative outreach and consultation across organizations to meet the needs of the person and, when required, facilitate smooth transitions

Supportive technology platforms are in place to enable cross-site information sharing and consultation

Staff are educated and trained to provide services which are sensitive to the unique needs of persons with responsive behaviours

Care plans travel with the patient between health sectors and settings

Staff are supported to promote consistent communication and care approaches to support person centered care as well as use comprehensive communication techniques amongst themselves



PERSON

Staff are trained and able to use appropriate best practice with an emphasis on non-pharmacological approaches when responding to behaviour

Clinical services always include current or future substitute decision maker, when appropriate

The person and caregiver experience shorter wait times for services and referrals

Staff are skilled in person-directed collaborative care

Practice guidelines are available to assist staff to achieve consistency in practice and ease of documentation

C3 Collaborative Care

RECOMMENDATION

A behavioural support system should be enabled by collaborative care whereby interdisciplinary teams working together create environments conducive to comprehensive person and family-centred assessment and intervention.

RATIONALE

Successful collaborative care requires recognition of the complementary and interdependent nature of team skills and functions of health providers from various disciplines, as well as appreciation of the importance of incorporating the values and preference of the patient and their caregivers. Professionals from different disciplines cooperatively evaluating the person and caregiver needs will develop a single plan of care that will translate across services and sectors. Health care is a system of interdependent personnel, services, and resources, the success of which is dependent on the extent of collaboration. Collaboration between disciplines and sectors enable cultural, professional and financial silos to be broken down. Key to this collaboration is the establishment and universal understanding of the roles and responsibilities within the care team (including caregivers), and the need for continuous communication between these parties.

Bartels et al. (2002)
Canadian Coalition for Seniors' Mental Health (2007); Health Force Ontario (2006)
Plsek (1999)
Lemieux-Charles & McGuire (2006); Shortell et al. (2004)
Haeslerm, Bauer & Nay (2007)

MAKING IT REAL * What would true collaborative care look like in the context of your environment? How would you get started? Who are your key partners? How would you / do you communicate with them?

SYSTEM

Cross-ministry collaborative approaches and structures are implemented

Intersectoral policy and funding is aligned to support collaborative approaches to care at the organizational, team and point of care level

Policy and funding approaches across health and social services are reviewed with a “senior’s mental health lens”

ORGANIZATION

Consultation and information sharing between organizations is supported through appropriate technology, policies and leadership

Relevant and supportive policies have been created to enable partnerships between academic and health institutions

Organizations have adopted a shared-care model

Organizations develop policies and procedures to address privacy and consent issues

TEAM

All members of the person and caregiver team are included in care planning

Inter-professional consultation is provided; health technology supports this consultation in rural, remote and under-serviced areas

PERSON

Persons and caregivers have been actively included in care decisions and care planning; caregivers are regarded as ‘experts’ with valuable knowledge to contribute

C4 Culturally Appropriate Services

RECOMMENDATION

Culturally appropriate services that recognize value, role, and impact of culture including but not limited to socio-economic status, language, food, geographic locations, ethnicity among others, should be available to enhance service accessibility and respect the individuality of the person, care providers and local community.

RATIONALE

Culture significantly impacts the persons experience with the support system. The MHCC stated, "there is good evidence to affirm that ignoring the diversity of needs and experience can hinder access to valuable services and contribute to disparities in health outcomes". The interface of the medical model and cultural perspectives is a pivotal challenge that requires learning, movement, growth, effort and vision. Understanding that culture is more than a person's country of origin, preferred language, or religion is key to providing care that best meet the needs of the person and to understanding behaviour and its triggers. Culture is closely tied to experiences of being marginalized, poor, powerless, dependent, non-assertive, poorly educated, socially underdeveloped, "colonized", vulnerable or at risk. Understanding the person's culture also includes incorporating the person's past (i.e. health history, family and life experiences), present (i.e. diagnosis, health status, capacity and functional ability) and future (i.e. disease trajectory, prognosis) into individualized care.

Canadian Coalition for Seniors' Mental Health (2006)
Mental Health Commission of Canada (2009)
Napoles, Chadiha, Eversley & Moreno-John (2010)
Canadian Mental health Association Ontario (2010)
Daker-White, Beattie, Gilliard, Means (2002)

MAKING IT REAL * What would true culturally appropriate services look like in the context of your environment? How would you begin to adapt current practices to better integrate the person's culture?

SYSTEM

A mutual respect between the person and all people/points in the system is observed

The system is actively informed by a variety of cultural perspectives and needs, relevant to the context of that system

Funds are available for translation to better align with regional demographics

Strategic policy supports the creation of culturally-specific anti-stigma programs and community education (via funding, policy, etc.)

ORGANIZATION

Policies and processes are flexible to reflect cultural differences

Services are available in cultural group languages, as determined by regional demographics

Cultural voices are represented at decision making tables

TEAM

Care providers have knowledge and demonstrate skills to assess, understand, plan and evaluate the role of culture as it relates to responsive behaviours

Professionals (translators or mediators) are accessible to assist teams in interpreting care measures for the person and their caregivers in their own language/dialect

Mutual accountability for learning and growth is achieved across the team including the professional team members, the person and his or her caregivers

PERSON

Culture is respected and recognized as a critical component of the person's identity

Culturally appropriate assessments and care plans are used

Translation is available to actively engage the person and caregivers in decisions about care and ensure understanding

Culturally specific treatments are valued

C5 Continuous Quality Improvement

RECOMMENDATION

Local, provincial and territorial service systems use quality improvement (QI) tools as an enabler to define issues, uncover causes, identify options/ strategies for improvement and define metrics to evaluate outcomes.

RATIONALE

The maintenance of successful practice, care, and systems, requires change. Engaging in reflective practice allows systems, organizations, teams and individuals to consider how small, continuous adjustments to practice and process, can greatly improve efficiencies and effectiveness. QI refers to a team, working towards a defined aim, gathering and reviewing frequent measures and implementing change strategies using many small and frequent practice adaptations. QI science provides tools and processes to assess and accelerate efforts for testing, implementation and spread of QI practices. When applied to clinical processes and conditions, QI efforts have been shown to contribute to better system and patient outcomes, including decreased costs of care, length of stay, adverse drug events, and improved patient quality of life scores. The main enabling factors of effectual QI are the participation of a motivated core group of healthcare providers, feedback to individual providers, and a supportive organizational culture for maintaining the gains that are achieved.

Canadian Coalition for Seniors' Mental Health (2006)
Mental Health Commission of Canada (2009)
Napoles, Chadiha, Eversley & Moreno-John (2010)
Canadian Mental health Association Ontario (2010)
Daker-White, Beattie, Gilliard, Means (2002)
See www.ohqc.ca for more information

MAKING IT REAL * What would continuous quality improvement look like in the context of your environment? How do QI tools help assure that the goals of the person are a focal point?

SYSTEM

System standards and funding endorse, require, and reward person-directed approaches to care

Common performance indicators are used and data is collected nationally to demonstrate the value of BSS components

QI is linked to accountability at all levels in the system (accreditation, license process in LTC homes, legislation, regulations, policy etc.)

Funds are available to support QI training across all health sectors

ORGANIZATION

QI approaches and evaluation (qualitative and quantitative) are built into existing organizational processes and policies

Qualitative and quantitative evaluation measures are consistently used, including cost analysis, resident/ family satisfaction, medication use, restraint use, falls etc.

The impact on quality of life is measured beyond traditional satisfaction measures

Organizational processes and care practices will be adjusted and adapted based on experiences of the person and caregiver

TEAM

QI training is provided to staff and staff are supported through leadership and policy in the application of QI techniques

QI approaches are integrated into team culture to continuously assess processes and make adjustments where necessary

Teams are supported in identifying QI goals, practicing QI approaches and measuring/interpreting QI outcomes in a timely manner

PERSON

Individual care plans are informed by results of relevant QI approaches (e.g. Plan-Do-Study-Act, Fishbone, 5 Why's, etc.)

Care plans are continuously reviewed to determine if the person's goals are being met

QI processes include the person and caregiver

C6 Supportive Access to Resources

RECOMMENDATION

Appropriate services and resources should be accessible to meet the needs of older adults and families through the entire course of the person's life and health stages.

RATIONALE

Supportive services for persons with dementia and related disorders are often under-resourced, particularly at the primary care level. Seniors with responsive behaviours and/or cognitive impairments should receive timely and equitable access to the resources and services that meet their complex needs without discrimination. When a community has equal access to health and social services, regardless of socio-economic status or geography, the overall health and social capital of a community improves. Individuals living in rural or remote communities are especially vulnerable, as primary care is often the only service available and access to specialist assessment and treatment is limited at best. Equal access to these services, regardless of socio-economic status or geography, is particularly critical when a person and his or her caregivers are coping with responsive behaviours as the nature of the challenge is complex and time-sensitive.

Callahan et al. (2006); Sachs, Shega & Cox-Hayley (2004)
Mental Health Commission of Canada (2009)
Teel (2004); Morgan, et al. (2009)
Canadian Mental Health Association (2010)

MAKING IT REAL * How can resources such as tele-health be used to promote system navigation in the context of your environment? What processes or mechanisms need to be in place in order to offer and honour choice of services for people?

SYSTEM

Service and resource accessibility, regardless of location, literacy, culture, language etc., is supported by system level policy and funding priorities

Investments are made, system-wide, to address stigma associated with cognitive impairment and associated behaviours

The system embraces the philosophy of supporting the person in his or her home environment as long as possible

ORGANIZATION

Health organizations, including acute and long-term care, have access to the resources and services required to support individuals living at home

Services and infrastructures are available to support organizational management of the person's care plan during transitions between different care settings

TEAM

Teams are knowledgeable of system funding and service resources and are able to share that information with the person and caregiver to enhance their ability to access appropriate services (i.e. act as informed "system navigators")

System navigator functions are fulfilled by individuals, teams and/or organizations and are readily available to individuals accessing the system

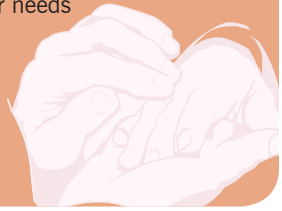
PERSON

Health technology is leveraged to enable comprehensive assessment in rural and remote settings

The person and caregivers are linked to appropriate services which meet their unique needs, through a system navigator where possible

Resources (including those for self management) are accessible for the person and his or her paid and unpaid caregivers

The person and caregivers are given opportunity to make informed choices from a selection of available and appropriate services, based on their needs



C7 Supportive Environments

RECOMMENDATION

Holistic environmental design should be implemented to help the individual better interpret their environment. Environmental factors that potentially contribute to responsive behaviours should be identified, reduced, and eliminated if possible.

RATIONALE

Many factors influence the person's ability to interpret their environment. As the person ages, there are a number of normal age-related changes that can be anticipated. Those with responsive behaviours have a greater challenge negotiating and interpreting their environment. As such, careful consideration for supportive environment will help mitigate behaviours that are in response to external cues. Environmental design includes both physical design (in terms of layout) as well as social design, which takes into consideration the processes, activities, relationships and interactions that occur within that physical environment. Numerous studies have demonstrated the inherent benefits of environmental modifications and their ability to improve safety, minimize sensory overstimulation, promote well-being, and reduce responsive behaviours in older adults.

Canadian Coalition for Seniors' Mental Health (2006)
Marquardt & Schmieg (2009); Verbeek et al. (2010)
Zeisel et al. (2003)
Bartels et al. (2003)
Day, Carreon & Stump (2000)

MAKING IT REAL * What would environmentally-focused evidence-based strategies look like in the context of your environment? What interventions could be adapted to respond to the changing needs of a person? How can you promote a least restrictive environment?

SYSTEM

Policies are in place to ensure the care continuum is supported to meet standards for environmental design

Incentives and opportunities are provided at points across the continuum of care to enable environmentally-focused strategies and interventions

ORGANIZATION

Organizational environments are person-centred, in that they are designed to respond to a range of abilities and changes in vision, cognition, hearing, and mobility

Environments are designed and equipped to enable physical exercise, wandering and safe use of abilities including the self-management of basic needs

Organizations are designed to ensure the person is enabled to be cared for in the least restrictive environment

TEAM

Team creates a sense of comfort and help the person feel 'at home'

Staff practice social design techniques (i.e. respect quiet space and privacy)

PERSON

Environments evoke feelings of comfort and security in the person and promote engagement in social activities appropriate to age, level of cognition and personal preference

Positive social relationships exist between people living in the environment and also with care providers

Environmental design enables activities that are socially and culturally appropriate

C8 Caregiver Support

RECOMMENDATION

Caregivers of older adults with cognitive impairment and responsive behaviours should be recognized as a defined target population for policy, health and services development.

RATIONALE

The person who cares for an older adult with behavioural changes has unique needs, independent of the person with the disease. Furthermore, research has consistently shown that caregivers experience not only little formal support, but also more negative outcomes when faced with behavioural issues, as compared to other symptoms. To reinforce the necessity for improved caregiver support, research findings show that higher levels of caregiver burden are correlated with increased aggression and problem behavior, creating a vicious cycle. Caregiver support groups and psycho-educational training have been found to reduce caregiver stress and delay placement of their loved ones into nursing homes. A supportive system will value this informal role and the expertise brought by the caregiver, who must be supported in defining their own role, improving their coping skills and identifying their support system.

Bookman & Harrington (2007)
Peacock & Forbes (2003)
Harvath (1994)
Kunik et al. (2010)
Bartels et al. (2002)
Gottlieb & Rooney (2004); Gaugler, Kane, Kane & Newcomer (2005)

MAKING IT REAL * What would a supportive system for caregivers look like in the context of your environment? What are the gaps in supportive infrastructures? How can respite be made more accessible to caregivers?

SYSTEM

Federal, provincial, territorial and workplace policies are in place to support care at home

Funding is provided, and is readily available, for caregiver respite

An array of services to support caregivers are available to help them remain engaged throughout the person's health stages (outside of respite)

Home care funding is available to support people with responsive behaviours, regardless of their physical function

ORGANIZATION

Organizations are enabled to provide home and respite support (including day and night programs)

Supportive infrastructures (e.g. crisis lines) are available for caregivers for in-the-moment care needs and advice

TEAM

The caregiver is included as a team member, whose level of participation is of their choosing

The caregiver is encouraged to be an active part of the person's long term care plan and is actively engaged and enabled to bring their expertise into team care planning to manage responsive behaviours

PERSON

Conversations with caregivers regularly include dialogue about their own health status (physical, emotional, etc.) as a means to flag for stress and burnout

Early in the caregiving experience, the caregiver is connected to in-person and virtual support services

Caregivers have access to tools and resources to support their understanding of responsive behaviours, and are trained in non-pharmacological approaches to responsive behaviour

C9 Education and Training

RECOMMENDATION

Continuous and consistent workforce capacity building (time, resources, supportive policies, etc) should be invested in to best address the unique needs of older adults with behavioural changes.

RATIONALE

A significant problem that exists among health care providers in geriatrics is the "expertise gap", the result of insufficient training and providers' failure to incorporate relevant, evidence-based findings into their daily practice. This gap is especially problematic given the complex nature of this target audience and therefore:

- There is ongoing need to enhance the skills associated with integrated, collaborative care approaches that involve a set of competencies and behaviours
- Knowledge from various fields needs to be continuously available and integrated into service delivery
- Frameworks are required to enable a continuous flow of new information to promote a common language and shared understanding across all points in the care system

A number of initiatives have been identified that can improve the knowledge and performance of providers through comprehensive training in effective assessment and management of patients, and personalized feedback. These education efforts, when implemented successfully, can serve as a catalyst for change in practice. Furthermore, families and caregivers often wish to assert their role in care planning and hands-on care and should be enabled to do so with appropriate training and knowledge exchange with care providers. These facts clearly demonstrate the necessity of educating patients, providers, and caregivers with relevant and current information.

Bartels (2002)
Cherry et al. (2004); Burns, Nichols, Martindale-Adams, Graney & Lummus (2003)
O'Brien et al. (2007)
O'Brien et al. (2007)
Haeslet, Bauer & Nay (2007)

MAKING IT REAL * What would standardized training in non-pharmacological interventions look like in the context of your environment? What changes in infrastructures are necessary in order to promote knowledge exchange and learning opportunities across care settings? How can education for persons and caregivers be better provided at the system, organizational, and team level?

SYSTEM

Standard education requirements are endorsed that include education in non-pharmacological interventions to responsive behaviour

Infrastructures to exchange and share knowledge regarding interventions and creative approaches across care settings are supported and readily available

ORGANIZATION

Professional organizations are involved in development of infrastructures to support continuous learning and development (i.e., clear expectations for staff performance, training curricula, policies to support practice change and continued learning, opportunities for knowledge exchange including team meetings and case conferences, etc.)

Organizational learning opportunities are continuous and comprehensive and includes all stages of dementia, mental health conditions, topics associated with behavioural changes in older adults (i.e. pain, sleep, delirium, depression etc.) and non-pharmacological interventions

Evaluation of educational initiatives and uptake of knowledge is embedded in learning strategies

TEAM

Mentoring and coaching of non-pharmacological approaches occurs by the team in the moment

Teams are enabled to learn together through in-person exchange and also have access to supportive virtual platforms (i.e. teleconference, webinars, discussions forums, blogs, etc.) to share their learning with teams from other points across the system

Continuous Quality Improvement approaches are used to support reflective practice and continuous learning

PERSON

Education and user-friendly information is available for the person and his or her caregivers which targets understanding the behaviour, improving quality of life and delay further decline

C10 Health Technology

RECOMMENDATION

User-friendly health technology should be utilized to enable system integration, collaborative practice, knowledge exchange and accessible care delivery.

RATIONALE

Health technology has the potential to connect providers, individuals, caregivers and information efficiently and effectively. It enables improved access to specialist services (e.g. consultations), through such technologies as telemedicine and e-Health. Numerous studies report successful uses of health technologies in the area of surveillance, engagement in activities and therapy, monitoring, risk management, and management of behavioural symptoms in seniors. Randomized controlled trials examining the value of interactive, computerized cognitive behavioural therapy on individuals with anxiety and depression demonstrated the significant improvements in those who used the therapy. Health providers are encouraged to explore the best fit for the current context; ensuring that technology is leveraged to support and augment care, without replacing the human connectedness of health care. It is important to consider ethical implications when implementing health technology so as to ensure patient privacy, and information security are protected.

DuBenske, Gustafson, Shaw & Cleary (2010); Shojania et al. (2009)
Canadian Mental Health Association Ontario (2010)
Westphal, Dingjan & Attoe (2010)
Goldzweig et al. (2009)
Black et al. (2011); Bylund et al. (2007)

MAKING IT REAL * What would optimal health technology look like in the context of your environment? How can E-learning for caregivers and staff be developed and promoted?

SYSTEM

Reliable online platforms are funded to enable knowledge exchange, collaboration, consultation, and the sharing of assessment tools and other related resources

Funding supports technology-based home / environment adjustments

A reliable online platform enables the sharing of electronic health records across sectors

ORGANIZATION

Organizations are supported in terms of capacity development (skills, knowledge, funding, human resources) to best leverage technology platforms and integrate them into current practice

TEAM

In teams, health technology is used to:
Enable clinical information transfer
Support patient safety
Engage caregivers in supportive conversations
Host 'live meeting' care plan discussions
Engage in consultation
Provide assessment
Exchange knowledge and collaborate within and between sectors

Mobile assessment technology is available for teams to assist with assessment, care planning, walking etc. (i.e. assess the person in their home rather than re-locate for assessment)

PERSON

E-learning opportunities are provided for caregivers and staff

Patient records are accessible, thereby eliminating repeated assessments

Alignment of Guiding Principles and Recommended Components

The following table suggests how the six guiding principles are represented in the ten recommended components of a comprehensive **behavioural support system**.

	Behaviour is Communication	Respect is Given for All	Care is Relationship Centred and Person Directed	Care System Must be Accountable and Provide Leadership	Care is Provided in the Least Restrictive Environments	Health Promotion and CDP are the Cornerstone of the Health System
An Integrated Care System				x		x
Comprehensive Health Services		x		x	x	x
Collaborative Care			x	x		
Culturally Appropriate Services		x	x	x	x	
Continuous Quality Improvement			x	x		
Supportive Access to Resource		x		x		
Supportive Environments	x			x	x	x
Caregiver Support	x		x	x	x	x
Education and Training	x	x	x	x	x	x
Health Technology				x	x	