October - November 2012

As part of the implementation of the HNHB Behavioural Supports Ontario (BSO) Project, the project team, BSO staff and key stakeholders have been working to spread information about the new models of care and success stories. The Ontario Telemedicine Network (OTN) was used to hold 12 live education sessions to share with health service providers the BSO models and case scenarios. Click here to view these sessions which are available on the BSO page of the LHIN website.

September 30, 2012 marked the end of the second quarter of implementation for the BSO Project. A report highlighting activities for the HNHB LHIN BSO models and services was submitted to the Coordinating Resource Office (CRO) to contribute to the provincial report to the Ministry of Health and Long-Term Care for all 14 LHINs. Quarterly reports are available on the HNHB LHIN website.

Action Plan Highlights

- Single point of contact for individuals and caregivers to connect with multiple resources and services
- Organization to support individuals and caregivers by taking a lead role in coordinating programs and services across multiple organizations
- Mobile outreach teams to support individuals and caregivers in the community when in crisis
- Mobile outreach teams to support individuals and caregivers in long-term care
- Toolkit for primary care providers to help them assess and manage patients with responsive behaviours

Francesca's Move is a Smooth Transition

For the past two years, Francesca has been living in a long-term care home. Though her family was concerned about how she would adjust given she only speaks Italian and understands few English words, things were going well for Francesca. She enjoyed growing tomatoes in the garden, playing bingo with other residents, and attending weekly mass in the chapel.

Eventually, a bed was available in a long-term care home in the neighbourhood where Francesca's family lives and she immediately accepted. Her family was very excited to live closer to her as it would allow them to visit more often. Concerned that the move might cause Francesca relocation stress, the long-term care home staff received consent from the family for BSO services to help Francesca successfully transition to her new home. When the BSO received the referral they met with Francesca, her family and the long-term care home staff to learn about Francesca and her specific needs. The team then met with the staff of the long-term care home where she was moving to and worked with them to prepare her room, the home and the staff for her move in.

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A plan for her care had already been developed and was waiting for her when she moved in. The staff knew about Francesca's routines, how she liked her coffee and had a list of key Italian phrases ready for her arrival. The day Francesca moved into her new home, the long-term care home staff were ready with the care plan in place. Her room was already furnished with her favourite chair, pictures, plants and clothes; exactly the way it was set up in her previous room. It made the first few days she was in the home easier for Francesca and the staff.

When the BSO team came to visit her they found Francesca was showing signs of agitation and not settling in as well as planned. Immediately they realized she was having a difficult time finding her way around the home. The BSO team worked with staff to develop and post signage in Italian to help Francesca find her way.

The BSO team continued to visit with Francesca until the third week when they determined her move in was successful - she could find her way around the home, knew the staff's name that cared for her and attended activities she liked in the home. More importantly, she was visiting with her family on a daily basis, sharing meals with them and going to church in the community.

Community

BSO Connect is taking calls for the entire HNHB LHIN (Hamilton began October 1). As of October 31, 2012, BSO Connect received 160 calls and completed 160 referrals to community agencies. The top five reasons for referrals were: confusion, seeking accommodation in long-term care, refusing care, aggression, and caregiver burden.

The Integrated Community Lead (ICL) has been rolled-out in all areas of the LHIN, with gradual implementation through new client referrals and for those clients that have begun to require more supports. Key stakeholders involved in the ICL implementation will continue to hold planning meetings by LHIN region to ensure consistency of practice, discuss collaboration and share how each organization is implementing the model.

BSO Community Outreach Teams (COTs) continue to function across the five regions of the LHIN. As of October 31, 2012 the outreach teams have received more than 176 calls collectively, with the top three reasons for referrals being: confusion, agitation and delusional thinking.

Long-Term Care

All 86 of the HNHB LHIN-funded long-term care homes (LTCHs) have signed a Memorandum of Understanding with St. Joseph's Villa to participate in the BSO Project enabling them to request services from the BSO mobile team. As of November 30, 2012, more than 80 of these LTCHs received services from the teams to serve residents, accounting for more than 650 referrals. Referrals are expected to increase in the next few months as the BSO team expands their services to help people as they move from hospital or their home in the community to LTCH.

Throughout September and October, the BSO Mobile Team Implementation Committee conducted quality improvement 'Plan Do Study Act (PDSA)' cycles to evaluate two components of the mobile team model: Client Transitions; and, Central Intake and Referral. The results from both studies were positive for the model and more importantly for the clients the BSO team served. For example, by studying transitions of clients moving from hospital to LTCH, it was shown that when people with responsive behaviours used BSO services to help them move, they did not experience any escalations of behaviours.

A new brochure is available for residents and families to help them understand the role of the LTCH mobile teams and how they work with homes to support residents with responsive behaviours. Please feel free to print this brochure to post it in public areas or share it directly with residents, family or staff.

Primary Care

As many LHINs continue working on their BSO Action Plans, there is an increasing focus on the role and partnership with Primary Care in working with the BSO population. The HNHB LHIN will begin the province-wide Primary Care Collaborative in January 2013 to bring stakeholders together to discuss the work happening and to share initiatives.

Learn More

- BSO Provincial Website
- BSO in HNHB LHIN

The Behavioural Supports Ontario (BSO) Project is about enhancing care for older adults and seniors with responsive behaviours and their caregivers. The HNHB LHIN's Action Plan outlines four key solutions to enhancing care locally. Four sub-committees have been developed to advance these solutions: ***Primary Care****,* ***Community****,* ***Long-Term Care*** *and* ***Human Resources****. The work of these sub-committees is being overseen by an Oversight Committee.*

***Responsive behaviours:** Includes pacing, wandering, verbal aggression, and physical aggression toward oneself or others.