Continuing Care Spring Forum
Large Group Engagement Summary Report

June 2018

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60 table top group activity sheets were collected from 61 tables across the province. Below are sample responses for each topic.

START:
Our clients/patients/residents would benefit if we collectively started doing this …

- *Ensuring better communication between client, family and care teams*
- *Communicating among and between care providers needs to be enhanced*
- *Using a standardized communication tool that supports information sharing and reduces the need for repetition between the client and the health care professional*
- *Improving transparency and sharing information from all health care areas (Noted that mental health is absent from this type of information sharing)*
- *Increasing the use of technology to help communication. e.g. broader access to SEAscape or one patient one record*
- *Joining DCS and Continuing Care for more collaboration on clients who cross both areas*
- *Start a collaborative council of all sectors*
- *Using data to make informed decisions*
- *Offer IT services to home care and LTC sector from the Heath authority*
- *Explaining to clients and families what to expect at various points of care*
- *Educating clients and family regarding setting expectations on community resources and realistic expectations*
- *Ensuring we are person centered and involving clients in decision making*
- *More planning around transitions by creating more of a focus on accurate and comprehensive information at transition points*
- *Introducing the following to help assist clients during transition; readmission to LTC on weekends, being proactive to ensure personal directives are completed and use of care maps / clinical pathways*
- *Having transition care units in vacant RCF beds*
- *Staff education references dementia friendly training, training on mental health illnesses, PIECES for RCFs. Education around dementia to primary health care staff by bringing partners into LTC facilities to understand the space, services and challenges*
- *Public education on CC services*
- *Understanding each other's roles and limitations*
- *Restarting Continuing Care zone meetings*
- *Pediatrics have appropriate care and resources in the home*
- *Acute care emergency department capacity regarding behavioural health matters*
- *Creating a team of behavioural health experts to "go" where the person is*
- *Starting QRP*
- *Finding other settings for people with disabilities other than a nursing home*
- *Increasing human resources e.g. Nurse Practitioner, Home Care, Physiatrists, RNs, LPNs, CCAs and hire the fourth level worker below CCA*
- *Looking at staffing levels versus the acuity in LTC*

STOP:

Our clients/patients/residents would benefit if we collectively stopped doing this …

- *Making assumptions that client's goals are the same as the service provider's*
- *Making assumptions based on roles of other professionals/sector*
- *Blaming other departments or organizations*
- *Making decisions without the involvement of front line staff*
- *Working in silos*
- *Being reactive to situations as opposed to proactive*
- *Not sharing information with each other in the circle of care*
- *Providing clients/family with information that does not match the reality of HC / LTC*
- *Pressuring the sector to take patients that may not be appropriate for certain facilities and stop accepting patients who exceed our resources*
- *Duplication*
- *Focusing on acute need and more on prevention*

CONTINUE:

Our clients/patients/residents would benefit if we collectively continued doing this …

- *Communicating, making connections and building relationships e.g. forums*
- *Engaging early, and on an ongoing basis, to plan transitions of care*
- *Working together to address the needs of complex client situations*
- *Being client focused, compassionate and caring*
- *Providing client advocacy*
- *Providing evidenced based care*
- *Being flexible with change*
- *Helping clients have reasonable expectations*
- *Continuing with home first philosophy*
- *Accepting that clients and families have the right to live with a certain level of risk*
- *Attending educational events*
- *Attending educational facilities to entice new students*
- *Having staff work to full or expanded scope of practice*
- *Utilizing care by design to shorten time away from the nursing home*
- *Recognition of hard work and employee effort*

NEXT STEPS:

This is what we still need to know …

- *Information on care by design and home first philosophy*
- *How to support pediatric clients from IWK*
- *More about seniors health*
- *Information on DCS waitlists e.g. how long are they*
- *What we can do to support those clients stuck between DHW and DCS facilities*
- *More about the roles of each team*
- *Create a directory of all facets of the system with contact names and information*
- *Have greater communication of provincial planning filtered down to the individual organizations*
- *More information about seniors mental health and DCS*
- *Better understanding of the story behind the data*

- *A shared computer information system between the LTC facilities*
- *What is our plan for health human resources*
- *Are we making efficient use of CCAs*
- *What gaps still exist in pediatric complex care*
- *Other options for younger residents who don't really belong in LTC*

This is what needs to happen after today …

- *Include DCS/HC/LTC in discharge planning when applicable*
- *Communication strategy involving all sectors, NSHA, health, government and community*
- *Site visits from NSHA to see what is happening and who is living in LTC*
- *More support from DHW when we reach out for help*
- *Advance the process of getting RAI funding*
- *Action and execute our plans*
- *DHW needs to give funds towards bursaries for CCAs*
- *Staffing ratios in LTC need to be increased to match the acuity of care in LTC facilities*

This is who needs to be involved after today …

- *All Health Care Sectors*
- *NSHA*
- *Physicians*
- *DHW*
- *DCS*
- *Government*
- *Community*
- *EHS*
- *Front line staff*