Providing Person & Family-Centred Care within Behavioural Support Transition Units (BSTU): The Critical Elements

Created by the Behavioural Support Transition Units (BSTU) Collaborative

Part of Ontario's Best Practice Exchange

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Report Background

In October 2016, the Behavioural Support Transition Units (BSTU) Collaborative started to gather information on **elements deemed critical to provide person and family-centred approaches within a BSTU environment.** Drawing on the themes that emerged from the September 2015 Ontario's Best Practice Exchange Catalyst Event, at each monthly meeting the collaborative members shared ideas and examples of person and family-centred care from their practice or lived experiences. Members discussed and determined essential components throughout the journey of a stay within a BSTU, as well as the necessary skills and expertise required of BSTU staff. Opportunities to leverage person and family-centred care were explored along with creative strategies implemented by BSTUs to overcome potential barriers and challenges.

Report Purpose

This report is intended to be a resource for professional care providers across the spectrum of care that support individuals and families in the transitions of moving into and moving out of a BSTU. These care providers include BSTU administrators, front-line staff, management, team members and relevant stakeholders including those supporting the entrance and departure of BSTU clients (e.g. sending and receiving organizations such as Home and Community Care). Rather than an exhaustive list, these examples capture emerging and best practices taking place within BSTUs that promote person and family-centred care. The report is intended to lay a foundation for and to inspire person and family-centred care within and beyond the BSTU environment.

What are Behavioural Support Transition Units?

For the purpose of this report, Behavioural Support Transition Units (BSTUs) refer to specialized units in Ontario, Canada designed for individuals expressing responsive behaviours associated with dementia, complex mental health and/or other neurological conditions. At the writing of this report, most BSTUs operated in a long-term care (LTC) home setting.

Since 2010, LTC homes in Ontario can seek to have one of their units, or a portion of a unit, designated as a 'Specialized Unit', which expands the home's ability to support residents within the continuum of care (Bruyère, 2016). These specialized units provide higher intensity, specialized care for individuals compared to that which is offered in regular LTC home units (Bruyère, 2016). Click here for further information regarding the legislation which governs Ontario's LTC homes.

Following a period of assessment, care planning and treatment, BSTUs operate to support an individual's return to the community or transition into a LTC home. Should higher levels of care are be required, specialized Complex Continuing Care units and/or Tertiary Mental Health programs may be considered.

What is the Behavioural Support Transition Units (BSTU) Collaborative?

The Behavioural Support Transition Units (BSTU) Collaborative is a part of Ontario's Best Practice Exchange supported by Behavioural Supports Ontario (BSO) and brainXchange. Its overarching goal is to bring forward emerging and best practices related to behavioural support care in Ontario. A group of health care professionals, leaders and individuals with lived experience meets on a monthly basis to:

- Learn about and share existing successes, challenges and person-centred approaches within BSTUs.
- Identify, understand and share the critical elements in providing person and family-centred care within the BSTU environment.

BSTU Collaborative Members

An integral part of the BSTU Collaborative is the participation and contributions of individuals with Lived Experience. In addition to members with Lived Experience, the following BSTUs and organizations are represented within the collaborative:

- Altamont Care Community
- Alzheimer Society - Chatham Kent
- Alzheimer Society - York
- Baycrest
- Behavioural Supports Ontario (BSO)
- brainXchange
- Bruyère
- Central East LHIN BSO
- Central LHIN BSO
- Champlain LHIN
- Cummer Lodge
- Erie St. Clair BSO
- Family Councils Ontario
- Grey County Lee Manor
- Hamilton Niagara Haldimand Brant BSO
- London Health Sciences Centre
- McGarrell Place
- Mississauga Halton LHIN BSO
- Mount Sinai Hospital
- Niagara Health
- North Bay Regional Health Centre
- North East BSO
- Nova Scotia Health Authority
- Ontario Shores
- The Perley and Rideau Veterans' Health Centre
- Quinte Health Care BSTU
- Regional Behavioural Health Services Thunder Bay
- Schlegel Villages
- Sheridan Villa
- South East LHIN
- St. Joseph Health Care London
- St. Joseph's Healthcare Hamilton
- Royal Ottawa Mental Health Centre
- Toronto Central LHIN
- T. Roy Adams Regional Centre for Dementia Care

"I was invited to Ontario's Best Practice Exchange [Catalyst Event] and joined both the Behavioural Support Transition Units Collaborative and the BSO Lived Experience Advisory. The BSTU Collaborative is an accepting group of professionals and practitioners who listen to those who have lived experience. It is very rewarding to see the work of everyone in the collaborative that is resulting in a living document that shows best practice for person and family-centred care."

- BSTU Collaborative Lived Experience Advisor

For more Information, click here to visit the BSTU Collaborative's web page.

If you are interested in joining the BSTU collaborative, please contact Jillian McConnell (jillian@brainxchange.ca).

Person & Family-Centred Care

Person and family-centred care is an approach that acknowledges that those receiving care, their family, and their care providers all bring expertise and experience to the relationship. As such, this approach is essential in ensuring that care reflects a person's individual needs and goals (Saint Elizabeth, 2016).

What does 'Family' mean?

In this report, the term 'family' refers to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared household/family responsibilities, and romantic attachments) with the person receiving health care. A person's family includes all those whom the person identifies as significant in his or her life (e.g., partner, children, caregivers, and friends) (Registered Nurses Association of Ontario, 2015).

A Person and Family-Centred Approach:

- ✓ Focuses on the whole person as a unique individual and not just on their illness or condition.
- ✓ Places the person and their family at the centre of their care.
- ✓ Puts the person and their family at the heart of every decision and empowers them to be genuine partners in their care.
- ✓ Fosters respectful, compassionate and culturally appropriate care that is responsive to the needs, values, beliefs, and preferences of the person and their family.
- ✓ Supports mutually beneficial partnerships between the person, their family and health care providers.
- ✓ Shifts providers from doing something ***to*** or ***for*** the person to doing something ***with*** the person.
- ✓ Ensures that services and supports are designed and delivered in a way that is integrated, collaborative, and mutually respectful of all persons involved.

(Accreditation Canada, 2015; Alzheimer Society of Canada, 2018; Institute for Healthcare Improvement n.d; RNAO, 2015 & Saint Elizabeth, n.d.a)

Why is Person and Family Centred Care Important?

Person and family-centred care has been associated with:

- ✓ Improvement in quality of care
- ✓ Enrichment of relationships
- ✓ Enhancement of person, family, and care provider experiences
- ✓ Greater involvement of family and support systems
- ✓ Increase in staff retention and job satisfaction
- ✓ Fewer conflicts, complaints, and misunderstandings
- ✓ Decrease in health system utilization costs

(Bender & Holyoke, 2016 & Saint Elizabeth, n.d.b)

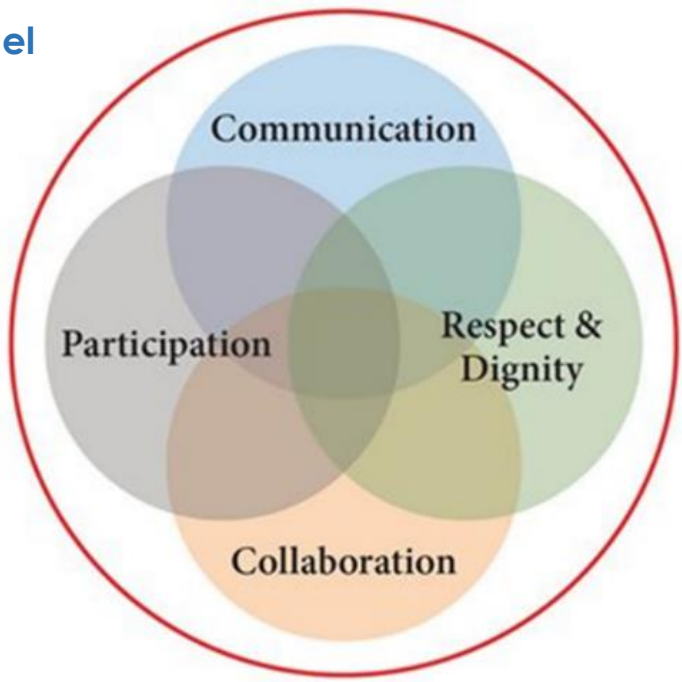
"The BSTU staff helped me feel at ease and relaxed because I was included. I felt part of the team. Since I was always included and consulted, I was comfortable to approach staff and I knew that my concerns were heard. I felt up to date regarding my husband's care needs because I was always part of his care planning. I was also pleased that my husband was included and participated in whatever way he could in the decision making process."

- Wife of BSTU Resident

Person and Family-Centred Care Model

The visual model to the right illustrates the essential and interlinked components of person and family-centred care.

Person and family-centred care is a valuable approach for all care settings. This report presents concrete examples of strategies that promote communication, respect and dignity, collaboration and participation within Behavioural Support Transition Units.



(Saint Elizabeth, 2016)

The Journey for the Person and the Family

The report is structured to reflect the person and family members' journey arriving, residing and moving out of a BSTU. Due to the specialized nature of a BSTU, individuals and families are referred to a BSTU when their care needs have exceeded the services of their current environment. This usually means that there is significant stress and concern for all involved. There may be a crisis that has prompted the referral or multiple transitions have transpired even before arriving at the BSTU. Knowing that the BSTU is transitional in nature can also pose as an additional stressor for families. Therefore, the need to provide person and family-centred care, with its essential components of communication, respect and dignity, participation and collaboration, is key to providing quality care with positive outcomes. **The following pages walk through the journey of the individual and their family and provide practical examples of how a BSTU can provide person and family-centred care each step of the way. The examples are grouped within the four critical elements of person and family-centred care and by each stage of the resident's experience (Prior to Moving into a BSTU → Moving into a BSTU → Staying at a BSTU → Moving out of a BSTU)**. There is also one page dedicated to Human Resources. Clearly there are approaches that will work at multiple stages of this journey and techniques that will strengthen and crossover more than one critical element of the care.

Prior to Moving into a BSTU | **Moving into a BSTU** | **Staying at a BSTU** | **Moving out of the BSTU**

Critical Elements in Providing Person and Family-Centred Care

Prior to Moving into a BSTU

Communication

- Communicate with family and soon-to-be resident *prior to* move in date. Ideally, meet in person.
- Provide written and verbal information about the unit (e.g. purpose of the unit, what to expect when moving in and during stay). This can take different forms, for example a 'what to expect' guide that covers what to bring on move in day, the benefit of family and/or friends accompanying the resident, and what paperwork to expect.
- Clarify the purpose of the BSTU and its transitional mandate. Confirm that the family understands the short-term nature of the unit.
- Provide information about the care elements involved in the person's stay on the unit (including assessment, care planning and transitional support).
- Acknowledge and empathize with the stressors and losses the person and the family may be experiencing.
- Provide the family a primary contact name, title and phone number.
- The main contact must be a staff member with strong interpersonal and communications skills in order to establish a therapeutic rapport.

Respect & Dignity

- Collect personhood information (e.g. the person's preferred name, vocation, preferred language, religious beliefs, cultural practices, loss/deaths, hobbies, personality traits, likes, dislikes). Click here for more information about personhood tools.
- Work closely with the family and Home and Community Care to ensure the bed and the services offered are suitable for the person and the family.
- Ensure that staff are aware of important relationships; recognize that the most important person for the resident may not be related.
- Avoid labels and stigmatizing language. Use person-centre language.

Collaboration

- Invite family members to partner with the BSTU staff to begin to build the foundation of an honest and open collaborative relationship.
- Once a referral is received, assign a primary staff member to connect with the resident and family, gather information about the person (e.g. history, strengths, care needs, effective person-centred approaches and daily routine), share learnings with the care team and begin to develop a care plan.
- Meet with the referral agency to discuss reason for referral and goals of referral. Discuss the responsive behaviours/personal expressions of concern, along with the identified contributing factors, strategies (pharmacological and non-pharmacological) that have been used previously and their effectiveness.
- Meet with other service providers within the circle of care (e.g. Mobile Behavioural Supports Teams, Home and Community Care, and Hospital).
- If available, have a BSTU staff member or a Mobile Behavioural Supports team member conduct a site visit at the sending facility in order to the meet person and their family prior to admission.

Participation

- Confirm the legal Substitute Decision Maker(s).
- Offer tours in advance of move in day to both the soon-to-be resident and family members.
- Discuss with the family why the person is moving into the unit and establish goals of the BSTU stay together.
- Provide examples to the family on how they can participate in the care team (e.g. family presence, care conferences, sharing their knowledge of the person and strategies that have been successful).
- If not already completed, ask the family to fill out personhood document.

Critical Elements in Providing Person and Family-Centred Care

Moving into a BSTU

Communication

- Prior to the person's arrival, provide to all staff a summary of the information collected.
- Confirm information provided prior to moving in (with Home and Community Care, family members etc.) and gather any remaining information gaps (e.g. medications, non-pharmacological approaches, personhood information).
- Reaffirm the purpose of the BSTU and its transitional mandate (versus a long-term residence) with the family and how the transitions in and out of the BSTU will be supported.
- Encourage the family to communicate goals, expectations, worries and concerns.
- Review with the family the risks inherent to living in a BSTU and why such risks exist.
- Acknowledge and empathize with the stressors and losses the person and the family may be experiencing.

Respect & Dignity

- Create a warm, calm environment where the person and family members feel welcomed and unhurried.
- Review the information already collected about the person and ask only those questions that remain to be answered, including cultural preferences.
- Ensure staff allots ample time to answer the resident and family's questions.
- Acknowledge the feelings of the resident and/or the family. These may include feeling overwhelmed, embarrassment, loss, sadness, anger, fear and/or guilt.
- Initially provide a private room for the person, but over time trial the type of accommodation that he/she will be moving to from the BSTU (e.g. shared accommodation).
- Suggest that the family brings in items that the person is familiar with that are easy to transport (e.g. comforter, family photos, chair, dresser).

Collaboration

- Provide the family with a consistent staff member as their point of contact; someone who knows the resident and who will be their 'go to' person throughout the BSTU stay.
- Include the family in the assessments of the resident that occurs on the day of arrival.
- If a Mobile Behaviour Support team is involved with the person/family prior to moving in, arrange for them to be present and/or assist in the move in process.
- Provide educational resources and connect families with supportive organizations, support groups and tools related to dementia and responsive behaviours.
- Ensure that family members' suggestions are listened to and utilized.
- Request that any behavioural assessment tools that were utilized by previous service providers be passed on to the BSTU to assist in the assessment and to support transitions.

Participation

- Encourage the family (and specifically the substitute decision maker) to join the circle of care and confirm their participation.
- Invite family members to play an active role, for example in care conferences.
- Be flexible with dates/times and method of meeting (in-person, teleconference, etc.) to accommodate the family member's schedule.
- Emphasize the importance of families staying engaged and informed during the person's stay at the BSTU and for supportive transitions.
- Encourage families to communicate any changes they notice during the stay (e.g. changes in behaviour, personality, abilities).
- Ask families to provide a social history of the new resident. This and other information provided by family is to be valued and used as part of care plan development.
- Recognise that some family members may need validation from staff regarding their need to take a break from visiting and/or participating in care for a period of time.

Critical Elements in Providing Person and Family-Centred Care

Staying at a BSTU

Communication

- Regularly and frequently communicate with family regarding updates on the person's progress (including challenges and successes).
- Openly discuss the hopes and expectations of family members.
- Openly discuss any risks associated with responsive behaviours and mitigation strategies with the family.
- Clearly communicate to the family any requests for information and how the information gathered will be helpful in providing quality care.
- Share tip sheets and amendments to the care plan with the family throughout the stay. Invite the family to provide input.
- Individualize communication and family support.
- Speak the language the person with dementia best understands when in their company.
- Acknowledge and empathize with the stressors and losses the person and the family may be experiencing.

Respect & Dignity

- Utilize personhood information to help connect with the person. Personhood information needs to be easily accessible to all staff.
- Provide individualized, person-centred care and engage in supportive activities with individuals that are authentic, sincere and heartfelt.
- Recognize that personal expressions and contributing factors to responsive behaviours are ever-changing and (often) reflect unmet needs.
- Ensure staff engagement is consistent.
- Integrate cultural preferences and practices (e.g. indigenous, ethnic and/or cultural practices) into the provision of care.
- Make environmental modifications that promote the person's abilities.
- Use memory boards outside of the person's room to help the person recognize their room and to celebrate the life of the resident.
- Provide meaningful activities that foster a sense of belonging and success.

Collaboration

- Extensive care planning should occur throughout the stay. This includes multi-disciplinary assessment in order to understand the meaning and/or contributing factors of responsive behaviours and identifying individualized, person-centred strategies.
- Ensure that the care plan includes positive aspects (e.g. emphasizing an individual's capabilities) while providing clear strategies/ approaches to prevent and decrease responsive behaviours.
- Include external partners who are part of the circle of care (e.g. sending/receiving Long-term Care Home, Alzheimer Society, and Behavioural Supports Ontario) and the family in the assessment and care planning process.
- Have regular and frequent team meetings (e.g. weekly) to share strategies, successes and challenges.
- When trialling new approaches, consider how they fit with the requirements outlined in the LTCH Act and regulations.

Participation

- Have regular conferences with the family, where positive attributes of the person are shared and areas to focus on next are discussed.
- Encourage family members to visit regularly; yet acknowledge that there may be different preferences amongst the residents and families regarding their family involvement.
- Create opportunities for families and staff to engage in communication and learning opportunities outside or in addition to formal care conferences.
- Invite family members to observe and/or participate in the provision of care. Afterwards ask for their suggestions on how to improve the care experience.
- There may be times when the family's presence is challenging for the resident. Decisions related to family presence needs to be considered carefully and delicately with family members.
- Continuously review care strategies and consider decreasing frequency of specific interventions over time to prepare for discharge (based on observation and clinical decision making).

Critical Elements in Providing Person and Family-Centred Care

Moving Out of a BSTU

Communication

- As part of ongoing communication, ensure that staff and family are aware of any changes to care plans when the person begins to prepare to transition out of the BSTU.
- Communicate the goals of care, the contributing factors that have been identified related to response behaviours and the successful strategies/approaches to the receiving team prior to moving out. This will assist in planning the move and consistency of care throughout the transition period.
- Ensure families are aware of the transition plan (e.g. timing, supports in place).
- Acknowledge and empathize with the stressors and losses the person and the family may be experiencing in light of another move.

Respect & Dignity

- Ensure personhood information is provided to the receiving LTC home.
- Arrange for the person to be supported during the day of the move (e.g. accompanied by a family member, BSTU staff member or a BSO team member).
- Schedule a supportive meeting between a BSTU staff (e.g. social worker) and family member(s) to discuss the transition (offer this type of meeting before and after the move).
- Ensure management at receiving home is receptive and supportive of the planned move.
- Gather feedback from the family regarding their BSTU experience.

Collaboration

- Send the person's current care plan to the receiving LTC home prior to transfer.
- Invite staff from the receiving home to visit the BSTU at any point prior to the person's transition.
- Schedule a meeting at the BSTU involving the receiving home, the family and all external partners who will support the person in their new home (e.g. Mobile Behavioural Support Teams, LTC Home in-house physician).
- Arrange that staff from the BSTU accompanies the person to their new home; provide transitional support as well as care plan review with staff at the new location. Communicate this arrangement with the family.
- Connect BSTU team to the receiving organization's staff for phone consults after the resident moved out of the BSTU.
- Encourage Mobile Behavioural Support Teams to connect with the care team and embedded BSO staff within LTC home.

Participation

- Invite family to attend and participate in meetings related to moving out and transitioning to a new home.
- Create a plan with the family regarding how best to support the resident on the day of the move and during the transition period.
- Encourage the family to continue to be engaged and advocate for the person in their new home and with their new care team.

Critical Elements in Providing Person and Family-Centred Care Related to Human Resources

Communication

- Clearly express support of the provision of person and family-centred care within the BSTU (versus an emphasis on completing "tasks" before end of shift) and ensure consistent management support.
- Management support should be well communicated to front-line staff.
- Promote BSTUs as a desirable work environment.
- Foster an accurate and positive view of the experience of staff working within BSTUs.
- Exchange information amongst the team in a timely manner.
- Ensure that staff who provide direct care have access to and understand the care plan.
- Build up staff communication skills for open and therapeutic interactions with the resident and the family.
- Provide opportunities for staff to support each other to avoid compassion fatigue (e.g. through regular huddles).

Respect & Dignity

- Hire BSTU staff who have interest, are trained and have experience assisting individuals expressing responsive behaviours.
- Ensure all team players feel valued and respected.
- Acknowledge the hard work of all team members in their various capacities.
- Provide staff with appropriate training and education.
- Provide staff the option to temporarily move to other areas within the organization for a change in work life to prevent burnout/fatigue.
- Provide new staff a way to transfer to another unit without penalty if they recognize that the BSTU is not a good fit.
- Emphasize and value the clinical team's focus on the provision of person and family-centred care (versus task-focused care).
- Support and promote activities outside of Activities of Daily Living (ADLs) – including authentic relationships and meaningful engagement.

Collaboration

- Provide mentorship programs for staff.
- Provide ways for staff to debrief and find support when there are physically responsive behaviours that result in injury.
- Collaborate with all staff who interact with individuals residing in the BSTU and provide equal weight to thoughts, ideas and opinions.
- Create opportunities for teams to engage in meaningful discussions regarding items such as recent changes, successes, challenges and modifying the plan of care accordingly.
- Foster working together as a team.
- Work closely with partner organizations, sectors and disciplines.

Participation

- Limit/avoid float staff as consistency of staff is very important for residents and family.
- Offer **all** staff in the organization specialized education regarding the care of individuals with dementia; ideally staff are paid for their time and materials.
- Training in small groups (often exclusive to the BSTUs) tends to be preferable to help foster a sense of team.
- Foster staff pride in their work and their sense of belonging to the team.

Next Steps

The Behavioural Support Transition Unit Collaborative created this report to:

- Inspire implementation of practices that promote person and family-centred care.
- Lay the foundation for the development of emerging and best practices in person and family-centred care.
- Reflect on opportunities to standardize the expectations in care delivery for persons requiring a stay in a BSTU.

We recognize that not all organizations will perform each of the critical elements or follow the processes as laid out in the report. However, we present this report to inspire a province-wide dialogue on standards and care delivery practices. This report is a first step and should be viewed as a living document created to begin that discussion.

Join the Conversation!

We welcome your thoughts, feedback and inspirations!

1) How have you used this report to guide and/or support your practice?
2) Has your BSTU added a new approach or strategy that you discovered in the report?
3) Do you have creative and innovative person and family-centred care strategies you use within a BSTU environment? Please share your successful practices and approaches!

Post your responses on the BSTU Collaborative public forum (click here)

or

Email your responses to provincialBSO@nbrhc.on.ca

We gathered the processes described in the report mainly from BSTUs located in long-term care homes. The approaches described and the associated philosophy of care can be applied to other sectors that have a BSTU within their organization or indeed, throughout the entire healthcare system.

Stay tuned! Our BSTU Collaborative is developing companion documents that will further support person and family-centred care within BSTUs, including one specifically designed for family and care partners!

Acknowledgements

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