

Summary of Barriers to Implement and Support Person-Centred Care from the November 5, 2010 workshop

Participants were asked to define the barriers to implement and support person-centred care at their facilities or agencies. A summary of the primary barriers identified follows. All suggested barriers are included in Appendix 1.

1. Time constraints, work load and staffing levels

The most cited barrier to implementing person-centred care is time constraints resulting from staffing levels and work load. Participants felt that more time would be needed for:

- staff education and training on person-centred care,
- meeting the resident/client needs,
- using the behavioural assessment tools, and
- developing 1st person care plans.

2. Resistance to change

The second most cited barrier to implementing person-centred care is the resistance to change, both at the facility/agency level (moving from institutional to person-centred care), and with direct care staff (old habits are hard to break).

3. Lack of resources

There are insufficient resources to facilitate the change to person-centred care, including education and training for staff, and equipment, such as ceiling lifts, mobility aides, etc.

4. Lack of organizational support

If managers and administrators do not support and value person-centred care, it will not be implemented.

5. Tools require good comprehension of English language

The 1st person ADLs with long narratives and the behavioural assessment tools require a fairly high level of English which may be a challenge for workers where English is their second language.

6. Lack of inclusion of front-line staff into care planning

There is not enough consultation with all team members when developing the care plan, especially with the direct care staff, and not enough communication between the care disciplines to support a person-centred care approach.

Two participants reported that there were no barriers to implementing a person-centred care approach.

Summary of Strategies to Implement Person-Centred Care **from the November 5, 2010 workshop**

Participants were asked to define strategies to facilitate the implementation of person-centred care at their facilities or agencies. A summary of the primary strategies identified follows. All suggested strategies are included in Appendix 2.

1. Education, training and sharing Information

The most reported strategy to support person-centred care was to provide all levels of staff with education and training on person-centred care. Suggestions included providing in-service training, getting more staff to workshops, and mentoring. It was identified that it would be helpful to identify champions of person-centred care to help promote changes in care approach. Finally, it was suggested that nursing school curriculum needed to be updated to include more information on dementia and person-centred care.

2. Improve communication of and access to resident/client Information

Many participants reported that in order to implement person-centred care they needed to improve the communication of resident information at all levels, including between front-line staff and supervisors and between direct care staff. Specifically, strategies included having team meetings, ensuring care-plans and ADLs were updated and reviewed regularly, supporting staff to report changes in residents, and including direct care staff in the care planning process.

3. Care staff change their approach to and interaction with residents/clients

A significant number of participants reported that through changing how they interacted and provided care to residents, they could facilitate change to person-centred care. Changes in approach included to be more respectful, patient and caring, develop rapport, take the time to meet resident/client needs, and be aware of how information is communicated and received.

4. Change care planning process

Participants recommended that more time, effort and information is needed to develop care plans that reflect a person-centred care philosophy. This would involve actively seeking information from front-line care staff and family members, charting more information, and ensuring the resident is assessed as needed by different team members (i.e., psychiatrist, doctor, physiotherapist, etc.).

5. Improve staffing levels and increase scheduling flexibility

Several participants reported that staffing levels needed to be improved to provide person-centred care. Home care participants reported that increased time flexibility is needed to meet the varying demands of clients with dementia.

6. Organizational commitment

Commitment and support for person-centred care from all levels of the organization, including front-line care staff, is needed to implement person-centred care.

7. Suggested methods to facilitate changes to person-centred care

Many participants wrote down ideas on how changes to enable person-centred care could be supported and facilitated. These included:

- Do one thing at a time
- Encourage team work
- Pilot changes in small groups before incorporating change across whole facility or agency
- Involve resident, family, staff, and professionals
- Find champions
- Use mentors to model care strategies, attitudes, approaches, etc.

Appendix 1

Time Constraints, Workload and Staffing Levels

- Timing
- Time in the day
- Funded staffing hours to allow time to practice techniques
- Time & effort to prepare/update care plans. Have care plans in place quickly for new residents-documenting for all staff effective care measures
- Having time-heavy workload, multiple tasks all the time
- Time constraints
- Time constraints
- Time constraints in assessing and putting into realistic daily care plan, which I think is far better steps in a person confused dementia care
- Allowing more time to the resident, if the residents are more agitated
- Time allowing
- Allowing more time for patient care and dealing with difficult situations with patient in distress
- Limited time to do the job
- Time management-shower may take longer time or giving care
- Workload-increased time to do proper assessments & dialogue regarding resident's triggers, etc.
- Time Management. Its time consuming to read this, all the health records and input from different health sectors regarding one simple resident
- There are no differences in the time allotment for care tasks for client with dementia and clients without dementia-no accountability for different time needs for clients with dementia
- Time allotted to do care in clients' home
- Time
- Time is a factor that is a barrier to change-lack of time on the part of the worker
- Time
- Time constraints
- Not allowing enough time to express how they feel
- Time constraint
- Need more time to discuss & different approach
- Need longer hours
- Resistance because on time constraints. Requires a lot of time to train and educate care staff & to implement
- Give more time to communicate with them, listen and wait for the response
- Lack of staff/volunteers
- Staffing levels are too low
- Staffing funding
- Time spent with the staff to educate them about dementia and how to deal with dementia behaviors.
- RCA's doing care (morning/evening care) in a "rushed" manner due to staffing level

- Need more management support in staffing appropriately for changes
- Workload
- Not have enough situational time to discuss
- Not enough patience e.g. listen to what resident said

Resistance to Change

- Some people have a difficult time changing speech & language. Trying to influence others to change language by always being consistent and my own speech & language is my strategy
- Long-standing practices that are not person-centered
- Cultural shift in how you practice
- Being too comfortable in how you do your job
- Old habits are hard to break
- I think that many administrators/leaders are not always open for the changes as they concentrate on funding and budgets, so often times even staffing levels are issues to implement any changes
- Other team leaders and managers do not follow the same guidelines of believe in taking a person centered approach if it is not in the best interest or convenient for the facility
- The unwillingness of doctors to change
- Staff to change their old habits in regards to being task oriented instead of person oriented
- Resistance to change (staff)
- People don't like change
- General resistance to change
- To get your whole staff to agree to change, might be hard
- Acceptance of some staff on the new pattern of daily care plan
- A change in our facilities' routine
- Changing our approach to care and focusing on person-oriented care vs task oriented care may take time for some staff
- The ability of co-worker to want to change
- Stop and change old routines and habits of care
- Different beliefs about how things "should" be done
- Resistance
- Some staff's resistance to change - individual approach to change
- Acceptance of new implementation
- Negative attitude to change
- Sometimes different view
- Their cultures
- Beliefs of CA/S/HSW
- 1st person work culture to be developed
- Facilitate the change
- Leaving my non prejudices behind

- Re-educate /re-direct staff attitudes in handling residents having resistive aggravated and aggressive behavior
- Culture of facility-currently task oriented, staff first
- Attitude-shift to person-centered
- Getting staff to change
- Buy in from all stakeholders
- Organize or non-organized routine
- Trying to shift the focus on the person & not the task at hand
- To have “agreement” from all managers & nursing teams to implement or “try” new tools; ways of thinking and care plans

Lack of Resources

- Staff responses to changes as not all have the proper education on dealing with dementia & also breakdown in communication-will need education session for staff
- CHW needs more information about it. Health problems specifically in the community. So that we know what to do about precautions
- Education opportunities to staff equally-different languages for varied staff to use
- Lack of education
- Lack of education re: things like dementia, communication
- Lack of educational knowledge & support
- More education with in staff
- Lack of education with people with dementia.
- To educate staff on the “whole” of the new tools and approach
- Educating staff and the cost (wages)
- Education - only one educator for two facilities
- Education & training of staff. All staff need to be consistent in their approach to caring for demented residents
- Lack of education on approaching residents with dementia/Alzheimer’s
- Not having money or support for in services.
- Little chance of implementing a truly beneficial, workable care plan. e.g. behavior pattern record, my daily care needs
- For homecare-obtaining appropriate equipment and aids-mobility, walkers, etc.
- Lack of equipment (like ceiling lift, and even gloves) in the home setting
- Resources to assist with making the change
- Incorporating the new modules (eg. my daily care needs)
- Lack of understanding of all influences on behaviors
- Cultural differences (different approach to elders)

Lack of Organizational Support

- Management in our facility are not at this workshop
- Large organization with industry stakeholders who need to be involved in the change process
- Leadership-ownership for valuing & modeling mentoring person-centered care

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- No support from management, not holding staff accountable
- Lack of team approach
- Nurses complain that they are burned out and with too many responsibilities
- Finding quick fixes instead of using assessment tools and getting to know the resident better
- Staff, management, families, staff try to get them away from task focus. RN's not charting what is going on, so the resident doesn't get the help that is needed
- Management to be more involved with staff educational programs. To work together as a team to implement strategies
- Open communication
- As a community worker (LDN) supervising community health workers. Barriers involve lack of assessment area on my part, with lack of documentation and poor reporting. Problem solving may not be done in timely manner however. I can demonstrate my knowledge, strategies to CHW's through meetings and on spot activities

Tools Require Good Comprehension of the English Language

- Need to simplify this documental at grade VIII level
- Some staff's communication skills an issue (ESL)
- 1st person care plan looks lengthy & will take time to read. How can I make it most useful & efficient to communicate the information to care providers/caregivers
- More information
- Language barrier-we have some clients who don't know how who to speak in English anymore
- Policies
- Forms for filing out safety concerns, behavior, etc.
- Having more personal notes on residents themselves on ADL sheets
- Care plan may be too wordy to realistically expect staff to read it
- Print also too small
- More behavioral charts, on dementia, patients, to facilitate change. More documentation of issues and behaviors
- Allowing patient family to work with caregivers of patient to facilitate strategies to better care e.g.: ADLS/care plans realistically keeping in mind
- Care plan needs to be accessible to all levels of language skill & educational level

Lack of Inclusion of Front-line Staff into Care Planning

- Community health care workers need to have more input into putting together care plans-to have aids available
- Clinical staff to be more involved in meeting, seeing, visiting clients. It's not just paperwork

- More open discussion with the others involved - nurses, OT, PT, Case Managers - at times CHW know client better
- I'm working as a CHW and do not make a client care plan. Sometimes, some of the care plans I encounter are very outdated
- CHW/s to have more input into clients care plans. Also aids they may require
- Clinicians to be more involved in clients changing physical and mental status
- CHW not involved in team meeting's regarding client's overall care
- Behavioral assessment tool with family members
- Lack of involvement on charting and documenting for RCA's
- Staff/CHW reporting the behaviors'
- Supervisor's response to the CHW's reports
- Personal/professional boundaries in the units among staff & sometimes families
- Everyone has opinions

Access to Information to Develop Care Plans

- The individuals we support do not communicate well. Their cognitive abilities as well as the medications they are on will add to their chronological age. It will be difficult to know when they suffering from dementia
- Obtaining past history, biography, traumatic events about client
- That there is no readily accessible information. That is personal to resident
- To know all history of the person

Families

- When family don't co-operate with you. Recognizing what they want
- Background information given by family members, regarding the residents
- More information to family
- Family to understand the strategies provided
- Staff afraid to speak up. Fear. Family want them up and dressed
- Family not co-operating, not agreeing with strategies
- Working with family members and how they interact with client

Staffing Issues

- Different caregivers each day
- Difficult to maintain same CHW so that a trust relationship can develop
- Consistency of staff-not always the same staff working for the demented resident and there are gaps in communication

Other

- Difficult issues from other
- Peoples ability to listen to repetitive stories
- The need to remind the person to use mobility equipment - does not like being told what to do
- No other males. Other than staff controlled activities

- Due to physical aggression, most of the residents are 2 person care, one RCA unable to finish task or she is waiting for another RCA for assistance
- Team spirit
- A caregiver working alone in a client's home has less opportunity to "back off" or take a break away from client. And she cannot consult with others and brainstorm ideas.
- People with dementia, they don't like being told what they should do, have to do something
- Enter their world-by putting yourself to their need
- More passionate
- When I work, we have a resident whose husband spends his whole day with her giving her company, pampering her and when it's time for him to leave, she starts being agitated calling out help, help, help. She's now alone, husband is gone, so feeling isolated that escalates her anxiety, and then she becomes aggressive kicking, punching and holding on to the call bell all the time
- Aggression
- Update care plans in clients home
- Client's information given to next community health worker regarding a clients comment change in health

Appendix 2

Education/Training/Sharing Information Received Today

- Education
- Regular education
- Mini education sessions at the workplace (10min, every 2 wks)
- Education
- Refresher courses, short ones
- Videos
- Ongoing training for staff to recognize the changes & how to effectively work with the tenants
- More videos to show/provide we got the information
- Role playing at staff meetings
- All departments should attend workshops
- Provide ongoing education and support
- Provide ongoing education informal and formal
- More training
- Education & involving the whole team may facilitate change
- Educate & facilitate sessions & dialogue in person-centered care, agitation CPG & GPEG Model
- Training. In Service
- Education
- More education
- In service training
- Communication & staff education-empower them to have conversations same as we would empower residents
- It would be nice to have this presentation offered at each site
- Educate the supervisors regarding the process of responding to CHW's reports
- Put in education plan
- Training on approaches & communication
- Able to do more workshops
- I think we need to educate more, especially the health staff or give more workshops for the care staff
- Provide opportunity for learning
- Input this workshop in day to day practice by educating staff
- Mentoring sessions (small groups & 1 to 1)
- Research and work with staff to assure delivery of educating material is accessible to all staff
- Education approach
- Talk & document regarding the positive forms of this strategy. Show examples of these care plans
- Give us more information dealing with elderly people
- Share what we've learned with co-workers and supervisors
- Share strategies/concepts with Manager & RCL's

- Share with your co-workers
- Share all the information that I get today
- Integrate materials/principles/approaches to the existing Dementia Care education for CHW
- Give to them the all the tools we have here in the seminars, so they can implement all the changes to the entire staff of the facility

Improve Communication/Support Coworkers/Update Charts

- Need to communicate with supervisors about changing clients situations
- Supervisors taking more time focused on making sure care plans are updated
- Giving heads up to next co-worker on clients current health condition
- Continue to encourage & support CAs/HSW to chart & update
- Communication
- Proper communication
- Effective communication
- Open dialogue to discuss how to do things differently-moving the focus to people centred care
- Communicating with management team
- Communication
- Need more meetings with all departments to ensure resident/staff safety
- Lacking follow-up
- Frequent follow-up with CHW's, family and health care team
- Monthly team meetings/discussions
- Support staff in their daily work
- Discuss resident's with challenging behaviours on unit have a conference and involve all team members
- Encourage caregivers to call management and take more time to be discussed
- Communicate with case managers report behaviours and request for extra time when appropriate
- More meetings with staff on how overcome barriers and put changes in place
- Communicate with each other
- Updated care plan
- Talk to team leader/managers
- Do meetings frequently for better information

Change Personal Approach

- I like to point finger at myself and figure out how I can be an effective leader
- Respect
- Acknowledge person past and present
- Empathy
- Be patient
- We communicate through gestures
- Patience
- Try out the techniques ourselves on our clients

- Let's do together, even toileting and bathing. Really enter their world, respect what their thinking. Their concerns.
- More understanding
- Try to understand the resident, try to give more space to them
- Start with one person & then try to influence the rest of the workplace
- Be understanding and patience
- Consider their self to yourself
- Improving communication with persons with Dementia
- More understanding of the habits & preferences of the resident before delivering of care to develop a rapport with resident
- Try defer or report to nurse arrange next day to give shower
- Let the resident sleep in. Not force them to get dress. Try talking more to families to explain why not dressed. Let them refuse a bath, for few days.
- Just make time-demonstrate caring in day to day interactions however short
- Be conscientious and caring
- Respect
- Help client to prioritize, exclude rationale for interventions, be specific with interventions

Care Planning – Gathering Information/Input

- Edit care plans
- Have CHW's part of team making decisions – re: to care plan, equipment needed. Especially when client presents as a challenge
- Updating our approaches and career plans
- Time devoted to care planning & monitoring
- Incorporate personalized content into already being used CARE/ADL plan at HPC
- Provide RCA, opportunity to document behaviour on charts
- More charting
- Talking more with supervisor, family, and client
- To make questions available for family to answer when their family members comes to the facility
- By requesting information on residents by family or even long-time caregivers
- Involve all levels of care and management to attend programs
- Inform RN's to document all behaviours, small and big (all levels of behaviour)
- Allow and involve family members in all aspects of care and letting them know of all behavioural problems
- Getting the right referrals that the client needs-physio, recreational aide, psychiatrist, doctor, etc.

Staffing Levels and Flexibility of Staffing

- Division of labour or assign to a particular staff member & ensure the time is available to complete
- Time management-exercised

- More care staff
- Attempt to reduce number of CHW's
- Look for bridging or temporary increase in key resources (expertise, staff time, etc) to assist with completion of transition
- RN to help out with 2-person care of residents
- Budget for cost
- Allow more time to cover all aspects or problems so people will be able to implement their practices
- More staff to cover the flow (administrative concerns)
- The staff scheduler should be flexible and allow more time for workers. Normally staff are allowed just for a certain time
- Be flexible when scheduling
- Consistent caregivers
- Request for additional time can sometimes be successful but case managers may still deny extra time-very stressful for both client & CHW

Get Commitment From All Levels of Organization and Support Staff

- Reinforcing the idea that the resident is the most important person in "person centered care"
- Will try to advocate better to improve quality of life of our residents and to move forward to patient centred care
- You need the buy in from staff
- The changes cannot be a top-down trajectory, has to be from both sides
- Commitment to do better steps/changes to provide quality and person centered approach in people with dementia
- Showing support to co-workers
- Practice teamwork
- Start with head RN and managers to view and come together with a plan to implement "if adopted" to all nursing team
- Get buy in through staff participation & staffing levels

Implementation ideas

- Small groups
- Trial groups
- Brainstorming sessions on specific projects
- Person centred care plan for the whole floor
- One thing at a time
- Creating a plan for team
- Ongoing reinforcement of new practices with all staff levels with supportive tools to improve care of residents
- Prioritize
- Encourage teamwork
- Use the different modules to prove that it works (for elders with dementia) successfully

- Positive, identify champions
- Mentor & Model attitude & behaviour & communication signage of models/concepts
- Discuss with them all the anticipated practices & how to overcome these barriers
- Changes in policy
- Better organization-more planned admission will allow smoother transition of transfer to the facility
- Involve residents, staff & family & professionals
- Make it a team project; delegate; make a plan to schedule the time; make it a goal/strategic plan
- Develop relationships
- Validate the contribution of each role
- Focusing on person centered care

Other

- Staff needs to have more time get to know the resident. Environment/reason can be more well prepared
- Assess properly and encourage clients to rent equipment
- To talk to the husband to come in the evening, because that's the time she really needs someone to be with her but husband can't do it. Medications increase so hopefully it will help.
- Work "smart"-use techniques learned to de-escalate behaviour before it comes incorrigible
- Simplify form and language to a level direct care staff is able to understand