Reviewing Lean Philosophy and the Admission Process to Long-term Care

A Field Practicum Report

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By

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Abstract

This report reflects my practicum experience with the Kelsey Trail Health Region (KTHR) and the Parkland Place Long Term Care (LTC) Management Team in Melfort, Saskatchewan. The practicum took place between April 1 and June 30, 2013, with the objective to learn and practice at a senior management level with a focus on analyzing LTC policies, procedures and a Lean approach to admissions, management, and patient centered care through the lens of social work. This paper follows the direct practice framework recommended for integrative practicum reports as outlined by the University of Regina, Faculty of Social Work; covering theoretical frameworks used during field practicum including empowerment theory, systems theory, Lean theory, ecological theory and life course theory. Descriptions of the agency, practicum goals and objectives are also included. One case study of a client and his family’s experience with admission to LTC is examined along with a value stream map of the admission process. The ideology, values, ethics, relationships, strategies and skills used during the practicum are discussed, and the report concludes with my recommendations. This conclusion includes discussion related to my experiences during the field practicum in LTC management, and how a specialized skill set is required to be successful in the profession of social work.
Acknowledgment

I wish to thank Twila Yackel, Facility Administrator of Parkland Place with Kelsey Trail Health Region for providing me with a fulfilling practicum experience. The Parkland Place management team and staff both welcomed me and allowed me to be immersed into the day to day demands of LTC management. Transformational work is being done by management in order to accomplish daily improvements for residents, staff, and the agency, I am ever so grateful for the experience at Parkland Place. I also wish to thank Dr. Bonnie Jeffery and Dr. Nuelle Novik for their guidance during the final phase of the Master of Social Work Program. Thank you to Patti Cram, my Professional Associate for supporting my decision to complete a rural practicum. Patti provided me with encouragement and solid social work feedback throughout my practicum placement via teleconference.
Dedication

To my sweet husband, Rod: your guidance in navigating the roles I continually take on continues to amaze me, you make me feel whole. Also, a special thanks to my daughter and editor Brenna Strohschein for her editorial expertise. Lastly, thanks to my family, friends and colleagues for their understanding, patience and support throughout my education journey. In conclusion I must give thanks, honour and glory to God for giving me the strength, wisdom, insight and endurance to complete the demands and requirements of the Masters of Social Work Program.
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<td>Kelsey Trail Health Region</td>
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<td>Long Term Care</td>
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<td>ARC</td>
<td>Admissions Review Committee</td>
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<td>RAI-MDS</td>
<td>Resident Assessment Instrument Minimum Data Set</td>
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<td>CASW</td>
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Chapter 1: Introduction

Background

Dagnone (2009) recommends that the health system make patient and family centered care the foundation and principal aim of the Saskatchewan health system, through a broad policy framework to be adopted system wide. Developed with patients, families, providers, and health-system leaders, this policy framework should serve as an overarching guide for health care organizations, professional groups and others to make the Patient First philosophy a reality in all work places (p. 4).

I entered the graduate studies program with a desire to both learn and understand how leadership impacts clients, employees and communities. A field practicum in a Long Term Care (LTC) setting was chosen as it offered a great learning opportunity while also allowing for managerial development in social work leadership. In 2011, the Ministry of Health introduced Lean methodology to transform the face of healthcare in Saskatchewan (Saskatchewan Ministry of Health, 2011b). Lean methodology is a new way of service delivery promoting collaborative partnerships between healthcare providers, clients and families to improve safety, quality and reduce costs (Saskatchewan Health Quality Council, 2013). The field practicum was an opportunity to experience Lean management from the perspective of senior and middle management, front line staff, residents and families. As a professional social worker in healthcare I have been exposed to both the positive and negative reactions to Lean philosophy and methodology. My practicum was centered on learning Lean philosophy and methodology from a management perspective to gain a clearer understanding of the advantages and disadvantages in delivering patient and family centered care.

This setting provided the opportunity to complete my field practicum from a systems approach, and to look beyond day to day management in order to view social work practice from an altruistic and all inclusive leadership perspective. A systems approach provides an inclusive micro, meso and macro perspective necessary when working in a leadership position. Leadership in health care and social work go hand in hand because social work values the pursuit of social
justice and respect for dignity and worth of persons. LTC, like many aspects of our healthcare, bears its own issues such as ageism, policy reform and under-staffing, all of which I feel need to be addressed from a systems approach. A social worker understands the dynamics of systems work therefore can work towards addressing the multi-level issues. Results of a study on social work leaders found that these leaders were different than other professions because of their commitment to their code of ethics, systemic perspective and concern for the public image of the profession (Rank & Hutchison, 2000). Issues identified from local and provincial perspectives are confirmed by the World Health Organization and include:

1. The role of family and informal care and mechanisms to support the family
2. Issues of coordination among various LTC services and of LTC with the health and social service systems
3. Human resource strategies in delivery of LTC

(World Health Organization, 2003).

This field practicum placement provided an opportunity to bridge the needs of LTC residents and their families with the current focus on Lean philosophy as mandated by the Ministry of Health in Saskatchewan.

Selection of Practicum Placement: Personal Reflection

I completed course content for graduate studies by commuting to Regina and Saskatoon from Melfort over the past three years. I have extensive clinical social work experience within health care and felt strongly that this practicum experience would provide opportunity for further growth and development in health care to better prepare for career growth into a management position. The opportunity to increase my knowledge of Lean philosophy is timely given that the Saskatchewan Ministry of Health has mandated all heath regions provide kaizen basic education
for all staff, a training which provides basic Lean concepts, methods, tools and a common language and understanding (Kelsey Trail Health Region, 2012b). Kaizen is a Japanese term which means “good change.” I completed the kaizen basic training and learned that kaizen basics in healthcare examines various processes that can be measured, such as flow of patients, flow of supplies and flow of information. Kaizen basics promote standardized work processes by focusing on continuous flow for employees and residents. Some of the specific projects Kelsey Trail Health Region (KTHR) is currently involved in with LTC are; fall prevention, medication reconciliations, hand washing audits and patient satisfaction surveys.

A recently completed course on aging, society and human service work heightened my awareness of ageism and the growing need of services for seniors and those individuals requiring long term residential care. This course also pushed me to pursue a field practicum in this area to gain better understanding. For many seniors, requiring LTC is not a choice, but a necessity as 24 hour care is required, usually due to a medical crisis. To say that ageism exists in these situations implies that older people are specifically disadvantaged or treated in a less than desirable way because of their more advanced age (Kane & Kane, 2005). As a social worker in a management position I believed I would be better situated to address issues facing LTC such as ageism and problems associated with the admission process through a variety of approaches which would include a systems perspective. KTHR set improvement targets for March 2017 to reduce the number of patient days for seniors occupying acute care beds awaiting community services, to implement Lean across the care continuum, and continuously improve healthcare in partnership with patients and families (Saskatchewan Ministry of Health, 2011a). As such, I wanted my practicum to benefit the agency in assisting with moving forward the patient and family centered
care directives as well as bringing forward issues of coordination and transition to LTC, and human resource strategies with LTC.

Relationship building was integral to success for my practicum experience at Parkland Place which is operated by KTHR. A conscious effort was made to meet new staff and residents each day, intentionally meeting with different groups of workers at coffee and lunch breaks to discuss and share information about my practicum in order to begin the process of building trust and rapport within the agency. The practicum time was invested in learning through observation, participation, consultation and research; as such this paper includes my experience and critical analysis of Lean methodology and philosophy and the admission process at Parkland Place. The term Lean has been broadly used to define a way of thinking, a philosophy and a methodology. Therefore throughout my paper I will distinguish between both Lean methodology and Lean philosophy. Lean is a quality improvement model adapted by Kelsey Trail Health Region and the Saskatchewan Ministry of Health and is defined as “an improvement methodology based on customer centric definition of value and providing that value in the most effective way possible, through a combination of the elimination of waste and a motivated and engaged work force” (Sayer & Williams, 2007, p. 339). Wellman, Hagan & Jeffries (2011) define Lean philosophy is making it clear “that patient well-being is critical; that supporting the people who work in hospitals is essential; and that sustainable long term change that is broad and deep is the only answer” (p. 2).

Outline of Paper

This paper will provide a description of the agency and services provided, in addition to my practicum goals and learning activities which discuss the admission process and Lean philosophy and methodology. This paper will examine a case study and interviews with four
clients and families including a description of one Lean methodological tool called a value stream map. The case study and interviews will integrate and discuss ideologies, values, relationships, strategies and skills used during the practicum placement.
Chapter 2: The Practicum Placement

Description of Agency

My practicum placement with Parkland Place in Melfort, Saskatchewan was a three month full time practicum from April to June 2013.

Parkland Place is a LTC facility employing approximately 200 personnel and is dedicated to providing a caring environment that offers physical, social, emotional, spiritual support and a holistic approach to quality care. There are 105 private beds within six houses on two floors, including two respite beds and one specialized house for residents requiring specialized dementia services. Admission is coordinated by the Admission Review Committee (ARC) who review and make recommendations for placements to LTC facilities in the Region. The ARC is a single point of entry for long term placement and temporary respite. The purpose of single point entry is to provide clients of KTHR a common assessment point that will identify unmet needs and appropriately match client needs to available resources within Kelsey Trail Health Region.

The agency provides service to 105 residents. There are 100 beds designated for LTC, 17 of which are designated for a specialized care unit that provides care for individuals diagnosed with dementia and Alzheimer’s. Parkland Place also provides a respite care service providing pre-arranged respite care for family members for both planned and emergency respite. It was reported to me that over the past five years, Parkland Place has had an average of 60 admissions each year into the LTC beds while also providing respite care for families. The services provided at Parkland Place include in-house recreation, therapy programs, food services, foot care, housekeeping, laundry, nursing, social work, spiritual care and volunteer services. Residents and families are consulted by staff in order to better understand the residents’ hobbies, interests,
community outings, food preferences, family history, work history, faith community and general likes and dislikes. These efforts are designed to better meet the needs of each resident.

The Parkland Place management team is guided by KTHR’s Vision of ‘Healthy People in Healthy Communities’. The mission statement is ‘Working Together to Improve the Health of People,’ with the following values; respect, transparency, excellence, accountability and engagement (Kelsey Trail Health Region, 2010). In addition, KTHR has set objectives for planning, as outlined in the document *Strategic and Operational Directions for the Health Sector in Saskatchewan 2011-2012* (Saskatchewan Ministry of Health, 2011b). This document stipulates provincial and KTHR initiatives, three year targets and benchmarks used to assess targets. KTHR also must be in compliance with the Canadian Standards Association and Accreditation Canada Standards (CSAACS). The CSAACS is an independent not for profit organization that can provide an external review process for the KTHR Board of Directors. Kelsey Trail Health Region participates in the Accreditation Canada Qmentum Program which focuses on improving the quality and safety in health care. It is an effective and proven process for organizations to regularly examine and improve their services.

In March 2013, KTHR, introduced a document titled ‘KTHR Patient and Family Centered Care’ which aims to engage the family and patient as partners in their care; rather than the current state of patient and system focused care (Kelsey Trail Health Region 2012a). KTHR partners with patients and families at all levels in the organization, respecting their preferences, values and culture to ensure quality and dignity of life. KTHR promotion of patient and family centered care statement enhances the mission and values by outlining better care, better health, better teams, and better value as the basis of a new and improved model. Patient and family centered care is about providing respectful, compassionate, responsive care that meets the needs,
values, cultural backgrounds, beliefs and preferences of both residents and their families by working in partnership with them (Kelsey Trail Health Region, 2012a).

**Practicum Goals and Activities**

The following are my learning goals which aligned well with the Ministry of Health and Kelsey Trail Health Region’s LTC targets:

1. Improve the admission process at Parkland Place
2. Gain knowledge of management, Lean philosophy and methodologies.

In order to meet these learning goals, I was provided with a variety of learning opportunities. The following summary provides an overview of each of the activities I participated in over the three month practicum.

**Goal 1: Improve the admission process at Parkland Place.**

My learning goal was to review the current state of the admission process and make recommendations for improvement. Staff and management outlined concerns regarding the current admission process, detailing the short comings and opportunities. Staff reported the admission process took too much time for all parties, there was too much paperwork, and the process lacks input from families.

**Activity 1: Review admission process into LTC.**

In order to better understand the difficult nature of admissions, a literature review was completed and will be discussed in more detail in the next section. Staff, residents and families were interviewed for feedback on what improvements could be made to the admission process. A case study is presented in Chapter 3 which highlights the importance of the role of family, human resource strategies and issues of coordination among various available services. The case
Activity 2: Literature review of admission best practice to LTC.

A literature review was conducted on best practices for admission within which I learned that many admissions are crisis driven. Individuals and families will utilize all available supports and resources in the community in order to stay out of LTC. Often when a competent individual makes a planned move into LTC, even under ideal circumstances, it still is a difficult transition (Lloyd, 2009). The negative stigma associated with LTC points to an unhealthy setting for the aged that equates long term care as a *life not worth living* (Kane & Kane, 2005). As such when an individual and or their family member(s) are planning for a transition out of their home, admission can be a stressful time because of the associated negative stigma.

In addition to the negative stigma I will discuss why residents and families experience a sense of failure associated with LTC. The importance of adequate and quality staffing in LTC, relationship building between staff, residents and families, coordination of care, the significance of family and caregiver support, and life course theory will also be examined.

During my practicum experience I witnessed a majority of residents at Parkland Place coming from a rural background who survived the depressions of the 1920’s and 1930’s. Older adults from this era value their independence and tend to be unwilling to ask for help or to be perceived as an inconvenience to staff. “The value placed on independence, combined with a medical model of care contributes to the notion of individual failure on the part of those in LTC” (Armstrong et al., 2009, p. 20). The notion of dependence and failure are not valued in our society as independence is seen as a desirable trait. Individuals who are dependent on full time care are likely not going to return to a full state of independence. Therefore the notion of
dependency and failure perpetuates the assumption that LTC signals a time of waiting for the end (Armstrong et al., 2009).

A move into LTC is considered a life transition that most individuals have not prepared for and the transition phase can be experienced as a loss for many residents. Literature suggests that older adults transitioning into full time care are generally more passive and stoic which often hides feelings of loss and anxiety (Reed & Stanley, 2006). Literature also suggests that a smooth transition into these systems is critical to maintaining health and well-being; this requires coordination amongst all practitioners. An interdisciplinary effort is needed to provide integrated care whether that care is within one setting or with other organizations (Herman, 2009).

Human resource strategies are critical to successful admission transitions (Murphy, 2006). Knowledgeable staff, who are confident in their abilities to work with families and have the necessary supports to do the admission, are critical to setting the stage for a successful transition. Generally, when admission staff can create a positive outlook on an admission, the adjustment period for the resident and family is smoother and shorter (Fox, 2004). Inadequate staffing levels in LTC are a major factor in addressing quality of care for both residents and care staff. Minimum levels of nurse and personal care staff are necessary to avoid adverse outcomes, such as ulcers, and assist residents with activities of daily living, promote less time in bed and encourage social engagement (Murphy, 2006). In order to provide quality care, adequate staffing levels are necessary. Staffing data is often skewed because official staffing ratios are misrepresented when workers are not replaced when they are sick, on vacation, or if a vacancy occurs (Helfrich, McGregor, Cohen & McGrail, 2005). Inadequate staffing levels hinder the admission process as insufficient time does not allow new residents and family members to build relationships with staff though asking questions or building rapport. A critical component for
successfully guiding families through a tedious admission is a professionally and personally competent staff component (Presutti, 2007).

A good admission process is a process that also sets the stage for future relationship building and future gathering of critical information about the resident. During my practicum placement staff indicated they would like to better understand each new resident’s social history to build a more meaningful dialogue. The relationship staff develops with each resident forms the contextual frame through which staff views residents (Wiersma, 2010). Narrative practice in the format of storytelling and listening leads to ethical based care that prioritizes, resident’s personal meanings, and permits the resident to define quality care (Heliker, 1999). The days following an admission is critical for families, staff and residents to engage in dialogue that builds rapport, and helps the resident and family bond with personnel. Creating a strong bond can be done by incorporating care plans based on the personal story of each resident; these will be included in the file along with lab reports, treatment regimens and medication reviews to provide a holistic presentation of each new resident’s story.

In order to prepare and complete a new admission, adequate and informed staffing is critical, and staff must be available to assist residents in their adjustment. “Opportunities should capitalize on staff’s obvious awareness and empathy of the residents’ experiences, and the time and resources should be made available to allow staff to be present for residents in a compassionate and empathetic manner” (Wiersma, 2010, p. 433). It is equally important that staff are well informed about the transition and adjustment process for new residents so they can support residents in meaningful ways.

Issues of coordination amongst various services such as acute care, home care, and LTC with health and social services, impact how a client adjusts to admission. “Transition of care
takes place when a client requires a necessary change in services or care” (Taham, 2007, p. 41). Older adults can face several transitions of care among care providers and across care settings on a daily basis. As such, older adults are at risk for medical and psychosocial complications during transitions (Coleman & Berenson, 2004; Tahan, 2007). Transitions of care between services in LTC can be uncoordinated and complex; and this can therefore be detrimental to the wellbeing and health of older adults. Ideally, transitions should be planned and orderly thorough seamless communication between agencies. During such transitions, older adults are at increased risk for medical and psychosocial complications. “Quantitative studies have consistently shown that patients and their caregivers are unprepared for their role in the next care setting, do not understand essential steps in the management of their condition, and cannot contact appropriate health care professionals for guidance” (Coleman & Berenson, 2004, p. 533). Successful transitions in care depend on the collaboration and communication of every practitioner and organization involved in a client’s care, and social workers can play a key role in preventing and remediating problematic transitions. Therefore it is important that smooth transitions of care are planned as an aspect of a quality admission.

Without a coordinated approach, bottlenecks in the health care system will continue to occur given the sizable cohort of seniors whose needs have been underserviced. Bottlenecks occur in both urban and rural health care systems where hospital beds are occupied by people waiting for a long term care bed. Availability of informal and formal resources and availability of long term care spaces directly impacts individual’s options when considering admission into long term care. For example in Saskatoon demand for LTC beds outnumber current available services and resources for seniors. “Saskatoon Health Region has activated its emergency response to handle a record number of patients in Saskatoon hospitals. As of noon on September
26, 2013, 55 people were waiting for emergency departments, inpatient beds and 80 people waiting for long term care placement” (Saskatoon Health Region, 2013, p. 30). In addition a Saskatchewan Pilot Project Report (2011) indicates that the shortage of seniors’ housing in rural areas has created increased reliance on the Health Region’s LTC facilities (Jeffery, Bacsu, Martz, Johnson, Novik, & Abonyi, 2011). Research supports the idea that poor availability of in-home services in rural communities and seniors’ strong community attachment and unwillingness to relocate even in the face of health problems often limits their option to LTC (Keating, Swindle & Fletcher, 2011). For some residents this means LTC is their only option, regardless of whether they actually require this level of care. Often clients who do have access to home care services are able to stay in their home and receive adequate support do so. However, as demonstrated within the literature, rural clients may not have access to a full array of home care services and as a result, may only have access to family support (Keating et al., 2011).

Canadian research on care to frail older adults showed that children provided most of the care to both rural and urban older adults (Keating et al., 2001). If family is unable to adequately care for their family member and an admission to LTC is considered there is a notion by society that family has failed and this can contribute to the guilt of having to place a family member into LTC. The notion of failure is reiterated when the application to LTC is made because families must prove there is an unmet need before the individual can be placed on a waiting list. “LTC facilities are based on particular notions of care, of family, of individuals and of women. For the most part LTC is riddled with notions of failure on the part of them all, even though these notions are rarely articulated and rarely linked” (Armstrong et al., 2009, p. 12). It can also be said that family members especially women, wives, sisters, and daughters also face similar public scrutiny and a sense of failure when a family member is placed into LTC as women are
the caregivers in society’s eyes. “The notion of family failure can add to the guilt and concern women feel as relatives, as well as to the hesitation they have in considering sending their relatives into LTC unless every possibility is exhausted including their health” (Armstrong et al., 2009, p. 16). If the negative stigma of LTC was removed and families viewed LTC as a feasible option for maintaining quality of life for their family member, the family would not feel as though they failed. This would make the admission process less traumatic.

Admission into long term care impacts family members as families can experience a sense of guilt and sadness when having to make a decision to place a parent. The stigma of nursing homes together with emotional ties to parents can trigger a wide range of emotions for family members when placing a family member into care (Presutti, 2007). Literature suggests that family members are impacted when placing a loved one into care facilities and that the facility must consider psychosocial supports in the form of individual, family and group support to assist families in adjusting (Sidell, 1997). During my practicum, all residents moving into Parkland Place had a family member or friend accompany them to provide support during admission day. Residents who have healthy formal and informal supports generally transition better into care because of the successful integration of both public and private support (Arnett-Connidis, 2010). KTHR employs one full time Regional Social Worker to provide support to residents, families and staff in LTC who require case management and or counseling for adjustment difficulties and coping with complex situations during the admission process and residency.

When examining the admission process to LTC it is useful to consider what happens in early life as a link to the outcomes of family ties in later life. The emphasis of the life course perspective focuses on the older adult’s ability to successfully transition through each life stage.
Life Course Theory is based on the concept of aging as a normal developmental phase of continuing growth and productivity in the life cycle, with emphasis on a continuing contribution to society (Wells, Singer, & Polgar, 1992). Life course theory, when viewed through a social work lens, is relevant to admission to LTC home because consideration must be given to the residents and staff needs based on their life cycle. Arnet-Connidis (2010) refers to the life course theory as “linking the experiences of later life to earlier life stages and of older family members to younger ones” (p. 16). More specifically, life course theory promotes values of ongoing growth and development for new residents in which their contributions are valued and respected.

The transition is easier when social networks provide informal supports to protect and guide individuals through a life transition such as the admission process. The quality of the informal and formal social networks in both the private and public domain will have an impact on how older adults adjust. A life course perspective also improves the possibility of policy and program initiatives to address real situations and target appropriate intervention points during the life course (Arnet-Connidis, 2010). Also, positive social networks can be powerful advocates for older adults navigating a system of services to fit their needs. For example, ensuring that older adults have access to home care service, transportation, lifts, ramps and other adaptations for their homes’ so they may remain independent at home is important to the admission process because given the necessary supports individuals could remain in their home and prevent an unnecessary LTC admission. In addition, individuals who choose and require LTC should feel supported and confident in the care that is provided and social networks can definitely ensure positive transitions and placements.
KTHR policies and procedures are the strategic link between the organization’s vision and day to day operations. In the following section I will discuss how the policies and procedures impact residents and families experience with the admission process.

**Activity 3: Review KTHR admission to LTC policies and procedures**

The KTHR admission and discharge policies and procedures were developed in 2010, to establish a single point entry for residents applying to LTC. I reviewed the KTHR policies and procedures that were developed as per the Ministry of Health directive. The Admissions Review Committee (ARC) was established to review applications and place residents requiring care in a prioritized manner. Current admission forms were also reviewed and compared with admission processes in ten homes across the Kelsey Trail Health region. I found the admission forms and the admission process was different within the ten homes in the region. In order to provide feedback and recommendations to management a face to face meeting was arranged with Nipawin Pineview Lodge, a facility of similar size to Parkland Place within KTHR, to discuss admission processes, forms and flow for patient care. The meeting was productive and built capacity for sharing resources, building relationships, and making recommendations for change.

The ARC committee consists of a group of discharge planners from each acute care facility and home care office in the region and the regional LTC social worker. This Committee meets weekly in order to allocate LTC beds within the Health Region. One challenge that I observed from ARC committee participation was related to the process of how a client is determined to be most in need for the next available bed. One of the issues contributing to the problem is the assessment instrument used for rating client need. The instrument is called the Resident Assessment Instrument Minimum Data Set (RAI-MDS). The instrument scores are subjective based on the rater and on the resident’s health status at the time of rating. The inter-
rater unreliability causes problems when placement is based solely on the MDS score because some residents will score higher than what their actual care needs may be; thus placing them in a higher level of care. I also observed problems associated with the MDS electronic system saving and losing data and staff not being trained to update the electronic system. Policies and procedures related to assessment tools used to determine eligibility for LTC must be reliable and practical. In addition, the policies specified the ARC shall hold quality assurance reviews periodically to ensure the ratings of clients are consistent with the region. The ARC chairperson and Facility Administrators were not aware of how this policy is being followed.

From a Lean perspective the ARC uses an ineffective system of batching referrals meaning that, decisions to fill beds wait for the once a week ARC meeting. Lean methodology promotes continuous flow which means a continuous admission flow should occur so vacancies in LTC are filled immediately and beds are not left empty. An example of how continuous admission flow works is Saskatoon Health Region recently implemented a computerized tracking bed management system at a cost of $700,000 for managing hospital beds and the plan is to extend the program to LTC. The bed management system promotes continuous flow of patients within a region so that once a bed is available it is posted on the system and can be filled at any time as opposed to the previous system that utilized voice messaging systems to fill a bed (French, 2013). Another option the ARC committee could consider to improve flow of patients to long term care from the community and hospital would be to hold additional ARC meetings during the week to move patients from hospital and community to long term care more efficiently. The practice of residents waiting in hospital for a LTC bed is costly. Policy reform to improve admissions to LTC could include the Ministry of Health sharing resources such as the Saskatoon computerized bed tracking system with smaller rural health regions such as KTHR.
In addition to reviewing admission policies, one of my tasks during this placement was to assist the Agency in a review of existing procedures and forms used by staff, residents and families when moving to LTC. The focus of the review was to identify and update the current forms to reflect the new ‘patient and family centered care policies’. I reviewed and drafted revisions for the following documents; Residents Rights and Responsibilities, Parkland Place Information Booklet, the Supportive Care Agreement, and 62 individual Admission Forms some of which dated back to 2004 which are completed by business office staff and the admitting nurse.

As part of my placement I completed the tasks of drafting updates to the current forms and documents related to the admission process and to better align with the new policy on patient and family centered care. The Regional Supportive Care Agreement used between the resident and Parkland Place was revised by myself based on input from staff, residents and families to better reflect current practice and promote client and family centered care in two easy to read documents that separated the financial and support aspects of the agreement. The financial agreement covered a breakdown of costs associated with monthly fees, additional expenses and financial responsibility. The supportive care agreement covers Parkland Place and resident and or family responsibilities, general care policies, medical policies, transfer and discharge policies, and privacy and confidentiality policies. Another one of my tasks was to update and refresh the Welcome Guide, an information booklet for new residents and families moving into Parkland Place. The following information included in the welcome guide is; a description of services provided, general information, description of residents right and responsibilities and contact information. All proposed new documents were reviewed by residents, families and staff for input and feedback. Again, it was important to ensure that all documentation referring to the
admission process was aligning with the patient and family centered care policy and residents and families were given an opportunity to provide input on the revised forms and procedures.

Social work managers require a strong skill set to manage change successfully in a large organization such as Parkland Place. In order to manage even small changes such as revising admission policies and procedures it was important to be completely transparent with staff. Staff needs to feel valued and respected for the work they do and even a slight change to their routine can have a major impact on their performance. As part of my practicum placement I was responsible for keeping staff, residents and families informed about the review and proposed revisions being worked on to improve the admission process. I presented information about the goals of my practicum placement at a family council meeting. Family members were encouraged to provide feedback and input on the tasks I was involved with by contacting me or the Facility Administrator. A collaborative approach was necessary to successfully complete my practicum goal of improving the admission process therefore a partnership including, staff, residents, families, managers and myself was critical to accomplishing this task. The following section will discuss the details of how collaboration was critical in completing the task of developing an admission checklist.

**Activity 4: Develop admission checklist.**

Parkland Place staff requested an admission checklist be developed for staff to ensure consistency and quality care be delivered throughout the admission process. My role was to review Parkland Place current admission process and draft a checklist for staff to ensure a standard admission process that was consistent and focused on resident and family centered care. The 2013 Stats Report indicates there has been an average of one admission per week for the past three years (Parkland Place, 2013). I participated in one admission and witnessed the weekly
completion of admission forms by staff. Together with staff, residents, and families an admission checklist was developed to provide details for staff on the tasks requiring completion prior to admission, during admission and after admission. The checklist was designed to be user friendly and easy for new staff to conduct an admission with a new resident and family member(s) with current forms, procedures and practices included. The orientation checklist and forms were to be updated and replaced in each house at Parkland Place.

**Activity 5: Develop a feedback loop for residents, families and staff.**

I had the opportunity to participate in the design and implementation of a feedback loop to promote open communication with residents, families and staff from the time of application to LTC, admission and throughout the resident’s stay at Parkland Place. I was advised by management that a feedback loop was a lean initiative directed to Saskatchewan LTC facilities by the Ministry of Health. A feedback loop would be established by meeting face to face within 30 days of admission with resident, family, staff, management, and the multi-disciplinary team to discuss care. The face to face team meeting is an opportunity to work collaboratively and build partnerships with residents, families and staff as part of the patient and family centered care initiative. The director of activities and therapies was responsible to schedule the team meeting and it was her suggestion that the purpose of the team meeting be discussed with family and resident at admission and that a meeting date be scheduled on admission day. Team meetings are also scheduled annually or as requested by any member of the team.

An example of a collaborative approach at a team meeting I participated on was discussing a concern by staff of a resident’s risk of falling. Residents and their families have control over the amount of risk a resident takes. Residents may choose the amount of risk they are prepared to take and staff must inform the resident and family of the possible outcomes. The
amount of risk was negotiated between staff, resident and family in a way that was respectful to
the resident yet still met their needs. The family and resident did not want to use restraints to
protect the resident from falling. Therefore the resident would require constant supervision by
staff to prevent a fall which was not feasible. During the team meeting the resident, family and
staff negotiated an acceptable plan and as a result the resident agreed to wearing hip protectors
and using a bed alarm. This compromise allowed the resident their mobility and independence
yet reduces the risk of injury, and both parties felt their concerns were heard.

Patient and family centered care promotes empowering the client to have a voice that is
heard in order to move beyond slogans to actually direct resident’s care appropriately within
their health care team. Team meetings provide an opportunity for a feedback loop to allow open
discussion of a concern and brainstorm together a plan that is acceptable to everyone. When
managers work from an empowerment perspective and consider the needs of everyone involved
within the organization, the residents, families and staff, social justice is promoted. The main
characteristics of empowerment practice are the client and worker join to gather and evaluate
data and to formulate an on-going assessment of the internal and external components of the
problem and its context (Gutierrez, Parsons, & Cox, 1998). Today social workers in leadership
positions are ideally positioned to promote empowerment practice with individuals, families,
groups and communities. Empowerment also promotes self-determination and self-actualization
when client groups are valued, engaged and provide input into their care.

Some of the challenges associated with establishing a feedback loop included losing sight
of the purpose of the team meeting to have open communication with all team members and to
be resident and family centered. An example of how feedback loop is not working is when one
family member jokingly stated she “felt outnumbered” at the team meeting. The family member
attended the team meeting without the resident with seven staff members in attendance representing various departments. During my practicum placement seldom did residents attend the team meeting. Lack of resident input is a concern regardless of whether family members attend the team meeting or not. A feedback loop can only be effective if the resident and or family are at the center of the team. Patient and family centered care promotes client and family having power and choice. Therefore regardless of the reason why a resident is unable to attend ‘their’ team meeting, a client advocate should be available to participate on the team to ensure the clients best interests are promoted and documented as central to the feedback loop.

The current model of patient and family centered care is key to the implementation of the feedback loop. However, the feedback loop is not working because the model has not been embraced and operationalized by staff due to various limitations. Social work managers must be aware and utilize multi-level empowerment strategies to address personal, inter-personal and environmental issues for staff and residents. “Though empowerment practice builds on theoretical bases from social work practice its roots lie in a particular political economic perspective. This perspective assumes that social problems occur in all tiers of multi-level systems and exist with varying degrees of power” (Gutierrez et al., 1998, p. 7). This means in LTC the organization that serves the elderly has the power to control the quality of life of the resident. Community development strategies, like the resident and family councils, are a step in the right direction to heighten the awareness of resident concerns and level the power imbalances at the personal and inter-personal levels. Social work managers working in LTC must recognize the vulnerability of the groups they are serving who may be unable to advocate for themselves. Social workers have a responsibility to raise awareness of the issues of ageism, policy reform, and advocacy. Social work managers may use political networks to build a power base and
establish connections for change such as bringing forth the voices of residents and families so that there truly is a feedback loop with open communication within the care team.

**Goal 2: Gain knowledge of Lean management, Lean philosophy and methodologies.**

Lean is a term that has been used widely in Saskatchewan healthcare for the past several years. Lean is often associated with production or manufacturing industries and has yet to become commonplace across all sectors of business in our society. The Saskatchewan government and KTHR senior leadership believe they can transform healthcare through a Lean management system (Saskatchewan Ministry of Health, 2012). Lean is a quality improvement model adapted by Kelsey Trail Health Region and the Saskatchewan Ministry of Health and is defined as “an improvement methodology based on customer centric definition of value and providing that value in the most effective way possible, through a combination of the elimination of waste and a motivated and engaged work force” (Sayer & Williams, 2007, p. 339). Some of the methodological tools I will discuss in detail later in this chapter are; 5-S, Kanban and Value Stream Map. Wellman, Hagan & Jeffries (2011) define Lean philosophy is making it clear “that patient well-being is critical; that supporting the people who work in hospitals is essential; and that sustainable long term change that is broad and deep is the only answer” (p. 2). The term Lean has been broadly used to define a way of thinking, a philosophy and a methodology. Therefore throughout my paper I will distinguish between both Lean methodology and Lean philosophy.

In order to accomplish my goal to gain knowledge of lean management, lean philosophy and methodology I completed three learning activities. I will discuss what I learned in kaizen basic training, outline the four strategies KTHR has developed to achieve their vision of healthy
people in healthy communities, and discuss the challenges of implementing lean philosophy and methodology.

**Activity 1: Participate in Lean training.**

I participated in a workshop on May 25, 2013 on transforming health care through Lean philosophy and Lean methodology for KTHR staff presented by the Health Quality Council. Attendance at the workshop included front line staff, middle managers and board members. The regional training event was a KTHR initiative to begin information sharing, engage staff in Lean methodology and develop a readiness for change within the organization. Strong employee engagement is a strategic goal for a growing number of organizations in many industries including healthcare (Lowe, 2012). To better understand why Lean is being implemented the Patient First Survey detailed information from many people asking patients, clients, residents, and healthcare workers what worked best for them in regards to service in health care. The information gathered from this survey outlined key issues in health care and how things need to be done differently. Values identified from the survey included: putting patients first, providing health care workers with appropriate tools, and developing a more cohesive system (Dagnone, 2009). The Ministry of Health, Health Quality Council and Health Regions implemented Lean to improve healthcare based on the recommendations from the Patient First Report. In order to achieve the vision of healthy people in healthy communities and the mission of working together to improve the health of people, the Ministry of Health and KTHR developed four strategies:

1. **Better Teams**

   Build safe and quality workplaces that support patient-family centered care and collaborative practices, and develop a highly skilled, professional and diverse workforce that has a sufficient number of service providers.
2. Better Health

Improve population health through health promotion, protection and disease prevention and collaborating with communities and other government organizations to close the health disparity gap.

3. Better Care

In partnership with patients and families, improve the individual’s experience, achieve timely access and continuously improve healthcare safety.

4. Better Value

Achieve best value for money, improve transparency and accountability, and strategically invest in facilities, equipment and information infrastructure (Kelsey Trail Health Region, 2013a).

Dagnone (2009)”states it is time to realign the values of Saskatchewan’s health system so that the patient is again made the center of attention” (p. 3). A physician’s presentation on “The Skinny on Lean” suggests that “value added for clients means more than systems and processes but rather a kind touch, less waiting time and not getting lost in the system”(Dr. Susan Shaw, personal communication, April 19, 2013). All of these actions add value and indicate that value is about caring. Therefore if Lean methodology can actually put the client first by listening and doing what the patient values then as a healthcare providers we need to give it a try.

Some of the challenges I observed during my practicum and employment pertaining to Lean methodology are managers using Japanese terminology to measure and define processes over the past several years with staff and staff not understanding the point because of the foreign language being used. Also, staff resistance towards Lean philosophy was perpetuated from the organization’s weak employee engagement strategy. The roll out of lean has been nearly four
years and staff are only now receiving the ‘Kaizen Basic Training’. Radnor and Walley (2008) suggested that engagement in the change process may be more important than the concepts of lean itself. “…the contribution of Lean in such cases could have been much more to do with the engagement of the employees in the change process and the immediacy of the changes that occur implementing Lean” (Radnor & Walley, 2008, p. 9). In other words, if employees are not engaged then organizational change will not occur.

**Activity 2: Conduct a 5-S.**

I met with KTHR Kaizen promotion staff to learn more about the work their office does and the directives applicable to LTC. Kaizen is a Japanese term meaning continuous incremental improvement (Black & Miller, 2008). A kaizen promotion staff member in Saskatoon who is directly involved with LTC initiatives for the Saskatoon Health Region discussed some of her current projects with me. One of the major challenges with implementation of Lean methodology for KTHR is there are only two staff members hired to promote and manage Lean initiatives for the health region. KTHR has no additional funding to provide additional staff to work directly with LTC to assist with the extra work necessary to implement Lean philosophy and to chart the LTC initiatives using Lean methodology as directed by the Ministry of Health and KTHR management.

One tool that Lean methodology promotes is 5-S; my practicum supervisor gave myself and two staff from the recreation department an overview of 5-S to help us put Lean into action. 5-S is a tool used in Lean methodology for organizing the work place. The five ‘S’s refer to sort, sweep, simplify, standardize and self-discipline. 5-S is a visual system for organizing the workplace to keep everything neat and in a proper location (Black & Miller, 2008). The goal at Parkland Place was to decrease inventory of recreational and therapy items in the storage areas.
and create a more efficient, standardized workspace for employees. The standardized workspace allowed staff to spend additional quality time with residents. Currently, the activity department was using nine shared storage areas with the therapy department. Nurses, continuing care aides, licensed practical nurses, housekeeping staff, and maintenance staff all work in these areas. There is a large supply of inventory which is outdated and mislabeled with no system for replenishment. Staff reported that often they cannot find what they are looking for resulting in increased waiting time for residents in their recreational and craft activities. A three day blitz was completed; the outcome was an organized, efficient workspace with improved productivity, increased floor space and a showcase of materials and supplies. Staff commented that it was a pleasure to work in their department and know exactly where materials were stored. Because of this exercise, staff are available to spend more time one on one with residents, an increased variety of activities are available, staff waste less time searching for materials and staff, and residents are generally happier.

Through my practicum experience another Lean tool, a kanban was implemented by one staff person to save money and add value to residents at Parkland Place. A staff member volunteered to work on this project to improve access of nursing supplies for staff and to increase care for residents. A kanban is a Lean tool that automatically signals when new supplies are needed (Black & Miller, 2008). A kanban was used to organize and order supplies for the nursing cart located in each house at Parkland Place. The nursing supply cart was designed with an alphabetized list of inventory and a two bin system contained on the cart. The system works well because when the first bin of nursing supplies becomes empty, the bin behind that one is then moved to the front of the car and the empty bin is sent to materials management to be filled. An identical nursing supply cart was placed in each house standardizing the system for all staff.
Value is added to the residents’ because they now receive nursing care in a timelier manner and the agency only orders stock when necessary and no longer has stock piled supplies that expire before they are used. The kanban also proved effective for timely billing to residents for nursing supplies because in the past often no bill would get sent because there was not a system in place to keep adequate track of supplies used.

**Activity 3: Conduct a value stream map.**

Another task that I focused upon during my practicum placement was conducting a value stream map. A value stream map is a visual tool used to map out and understand the flow of residents/clients, supplies, and information through the health care experience. A value stream map shows the processes from the time the service is requested to when the service is completed (Black & Miller, 2008). It maps all actions currently required to deliver a service such as a new admission and provides a big picture perspective that focuses on improving the whole from the standpoint of the client. A value stream map is another Lean methodological tool used to measure baseline and progress. I will present a case study in Chapter 3 which illustrates the use of a value stream map by describing the current state of admissions while formulating a plan for the future state to improve flow and increase value to the resident.

**Agency Values**

Dagnone (2009)”states it is time to realign the values of Saskatchewan’s health system so that the patient is again made the center of attention” (p. 3). The entire purpose of introducing Lean philosophy and Lean methodology was to improve the current state of the health care system by placing the patient/resident at the center of their care. This means the staff must actually listen to the resident and do what the resident and family value. KTHR promotes the values of respect, transparency, excellence, accountability and engagement. Respect is shown by
supporting clients, colleagues and partners in positive productive relationships. Transparency is demonstrated by taking every interaction as an opportunity for caring, compassion, and to build trust with each person. Excellence is pursued through diligent effort, both individually and collectively. Accountability is demonstrated by thoughtful guardianship of resources. Lastly, engagement is continually worked on to earn confidence, faith and collaboration with clients and colleagues (Kelsey Trail Health Region, 2010).

Therefore in order to know whether an improvement will add value a tangible measure is needed. For example using 62 forms for an admission could be a baseline to determine if, in fact, all forms are necessary to add value to the resident during admission. Lean methodology identifies waste as anything that does not add value to the customer. Some of the types of waste identified in Lean thinking included: wait times, processing (unnecessary or redundant steps), corrections, managing complaints, search time (time spent looking for information) storage of unneeded items or excessive inventory (Black & Miller, 2008). Is it conceivable that the number of forms can be reduced with minimal interruption of work flow for the admission of new residents which will increase value for the resident by an added touch or listening ear as they go through what may be one of the most difficult transitions of their life? Is it possible that standardization of admission forms will free up staff to spend more one on one time with resident? Lean methodology promotes removing waste so staff will have extra time necessary to build rapport with the new resident and family which will truly add value to the resident and family experience.

Identifying the Population in Long Term Care

A manager working in LTC has the overall responsibility for the well-being of the entire organization which includes; residents, families of the resident and staff. Clients who call
Parkland Place home are currently between the ages of age 2-100 years and require LTC in their home community. Table 1 provides a breakdown of resident’s ages and gender encountered during my practicum.

Table 1 Age and Sex of Parkland Place Residents

<table>
<thead>
<tr>
<th>Age</th>
<th>#</th>
<th>Female</th>
<th>%</th>
<th>#</th>
<th>Male</th>
<th>%</th>
<th>#</th>
<th>All</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>69</td>
<td>68.32%</td>
<td>32</td>
<td>31.68%</td>
<td>101</td>
<td>100.00%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;65</td>
<td>7</td>
<td>58.33%</td>
<td>5</td>
<td>41.67%</td>
<td>12</td>
<td>11.88%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>4</td>
<td>44.44%</td>
<td>5</td>
<td>55.56%</td>
<td>9</td>
<td>8.91%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75-84</td>
<td>21</td>
<td>70.00%</td>
<td>9</td>
<td>30.00%</td>
<td>30</td>
<td>29.70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;85</td>
<td>38</td>
<td>76.00%</td>
<td>12</td>
<td>24.00%</td>
<td>50</td>
<td>49.50%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1 illustrates that women currently comprise the majority of residents (68 %). While 12 percent of residents are under the age of 65, most (49.5 %) are 85 years old or more, and 29.7 % of residents are between the ages of 75 and 84. Between the ages of 75 and 84 the proportion of women to men is roughly 2 to 1. This increases to a ratio of more than 3 to 1 for residents over 85 years of age.

These individuals have personal and health care needs which can no longer be met by community services such as home care and day programs. All clients residing in LTC must meet the criteria of the ARC through an assessment process which is completed by homecare services. Clients are assessed using a MDS scoring system to determine the need for services based on several factors such as medical needs, available supports, ability to walk, and cognitive ability.

Families play an important role in the transition of a resident as they too are impacted by the admission of a family member. As such, it is important that their needs are recognized and addressed by management and staff. Literature clearly shows that when individuals move to LTC there are adjustment phases for family members to adapt to (Sidell, 1997). Numerof (1983) suggests that family members have many of the same needs as new residents moving into LTC.
including the need to be oriented to the environment, to form a new support base, to establish new role definitions, and to redefine previous roles. “Placing a family member in LTC can be a traumatic event and requires a skilled, informed multidisciplinary response by staff” (Presutti, 2007, p. 54).

Managers must also consider the needs of their employees. The quality of relationships in the workplace relates directly to the quality of care providers’ work life and the quality of care they provide (Cohen & Yassi, 2003). Management needs to address the needs of both care providers and care recipients in order to improve the quality of care. Research shows that facilities with low worker injury rates have a combination of higher direct-care staffing levels and a more positive work environment (Cohen & Yassi, 2003).

Parkland Place is home to a few younger residents who value client centered care and have been advocates for client centered care. These residents value the patient and family centered care approach and are much more vocal, involved, and proactive about their care. These residents view themselves as consumers who are not a burden on the system. With baby boomers nearing the age of requiring more care services it is plausible that the current level of services provided would be deemed unacceptable. Through my practicum experience I participated in many multi-disciplinary team meetings and there was only one meeting in which a resident attended his team meeting and participated as a consumer. This team meeting was a true example of patient and family centered care which was directed by the resident advising staff what specifically adds value to his care. To better understand the how the resident is impacted by the various processes and systems in LTC an ecological framework will be discussed in the next chapter.
Ecological Framework

There are a number of theories and models that can be applied to management and enhance the quality of life for residents and staff in LTC. Through my social work education I learned how theoretical frameworks guide our practice with clients, staff, communities and government. Ecological theory directs attention to people’s transactions with their environment and works toward improving the individual-environment fit (Wells et al., 1992). An ecological framework for the conceptualization of management in a LTC home examines multiple processes unfolding over time. These processes relate to the resident, family, staff, and other interested person who are concerned about the resident in the context of changes in their physical, psychological, and social environments. Arnet-Connidis (2010) refers to the ecological framework as:

Connection of individual agency with the larger social world is referred to as an agency within structure model and provides an important link between macro and micro levels of analysis in connecting larger social, political and economic forces (macro) and individual experience (micro) over time. The meso level connects the social institutions in which we live our lives that are ultimately connected to the macro level (p. 16).

The ecological perspective is useful when analyzing resident care in a LTC home because it looks beyond the resident and staff to investigate the relationship between the systems. These processes can be examined by social workers to identify issues and make recommendations. As a registered Social Worker with the Saskatchewan Association of Social Workers, I have the obligation of abiding to the Canadian Association of Social Workers (CASW) (2005a; 2005b) “Code of Ethics” and “Guidelines for Ethical practice.” One of the underlying principles outlined in the CASW Code of Conduct (2005) states that “Social Workers advocate for equal treatment
and protection under the law and challenge injustices, especially injustices that affect the vulnerable and disadvantaged” (p.5). Social workers have a responsibility to advocate for fairness and promote equitable distribution of resources. During my practicum placement an issue was identified by several residents and families about the unfairness of a universal charge to all residents living in LTC in Saskatchewan, who were being charged a monthly fee of twenty dollars per month to cover their toiletries. One resident stated he had no objection to paying the fee: however he wanted a choice in the products purchased as the current products did not meet his personal needs; razors were of poor quality and would cut his face, and the deodorant and body wash were also of poor quality. Although staff was aware of the concern they continued to use substandard products because of the aforementioned policy. Residents are able to supply their own products, yet still must pay the monthly $20 fee as it is provincial policy. To address the concern raised it was necessary to file a written complaint with KTHR Kaizen Promotion office and await a response. Interestingly, when speaking with other LTC facilities, all have concerns with this provincial policy.

Social work managers have a responsibility to understand macro system issues that affect clients and staff. Factors at the macro level include cultural norms, public policies, and statutes. A social work manager must think from a systems perspective; and working in a management position would allow for ease and flexibility to accomplish more while making a bigger difference working from a systems approach. Developing macro level skills during this practicum was a challenge. At one meeting I was able to advocate for policy change with the Ministry of Health regarding the directive on charging all residents $20/month for personal care products that are of poor quality and do not meet their needs. This policy does not give residents the choice to opt out or request the products of their choice for the $20 mandatory fee. This
policy appears to be easy money grab for the government to scam off each resident’s monthly bill. The $20/month charge usually garners no questions because most seniors don’t want to be a bother and will usually buy the brands of their choice.

There is a values conflict between what the system of LTC provides, staff preference on using quality products and residents needs based on their choice and preference of product. “The systemic issues of lack of funding and staffing in conjunction with a punitive regulatory system must be changed to allow staff to meaningfully and thoughtfully care for residents rather than marginalize them (Wiersma, 2010). Saskatchewan does not currently have an independent Ministry responsible for older adults and has no adult protection laws. Macro level factors are embedded into sociocultural and policy environments. Social work managers may use political networks to build a power base and establish connections for change such as bringing forth the voices of the residents most profoundly affected by policies and procedures. An ecological framework examines how the resident is impacted by the larger systems such as the agency and government policies. A macro, meso and micro perspective can be applied to LTC when analyzing resident care. A macro perspective recognizes that provincial policies directly impact the quality of care for residents. A meso perspective recognizes how staffing policies must serve to meet resident needs and enable staff to do their work in a supportive and collaborative work place. A micro perspective recognizes the unique needs of residents and family member(s) adjustment to LTC and aligns with the patient and family centered care initiative. The field practicum section will provide further examples of how the ecological framework looks beyond the resident and staff and investigates the relationships between systems.
Field Practicum

The practicum placement included administration work, human resource management, and overseeing of resident care. The administration piece of the practicum included assisting the practicum supervisor at two levels: the strategic planning level and the day to day management level overseeing routine aspects of day to day operations. The strategic planning level focused on the projects that were directives from the Ministry of Health and KTHR Strategic directives. The day to day management involved addressing the issues of the day and setting daily and monthly objectives to achieve the strategic provincial and KTHR directives. The day to day management strategies tended to be more crisis driven and unplanned yet still required management direction. For example on my first day of the practicum two of the whirl pool tubs had stopped working; these two tubs had no hot water, thus leaving only two tubs in operation. The practicum supervisor and I met with disgruntled staff to understand how the broken tubs were impacting their work and the increased stress and anxiety staff were experiencing as a result of having to deal with residents and families regarding the broken tubs. A contingency plan was formulated with staff, residents and families. Subsequent meetings were planned to determine how to fix the tubs. A meeting with the building and maintenance director was called to review the maintenance history. Maintenance staff recommended purchase of a new tub as the most cost effective choice compared to getting replacement parts. The finance department denied this request, so the practicum supervisor worked together with the director of building and maintenance to repair the tub. Tub repairs took eight weeks to resolve; during this time increased communication with staff, residents, family members, finance department and maintenance department were conducted to come to a satisfactory resolution of the problem and keep everyone informed of the process.
Attending meetings was a major part of the day to day management function of the practicum, averaging one meeting per day. Meetings are important as information is shared; and trust and rapport are developed between departments, staff, and community. Some of the meetings I attended were; communications, occupational health and safety, family council, kaizen promotion, staff disciplinary, resident complaints, family complaints, staff complaints, scheduling department meetings, and daily huddles with the nurse manager. Daily management huddles are a Lean tool that is used as a strategy to engage with frontline managers and staff to provide coaching and mentoring (Wellman et al., 2011). Facility administration is complex because the facility administrator does not have authority for all facility operations, therefore when problems arise an interdepartmental approach is necessary. Other manager’s deal with specific departments within Parkland Place, therefore the reporting lines of authority may not be working as effectively and may require review for Lean efficiencies.

KTHR senior management structure for LTC is the responsibility of Vice President of Institutional Care and Emergency Care who oversees the Departmental Director of LTC. The departmental director provides off site management and the facility administrator provides the overall management of the facility in their absence. The nurse manager and the recreational and therapies manager report directly to the facility administrator. The Lean implementation strategy to date has been to train top managers first on Lean philosophy and promote a pay for performance for top managers. The facility administrators and front line managers are now beginning to receive the Lean basic training. “Lean thinking can be applied by anyone anywhere, but the full power is only realized when it is applied to all elements of the enterprise and when work is viewed as a whole system (Lebow, 2007, p. 11). Unfortunately, the roll out of the Lean training for all staff has not occurred over the past several years resulting in staff that is not
engaged with the change process which Lean methodology and philosophy promote. Staff engagement is critical to ensuring a positive association with patient satisfaction (Lowe, 2012).

Human resource management is an important and time consuming responsibility when overseeing 200 employees and 105 residents. One function of management is to work closely with human resources to post job vacancies while working with scheduling to fill difficult shifts during peak holiday times due to staff holidays. The postings for Parkland Place jobs remain posted until filled and recruitment is on-going. During my practicum it was evident certain positions are difficult to fill, namely nurses and care aides.

As previously mentioned building relationships with staff, residents and family was key to the success of the practicum experience. Each day I made time to listen to staff and resident ideas for change. As a student, I was in an ideal position to spend time building relationships, especially because in the facility administrator role little time is available for relationship building due to other responsibilities. Lean methodology promotes daily and/or weekly front line huddles with managers in order that current issues and strategies are promoted and acted upon. On the other hand it is impossible for managers to meet with every employee in a huddle therefore an effective communication strategy that engages an employee is imperative to ensure successful programs.

The responsibility for resident personal care needs is overseen by the nursing supervisor. On a daily and weekly basis, I had the opportunity to do rounds with the nursing supervisor to better understand facility operation and how staff meets the unique needs of each resident. I attended a family council meeting, several resident multi-disciplinary team meetings, and staff training on hand washing, falls prevention training and the weekly ARC meeting to participate in the review of clients nominated for long term placement. I also worked closely with the manager
of recreation therapy who was in charge of arranging the annual multi-disciplinary team meetings, resident’s outings and in-house entertainment. Daily management huddles are a Lean tool that is used as a strategy to engage with frontline managers and staff to provide coaching and mentoring (Wellman et al., 2011). Lean management should result in a more engaged manager that spends time understanding the processes and how the processes affect staff and residents. Literature supports the correlation between leadership behaviors and organizational performance. “Transformational leaders can be found in social work and participants preferred leaders who engage them in the transformational behaviors associated with individualized consideration and idealized attributes” (Gellis, 2001, p. 24).

Staff training is critical to support staff in their work. Management is dedicated and committed to ongoing in-house training to meet licensing requirements and staff needs for further education. For example, a course on using gentle persuasion when dealing with challenging behaviors was organized for staff to give the tools necessary to do their work. Managers need to ensure a safe workplace for both staff and residents and provide support, specialized training and debriefing when necessary.

During my practicum I met with four residents and their families to discuss the admission process. Engaging everyone in a patient focused culture is critical to the success of cultural transformation (Wellman et al., 2011). The reason it was important to meet directly with residents and families was to hear their perspective directly on their care experience and not assume that staff knows what residents and family want. A value stream map detailing the admission process was completed, and I was able to interview staff, residents and family to gather feedback on the opportunities and challenges they personally experienced with the admission process. In order to best understand the patient and family voice it is necessary to ask
how service has been for them. The Ministry of Health has been surveying families and residents on their long term experiences across the province. The KTHR survey is distributed quarterly to a quarter of all residents and their families with their month end billing statement. The survey asks nine close ended questions using a Likert response scale. The survey data is posted on the health region’s websites under ‘hearing the voice of the customer.’ The March 2013 quarterly results indicated that 57 out of 119 surveys were completed at a response rate of 48%. The target response rate for 2017 is 80%. The comments from the surveys are organized by the following themes: communication, safety, care provision, activities and home. One resident reported that “it is difficult to rate the staff as a whole because some are excellent while others are not.” Another comment was, “family meetings should include residents that make their own decisions as lots of time family does not see what is really happening in the facility” (Kelsey Trail Health Region, 2013c).

Challenges

I came to realize early in my field practicum placement that although I was practicing in a management position, it was in fact a middle management position that had little authority or power to change systemic issues because of hierarchical management. Middle managers receive directives from their Vice President, Director, Chief Executive Officer, and KTHR Board of Directors, who receive direction from the Ministry of Health. As a student, I felt my emails to the Director were low priority, and the lack of response verified this. Originally, my practicum supervisor advised me to contact the LTC Director to receive approval to approach all KTHR facility administrators to review policies and procedures. Parkland Place is not a stand-alone facility but one of nine facilities which follow regional policies applied to all facilities in KTHR. During my practicum placement I approached facility administrators and learned they also felt
changes and revisions were needed to update current policies, procedures and forms and welcomed my recommendations and input.

Human resource shortages and over-worked staff are a common occurrence. The pressures and work load are heavy for staff within LTC setting as understaffing is an issue that continues to burden healthcare. This constraint made it impossible to have a sit down meeting to gather input and feedback from staff. This was illustrated when I updated the Welcome Guide for Parkland Place. Initially information was solicited from all departments to include in the Welcome Guide. Once a draft was completed I requested staff proofread the draft, however staff did not have time during work to re-read the document and basically trusted me to collate the information they provided.

One of the most difficult challenges relating to person and family centered care was working with differing attitudes. On several occasions, I witnessed the concerns of family and staff prioritized over residents. This situation was frustrating at times, although the resident was competent and able to speak for himself, family and staff would be consulted before the resident even during medication reviews. Typically, residents are on many medications, and the Ministry of Health has a directive which states that all residents and or family member (s) must have a quarterly medication review with their pharmacist and nurse. I was advised by staff that residents do not really want to know about their medications as they trust their doctor to do what is right. It is concerning that residents may not be given an opportunity for input. At the same time, I understand it may be more efficient for staff to arrange these meetings without the resident in attendance in the interest of time management because one nurse is responsible for 105 resident’s quarterly medication reviews.
The driving factor as to why patient centered care is not patient centered in some cases is ageism. Ageism is the stereotyping of, prejudice against, or discrimination against a person because of their age (Kane & Kane 2005). To say that ageism exists implies that older people are specifically disadvantaged or treated in a less than desirable way because of their more advanced age (Kane & Kane, 2005). Ageism for some individuals living in LTC means they simply are not heard or not listened to because of their age. Families and caregivers often believe they know what is best for the resident without consulting with the resident regarding treatment planning, health care directives and medication.

One of the underlying principles outlined in the CASW Code of Ethics (2005a) states that “Social workers uphold each person’s right to self-determination consistent with that person’s capacity and with the rights of others” (p. 4). Social workers have a responsibility to promote the self-determination and autonomy of clients. This principle, when applied to residents, should be one of the rules by which all decisions are gauged. “Social workers promote the self-determination and autonomy of clients, actively encouraging them to make informed decisions on their own behalf” (CASW Guidelines for Ethical Practice, 2005b, p. 4). This principle resonates for me as I reflect on my experience as self-determination is vital to the four pillars of patient and family centered care. The four pillars of patient and family centered care are; better care, better health, better teams and better value. The following concepts should be used as the rules which measure patient centered care; respect and dignity, information sharing, participation and collaboration. Therefore a system limitation occurs when there is no mechanism to monitor how the system measures residents and staff ability to meet the core concepts described in patient centered care.
The challenges I observed during my practicum were learning opportunities that provided me with realistic and transparent experiences. To highlight a few, a discussion on the role of middle management and complexities associated with responsibility yet no authority. A discussion on overburdened staff and how ageism impacts the day to day activities at Parkland Place were explored. Lastly, a question is raised on how patient and family centered care is measured? A case study will be presented to provide an analysis of the ecological framework and gather information from the resident and family on what value means to them.
Chapter 3: Case Study Introduction

A case study was selected to highlight issues related to LTC and to discuss ideology, values, ethics, relationships, strategies and skills used throughout the practicum. Patient and family shadowing was used as a method to gain firsthand information for the case study. Lean methodology is also used in the case study to illustrate a Lean tool called a value stream map. A value stream was used to visually map out the admission process for the case study client and family. I had the opportunity to participate in patient and family shadowing for the case study which allowed me to observe the patient and their family members throughout the admission process, and to capture details of the entire care experience from the patient and family point of view. Often health care workers assume they know what their patients and families experience, but without proper observation and evaluation staff does not truly know what the experience feels like to those going through it. Patient and family shadowing eliminated staff resistance to change and defensiveness as it removes blame from caregivers by placing focus on transforming the patient and family experience. Also, it created a sense of urgency as staff gains an appreciation for the care experience through the eyes of the patient and family (DiGioio & Greenhouse, 2011). Patient and family shadowing can be a powerful tool that engages staff to experience firsthand the resident’s care experience which can promote willingness for staff to participate in a change process rather than resist change. Although I was able to participate in one resident and family admission experience the resident passed away soon after admission. Therefore it was decided by my practicum supervisor and me to contact three other residents and families to gather feedback through a questionnaire on their admission experience which I will discuss at the end of this chapter.
Ideology represents my belief system about human life which directs the work I do as a social worker and manager. In the context of my practicum experience, the call to action from the Patient First Survey and the Canadian Association of Social Workers (2005a) Code of Ethics were key to the ideologies I envisioned. The CASW Code of Ethics provides the overarching framework for the foundations of respect for the dignity and worth of persons, pursuit of social justice, service to humanity, and integrity in professional practice; and the Patient First Survey promotes the values of patient and family centered care foundations, respect and dignity, information sharing, participation and collaboration. Specific to LTC the beliefs and values that should be adapted as the ideological foundation for change are:

1. is a unique individual who has worth no matter what the age or physical or mental capacity;
2. has the right to live a life of dignity;
3. has one’s personal autonomy protected and that the development of self-determination for the individual must be nurtured;
4. has the opportunity to live as a full member of society;
5. has the right and responsibility to contribute to decision that effect one’s lifestyle. (Wells et al., 1992, p. 6).

Case Study

For confidentiality purposes the names of client and family members selected for this case study have been changed. Mr. Jones is a 92 year Caucasian male applying to LTC after a fall at home where he sustained a hip fracture. An application was completed by Mr. Jones, his family, and the home care assessor while he was a patient in hospital. His application was presented to the ARC by the discharge nurse and he was placed on waitlist. The family and Mr.
Jones were offered a respite bed at Parkland Place, and they accepted the bed the next day. As a result, Mr. Jones was transferred to Parkland Place.

Prior to hospitalization, Mr. Jones was living at home on the family farm with his wife of 60 years. Mr. Jones’ son, daughter in law, and grandson live nearby and farm the family land. Mr. Jones was in good spirits and able to make decisions on admission day. Mr. Jones’s preference was to return home from hospital rather than move into LTC; however there were no homecare supports available where he lived. As such, Mr. Jones and his family agreed that a short term respite stay would provide the necessary convalescing and rehabilitation required after his hip fracture to ensure his mobility and improve his quality of life in order for him to return home.

Mr. Jones, his wife, son and daughter in law arrived at Parkland Place at 10 am. The admitting nurse greeted them in the foyer and provided a tour of the facility. This was Mr. Jones and the family’s first visit to Parkland Place. The nurse took the family and Mr. Jones to his room where the nursing assessment began. The assessment and form completion took two hours to complete, at which point everyone took a lunch break. At 1pm the nurse manager met with the family to discuss and sign the supportive care agreement while Mr. Jones napped. The supportive care agreement covers essential information such as an advanced health care directive, communication protocols, and fees. At 1:30 pm the family met with the administrative assistant to complete the financial portion of the agreement. The Jones’ income tax information was photocopied as well as the power of attorney documentation from their son. The Ministry of Health sets the fee for service based on the tax information provided; as such, families do not know what the fee for service will be at the time of admission. The Ministry of Health assesses the resident’s income and a decision regarding fee for service is established within six weeks of admission. One week later the facility administrator met with the family and Mr. Jones to discuss
her role and to see how the family was adjusting. Also, the recreation director met with Mr. Jones to gather a social history and receive input on activities and outings that would be of interest to him. A multi-disciplinary team meeting was scheduled for May 21, 2013 with Mr. Jones and his family to discuss how Mr. Jones was adjusting to LTC and how best to improve care for the client. The team meeting did not occur because Mr. Jones was admitted to hospital and passed away.

Mr. Jones was in hospital for a total of twenty days before his move into LTC. His application was made while in hospital. Mr. Jones waited in hospital for nine days to be transferred. Compared to the Saskatoon Health Region where waiting periods for beds can be up to 90 days, a nine day wait was reasonable. Mr. Jones also was able to get his first choice of facility which meant he did not have to go to a facility of second or third choice and then transfer when a bed became available.

Currently I work as an Assessor Coordinator with Mental Health and Addiction Services in the KTHR and therefore had to ensure there was not a conflict of interest with any potential persons selected for the case study. As a Registered Social Worker with the Saskatchewan Association of Social Workers, I have the obligation of abiding by the Canadian Association of Social Workers (2005a; 2005b) “Code of Ethics” and “Guidelines for Ethical Practice.” In particular, a social worker should “inform clients when a real or potential conflict of interest arise, and take reasonable steps to resolve the issue in a manner that make the clients’ interests primary” (CASW, 2005b, p.11). Often in rural social work practice clients know the social worker and in this case I knew the family as an acquaintance from church. The family and resident were approached by the admitting nurse and consulted to see if they were comfortable working with me as a graduate student. Dual relationships with clients occur so it was important
clients were reassured that the work I did with them as a social worker was confidential. The resident and family were fine with this and they explicitly granted consent.

The client and family journey through admission to LTC was mapped out as it occurred and will be referred to as ‘the current state of the admission process.’ The visual mapping is referred to as a value stream map, a measurement tool used in Lean that identifies waste and creates a plan to improve the admission process. The first step examines the current state of the admissions process and looks for ways to improve the process using technology, procedures and regulations. The second step is to identify problems or waste in the admission process from multiple perspectives, in our case from the staff, family and resident. Lean philosophy promotes elimination of waste and standardization of processes to improve customer and staff satisfaction (Kenny, 2011). Staff reported that the paper process was time consuming and repetitive, resulting in a waste of valuable time that could be better spent assisting the resident’s and family’s adjustment. Families and staff both agreed that forms should be standardized across the Health Region within all LTC and acute care facilities for ease of transitions and to reduce duplication of forms that become outdated or irrelevant. The review of forms was necessary because some forms had expired and continued to be used. For example, a form was being signed by the new resident and sent to a government department when in fact the form had expired and was no longer required.

It was exciting to be able to speak directly with residents and families about their care experience and to take the slogan ‘patient and family first’ to another level to get feedback that informs the change process. The case study family was appreciative of the opportunity to provide feedback. Families reported they valued staff introducing themselves and wearing their nametags,
they commented on the warm and friendly colors throughout Parkland Place and also appreciated
the bistro café and coffee they received upon their arrival.

A future state map is the next step in the Lean value stream map; it outlines the plan to
get to a future ideal state for the admission process. Families and residents reported a lack of
timely information available prior to admission. Initially, families are given one information
booklet from homecare which is usually kept by the power of attorney or somebody designated
by the client who can unintentionally exclude other family members from admission process.
Staff report they often find out more about the resident from their obituary and regret that they
could have done more had they known more personal details.

A management practicum provided me an opportunity to reflect on both the front line
clinical aspects of this placement, and at the same time provided opportunity for me to consider
the impact of system changes within the ethical responsibilities of social workers and managers
under the Code of Ethics. The Guidelines for Ethical Practice specifically discuss the following
responsibilities of social work managers: educate administrators about ethical responsibility,
strive to promote teamwork and communication, maintain adequate staffing levels, facilitate
access to professional consultation and or supervision for professional social work practice,
promote ongoing training for staff development needs and arrange for debriefing and
professional support when staff experience a traumatic event (CASW, 2005b). Therefore social
work managers have an ethical responsibility to adhere to their Code of Ethics when it comes to
matters of patient and family centered care, as well as human resource strategies and
coordination of various services which directly pertain to the improvement of the admission
process.
Managers who place an emphasis on care demonstrate that they value and organize work in a manner that encourages relationships with clients (Lopez, 2006). When care is understood as relational and client centered by managers, clients tend to be satisfied and content. Relational management was demonstrated throughout my practicum when the facility administrator met with each new resident and family to get to know them and build a relationship. Another example of an agency practice that builds relationships was when the facility administrator moved her office to a more central location in the building so she was visible and accessible to residents and staff. “The quality of relationships in the workplace relates directly to the quality of care providers work life and the quality of care they provide. Therefore management needs to address the needs of both care providers and residents in order to improve the quality of life in LTC facilities” (Armstrong et al., 2009, p. 101). The facility administrator met with each resident and family within a week of their admission to get to know them and ensure the resident and family knew who to approach if they had questions or concerns.

In addition, as an employee and practicum student of KTHR I was required to adhere to the organizations’ code of ethics. KTHR has a regional ethics committee whose objective is to promote high standards of ethical health care practice through review and discussion of policies, procedures and practices that have ethical implications. The ethics committee is available to provide a consultative service for the purpose of giving advice on ethical principles and to assist with resolution of ethical disputes concerning the care of a resident. The following ten principles outlined in KTHR code of ethics fit well with social work values and include; advocacy, confidentiality, commitment to patient care, conflict identification, dignity, employee safety, fair and equitable access, health and well-being, empowerment and relationships among other trustees and agencies (Kelsey Trail Health Region, 2013b). Through my practicum and work
experience with KTHR I have experienced situations that may have benefited from an ethical consult, however the managers and staff involved in the situation were not aware of the KTHR ethics committee and the supportive role the committee can have for staff.

**Discussion from Case Study and Family and Resident Feedback**

In order to map out what an ideal admission process would be for clients, families and staff; the ‘current state of the admission process’ as previously discussed was shared with stakeholders during a meeting to review the value stream map. The following discussion and recommendations came from consultation meetings with four residents and their family members and staff who helped outline the ‘future state of the admission process’ and recommendations for managers and administrators.

The one resident and family I conducted the case study with, together with three other residents and their families, provided input and feedback on their admission experience. The families and residents suggested LTC and respite admission information be available on the Internet for the general public and family members of residents. Families reported to me that because admission is crisis driven it is a hectic time, especially when families are geographically spread out across provinces. A website that includes the application, welcome guide, what you need to know and bring to your new home, educational information on adjustment to LTC for residents and families, and the moving in and financial agreement would be convenient and helpful. Increasing technology use was identified by families as integral to keeping residents, families, and staff up to date on current information about Parkland Place. It was recommended that family members provide their email addresses on admission to allow for electronic updates and notices to inform families of agency events.
Families and staff both agreed that elimination of redundant forms and standardization of forms between facilities and hospitals would allow for ease of transfer. In addition a continuous review process of forms should occur to eliminate stockpiling of outdated forms and reduce time wasted by staff looking for forms. The use of electronic medical records would eliminate duplication of information gathered on admission and ensure patient information is consistent throughout the transitions of caregivers and facilities thus reducing the potential for errors. An admission checklist that outlines and standardizes the admission for all staff involved in the admission would increase efficiencies.

Two residents and families reported they had one transfer to make prior to arriving at Parkland Place which was difficult for both resident and family. One resident stated that “it threw me, I became confused and when I would wake up I would ask myself where am I?” For this resident, in a one week time frame, she moved from hospital to St Brieux and then to Melfort. The family reports the two moves were challenging because they had moved their mother’s furniture to St Brieux and then had to move it back to Melfort. Had they known the transfer would have been arranged in less than a week, they would not have taken her furniture to St Brieux and would have waited to set up her suite in Melfort.

Each family member and resident interviewed reported that admission day was busy and they had no suggestions on how to improve the admission day process. Families and residents appreciated the morning interview with the nurse and having a lunch break. They reported that the lunch break was nice and meeting in separate rooms was comfortable. One of the questions asked of families and residents was “would you prefer to complete the admission paperwork in one room and have the different staff come to you rather than move through three meeting rooms?” The rationale for asking this question was motivated by Lean methodology to find out if
residents and family members preferred to have their steps reduced by utilizing one meeting room rather than three. Families and residents all reported they preferred to meet in separate rooms for various reasons.

One resident requested that specific information on what clothing to bring would have been helpful. Another family member suggested a tear out sheet in the information booklet with all the contact numbers on who to call if there are questions and each resident stated that they were appreciative of their family members support and “how they took care of everything.” Another family member was “surprised his mother was placed in the dementia unit because he did not think she had dementia.” Overall, residents and families were satisfied with their admission experience and offered compliments on how “caring and nice” all the staff was.
Chapter 4: Recommendations and Conclusions

A field practicum in LTC was a great learning opportunity for managerial development in social work leadership. This section will discuss recommendations for the issues identified in LTC relating to the role of the family and resident centered care, issues of coordination with LTC, and human resource strategies. Lean methodology will be discussed outlining the advantages and challenges for integrating Lean into LTC.

The introduction of Lean methodology to transform health care has created an acknowledgement that the current system of health care is not working as well as it should. If the purpose of Lean methodology is to create value for patients by decreasing waste such as waiting time and reducing redundant paperwork to ensure care is delivered compassionately and patients and families are at the center - this message supports social work principles. The CASW (2005b) Guidelines for Ethical Practice identifies the ethical responsibilities to clients whereby social workers must maintain the best interest of residents as a priority. The role of the Social Worker in LTC would be to “collaborate with other professionals and service providers in the interests of the clients with the client’s knowledge and consent. Social Workers recognize the right of client determination in this regard and include clients in such consultations” (p.3).

Management must recognize a model that incorporates medicine but also promotes dignity and respect by recognizing the context of individual lives, the contributions and skills of providers, and the importance of social relations as well as of social meanings (Armstrong et al., 2009). The introduction of Lean methodology into health care, when viewed through a social work lens, makes sense when patient and family care is truly at the center and when staff are supported and valued.
While the current focus of staff in this long term care facility is primarily on caring for the physical needs of residents, staff indicated they would like to better understand each new resident’s social history in order to build a more meaningful dialogue. Staff identified personalizing care as a priority because as one staff reported “staff finds out more about a resident reading their obituary than while they were living at Parkland.” The relationship that staff members develop with each resident forms the contextual frame through which staff members view residents (Wiersma, 2010). Narrative practice in the format of storytelling and listening leads to ethical based care that prioritizes resident’s personal meanings, and permits the resident to define quality care (Heliker, 1999). In the days following an admission is critical for families, staff and residents to engage in dialogue that builds rapport, and helps the resident and family bond with personnel. Creating a strong bond can be done by incorporating care plans based on the personal story of each resident; these should be included with lab reports, treatment regimens, and medication reviews in order to provide a holistic presentation of each new resident’s story.

Client centered care, as defined by KTHR, places the resident in the center of their care by giving them choices and the ability to participate in planning their own care. Narrative practice is a strategy that promotes client centered care. Staff, residents and families must strive to learn more about the residents’ story and document it in a way that staff can better understand, and bond with, the persons they are caring for beginning at the admission.

Families play an important role in the transition of a resident into LTC and must be included and respected throughout the placement. Families also are impacted by the admission of a family member and their needs should also be recognized and addressed by staff and management either through individual or group support. Families need access to timely
admission information when placement of a family member is imminent. Education and awareness of home based services, subsidized day programs, respite services within their communities and contact information for support persons to contact should questions arise. Public information campaigns that promote taking care of personal business such as writing a will, the benefits of power of attorney and a completed health care directive make these life transitions go much smoother.

Issues of coordination amongst various services such as acute care, home care and LTC with health and social services impact how a client adjusts to the transition into LTC. Ideally, transitions should be planned and orderly through seamless communication between agencies. Indeed, social work managers that use an ecological framework to analyze resident care by looking beyond the resident and staff to examine the relationship between the systems will find that smooth transitions to care are possible when care is seen as a continuum rather than separate turfs. These processes must relate to the resident, family, staff, community and policy makers.

A change management strategy will be necessary to promote and obtain staff support for implementation of Lean methodologies. Progress cannot be achieved without change. The more emphasis that is placed on communication, the greater the quality of care will be for the resident. When two way communication and public relations are encouraged with all stakeholders in LTC this is the most effective strategy for increasing the effectiveness of an organization (Meath, 2006). A staff person indicated that she “didn’t get into health care to fill out forms rather she wanted to work in healthcare to increase care.” The Lean journey and patient and family centered care both offer much promise for improved experiences for residents, families and staff.

However a systems approach is necessary to address and change the issues of ageism, lack of coordination among services, and staff shortages.
The key advantage of using Lean methodology is engagement with residents and families to direct the change and improvement process. I had the privilege of working together with all the stakeholders to identify the gaps in the admission process and to actualize the recommendations by drafting documents to improve the process. Learning and practicing the Lean methodology brought to light how improvements could be made to existing processes. The 5-S, visibility wall, value stream map, huddles and daily management mapping were each beneficial to the resident, family and employee. Residents and families who are comfortable working in partnership will do well in advocating for their care needs, while residents and families without the capacity or support to represent themselves may require an advocate or client navigator to assist them.

Some drawbacks of using Lean methodology were the apparent difficulties in educating and promoting Lean philosophy in a large organization. The lack of information and engagement for staff perpetuated negative perceptions, skepticism and resistance to change. For example, most staff were not informed about what a value stream map is, so when they saw sticky notes posted on the walls of Parkland Place, a staff member reported “the sticky notes looked ridiculous pasted all over the wall.” Unfortunately, the visibility wall that was designed for employee engagement and input could not be utilized for the intended purpose because staff was unaware of the benefits.

Challenges for management include additional work load requirements as a direct result of Lean directives that make managers accountable for established targets. The Ministry of Health requires organizations to meet targets, yet provide no additional funding or resources to assist with education of front line workers, back fill for managers having to leave their agency to
take Lean training, and lack of resources for completion of required graphs and charts displaying the agency goals and strategies.

The purpose of this Master of Social Work field practicum was to learn and practice at a senior management level with a focus on policies, management, human resource development, and patient centered care analyzed through a social work lens. I gained from this practicum a realistic experience working in a large multi-disciplinary agency providing programs and services to 105 residents and their families. I have learned that relationship building, patience, communication, and involving others in change is essential for engagement and progress. Through my involvement with Parkland Place I have expanded my knowledge through research in the areas of Lean management and LTC and confidently conclude that a career in social work and management is a future career goal.
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