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TODAY

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Small steps, big benefits

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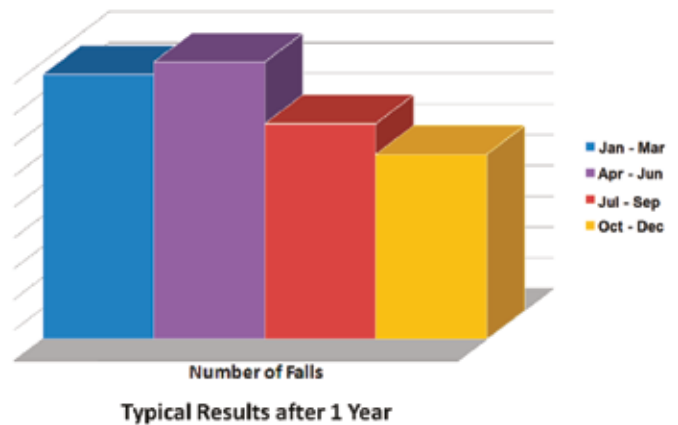


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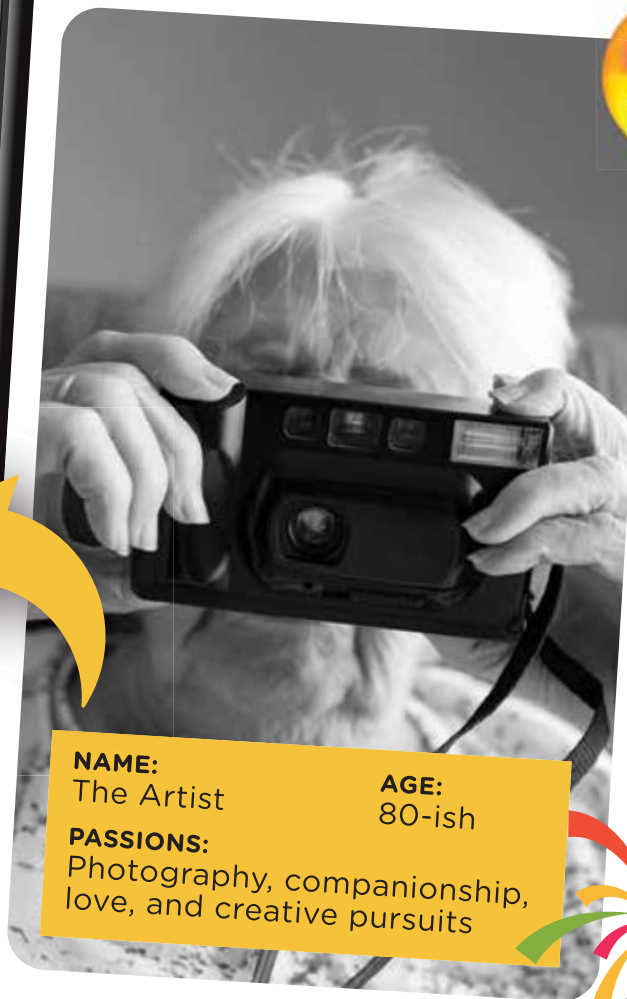


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Photo courtesy of The Gardens at Kensington Health, a long-term care home in Toronto.

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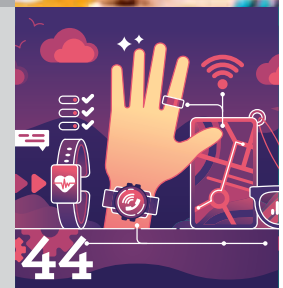
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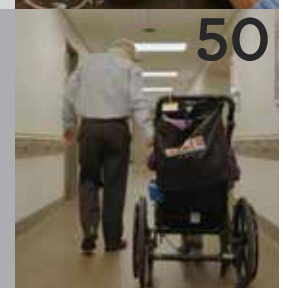
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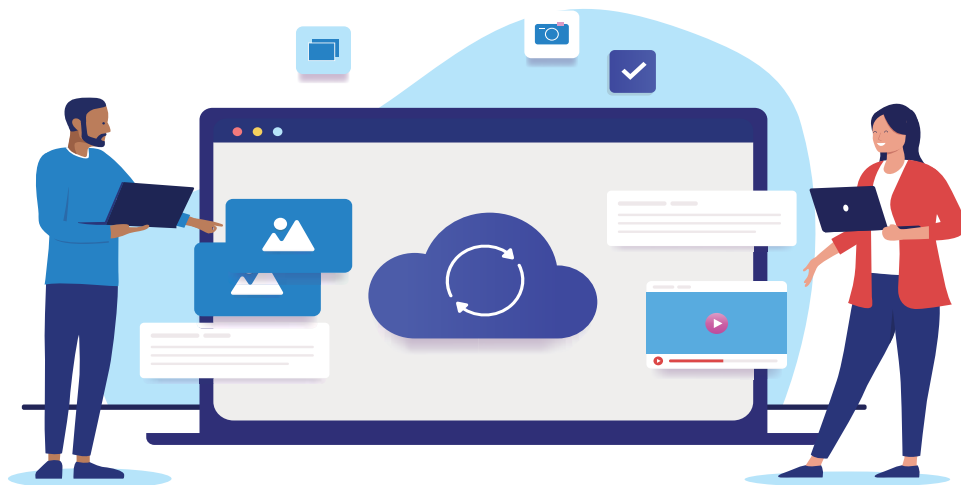


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Stuart Feldman,
VP Canadian Market
Lead, PointClickCare

Getting started with technology

Advice for smaller homes from PointClickCare

For many smaller long-term care operators, adopting new technology can feel daunting. At the same time, AI and other technologies are increasingly important to supporting resident care and staff workflow.

In his role as VP, Canadian Market Lead, at PointClickCare, Stuart Feldman has heard from many homes across North America about their technology strategies. In this article, he shares practical advice for homes looking to get started.

Coping with pace of change

Some long-term care home organizations are early adopters – they implement new tools quickly and build strong innovation cultures. For others, especially smaller homes, the gap between where they are and where they think they “should be” can feel overwhelming.

New AI tools and other technologies are coming forward constantly, and that pace is only going to accelerate. When a home is already stretched thin by funding pressures, staffing shortages, or day-to-day operational issues, it can be hard to imagine taking on something as big as a new technology strategy.

“I use the analogy that leading innovators in the sector are like professional athletes. That drive

and innovation are terrific, but not everyone is able to operate on that level, and other homes shouldn’t feel like that’s the expectation,” Feldman says. “It’s about starting small and implementing what makes sense for your home.”

Start small

Starting small and looking for a “quick win” is a good way to start the process. Think of it like training for a marathon, Feldman says. If you haven’t been exercising, you start by walking around the block. In the same way, the muscle for managing technological change is built slowly.

The most important first step is making sure that technology has personal relevance for your team and your home, he adds. What’s your North Star? It could be improving workflow, supporting quality indicators, reducing inefficiencies – but the need for change only becomes real when individuals can see direct benefits to their day-to-day responsibilities. Staff need to know: How will this make my work easier today?

Homes don’t need to begin with a complex transformation. Pick a small, achievable goal. “That first win creates momentum, confidence, and buy-in, and strengthens a home’s ability to take the next step.”

Quick wins: Workflow

“Look for places where daily irritation slows down your staff,” Feldman advises. These are often called the “low-hanging fruit” of technology adoption – changes that reduce friction and confusion in the home.

For many homes, improving communication is the best place to start. Shift handoffs are often an area that benefits from improvement: moving critical information from binders, scattered notes, or inconsistent processes into more structured accessible formats can make an immediate difference.

That might not even need new technology, Feldman says. For example, moving information from a binder to a managed bulletin board could help to streamline communication overnight. Starting to look at these problems and testing solutions is part of building the muscle for change.

If you are ready for digital tools, staff communication apps and secure messaging platforms can be powerful, he adds. They can significantly improve communication across your team, and free up more time to spend with residents. At the management level, technologies for staff scheduling that offer features such as automated shift callouts can make a significant difference.

Another “quick win” is addressing workflow irritants. What are the things staff say get in the way of their work? Ask for feedback if it’s not clear. Look at the technology other homes have implemented successfully for the same problem, he says, with their insights into costs and implementation.

Sometimes small homes are concerned about a lack of fibre internet and other infrastructure barriers. These challenges are not what they used to be, Feldman explains. Satellite options have dramatically expanded access and reduced costs. What once felt impossible is now achievable for many homes, even in rural settings.

Quick wins: Resident care

The market and sector are rapidly expanding the many ways that AI and technology solutions can support resident care.

For small homes that don’t know where to begin, Feldman says that looking at wound care is a simple and tested way to start. Wounds are complex, painful, and difficult to assess consistently.

Modern wound care tools use imaging to deliver consistent, accurate assessments. For small homes especially, this means staff do not need to be experts in measurement – they take a photo, and the system analyzes it.

This improves accuracy, supports clinical decision-making, reduces the burden on staff, and increases their clinical confidence.

For homes using PointClickCare, a wound care partner’s program with this capacity is integrated directly into the system.

Building on early success

For a small home starting the

technology journey, small “quick wins” can make a big difference.

“Quick wins are viewed positively by your team and build momentum,” Feldman says. “They show your staff, show residents and families, and just as importantly show you that change is not only attainable, but it also actually makes an impact.”

Share the data that backs up your efforts and be sure to celebrate your success with staff. Start the conversations about other possibilities.

When building an ongoing approach, Feldman adds that a collaboration of both “top down” and “bottom up” perspectives has the best results for solid and successful innovation. Keeping the approach to technology inclusive, and ensuring diversity of suggestions and participation, is a great way to ensure everyone is benefiting from the changes. [LTCI](#)

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Looking at ways to remove workflow irritants isn’t just about implementing new technology – often, it’s about making adjustments to technology you already use.

With the majority of homes in the province using PointClickCare (PCC), a simple way to reduce friction for staff is to make sure the content in a home’s PCC is clean and current, says Stuart Feldman, VP, Canadian Market Lead, PointClickCare.

“PCC provides the shell – the structure of an electronic health record. Everything that you put into it becomes living, breathing content – but over time, every electronic record accumulates ‘noise,’” Feldman says. Dropdown menu “pick lists” get cluttered with old hospitals or facilities. Assessments and order sets become outdated. User-defined fields tend to expand. These small issues create frustration – staff spend more time scrolling, guessing, or working around the system instead of using it efficiently.

Homes often underestimate how much efficiency they can gain simply by ensuring that their data and documentation structures are accurate, consistent and relevant.

Good governance – a clear, consistent process for keeping systems clean – makes everything run smoother. Most organizations that have been successful with this have made updates a daily commitment. As part of this process, homes need a regular feedback loop: What’s confusing? What’s outdated? What’s missing?

“It’s not easy to keep up with content when there are other pressing priorities in long-term care. But when your data is optimized, it allows for a home to be humming and working at peak performance, rather than facing little glitches that slow people down and create confusion,” Feldman says. “We tend to underestimate how much people can feel bogged down by inefficiency.”

As Ontario homes switch to the new interRAI Long-Term Care Facilities (LTCF) assessment system, Feldman adds that it’s an opportunity to look at the system with fresh eyes and rethink how to set up homes for success.

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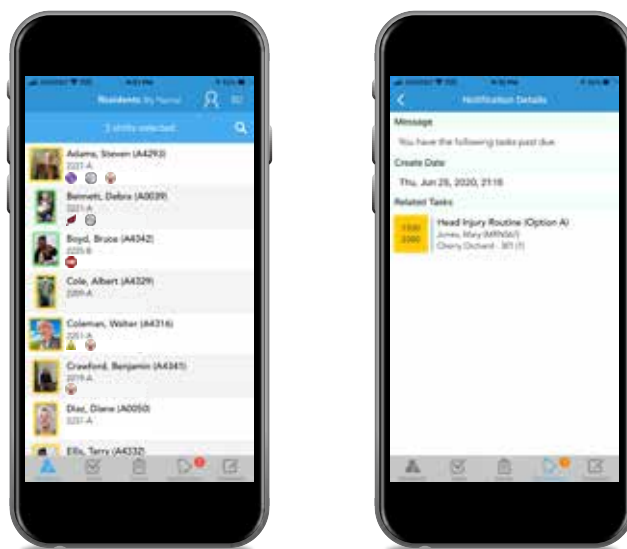


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When a stand-alone home goes big on technology

A conversation with Trinity Village



Example of DOCit app. Resident names are fictional.

Trinity Village, a 150-bed home in Kitchener, Ontario, is one of Ontario's long-term care technology innovators. From mobile documentation and self-scheduling to robots and the use of AI tools, the home is often cited as an example of what is possible when technology is embedded thoughtfully into everyday operations.

Long Term Care Today sat down with Chief Executive Officer Debby Riepert to understand how Trinity Village achieved this level of innovation, what tools have made the biggest difference, and what advice she would offer to other small home leaders looking to move forward with confidence.

Q: Trinity Village is often described as a technology leader in long-term care. How did this begin?

It actually goes back much further than most people realize. Trinity Village computerized its care planning in 1994. At the time, that was extremely early.

Part of that came from circumstance. In the mid-1990s, there was a change in our ownership, and we had access to some new funding. We had to decide what to do with that money, and we decided to invest it in computers and infrastructure.

Once that foundation was in place, technology just became part of how

we operated. It's embedded in the culture. When we hire, we're pretty clear about how we operate. Our staff see the value of technology and know that we don't adopt something for its own sake – it has to have a benefit for both staff and residents. It's going to improve your work and often it's going to be an improvement for issues like risk and safety.

Q: When people visit Trinity Village today, what are the most significant technology innovations they notice?

There are 13 active technological applications we have on the go. It's hard to pick which ones to highlight – but I'll highlight a few that stand out.

One is that our entire frontline care environment is mobile. Staff have a real-time task and documentation system on phones that we provide. Documentation, tasks, residents' activities of daily living (ADLs), communication, alerts, self-scheduling for staff – it's all accessible at the point of care.

We also use artificial intelligence (AI) in several areas – including common-area camera systems that support safety and investigations, an AI-enabled toileting system, a call-bell system, and we've recently installed in-room AI sensors.

We have a call-bell system that produces reports with data on call-bell

use and response times by home area, which helps not only with resident care but with assessing workload.

We have also been testing robots for support such as specific types of social engagement and visitor registration.

None of these tools exist in isolation. They all connect back to the same goal: better care, less wasted time, more direct care time with residents, and clearer information.

Q: How did you make the decision to go to a mobile system? What advantages have you seen?

When we were first exploring mobile documentation, we tested everything – tablets, laptops, different phone sizes, wall screens. We didn't decide in a boardroom. We had staff test the options and vote. As a result, we made a very deliberate decision to standardize on iPhones for frontline staff.

These are not personal phones. They're leased devices, managed centrally, refreshed on a regular cycle, and locked down so they only work within our system. They don't access the internet or personal apps. They exist to support care. We even use a standardized colour of the phone cases so families and residents can immediately see when a staff member is using a work device.

Each staff member sees exactly what tasks are required for their role on that shift. Tasks turn green when they indicate they're completed. If another team member is needed, they send a prompt and it will show up on their phone. Let's say you're a PSW giving a resident a bath, and you notice there's an issue of skin integrity. When you're giving a bath, you sign off on the phone whether the skin is good or not. If it isn't, you draw where the problem is on an image of the body and it sends an alert right to the RPN.

Staff don't have to leave a resident's room to document or to track someone down. If they're waiting for a second staff member for a transfer, they can document while they wait. If they're sitting with a resident who is upset or lonely, they can complete required documentation right there instead of walking away.

At the end of the shift, staff know – without question – that their documentation is done. Before this, we had staff tracking down missed documentation. That work largely no longer exists. It also reduces stress. Staff aren't going home wondering if they missed something or waiting for a call on their day off to fix paperwork.

Our mobile system isn't limited to care – over time we've added other features too. For example, there are features to put in IT requests, human resources questions, to notify maintenance if staff see anything that needs repair. It's eliminated a huge amount of back and forth. This year we've added a system for staff to indicate their satisfaction at the end of each shift. It helps us identify if there are any issues that need follow up.

We also have a system for staff to manage their own schedules. They can swap shifts, give away shifts, and manage availability within clear parameters. Our team knows that self-scheduling is a responsibility as well as a privilege. The system supports staff autonomy, but it also creates accountability. It has significantly reduced scheduling friction and eliminated a lot of back-and-forth that used to take up management and HR time.

Q: You're using AI increasingly throughout the home to support clinical care. What are the benefits?

One example is our AI-enabled toileting systems. Traditionally, toileting routines are based on staff observation and interpretation. That can vary significantly.

The AI system provides accurate, objective data on each resident's toileting patterns. That allows us to develop individualized care plans

rather than relying on generalized routines. It also supports earlier identification of changes and reduces unnecessary interventions.

We recently installed room sensors as well. The data comes to us in a dashboard that shows us things like whether the resident is getting out of bed, out of their room, if they're headed to the washroom, their temperature, heart rate, breathing pattern, sleep cycle (including rapid eye movement (REM), breathing, deep sleep) – and we can set customized

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alerts for each person. This is going to help us be proactive with their care, including fall prevention.

Another area is AI in our camera surveillance system – it’s in all common areas, everywhere except in resident rooms. We’ve had some cameras for more than 20 years, and built on them over time, but we did a full overhaul with a new AI camera system that can help us seek specific information. They are used for safety, audits, and investigations of incidents. You can customize what you want to look for, and where you want to look. Let’s say a resident has a fall in a common area – you can see the nature of the fall including whether they hit their head, which helps guide the clinical investigation.

As for audits, PPE audits would be a good example. We can ask the cameras to find examples of gowns being worn in common areas, when they should only be worn in resident rooms. We don’t use this as a “gotcha” – it helps us support staff education and reflection on their practice.

Because cameras and audits have been part of our environment for a long time, staff are comfortable with this. They know they’re about safety for residents – and protection for staff. For example, when residents are living with advanced dementia, one of the symptoms can be suspicion. Accusations of theft are not uncommon. The camera will show us and the residents’ families what actually happened.

Q: How do you decide which technologies are worth pursuing? How much of your budget do you invest?

We do continuous quality improvement, regular reviews, and we listen closely to what staff are saying. When a pattern emerges – whether it’s workflow, documentation, safety or communication – we look for tools that address that specific issue.

We also involve staff early. They test solutions, give feedback, and help shape implementation. That buy-in is critical.

And we don’t roll everything out at once. We pilot, refine, and then scale. Sometimes we use existing products; other times we’ve worked with companies to develop them. It really depends on what process you’re trying to improve.

Technology is a core line item for us. It’s not optional and it’s not temporary. We spend just under 2% of our total budget on software and technology. If technology supports care delivery, workflow and safety, it belongs alongside staffing as essential infrastructure.

Q: What role does data play in your culture?

A very big one. We use data to support fairness, transparency and learning. Each home area has a report card that includes indicators related to workload, safety, documentation and resident needs.

This has eliminated a lot of informal narratives – like one unit having a heavier workload than another – and replaced them with facts. It also helps with admissions planning and discussions with system partners.

We also use data to support staff development. Performance feedback is grounded in real information rather than perception.

Q: What advice would you give to other long-term care home leaders?

Start with your culture and your problems. Identify what is getting in the way of good care or good work and look for tools that remove those barriers. What are you spending too much time on?

Involve staff. Pilot thoughtfully. Make sure your IT foundation is solid. Our experience is that technology works best when it’s invisible – when it simply makes work easier. **LTCI**



Debby Riepert, CEO
Trinity Village

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Canadian Consensus Statement: The management of venous leg ulcers

A panel of 19 Physicians, NSWOCCs, Wound Specialists, and Therapists with experience in treating VLUs, using the Muscle Pump Activator device, and advanced wound treatments.

This panel agreed that the geko™ device (Muscle Pump Activator) should be added to the treatment plan when:

- A patient cannot tolerate compression
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- No progress is seen in a wound after 2-4 weeks
- A wound has not healed 30% in 30 days

- Dr Asem Saleh
- Dr John Hwang
- Rosemary Hill
- Josee Senechal
- Michele Langille

- Bev Smith
- Carly St Michel
- Paulo da Rosa
- Amanda Loney
- Michele Labbie

Leads:



Dr Michael C. Stacey



Dr Robyn Evans



Dr Gary Sibbald

The geko™ device demonstrated greater than two-fold increase in wound healing rate¹ and a reported reduction of pain² in venous leg ulcers vs compression alone. Harding et al, 2023



Professor Keith Harding

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1. Bull R et al. Int Wound J. 2023; 1-9
2. Jones N et al. Br J Nurs 2018; 27(20): S16-S21.
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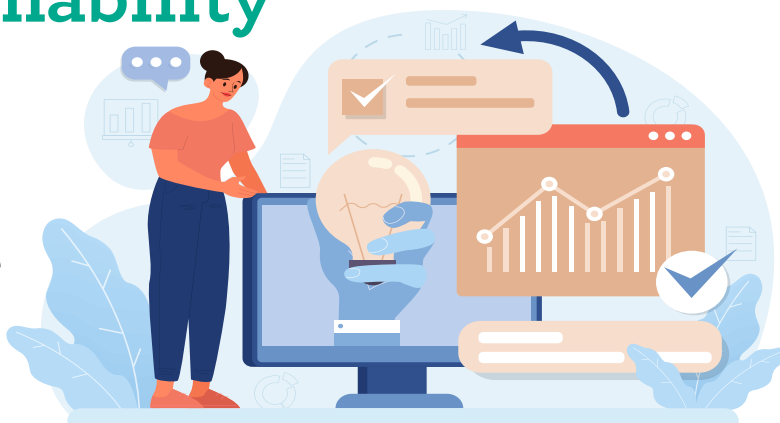


From exploration to sustainability



Five key phases for implementing technology in long-term care

By Sydney Taylor



We are living in a period of change – our population demographics are shifting, and the needs of adults 65+ are reshaping how older Canadians are supported as they age. While this presents unique challenges, it also provides exciting opportunities for innovation to ensure older adults receive care that reflects their preferences as they age in the place of their choosing.

As Canada's technology and aging network, AGE-WELL plays a unique role in the innovation ecosystem: we connect innovators with researchers, older adults, and adoption partners, fund the development and validation of technology that addresses real-world needs, and critically, support sustainable implementation.

We have heard many operators express frustration about pilot projects that do not lead to lasting change. The challenge is rarely a lack of innovation – it's the difficulty of integrating technology in a way that fits workflows, supports staff, and delivers lasting value. To help operators address this, we embarked on a journey to support their implementation efforts by drawing on a co-creative approach and AGE-WELL's wealth of experience over the past 10 years. Our goal is to help operators move beyond pilot projects to create meaningful, lasting impact through the sustained integration of technology.

Implementation is a non-linear journey, one without a one-size-fits-all approach. So, where do you begin? We break the journey down into five manageable, iterative phases that reduce risk and increase the likelihood of sustained success. In this article, you'll find practical insights to navigate the implementation journey and identify key activities at each phase in the process. Let's dive into each phase in more detail.

Exploration

Although this step can be easily skipped, it is essential to understand what's working and what isn't, providing a natural opportunity to include the voices of your residents from the beginning. Start with a needs assessment to identify priorities, uncover the core need (e.g., a root cause analysis), and develop a shortlist of technologies to meet the need. Then, perform a readiness assessment (e.g., Readiness Thinking Tool) with your team, including IT, to evaluate your site's preparedness for change. By creating a shortlist of potential technologies and assessing readiness, you can determine how well an innovation fits within your site's unique context.

Through these assessments, you can map out: 1) the overall goal of the change (the "why"), 2) who will be required to do what differently, 3) the anticipated value and impact of the project, and 4) potential challenges at your site. Communicating these elements clearly provides direction

throughout the project, aligns people at your site with the project goals, and helps you define how success will be measured: all critical for buy-in and long-term impact.

Planning

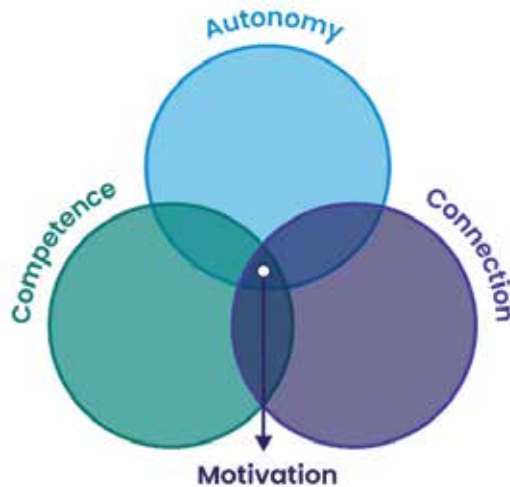
Take time in this phase, as you will map out how the implementation will unfold and how progress will be monitored and evaluated. To help you with this, start by developing your implementation plan to steer the project. Your plan should include:

- Objectives for each phase
- Tasks and responsibilities
- Timelines for each task
- Anticipated resources and outcomes
- Risk management strategies
- Monitoring and reporting processes

Once you have this drafted, share the plan with those who will have active roles in the implementation process to gather feedback and provide clarity. As part of this, form your implementation team – those individuals who will be delivering and monitoring the implementation.

Expect some resistance, as change can be hard, especially for those impacted by the integration of the technology. To help mitigate this, engage people at your site to help

Motivation Drivers



Based on Ryan & Deci (2020). Image developed by The Center for Implementation. © 2024 | V2024.01 | For full citation: <https://thecenterforimplementation.com/toolbox/motivation-drivers>

identify challenges to integrating the technology. Then, have them help to choose change strategies that directly address those challenges, such as training, engaging champions, incentivizing, etc.

Finally, start to plan for sustainability and, if applicable, scaling. Long-term success depends on thinking beyond the end of the implementation project.

Early implementation

Now the fun can begin! In this phase, you operationalize your implementation plan in a small-scale environment to observe how the technology is used and gather feedback from end-users, including residents. Be clear about the “why” of the project and set expectations early to maintain alignment with people at your site throughout the project.

Motivate people to support and deliver the change by fostering their autonomy (ownership), competence (confidence) and connection (belonging). Explain what is changing and what is staying the same. Ask what matters most to them, what their commitment is behind the change, and what they see as potential gains or losses due to the integration of the technology.

As this phase progresses, look at ways to support your implementation team through tools, training and coaching. Use cycles of improvement, such as *Plan, Do, Study, Act*, to monitor the implementation progress and identify areas for improvement. Use this feedback to refine your implementation plan and ensure that any necessary resources are readily available.

Full implementation

After using the gathered insights to refine the implementation plan, it’s time to fully integrate the technology.

It’s important to keep engaging people at your site. What is their experience, and what adaptations are needed to your implementation and sustainability plans? Collect their feedback regularly at key intervals (i.e., three, six and 12 months post-implementation).

Monitor whether implementation is happening as planned and confirm that your environment still supports the change. Check that resources are still readily available. Continue to perform cycles of improvement accordingly and provide ongoing support to your implementation team.

Evaluation and sustainability

While listed last, evaluation and sustainability activities happen throughout the entire process. Overall, this phase looks at how the implementation went, whether your anticipated outcomes were achieved, and whether the original need was addressed.

Various types of evaluations can be used throughout the implementation phases.

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Technology implementation is rarely a “set it and forget it” experience. Plan for sustainability early and build in activities to monitor the sustained use of the technology.


These evaluations include:

- Formative: Used to make early improvements and set up the project (i.e., needs and readiness assessments)
- Process: Looks at how the implementation happened and what activities were done when
- Outcome/Impact: Determines the effectiveness of the implementation and looks at behaviours, attitudes or conditions resulting from the change
- Summative: Looks at whether a project reached its goals and how effective the technology integration was

To sustain the impacts resulting from the integration of technology, your site must maintain the change. Technology implementation is rarely a “set it and forget it” experience. Plan for sustainability early and build in activities to monitor the sustained use of the technology. Be prepared to adapt to your site’s changing context, which will affect your sustainability needs over time.

In summary

Implementation is an iterative process. Understanding the need you are trying to address will help you build out your “why,” which can then be clearly communicated to your site. While there are many important considerations, keeping people at the centre of what you are doing is key.

To support your site’s implementation efforts, AGE-WELL offers tailored assistance to help you make significant strides, particularly with exploration and planning support services. If you are interested in learning how we can help you, please contact us directly at implementation@agewell-nce.ca. 

Sydney Taylor is the Program Manager of Implementation at AGE-WELL. Please contact the author for any resources mentioned in this article or for a referenced copy of this article.



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Dementia Care Preparedness Initiative

Helping homes assess, strengthen and sustain dementia care

By Ontario CLRI at Baycrest

Ontario is on the cusp of a profound demographic shift. Between 2020 and 2050, the number of people living with dementia in the province is projected to rise by 202%. With 42% of Ontarians aged 80 and over who live with dementia residing in long-term care, the pressures on homes will continue to grow, and so will the opportunity to elevate care for residents and families.

Against this backdrop, the Dementia Care Preparedness Initiative (DCPI) set out to learn from long-term care homes across Ontario and support them in assessing their readiness to implement, enhance and sustain high-quality dementia care programs.

What is DCPI?

Led by Baycrest through the Ontario Centres for Learning, Research and Innovation in Long-Term Care (CLRI), DCPI is a province-wide initiative to assess current dementia care and prepare homes for the future. From December 2024 to January 2025, the project team created a 30-question

online preparedness assessment, informed by research on dementia care models, frameworks, education and implementation readiness. A total of 301 long-term care homes completed the assessment and 30 participated in follow-up interviews to add richer, practice-based insights.

All participating homes received a personalized preparedness profile highlighting their readiness to implement new or additional dementia care practices, benchmarking comparisons with other homes, and clear opportunities to elevate aspects of their approach. To recognize the time and effort required, financial support was provided to each participating home.

What LTC homes told us

The assessment and interviews illustrated the dedication and compassionate care currently occurring in the sector. They also revealed that leadership across long-term care homes shared future visions rooted in person-centred

care and continued efforts to grow dementia care programs according to a changing landscape.

Homes are at different points on their implementation journey. Most participating homes identified as being in the initial implementation stage (99 homes; 36.1%), followed by those at installation (66 homes; 24.1%). This range signals both momentum and an opportunity to tailor supports to where each home is today.

Care philosophies are diverse and complementary. The predominant philosophy reported was person-centred care (262 LTC homes), followed by emotion- or relationship-centred care (169 LTC homes) and strengths-based approaches (145 LTC homes). Many homes blend these philosophies to meet resident needs in flexible, responsive ways.

Programs in practice reflect Ontario's strengths. The two most used approaches among respondents were the Ontario 5 STaR Program

(204 LTC homes) and Montessori methods (166 LTC homes). Together, these speak to the sector's embrace of evidence-informed, compassion-driven care.

Long-term care homes reported that education and training on dementia care is being delivered to team members, caregivers and volunteers. At the same time, the assessment and interviews highlighted a clear need to deepen and broaden that training across roles and over time, ensuring consistency, confidence and sustainability.

A 10-year vision

When homes looked ahead a decade, three themes stood out in terms of what they hope to build:

1. **Person-centred environments:** Homes envisioned "home-like," safe and supportive spaces that foster community, agency and engagement. Many pointed to the promise of technology to enhance communication, safety and personalized routines, and a holistic approach that acknowledges the

whole person – physical, cognitive, emotional, social and spiritual.

2. **Staffing and skills:** Homes want every team member to be educated in dementia care, with sufficient staffing to enable one-on-one, relationship-centred support. Many aspire to specialized roles that can champion dementia care across the home – coaching colleagues, coordinating responses and evaluating impact.
3. **Resident well-being and public perception:** Almost all homes anticipated positive impacts on residents' quality of life as dementia care strengthens. Several also hoped for broader reductions in stigma, with families and communities gaining a more nuanced understanding of dementia and the rich, purposeful lives residents can lead in long-term care.

What does this mean?

You may decide to pause, reflect and gather your home team to explore:

- Is your home leaning towards a particular dementia care model?
- Has your home started working towards this model yet?
- What are some of the strengths of your long-term care home's existing dementia care practices?
- What are some areas of opportunities when it comes to dementia care in your long-term care home?
- Are there team members who could act as dementia care champions or leaders in your long-term care home?

Further thoughts

As the number of Ontarians living with dementia grows, the sector's commitment to person-centred, relationship-based and strengths-focused care is unwavering. By building on the strong foundation many homes already have – and by investing in the people, processes and environments that make care possible – we can ensure residents live fulfilled lives, receive excellent care and have a voice. [LTCT](#)



Stacey Guy



Alma Lekic



Nafis Hashemi

The authors are from the Ontario Centres for Learning, Research and Innovation in Long-Term Care at Baycrest: **Stacey Guy**, Manager Knowledge Mobilization; **Alma Lekic**, Regional Engagement Liaison; and **Nafis Hashemi**, Project Coordinator. For supports to enhance dementia care programs, please explore the Ontario CLRI training and resources at clri-ltc.ca.

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Honouring emotions

Creating workplaces that acknowledge and support staff grief

By Matthew Bradford

Grief, it has been said, is the price we pay for love. And in a sector that prioritizes forming human connections, it is inevitable that many long-term care professionals experience grief in all its many forms.

“We’re told from the day we enter long-term care that it’s person-centred care – and the expectation is that we will get to know the residents like they’re our family,” says Nadia Potoczny, Education Coordinator at the Ontario Centres for Learning, Research and Innovation in Long-Term Care at Bruyère Health. But when residents die, she says, grief support isn’t always available to staff, or the support may be informal or inconsistent.

Potoczny, who worked for many years in long-term care homes, knows these challenges firsthand. Ongoing exposure to loss can leave staff feeling burned out, emotionally drained, and unable to bring their full selves to work, she says. Grief is a common experience as the majority of long-term care staff report managing grief symptoms (72%, according to research published in the *Journal of Long Term Care*).

Fortunately, an increasing number of homes are addressing these support gaps with practical, meaningful interventions. In a presentation at OLTCA’s 2025 *This is Long Term Care* conference, Potoczny shared examples and advice for homes on

creating workplaces that recognize and support their team members’ grief, highlighting that some of the interventions came from frontline staff who have attended the CLRI’s All-In Palliative Care training.

Education on grief and self-care

The work of creating grief-friendly workplaces begins with understanding what is often a complex emotion. Grief is a natural human response to loss. It is not a weakness, and neither is it something that can easily be brushed aside.

Grief does not follow a neat, predictable line. That’s why it may fly under the radar or be mistaken for stress or fatigue. Providing education on grief and self-care to staff helps them identify when they’re grieving, how to address the emotion, and what supports are available to them.

Ceremonies and remembrances

Many homes hold honour guard processions where the resident is escorted out of the front door under a dignity blanket, surrounded by staff and residents, and accompanied by music chosen by the resident or family.

“It’s one of the most powerful things I’ve seen,” says Potoczny. From her experience, these moments can resonate beyond staff to other residents and family members, contributing to “huge changes in the culture.”

Memorial services – often framed as celebrations of life – are another way that homes honour residents collectively as a team. These can include a guest book placed beneath the resident’s photo, where residents and staff members who aren’t vocal can write their thoughts.

Reflection rooms

In some cases, homes may lack a dedicated room for grieving. Reflection rooms address this by providing a safe, private place for grieving staff who would otherwise be left “nowhere to hide,” says Potoczny. “Reflection rooms are a place where they can write a reflection, or just sit, have a glass of water, have a cry,” she adds, emphasizing the importance of literally making “room” for a shared human experience that deserves time, space and care.

Set times to talk

Sometimes, grief just needs an open ear. With this in mind, homes are beginning to implement designated times after a resident’s death to provide a welcoming forum in which staff are free to express grief and share memories. These are voluntary and across shifts. Sometimes this is referred to as a grief debrief.

Peer support initiatives

Everyone grieves in their own way on their own time. Nevertheless, it’s important to foster a workplace in which peers are “checking in” on one another and are comfortable stepping in when their coworkers are struggling.

“Building these connections is an important form of self-care,” Potoczny says. At a more formal level, there is value in designating a staff member to check in with coworkers after a resident dies to connect them to resources, encourage participation, and notice who may need extra support.

Leadership acknowledgement

Leadership is pivotal in shaping a grief-informed culture within long-term care homes. “You lead by example,” says Potoczny. “During my years in long-term care, I had an administrator who was there at every single celebration

of life and all the team debriefs, and people saw that it was important.”

Visible leadership at memorials and team debriefs signals that grieving matters. It models compassion and sets the tone for the entire home. It signals that acknowledging loss is important and no one is too busy to take the time to grieve and support each other.

Advanced care planning conversations

Advanced care planning offers an opportunity to incorporate grief-aware practices before death, helping reduce confusion, distress and ethical tension for staff afterwards. These discussions allow residents and families to express preferences about honour guard processions, announcements, music and post-death identification.

Documenting these wishes ensures respectful, consistent practice. Moreover, by embedding these conversations early, long-term care homes will be prepared to support both families and staff while honouring resident choice and privacy, creating a structured yet compassionate approach to grief that benefits both employees and the communities they serve.

Next steps for homes

Potoczny offers the following suggestions for homes that are exploring how to improve on their grief supports for staff:

- **Conduct an anonymous staff survey** to understand how team members are experiencing and coping with loss, and what supports they feel will help.
- **Trial one of the rituals mentioned above** (i.e., honour guard, reflection rooms, or grief debriefs) to see what resonates with staff and what works for the home.
- **Designate a grief support lead / champion** who can be a point of connection for staff experiencing grief and empower the lead to follow up with individuals.

Potoczny offers a quote to help staff to think about grief and loss from author and physician Dr. Rachel Naomi Remen, whose practice focused on chronically and critically ill patients:

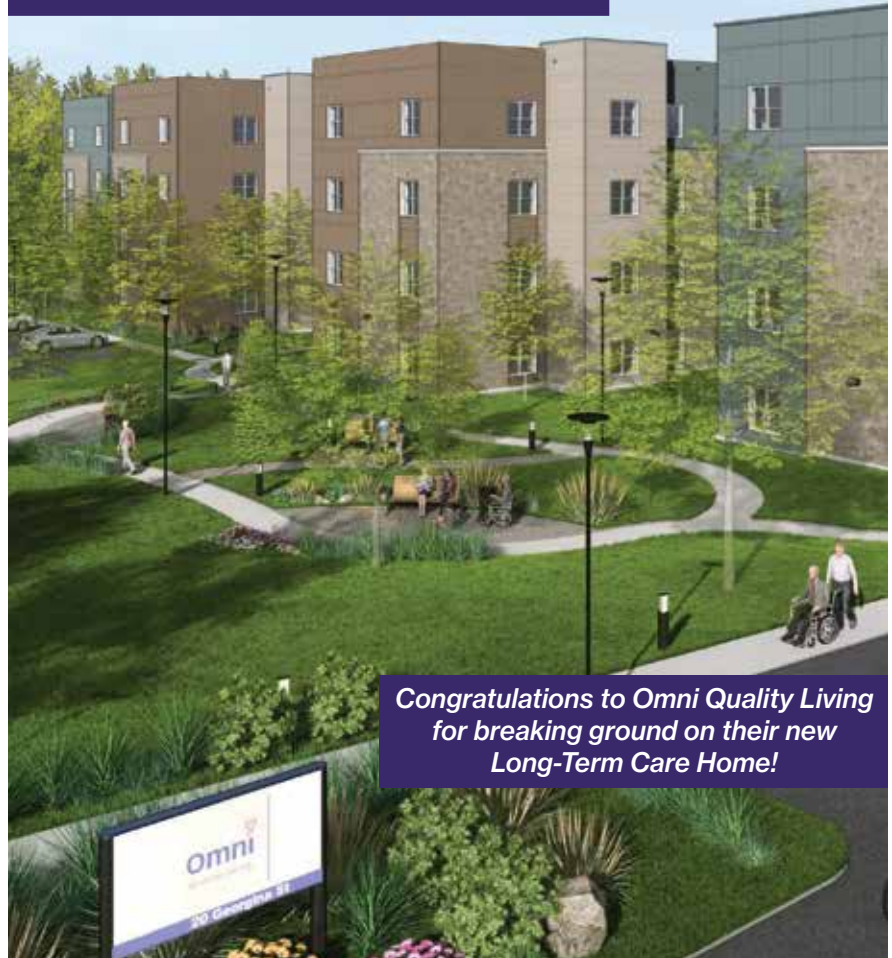
“The expectation that we can be immersed in suffering and loss daily, and not be touched by it, is as unrealistic as expecting to be able to walk through water without getting wet. This sort of denial is no small matter. The way we deal with loss

shapes our capacity to be present to life more than anything else. The way we protect ourselves from loss may be the way in which we distance ourselves from life and help. We burn out not because we don't care but because we don't grieve.” [LTCI](#)

Matthew Bradford is a freelance writer with *Long Term Care Today*. The research article about grief can be found in the October 5, 2020 issue of the *Journal of Long Term Care*.

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The Optimal Mobility Program

Transforming mobility, confidence and fall reduction in long-term care residents

By Alicja Bidzinska, Toula Reppas, Christian Gallucci and Diana Gillstrom

In long-term care, change is constant, and so is the need to evolve. Residents' needs are becoming more complex, family expectations continue to rise, and care teams are under increasing pressure to deliver more with the same resources. When the Ministry of Long-Term Care introduced funding to expand allied health care support, Kindera™ Living saw an opportunity, not simply to add more services, but to add more impact.

Instead of asking, "How do we add one more physiotherapist?" the question became: "How do we meaningfully reduce falls, improve mobility, and strengthen resident confidence in a measurable, sustainable way?"

That question led to the creation of the Optimal Mobility Program (OMP), a new solution to one of long-term care's oldest challenges.

A persistent and costly challenge

Falls remain one of the leading causes of injury, hospital transfer, functional decline, and loss of independence in long-term care. For some residents, a fall is not simply an event, it's the

beginning of a downward spiral marked by fear, decreased mobility, and reduced quality of life.

Frailty in our residents is not defined by age alone. It is shaped by physical, cognitive, emotional and social factors. Addressing falls requires more than exercise or equipment; it requires an approach that understands the entire person: their strengths, their vulnerabilities, and their potential for recovery.

Creating a new model

Kindera™ Living partnered with Achieva Health with a focused request: *Develop a program that targets residents at risk for falls, especially those with repeated falls, using a validated, evidence-based, person-centred approach to care.*

The result was the Optimal Mobility Program (OMP), launched across seven Kindera™ Living long-term care homes in November 2024 and expanded to nine long-term homes by September 2025. Built on clinical research and practical experience, the program integrates the latest understanding in:

- Strength and functional training
- Balance and gait interventions
- Range of motion and flexibility
- Cognitive engagement during mobility tasks
- Emotion-oriented, person-centred care

At its core, OMP is designed to restore not only physical ability, but also confidence, motivation and engagement.

A structured, consistent model

The OMP is not a loose collection of exercises, it is a structured, standardized approach applied consistently across participating long-term care homes. Each resident receives:

- Three 30-minute one-to-one physiotherapy sessions per week customized to each resident's physical needs
- Three 30-minute group exercise classes per week that are tailored to ensure optimal mobility

"The Optimal Mobility Program has truly changed my life. I'm walking again... I feel better than I have in years."

- Ronald B.

- A total of 180 minutes of structured mobility exercises weekly, exceeding the World Health Organization's recommendation of 150 minutes for older adults

To ensure objective, measurable progress, five key performance indicators (KPIs) are assessed on admission and monthly:

1. **Range of motion (ROM):** Knee extension on the impaired side
2. **Strength:** Quadriceps strength using manual muscle testing
3. **Balance:** Using a standardized sitting balance test
4. **Mobility:** Scored using a validated mobility scale
5. **Falls:** Documented every month

Each category is scored from 0 to 5, with a total possible score of 25. These metrics make resident progress visible, trackable and actionable.

Why physical decline happens

Age-related changes in muscle, flexibility, coordination and cognition begin earlier than most realize:

- Muscle mass begins to decline around age 30 and accelerates after 60
- Balance and coordination begin declining around 40
- Range of motion decreases with inactivity and sedentary behaviour

- Cognitive changes can influence mobility, safety, gait and transfer ability

While these changes are physiological, research shows they are not fixed. Regular physical activity, meaningful engagement, and targeted interventions can significantly slow (and in many cases reverse) functional and physical decline.

The OMP focuses particularly on strengthening the quadriceps,

a key muscle group responsible for standing, walking, transfers and fall prevention.

Person-centred approach

One of the strongest differentiators of the OMP is its positive emotion-oriented care approach. The team members implementing the OMP are trained to:

- Use validating, motivational language

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"Since joining the OMP, the difference has been remarkable. I haven't had a single fall, and I feel stronger and more confident every day."

- Johnathon M.

- Reinforce small and big successes
- Acknowledge effort; even small gains are celebrated and meaningful
- Create an environment where residents feel safe, supported and proud of their progress

Simple phrases like "You're doing great, I can see you are getting stronger," or "Your balance looks much better today," aren't simply encouraging;

they are therapeutic. Research shows that positive emotional engagement improves participation, confidence and treatment outcomes – especially in residents with dementia.

The Program uses mirroring techniques, visual prompts, and simplified cues to support residents across a wide variety of cognitive levels, making the OMP inclusive for both ambulatory and non-ambulatory residents.

Coaching and care coordination

A dedicated Care Coordinator Coach (CCC) plays a critical role in ensuring:

- Consistent delivery of best practices
- Standardized assessments across all long-term care homes
- Ongoing support and follow-up
- Accurate KPI tracking
- Timely adjustments to resident care plans

This oversight ensures that the program is not dependent on any single clinician; it becomes a

standardized part of the long-term care home's care culture.

Meaningful improvements

The first year of implementation has produced compelling outcomes:

Behind each percentage is a human story:

...A resident who stands taller.

...A resident who transfers without fear.

...A resident who returns to activities they once avoided.

...A resident who laughs again during exercise class.

These successes are why the OMP is more than a program – it is a shift in how we understand aging and mobility in long-term care.

A new standard

Aging is natural, but decline is not inevitable. With structured support, meaningful engagement, personalized interventions, and emotional connection, residents can regain more than movement. They can regain joy, confidence, dignity and independence.

The Optimal Mobility Program demonstrates that clinical excellence and human compassion are not opposing forces. They strengthen one another. When evidence-based practice is paired with empathy, residents thrive.

As Kindera™ Living's guiding principle reminds us: Connected Through Kindness. It is this combination of consistency, empathy, data and heart that is shaping a new era in resident mobility and fall prevention. [LTCI](#)



"I am feeling 100% better."

- Ronald B.



Alicja Bidzinska



Toulia Reppas



Christian Gallucci



Diana Gillstrom

Alicja Bidzinska is Vice President of Clinical Services at Kindera™ Living. **Toulia Reppas** is the Owner and CEO of Achieva Health. **Christian Gallucci** and **Diana Gillstrom** are Care Coordinators at Achieva Health.

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Families and care plans

From gatekeeping to partnership

By Matthew Bradford



Giving resident families 24/7 digital access to care information is an emerging practice in Canadian long-term care homes. At OLTCA's 2025 *This is Long Term Care* conference, three Ontario long-term care organizations discussed their positive experiences with using a resident and family portal.

Meighen Health Centre in Toronto was the first long-term care home in Canada to launch a portal, about two years ago. "We had always reassured our families that we didn't have anything to hide – that we love our residents, we love our jobs, and we want them to know that we care about them," said Monica Klein-Nouri, Executive Director of the Salvation Army's Meighen Health Centre. "But we saw that we needed to back that up, and the portal was the best evidence that we stand behind our words. We had to walk the talk."

Klein-Nouri said staff were initially hesitant, concerned about what families would say, how they would react to errors or imperfections, and whether the portal would open the floodgates to complaints or enhanced scrutiny.

Staff at Villa Colombo and Omni Quality Living, which have also

implemented a portal, had similar concerns when they moved to offering digital access to information. "Staff thought there would be more family concerns, more complaints," said Nikki Mann, Director of Resident Services at Villa Colombo. "There were concerns about errors, about compliance exposure. That's where the hesitancy came in."

"At one time, we would sit with families in a room with the chart and be there while they went through it," said Laura Scott, Director of Clinical Services at Omni Quality Living. The thinking was that if families had questions, staff could prepare, explain and provide context, she says, noting that it didn't make sense as a family could file a request for copies of the information. "We build an unnecessary and false sense of gatekeeping security."

Each organization is currently at a different stage in their rollout of what's available on their portals. Some panelists noted they need to work through questions with physicians before expanding access to certain clinical records.

"Patient portals are common in hospitals and other areas of health care but they're still new in long-term care," said session moderator Varsha

Chaugai, CEO and Co-Founder of Evoke Health, which offers the portal Engage+ used by the three organizations. "In any new practice like this, there are understandably going to be concerns to work through."

The three speakers highlighted the benefits they've seen to date in using the portal. The first point they noted was the way the portal strengthened family relationships – they use their access to become stronger, more informed care partners. "Our most engaged family members have printed the care plans, updated them, and then sat down with our team to say, 'I think Mom has changed; we need to look at this,'" Mann said.

The portal helps families feel empowered, added Klein-Nouri. "Families often feel isolated because they don't have access to information on a day-to-day basis. When we opened up everything to them, they began to trust us more and participate actively in the care plan, which was amazing. They regained some of the power they lost when they brought their loved one into the home. And that means a lot." She said she was expecting challenges, but that implementation went smoothly.

Practical takeaways for LTC leaders

- Acknowledge concerns and walk the pathway with staff – fear is natural, but it can be addressed through dialogue, coaching and support.
- Start with high-impact transparency – open care plans, vitals, diagnostics or medication changes first, then expand.
- Educate staff on professional documentation – transparency is an opportunity to elevate standards.
- Leverage technology strategically – select flexible platforms that fit your home’s workflow and allow staged implementation.
- Engage families as partners – treat questions and corrections as collaboration, not complaints.
- Respect residents’ consent – ensure residents control what is shared and with whom.
- Measure and iterate – collect family feedback continuously to refine communication processes.

Scott added that initially this level of engagement felt overwhelming to staff, but the “growing pains” were short-lived. “When we review the care plans now with families, they come in well informed and it’s a real collaboration.”

Some of the homes provided micro-classes for residents and their family members to learn how to use the portal, recognizing that not everyone is comfortable with technology. Chaugai said that typically about 80% of residents and families will use a portal, with the remaining 20% still needing other kinds of communication. Klein-Nouri also discussed the importance of a consent process for the portal, noting that a few residents chose not to allow family members to have access.

Each speaker also highlighted that transparency has bolstered their ability to demonstrate regulatory compliance. “By sharing records proactively, organizations can show that families receive timely information and are engaged,” said Scott.

Staff have also benefited from the culture shift. By making records transparent, staff have become more precise in their documentation and have embraced the process as a chance for continuous improvement.

The portals also support smoother staff workflow by reducing phone calls and communication burden on

staff. Klein-Nouri said it has made a significant difference across many staff activities – for example, consent for vaccines is now much easier, as is sharing billing statements.

Speakers were asked for advice for other homes that were considering a portal. “What works for us might not work for you,” said Scott. All speakers noted that they are in different stages of using their portals, and that adding new information over time is a continually evolving process. Klein-Nouri noted that her home started with care plans, medication,

diagnoses, vitals, then consents, and then moved on to billing. And after using it for two years, she said that staff are now coming forward asking for other ways to use the portal to improve communication and efficiency.

“There’s so much you can do with a resident and family portal,” added Mann. “It’s a whole new world to explore.” [LTC](#)

Matthew Bradford is a freelance writer with *Long Term Care Today*.

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Dementia beyond segregation

A perspective on inclusive living

By Matthew Bradford

Effective dementia care is rooted in new perspectives and the willingness to engage in difficult conversations, says Dr. Allen Power.

As the Schlegel Chair in Aging and Dementia Innovation, Dr. Power has spent much of his time in the sector working with “some of the most amazing people on Earth” to explore the pillars of dementia care. During a recent presentation at OLTC’s *This is Long Term Care* conference, he offered his perspective on current practices and how they can be improved. Dr. Power’s talk encompassed collaborative work with Jennifer Carson, PhD, and Pat Sprigg, including material from a book they are co-authoring on the topic.

Addressing segregation

Dr. Power begins his presentation with an overview of several barriers to more empowering care for people with dementia. The first is what he coined as the “Fallacy of

Homogeneity” – that is, the idea that modern care is based on a uniform understanding of what is, in actuality, a group of people with diverse abilities, strengths, coping skills, personal histories, cultural backgrounds, and stages of dementia.

The question, Dr. Power posed, was whether today’s one-size-fits-all housing model is the best way forward given the vastly different people within it. For example, he asked, “If you were diagnosed with dementia, would you want to live the rest of your life in a place that only has other people with dementia living with you? What about a home just for people with high blood pressure? One for people with the same grade point average?”

The point, Dr. Power added, is this: “We don’t sort people into living places based on one characteristic or past role, because that’s not how identity works. Yet, with dementia,

we’ve decided that one diagnosis is enough to define where someone lives for the rest of their life.”

Dr. Power provided several other arguments against segregation practices in dementia care. For one, he argued, there is no conclusive evidence that placing long-term care residents with dementia in locked, segregated units has resulted in net-positive outcomes. Rather, he argued, studies like Namazi and Johnson suggest the opposite: “With the doors locked, there were 1,534 distressed expressions. When the doors were unlocked, that dropped to 419.”

There is also “Demographic Reality” to consider when discussing the segregation of residents with dementia. The number of people living with dementia is rising rapidly while the pool of available caregivers is shrinking, making segregated care an increasingly difficult model to

scale. Dr. Power warned this was not something the industry can “build our way out of” with more locked or specialized units, as there will not be enough workers to staff them, let alone staff them well. The good news is that a large proportion of people with dementia are already living in integrated settings today, providing evidence that the more labour- and resource-intensive segregated models may not be needed in the future.

For Dr. Power, perhaps the most compelling argument against segregation is that locked units are not so much a clinical issue as a rights issue.

Pathways to inclusion

From the outset of his presentation, Dr. Power assured attendees that his intent was to explore difficult conversations with a caring, compassionate sector. And given his faith in the sector’s ability to reflect and evolve, he dedicated the remainder of his time to focusing on how the long-term care community can build stronger pathways to more inclusive dementia care.

- 1 - **Reframe dementia:** Long-term care professionals understand that dementia is more than a medical condition; it is a life-altering “change in experience.” Dr. Power underscored the importance of keeping this in mind as it reframes the concept of dementia “care” from control to accommodation: “We build wheelchair ramps, but we don’t build cognitive ramps. We take people whose brains are changing and force them to live in a world based on our rules, our schedules, our rhythms.... We need cognitive ramps, not locked doors.”
- 2 - **A stronger focus on well-being:** In reframing dementia, Dr. Power argued that it’s important to shift attention away from managing “behaviours” and toward understanding unmet human needs. “A lack of well-being, not dementia, is much more the root cause of distress,” he said. “Dementia affects your reaction to the world, but it is not the cause of the distress itself.” True well-being, he continued, is

"There is no risk-free choice and no risk-free environment. Trying to remove all risk will always come at the expense of well-being. People will be safer, yes, but they will also be less human, less autonomous, and more distressed."

- Dr. Allen Power

built on seven factors, referring to the framework of The Eden Alternative Domains of Well-Being: Identity, Connectedness, Security, Autonomy, Meaning, Growth and Joy. “All people need all seven to live well,” he explained.

“When one or two of those are missing, distress is a very normal human response.”

- 3 - **Leverage collective capacity through dialogue:** Dementia care is too complex for top-down rules. Instead, Dr. Power said, it requires shared thinking from the whole care team. “When complexity is present, you need dialogue, not directives. You need to bring people together to think, to share perspectives, and to make sense of what’s happening in real time.” He emphasized that permanent, consistent staffing enables this dialogue, allowing teams to build collective insight and respond with nuance rather than control.

- 4 - **Create enabling environments.** Living spaces for people with dementia should foster freedom rather than mask confinement: “If you can never leave, it will never feel like home,” Dr. Power quoted Emi Kiyota as saying. “No matter how pretty the wallpaper is or how cleverly you disguise the hallways, it’s not a home if people can’t make choices about where they go.”

The same concept applies to restrictive technologies, he added: “It’s not about the gadgets. It’s not

about bells, cameras or sensors. It’s about the assumptions we make about what people can and cannot do, and whether we design environments that respect their capabilities rather than try to control them.”

- 5 - **Negotiate risk, don’t eliminate it:** Dr. Power suggested reframing safety as a shared, values-based decision, not a technical exercise in eliminating danger. “There is no risk-free choice and no risk-free environment. Trying to remove all risk will always come at the expense of well-being. People will be safer, yes, but they will also be less human, less autonomous, and more distressed.” To that end, he urged long-term care professionals to weigh action and inaction equally, and to engage residents, families and staff in open dialogue about values, dignity and acceptable trade-offs. These collaborative insights are key designing supports and environments that balance freedom and safety rather than defaulting to confinement.

In long-term care, difficult conversations come with the territory. By applying an objective lens to current practices, Dr. Power’s presentation offered long-term care professionals much to consider as they continue their good work. [UCT](#)

Matthew Bradford is a freelance writer with *Long Term Care Today*.

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Are wearables ready for long-term care?

The promise and pitfalls of wearable technology

By Dr. Andrea Iaboni

Smart watches that detect falls, sensors that flag early signs of illness, wristbands that track sleep or movement patterns: it sounds like the dawn of a new era in long-term care. But there's reason for pause.

While pilot studies often yield promising results, many technologies subsequently overpromise and underdeliver in real life. In long-term care, where relationships, privacy and trust are paramount, pursuing unproven innovations carries unacceptable risks. We need to ask hard questions about how these tools really work and what they might actually change in day-to-day care.

I have been leading research on the use of wearables in people with dementia in long-term care settings for the past 10 years, and this has given me a unique perspective on the pros and cons. Let's start with the upsides.

Used thoughtfully, wearables can provide clinically important information

about a resident – their health status and overall well-being. For residents, it can feel reassuring to know someone is keeping an eye out. Families often like the idea too, especially if they are offered updates and data that address safety concerns. In some pilot programs, these tools have led to fewer hospital transfers and better insights into residents' daily rhythms. The potential is real and worth exploring.

But then there are the downsides. A lot of companies selling wearables to long-term care facilities are start-ups still finding their footing. They toss around terms like "AI-powered" and "predictive analytics," which sound impressive but often mean very little once you dig deeper. Many of these systems haven't been tested with the people who live in long-term care, and particularly those who are frail or cognitively impaired. And because many companies treat their algorithms as trade secrets, it's hard to know how

accurate or biased they might be. The result is that you might end up with gadgets that flood staff with false alarms or miss real problems entirely. That's a distraction, not an innovation.

Even when technology functions effectively, not every long-term care home is equipped to immediately install and sustain it as an integrated system within existing workflows. Without dedicated champions to lead staff training, educate caregivers and residents, and manage routine tasks like assigning wearable devices and login accounts, even well-developed technologies risk remaining unused. Sustaining long-term use demands substantial additional effort to monitor device wear, equipment loss or damage, and to communicate system updates to staff, residents and caregivers.

Effective systems also change how people work. Real-time monitoring can make staff feel accountable to data instead of their own professional

judgement. It can also shift attention away from genuine human connection. For families, having access to their loved one's data can comfort some but stress out others. Residents may also feel uncomfortable being tracked, especially if they don't fully understand what's being collected or why. In long-term care, where many residents have dementia or other cognitive impairments, meaningful consent gets tricky. One person's "safety feature" is surveillance to another. Good intentions can easily slip into questionable practice.

Long-term care organizations need strong policies about data ownership, storage and deletion, along with clear communication with residents and families about what is being tracked. Without that, even the most well-intentioned innovations can backfire, undermining the trust that's essential to good care. And all of this takes significant investment, time, resources and ongoing effort, with a payoff that isn't always clear.

In my research, I learned quickly that some wearable technologies are much more feasible than others. Devices that require frequent charging or removal, or that come with high costs, are basically non-starters. Wearables will break or get lost, so they need to be easily replaced. Residents need to want to wear the device, and staff need to buy-in to its value as well, because it won't be useful if it's sitting on the bedside table or in the nursing station.

This is why my research focus has shifted over time, from expensive wearables with physiological sensors to simple location-tracking systems that serve a dual purpose: as a safety system (to support buy-in) and for data collection. So far, using simple information about residents'

How to be smart about adoption of wearable technology

- Ask questions – a lot of them. How was the device tested? On whom? What's the error rate? Can the company explain the algorithm in plain English?
- Look for real evidence, like peer-reviewed research or independent evaluations.
- Try before you buy. Run a small pilot program. See how it affects workflows, staff workload, and resident/family comfort.
- Involve people early. Let residents, families and frontline staff weigh-in before policies are set.
- Think long-term. These devices need maintenance, updates and training. Make sure you're ready for the ongoing effort.

movement in space over time, we have been able to describe social engagement, levels of motor agitation, circadian rhythms, and even the risk of contracting infection. I think there is a great deal of promise here, supporting proactive care planning, improving safety, guiding reassessment, and helping staff respond more effectively by identifying emerging risks such as delirium or falls.

At the same time, I'm realistic that there is still a long way to go in learning how to implement these technologies and algorithms in ways that truly support person-centred and compassionate care, while also empowering staff. The next challenge is translating these early research successes into everyday practice, ensuring the technology enhances human relationships at the heart of care.

Wearables have the potential to reshape long-term care for the better. They

can offer new layers of insight to help deliver better care. The challenge is to explore this potential without falling victim to the hype: technology should fit into care, not the other way around. So let's be excited about what wearables can do, but let's also stay wary. In the end, care isn't just about data; it's about people. [LTC](#)

Dr. Andrea Iaboni is a Geriatric Psychiatrist Clinician-Scientist. She is the Medical Division Lead in Seniors Mental Health at the University Health Network, Medical Director of the Specialized Dementia Unit and Virtual Behavioural Medicine Program at Toronto Rehab, and a Senior Scientist at the KITE Research Institute, Toronto Rehab.



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Implementing on-site speech-language pathology at Kensington Health

By Joshua Chan



The Gardens, the long-term care sector of Kensington Health, piloted an on-site Speech-Language Pathology (SLP) service model in response to internal observations, sector-wide evidence, and recognition that existing dysphagia management was not adequately meeting the needs of residents or staff.

Their experience mirrors the challenges faced by many long-term care organizations across Ontario: increasingly complex resident needs, rising choking incidents, limited access to external SLPs, and the overextension of existing clinical staff such as registered dietitians (RDs). By establishing a dedicated on-site SLP model, Kensington sought to strengthen resident safety, streamline processes, and build a more collaborative and competent circle of care within their long-term care home.

Why Kensington decided to introduce an on-site SLP

The Gardens' decision was shaped by three major pressures that increasingly affected clinical quality and confidence across the home.

Rising choking incidents and unmanaged dysphagia

Over recent years, the Gardens experienced an increase in choking incidents, some of which became critical events. These incidents are often traced back to incomplete or missing documentation, inconsistent swallowing assessments, and missed signs of aspiration risk. With 350 residents – many presenting with complex needs – the Gardens recognized that failing to manage dysphagia properly was a serious safety concern.

Insufficient staff support

Frontline teams struggled to maintain a consistent and safe approach to feeding and swallowing. Nurses and dietitians often had questions or concerns about diet textures or aspiration risks but lacked timely access to the specialized expertise required for confident decision-making. This created variability in care, uncertainty among staff, and put stress on team members to make decisions outside their primary scope of practice.

Long waits and limited scope with standard SLP model

Traditionally, swallowing concerns were referred externally to Ontario Health at Home. This involved multiple steps: identifying who could submit, navigating the RM&R system, faxing forms, interacting with care coordinators, and waiting for agencies to find an available clinician. Delays of two to four weeks were common. Many assessments were virtual, limiting access for residents with cognitive impairment or oral-motor challenges. These systemic barriers reinforced that a different approach was needed.

A literature review confirmed that these issues were widespread in long-term care across Canada: limited SLP availability, high dysphagia prevalence, and reliance on non-SLP clinicians for swallowing care. Recognizing the risks of delayed specialized care and the mounting pressure on staff, the Gardens chose to challenge the "status quo" and design a model that aligned with their circle-of-care philosophy: holistic, resident-centred and team-based.

How this SLP Model is structured

The Gardens launched its dedicated on-site SLP model on August 1, 2024. Although implemented in partnership with external providers, the model was deliberately structured so that the SLP functioned as a fully integrated member of the Kensington team.

Consistent presence and staffing

The Gardens assigned one regular SLP on-site one day per week, rather than a rotating pool. Continuity allows the clinician to build familiarity with residents, understand unit dynamics, and collaborate effectively with team members. This relationship-building is essential for resident-centred care and for reliable follow-up.

Defined responsibilities

The SLP's scope includes:

- Swallowing assessments
- Dysphagia management, with education to residents and staff on altered diet textures
- Recommendations for safe swallowing strategies
- Support for resident communication challenges

This last point is significant: because traditional community-based SLPs prioritize dysphagia-related concerns, the Gardens intentionally created a broader scope to support its residents' needs.

Integrated onboarding and training

Kensington treats the contracted SLP like a regular staff member:

- Full organizational orientation and access to training modules

- Access to their documentation systems and care planning processes

This dual training – through the Gardens and the community agency – ensures clinical consistency and high competency.

Internal referral system

From model launch day to March 31, 2025, referrals were routed through RDs, overburdening them and causing inconsistencies. In April 2025, the Gardens launched an improved internal referral process within PointClickCare (PCC). They:

- Created a dedicated SLP referral category
- Removed swallowing-related options from the RD referral forms
- Socialized the new referral through posters, unit huddles, and staff-wide communication

This change dramatically increased appropriate, timely referrals and staff engagement.

Benefits of the model

Data collected from August 1, 2024 to September 2025 shows meaningful improvements in safety, workflow and outcomes.

Major reduction in wait times

The median time from concern to assessment is now six days – down from two to four weeks. Faster assessment translates into earlier intervention, lower risk, and peace of mind for staff and families.

Comprehensive clinical activity

- 109 new referrals
- 146 total visits, including assessments, follow-ups and reassessments
- Increased volume of referrals occurred after improving the internal process – a positive indicator of staff engagement and trust in the service

Impact on dysphagia management

Among residents assessed for dysphagia:

- 51% retained their baseline texture but with added safe swallowing strategies
- 36% required downgraded textures

- 7% were upgraded
- 4% were not assessable

This shows that texture decisions were individualized and clinically thoughtful – not automatically downgraded, not overly conservative.

Significant reduction in choking incidents

Before implementation, there were five choking-related critical incidents in the quarters leading up to the launch. After launch, only one incident occurred from Q3 2024 to Q3 2025.

This reduction is a key marker of improved safety and validates the importance of specialized, timely assessments.

Greater staff confidence and improved resident experience

Residents now feel safer knowing they can be assessed within a week. Staff feel empowered to raise swallowing concerns, whereas previously they may have hesitated. Dietitians can refocus on nutrition, instead of spending disproportionate time on dysphagia management.

This improves clinical quality, reduces burnout, and brings discipline-specific expertise back into alignment.

Advantages of using SLPs compared to RDs for swallowing assessments

Kensington outlined several advantages of having SLPs conduct swallowing assessments.

Specialized dysphagia expertise

While RDs have competency, they often do not feel comfortable making significant texture modifications, particularly for complex cases. SLPs, by contrast, are trained extensively in:

- The physiology of swallowing
- Oral motor function
- Communication issues that intersect with feeding
- Prescribing exercises or techniques for safe swallowing

More balanced diet texture modifications

SLPs confidently modify diet texture (upgrade or downgrade), providing

more balanced clinical judgement and opportunities to improve quality of life. RDs often felt uncomfortable upgrading diet texture due to risk involved.

SLP involvement reduces risk of adverse events

The reduction in choking incidents supports the conclusion that specialized assessments improve resident safety.

Better alignment of roles

SLPs can focus on dysphagia and communication; RDs can focus on nutrition.

The on-site model ensures each discipline practices within its optimal scope, reducing burnout and improving quality of care.

Conclusion

Kensington Health's dedicated on-site SLP model demonstrates how long-term care homes can meaningfully improve resident safety, reduce clinical risk, and enhance staff confidence by introducing specialized expertise into the circle of care.

Through a well-structured subcontracting model, internal referral redesign, and strong interdisciplinary collaboration, Kensington reduced assessment wait times to six days, improved dysphagia management, and significantly reduced choking incidents.

The advantages of SLP-led assessments – greater clinical competency as it relates to dysphagia, balanced decision-making, communication support, and reduced burden on dietitians – highlight the value of this discipline within long-term care. Kensington's experience offers a compelling, data-driven case for rethinking traditional models of dysphagia management and investing in consistent, specialized, on-site SLP services. [LTCI](#)

Joshua Chan is Manager of Allied Health at Kensington Health in Toronto.



Prioritizing mental health training

Strengthen retention, reduce stigma, and build resilience

By Matthew Bradford

In today's long-term care, mental health training is more than a "nice to have." Equipping teams with the resources to both understand and address mental health challenges is essential for strengthening teams, reducing stigma, and improving care outcomes.

At OLTC's 2025 *This is Long Term Care* conference, members of Responsive Health Management and the Responsive Group shared their experience and advice on mental health training for long-term care teams.

Make it a priority

There are many reasons why mental health training deserves greater priority in health care, said Sydney Major, Web Coordinator at Responsive Group Inc. and a mental health trainer.

Mental health training equips teams with practical tools and strategies to manage sources and symptoms of mental stress before they accumulate and ripple negatively into both work and home life. Whether it is a heavy workload, the complex emotions associated with end-of-life care, caring for residents with challenging behavioural expressions, or the pressure of constant scrutiny from regulators, family members, and the

public, work stress in long-term care can become normalized as "part of the job," Major said.

Left unaddressed, these stressors can leave long-term care professionals drained of the energy, emotional capacity, and motivation needed to bring their full selves to their work.

Brie Munshaw, Quality and Accreditation Coordinator with Responsive Health Management, is another mental health trainer who works alongside Major. She emphasized the value of being able to identify symptoms early and to engage in meaningful exercises and conversations while on the job, before a situation escalates into crisis.

"It's helpful in those moments to have those conversation tools ready so you can dig into how you feel with your peers and start reversing those negative effects," Munshaw explained. By normalizing these kinds of conversations, "mental health becomes part of everyday work, not an emergency-only topic."

Perhaps most importantly, mental health education strengthens retention in a workforce that is already stretched thin. As Major noted, "Retaining our workforce results in

reduced recruitment costs and makes it far easier to maintain consistency of care." When team members feel seen and supported, she added, they are more likely to stay, collaborate and provide safer care, a win for workers, residents and organizations alike.

Move beyond the stigma

One of the most significant benefits of mental health training is its role in confronting stigma and longstanding misconceptions. Only when long-term care teams truly understand the mental health challenges they face can they begin to create workplaces where those challenges are acknowledged and supported, rather than hidden out of fear of being perceived as weak or incapable.

Mental health stigma manifests in several forms, said Major. Personal stigma is driven by negative self-beliefs and internalized judgements that lead to persistent feelings of guilt and shame. Systemic stigma occurs when policies, laws or institutional practices, often unintentionally, result in discrimination that limits access to rights or opportunities. Stigma is also shaped and reinforced by broader societal attitudes and stereotypes.

Munshaw pointed to the powerful role media plays in shaping these perceptions. "Whether it be TV and movies, video games or social media, it's really important to realize that, for the most part, these virtual realities typically show the most extreme versions of mental health conditions," she said. "They almost always fail to educate viewers on the wide range that each condition can span, or even the positive side of recovery. This in itself contributes heavily to the stigmas being created and unfortunately absorbed by so many people in society."

Mental health training helps bring these stigmas into the open, challenging assumptions and clearing the way for genuine, empathetic support.

Building resilience

Resilience is commonly defined as adapting well in the face of adversity, trauma or stress. In simple terms, Munshaw described it as "the ability to bounce back from difficult experiences and situations."

Through mental health training, long-term care professionals gain both insight and practical tools to help build and sustain resilience in their roles. The goal is not to eliminate stress, which is unrealistic in such a demanding sector, but rather to provide easy, repeatable strategies that help team members cope more effectively. These strategies often include:

- **Deep breathing:** Resetting the nervous system through controlled breathing cycles
- **Positive self-talk:** Identifying and challenging negative thinking patterns
- **Mental rehearsal:** Visualizing possible outcomes to prepare for stressful situations
- **Goal setting:** Breaking challenges into manageable, short-term steps

Mental health training also emphasizes the importance of self-care. “We cannot expect to be at our own personal best and supporting our teams when we ourselves are not taking care of ourselves,” said Munshaw. She noted that examples shared during training sessions included “karaoke nights, running, meditation, painting, gardening, buffets with friends, crocheting emotional support squiggles. It doesn’t have to be fancy or expensive; it just has to fill your cup.”

Available supports

Long-term care homes do not have to go it alone when implementing mental health supports. A range of external programs and resources can provide a strong foundation. One such example is The Working Mind, an evidence-based mental health training program developed by the Mental Health Commission of Canada to reduce stigma, build resilience, and foster supportive workplaces.

Munshaw and Major are among a growing number of long-term care professionals who have completed the program’s five-day facilitator training, funded by the Mental Health Commission of Canada, and are now helping to bring the program into the broader sector. As Major explained, “The Working Mind significantly broadens your perspective, not only

on mental health, but also on the importance of empathy and putting yourself in other shoes.”

Together with tools such as the Mental Health Continuum, The Working Mind is one example of the many available resources that can help foster supportive environments, strengthen resilience, and improve retention in long-term care settings.

Essential training

Mental health training is not about adding yet another responsibility to

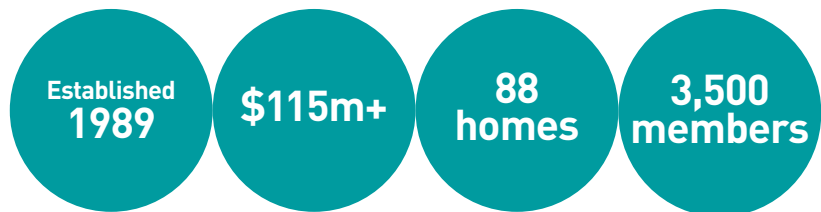
already overwhelmed teams. Nor is it about diverting resources from other essential education, Munshaw and Major stressed. Rather, prioritizing mental health training, in whatever form it takes, is about giving long-term care workers the language, tools and permission to care for themselves with the same commitment they show to caring for others. [LTCI](#)

Matthew Bradford is a freelance writer with *Long Term Care Today*.

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A significant benefit of OLTCA membership is accessing the OLTCA retirement savings plan, including a pension, RRSP and more! It’s a low-cost plan that is flexible and requires low admin.



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- 2 Support.**

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- 3 Want to know more?**

To learn more, speak to an OLTCA board member or contact: Jacquelyn Warden, Group Retirement Consultant, Leslie Consulting Group, jacquelyn@lesliegroup.com or Lisa Hickey, Client Relation Manager, Manulife, lisa_hickey@manulife.ca.





Supporting care partner well-being

How to assess your organization’s support for caregivers

By Alison Kilbourn, Lisa Raffoul & Mariam Zohouri

Caregivers, or care partners – often referred to as unpaid family caregivers (though the role may also be filled by a friend) – provide up to 90% of patient care in the community and up to 30% of resident care in long-term care homes. They are essential for better health outcomes and quality of life for residents in long-term care.

When they’re present, studies have shown that residents’ physical and psychological well-being improve, with their role enhancing care management, reducing costs for long-term care homes, and protecting the physical and cultural safety of residents (among other outcomes).

To be able to contribute to resident well-being and partner effectively with

long-term care teams, caregivers need to be well, yet many are already on the brink of burnout. Data from the Ontario Caregiver Organization’s (OCO) 2025 Spotlight report shows that almost half of caregivers (46%) feel lonely, isolated and depressed, 60% feel burnt out, 52% say caregiving is taking a toll on their health, and 72% say they feel unable to maintain their own healthy behaviours.

This doesn’t just impact the caregiver: it can compromise resident safety and lower the quality of care, increasing stress for teams if caregivers are not well or at their best.

For long-term care homes facing competing priorities and chronic team shortages, introducing new initiatives, however great their potential for good, can feel impossible. But to support caregivers, you don’t have to start from scratch; starting can be as simple as enhancing existing practices – such as any that currently support more effective communication with residents, family and members of your team – or encouraging team members to ask caregivers “how are you doing?”

This is the approach our team takes at the Ontario Caregiver Organization’s (OCO) Essential Care Partner Support Hub, which exists to guide and support health care organizations as they adopt caregiver-inclusive practices. With long-term care teams, our goal is to help them find out how to embed caregiver inclusion and support in a way that works with their teams and support their goals – without straining resources.

Here’s how we do it:

Getting clear about where you’re at today

When connecting with your team, our first step is seeing what you’re already doing to support caregivers. For instance:

- When a new resident comes to the home, how are families welcomed? Is there any orientation in place for caregivers?
- Do families and caregivers receive resources to support their well-being?
- Are any supports offered for caregivers by the home, such as caregiver education opportunities or a support group?

Aligning with your priorities

Now clear on what you currently have in place, our team can work

Resources for caregiver support

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- Our “I am a Caregiver Toolkit” adapted for caregivers in long-term care
- A short, two-minute animated video to help caregivers self-identify
- A tip sheet with six easy ways for providers to support caregivers
- A resource that identifies simple strategies to support caregiver well-being

Reach out to our team to get your copy (plus, we can print and ship caregiver resources to qualifying long-term care homes for free).

with yours to understand your vision for the future, identifying how caregiver support can align with your organization's priorities, like:

- Providing more person-centred care
- Improving communication between families and teams
- Improving working environments

With their deep knowledge and experience with residents, caregivers are key to ensuring care is both culturally safe and appropriate, while their collaboration as an essential partner can reduce pressure on staff.

Recognizing your impact

Through our engagements, we've noticed that long-term care homes are often doing a lot more than they think. Simply printing and providing resources to caregivers on-site goes a long way to helping them connect to the support they need.

One long-term care home welcomed caregivers into the home by ensuring they were prepared for, and involved in, move-in day for the resident by providing them with an information package that included a caregiver handbook with key information about the home as well as the OCO I am a Caregiver Toolkit.

Another home, seeing that many caregivers were already burnt-out and facing complex feelings like loss and grief when a resident moved in, made reducing their stress and improving their well-being a priority.

For teams seeking to do the same, mental health support like those offered through OCO's SCALE (Supporting Caregiver Awareness, Learning and Empowerment) program can help caregivers navigate these challenges with support. This eight-week psychoeducational webinar series unpacks difficult caregiver

SCALE Together impact

- 85% of caregivers feel more emotionally supported in their caregiving role
- Settings increase their capacity to offer caregiving support
- Greater sense of connection, community and support among caregiver peers

emotions and provides workbooks that offer strategies and tools to cope with the emotional aspects of caregiving.

While many supports are offered online, creating peer connections and a shared sense of community with other caregivers can contribute to well-being. To offer a solution that is both accessible and embedded with their local community, this long-term care home became one of the first to pilot OCO's SCALE Together program.

Through SCALE Together, long-term care homes can easily provide practical, in-person mental health support on-site. Hosting weekly sessions, they stream OCO's live or recorded webinars, following which a health care professional from the home will facilitate a debrief session, using a workbook provided by OCO to guide the discussion.

By helping caregivers find balance between their caregiving role and personal needs, SCALE Together successfully transforms caregiver well-being, and care delivery in turn.

Here's how it works:

1. **Get started:** OCO will meet with your team to see how SCALE Together can meet your goals, helping you choose the right program for your needs.
2. **Prepare:** OCO will support your team with promotion, recruitment,

registration and logistics, providing you with all program materials (i.e., recordings, workbooks, data collection tools, program checklist, facilitator tips, etc.). Ideally, you want between 10 and 12 caregivers per group.

3. **Host:** Deliver the eight-week program as scheduled, connecting with the OCO team mid-launch for support and to share a participant feedback survey. After the program has wrapped, review its implementation, share feedback, and submit final data collection to OCO on participant registration and attendance.

At this long-term care home in particular, the results were overwhelmingly positive. In the words of their Director of Assisted Living and Community Programs, "What we witnessed was truly moving – anxious expressions softened, and participants found clarity."

Above all, this work helps to advance the kind of connected, person-centred care crucial to improving the quality of life for everyone in long-term care.

If you're interested in learning more, our team would be happy to connect; you can email us at ecpsupporthub@ontariocaregiver.ca. Together, we'll help you support caregiver well-being and strengthen a culture of respect and collaboration that works for everyone. [LTCI](#)



Alison Kilbourn



Lisa Raffoul



Mariam Zohouri

Alison Kilbourn is the Manager of the Essential Care Partner Support Hub at the Ontario Caregiver Organization. **Lisa Raffoul** is an Implementation Lead at the Essential Care Partner Support Hub at the Ontario Caregiver Organization. **Mariam Zohouri** is the Communications Manager at the Ontario Caregiver Organization. Please contact the author(s) for a referenced copy of this article.



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