



NHSRU

Nursing Health Services
Research Unit

Promoting Awareness and Uptake of Best Practice Guidelines in Long-Term Care: An Impact Evaluation

Phase 2 Interim Report

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EXECUTIVE SUMMARY

In 2006, the Nursing Health Services Research Unit (NHSRU), University of Toronto site, conducted a process evaluation of the Best Practice Guidelines (BPG) Coordinator Initiative. This report was entitled “*Promoting Awareness and Uptake of Best practice Guidelines in Long-Term Care: A Process Evaluation-Summary of Phase I Findings*.” This document is an interim report for Phase 2, an impact evaluation of the BPG Coordinator Initiative. The information for this phase was collected between February and August 2007.

Key Messages

- The BPG Coordinator Initiative has been effective in increasing awareness and uptake of BPGs in the long-term care sector.
- Increased implementation of BPGs through the efforts of the BPG Coordinators has had benefits for both residents of the homes and staff members
- The BPG Coordinators have led a number of activities related to implementing BPGs in long-term care homes across Ontario
- The guidelines being used most frequently by homes include those related to falls prevention, skin and wound care, least restraints and promoting continence
- The implementation of BPGs in long-term care is a slow and time consuming process and some homes struggle to facilitate implementation due to challenges including sufficient staff and other resources
- Staff require appropriate training in order to understand and implement BPGs
- In general, few residents were aware of the BPG Coordinator initiative, however they expressed a desire to know what BPGs meant for their care.

Recommendations for the MOHLTC

1. Consider increasing the number of BPG Coordinators per region OR consider funding an on-site BPG Coordinator role in each home.
2. Continue to support (fund) the BPG Coordinators and LTC staff members to attend BPG-specific education and development programs such as the RAO annual Summer BPG Institute and BPG Champion Workshops within the regions.
3. Provide sustainable funding for the BPG Coordinator in Long-Term Care initiative and continue to evaluate the impact of the implementation of BPGs in long-term care on patient, system, and health provider outcomes.
4. Consider providing funds directly to LTC homes to support additional best practices activities such as continued staff in-services, and supplemental staffing needs.
5. Encourage homes to share information about BPG implementation with resident/family councils on a regular basis.

GLOSSARY OF TERMS

Best Practice Champions

The Best Practice Champions Network is an initiative from the RNAO to prepare nurses to take active roles in promoting, influencing, supporting and implementing best practice guidelines in their practices throughout Ontario. The Network was launched in June 2002. To date the Network has already engaged over 450 nurses throughout the province.

Best Practice Guidelines (BPGs)

BPGs are systematically developed statements based on best available evidence meant to assist practitioners and clients with decisions about appropriate health care. The guidelines are a resource tool to use in assessing current practices, developing policies, procedures, protocols, educational programs, quality standards, and assessment and documentation tools, within a practice setting.

Communities of Practice

Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly. (Source: www.ewenger.com/theory/communitiesofpracticeintro.htm, Retrieved August 22, 2007) The BPG Coordinators have worked to create these groups consisting of Directors of Care, Nurse Practitioners, staff nurses and allied health members within their regions. This format has created networking and learning opportunities in the long-term care setting.

Host Agency

LTC homes that have a contract with the MOHLTC, to manage the hiring and administrative responsibilities for the regional Coordinator. This includes providing physical space to house the Coordinator and access to the internet.

RAI MDS System

The Resident Assessment Instrument was developed in the United States in the early 1990's for the US Health Care Financing Administration. It is required by legislation for American nursing home residents. It is a tool being implemented to enhance standards of care and increase quality of care through benchmarking.

Ontario has recently begun to implement the RAI MDS in Ontario homes. Staff and DOCs have described the implementation of this system as time consuming adding to the workload of RNs and RPNs by increasing documentation requirements.

INTRODUCTION

Background

In 2005 the Ministry of Health and Long Term Care (MOHLTC) announced funding for a project to promote the dissemination and uptake of nursing best practice guidelines (BPGs) in the long term care (LTC) sector. In July, 2005, eight regional best practice guideline coordinators were hired for this 2.5 year project. Each of the eight coordinators has an assigned geographical region of Ontario. In February 2006, the Nursing Health Services Research Unit (NHSRU) was asked by the MOHLTC to conduct a process evaluation of the BPG Coordinator initiative. This process evaluation was conducted between July and November 2006 and the corresponding report entitled “*Promoting Awareness and Uptake of Best Practice Guidelines in Long-Term Care: A Process Evaluation-Summary of Phase 1 Findings*” is available online at www.nhsru.com.

Also, in February 2006, the NHSRU received new information from the MOHLTC regarding the timeline for the LTC BPG project. This information and additional funding created the opportunity for the NHSRU to extend the original study design (modified process analysis) to incorporate multiple data collection points in order to conduct an impact analysis. This document is an interim report for Phase 2 (an impact evaluation), which took place between February and August 2007.

Table One: Proposed Study Timeline for Promoting Awareness and Uptake of Best Practice Guidelines in Long-Term Care 2005 to 2007

Phase 1	Phase 2	
Process Evaluation	Impact Evaluation	
July to November 2006	Baseline Data Collection 2 January to March 2007	Subsequent Data Collection November to December 2007

STUDY PROCESSES AND FINDINGS

This interim report for Phase 2 (baseline data collection) describes the study processes and findings to date. Phase 2 of the study aims to determine the impact of the BPG Coordinator Initiative on the implementation of BPGs in Long-Term Care facilities by examining: 1) which specific BPGs have been implemented in long-term care; 2) to what extent the BPGs have been implemented; 3) the strategies used to implement the BPGs; 4) feedback from the front-line staff (users) of BPGs; and 5) the impact of BPGs on resident care.

Study Purpose and Objectives

The study entitled “*Promoting Awareness and Uptake of Best Practice Guidelines in Long-Term Care*” is a two phase study involving data collection at three points in time between 2005 and 2007. The overall study objectives are as follows:

1. Identify if the implementation of the BPG Coordinator positions have met desired outcomes.
2. Identify the methods utilized by the BPG Coordinators to facilitate the uptake and dissemination of the guidelines.
3. Identify the strengths and opportunities in the program as it was implemented
4. Elicit feedback about the program from stakeholders
5. Provide information needed to inform decision-making about retaining, expanding or discontinuing the program, given that this is the first time it has been offered by the MOHLTC.

Phase 2 Objectives

The purpose of Phase 2 is to conduct an impact evaluation of the Best Practice Guidelines in Long Term Care initiative. The specific objectives for Phase 2 are to:

1. Examine which specific BPGs have been implemented in LTC.
2. Examine to what extent the BPG(s) have been implemented.
3. Evaluate the strategies that have been used to implement BPGs.
4. Elicit feedback from the users of BPGs (i.e. frontline staff) regarding the implementation of the BPGs (e.g. education/training provided, challenges, and level of understanding).
5. Identify the areas of impact of BPGs on resident care.

Baseline data were collected between February and August 2007 and the results are provided in this report. Additional data will be collected in November through December 2007. This will facilitate a comparison and sharing of these results.

METHODS

Eight randomly selected long term care facilities throughout Ontario were included in the research. The methods used to conduct the Phase 2 impact evaluation were as follows:

1. Interviews were conducted with the BPG Coordinators, Directors of Care (or designate) from each participating site, and the project managers at RAO and MOHLTC where interview notes were taken.
2. Focus groups were carried out with frontline staff; and residents and family members in each participating site. The focus group discussions were tape recorded and then transcribed.
3. Analysis of the interview data (interview notes or transcripts) consisted of both quantitative (SPSS analysis) and qualitative (NVIVO) techniques.

This research project received ethics approval from the University of Toronto Ethics Review Office. All participating LTC homes accepted the University of Toronto ethics approval to proceed with the study.

Study Recruitment

BPG Coordinators

The eight Regional BPG Coordinators were contacted (email) by a member of the research team inviting them to participate in the study. Participation was voluntary.

RNAO Project Manager and MOHLTC Project Liaison

The RNAO Project Manager and the MOHLTC Project Liaison were contacted via email by a member of the research team and invited to participate in the study.

Site Recruitment

BPG Coordinators were asked to provide a list of LTC homes within their regions that were engaged in implementing BPGs. Sites were then randomly selected from the lists for each region. The process for recruiting sites took longer than anticipated, as not all sites responded to the first email invitation and the research staff had to resend several invitations to some sites before receiving a response from the site. Recruitment for sites started in April 2007 through July 2007 to successfully recruit one site per region. A total of 21 sites were contacted in order to obtain the 8 final sites. In some regions, research staff contacted up to 4 sites in order to find a site willing to participate. The sites that declined participation in Time 2 did so for the following reasons: not enough time to participate; not far along enough in the implementation phase and felt they could not contribute anything useful at this time; competing priorities in the organizations such as other required staff training; and language barrier of the residents/family members.

Directors of Care

The DOCs from the eight participating sites were contacted by phone/email and invited to participate in an interview. A letter from the principal investigator explaining the study was sent to those who agreed to participate (Appendix D).

Instruments

The BPG Coordinator interviews were conducted by telephone by a member of the research team, using a structured interview guide (Appendix A).

The DOC interviews (Appendix E) and the focus groups were conducted in person by a member of the research team using the respective interview guides:

- BPG LTC Coordinator Interview Guide Appendix A
- RNAO Project Manager Interview Guide Appendix B
- MOHLTC Project Liaison Interview Guide Appendix C
- Letter of Invitation to Directors of Care at Participating Sites Appendix D
- Director of Care Interview Guide Appendix E
- Invitation Letter to Frontline Staff for Focus Group Participants Appendix F
- Information Sheet/Consent Form for Focus Group Frontline Staff Appendix G
- Frontline Staff Interview Guide Appendix H
- Invitation Letter to Family/Resident Council Focus Group Participants Appendix I

- Information Sheet/Consent Form for Focus Group? Family/Resident Council Appendix J
- Residents & Family Members Interview Guide Appendix K

Data Analysis

The data analysis consisted of both quantitative and qualitative processes. The research team transcribed tape recorded interviews and interview notes and then compiled and sorted the qualitative data. Analysis of the focus group and interview transcripts was facilitated using NVIVO (2.0) Content analysis was used to identify major themes. Quantitative data from the interviews and focus groups were entered into SPSS (version) databases and descriptive statistical analyses were conducted.

RESULTS

I. Summary of Participants

BPG Coordinators

All eight regional BPG coordinators participated in the interviews which were conducted between February and April 2007. Six out of eight (75%) were working full-time and 2 out of 8 (25%) were working on a part-time basis. All coordinators were female and were registered nurses. Three were prepared at the baccalaureate level (BScN) and 5 at the masters level (including MN, MBA, MHS).

The coordinators reported being in their roles for varying lengths of time ranging from 7 months to 1.5 years with most in the role for over one year. Their years of experience in the nursing profession ranged from 10 to 32 years, and their years of experience in long-term care range from 7 months to 29 years. The number of LTC facilities that the Coordinators were responsible to cover, varied by geographic region and ranged from 21 to 109. Each Coordinator reported being responsible for an average of 77 facilities.

Project Managers

The RNAO Project Manager and the MOHLTC Project Liaison both participated in the interviews for this phase of the study. The RNAO representative had changed since data were collected in the first phase of the study

Long-Term Care Homes

Eight long-term care homes, each representing their respective geographic region, agreed to participate in the study. The homes were a combination of non-profit, charitable, municipal and for profit facilities. Three of the homes were members of the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS). The homes ranged in size from 120 to 390 beds.

Directors of Care (DOCs)

Eight DOCs plus one Assistant DOC (ADCOC) participated in the interviews. All of the DOCs were female and the ADCOC was male; all worked on a full time basis; and all identified RN as their professional designation. The average number of years in the

nursing profession was 23.3 yrs; the average number of years in their current role was 2.8, and the average years in their current LTC facility was 3.3. The educational background of the DOCs (& ADOC) varied with a majority prepared at the diploma level. Three DOCs had a BScN and one DOC had a BA.

The scheduling of the DOC interviews and focus groups took longer than expected for the following reasons:

- The length of time for DOC to respond to the study invitation
- Staff availability to participate in focus groups was limited
- Summer vacation for DOCs and staff
- General workload in the homes and difficulty in finding a convenient time to conduct the interview and the focus groups
- Competing priorities/initiatives in the homes and DOCs not wanting to overwhelm staff with another “project”

Frontline Staff

The total number of staff participating in this study was 48 of which (94%) were female. The participants were composed of 16 RNs (33%), 20 RPNs (42%), 5 PSWs (10%). Full time status was held by 36 participants (75%), part time status was held by 11 participants (23%) and casual status was held by 1 participant (2%). Although the range of experience in the long term care setting was from less than one year to 35 years, 20 (42%) had held positions within the long term care sector for more than 10 years. These participants’ total work experience within their field ranged from 0 to 36 years; with 14 (38%) having accumulated 25 or more years of total experience.

Residents and Family Members

A total of 47 residents and family members participated in this study. Thirty-one (66%), of the participants were long term care residents of which the majority 24 (77%) were female and only 7 (23%) were male. Among the resident participants, 24 (77%) were female and 7 (23%) were male. The mean age of the residents was 80, and the mean length of their stay in the homes was 2 years.

Family members constituted the remaining participants at 16 (34%); these family members were comprised of:

- 1) 4 (9%) spouses of residents,
- 2) 9 (19%) daughters
- 3) 1 (2%) son-in-laws
- 4) 1 (2%) power of attorney
- 5) 1 (2%) other

II Advancement of the BPG Coordinator Role

The BPG Coordinators indicated that their roles tended to vary by region based on their region’s needs and they all conveyed that they are confident in their roles at this point in time. They have developed a supportive network amongst themselves to share resources, and call on each other for support as required via teleconferences, face-to-face meetings and email communication.

One Coordinator expressed her enthusiasm about the role and the project and stated she sees it as really innovative *“it is about really helping long-term care nurses and staff, looking at what current knowledge is out there and translating it so they can understand and ultimately it is about giving the best care to residents...”*

Another Coordinator commented *“I love this job. I love going to the homes and networking and I believe that I am making a difference in the homes. It has been a wonderful experience so far.”*

A third Coordinator commented how much she enjoys the contact with the frontline staff.

A sense of job satisfaction was described by one Coordinator when she reflected on the presentations she does for staff *“it’s amazing to see what effect you can have in a half hour presentation and staff say it makes sense to me now.”*

The Coordinators have taken on various roles to assist LTC homes in learning about and implementing BPGs. The Coordinators describe their roles to be diverse and multi-faceted and are somewhat different by region, by individual home, and by the individual Coordinator’s personality and experience. They have described their roles as follows:

- Translator of information –increasing awareness about BPGs
- Information provider
- Mentor/coach (one Coordinator had staff co-present with her at a conference)
- Facilitator to guide the homes through the implementation steps
- Educator-provided education sessions about BPGs and evidence-based practice
- Participate in LTC home practice committees as requested (2)
- Assisting with policy and procedure development within the homes
- Knowledge broker
- Research Guide
- Leader - building leadership capacity in LTC staff

The Coordinators have led a wide variety and scope of activities within their regions in order to increase awareness and engage long-term care homes in the implementation of Best Practice Guidelines. Activities have included:

- Staff education about BPGs and other related topics such as documentation (workshops and in-services)
- Development of new assessment tools based on the BPGs
- Changes in policies and procedures that are based on BPGs
- The development of Communities of Practice where homes from one geographic area get together and discuss how they are implementing BPGs
- Delivery of BPG Champion workshops to increase the number of BPG Champions in the homes (approximately 100 BPG Champions in Toronto)
- Promoting an increase in the number of BPG Champions in one region from 6 in 2005 to over 70 now

- Development of resource tools such as a quarterly newsletter for region which provides concise information about BPGs in LTC
- Working with staff on a one-to-one basis
- BPG Champion Open House in Fall of 2006. Booths were set up by homes who have implemented aspects of BPGs to feature their resources and the work they have done
- Help Directors of Care write proposals
- Set up working groups for different BPGs in the region
- Giving presentations to homes when invited to do so
- Establishing working groups within different homes
- 1st LTC facility named as a Best Practice Spotlight Organization (BPSO)

The BPG Coordinator Role has been viewed positively by most Directors of Care and frontline staff (mainly RNs) who have been involved in implementing guidelines in their homes. Directors of Care saw the Coordinator role as an excellent resource. The coordinator role was described by the DOCs in six of the eight facilities as being helpful in the capacities of facilitating meetings and developing networks between homes, providing information regarding other homes, acting as a resource and consultant for BPG implementation, and increasing awareness of BPGs in staff. One DOC described the Coordinator role as “a tremendous benefit” and an essential role in getting the BPGs ‘off the ground’.

“The Best Practice Guidelines in LTC initiative is an excellent resource to DOCs through guided productivity, collation of shared ideas and the production of positive outcomes.”

Another DOC commented *“Our Best Practice Coordinator has been a lifesaver to our home. The workload to keep pace with the changes in long-term care has been challenging and especially in a rural area where many of us felt like we were isolated islands. It is so reassuring to have a bridge to connect us, provide resources and help navigate the waters.”*

Overall, seven out of nine DOCs felt the BPG Coordinator initiative had been somewhat to very helpful to their organizations in increasing awareness and uptake of BPGs in their homes and regions. Two DOCs described the Coordinators as being “not at all helpful” one DOC attributed this to the coordinator having too large a region; and the other DOC indicated this was because attempts to schedule meetings between the DOC and Regional BPG Coordinator were unsuccessful.

Most Coordinators felt their outreach has been supported by the majority of homes within their regions and 4 out of 8 Coordinators indicate that over 95% of the homes in their regions have supported/welcomed their outreach.

Both the MOHLTC Project Liaison and the RNAO Project Manager also indicate they have seen the Coordinators advance in their roles despite many challenges in the LTC sector and feel they have created “excitement” about BPGs in long-term care. Both

project managers felt that the project had achieved the goal of increasing awareness about BPGs in long-term care.

III Implementation of Best Practice Guidelines in Long-Term Care

The LTC homes participating in this study have begun to incorporate BPGs into the care they provide to residents. Some homes are further along in the process depending on various factors such as DOC and staff commitment to evidence-based practice; the utilization of BPG resources from Coordinators; the presence of onsite staff resources such as educators, BPG Champions; and the ability of homes to provide education and training for front-line staff.

The guidelines that have been mentioned by the participating sites include:

- Falls Prevention: Prevention of Falls and Fall Injuries in the Older Adult (7 homes)
- Skin and Wound Care (7 homes)
Risk Assessment and Prevention of Pressure Ulcers
Assessment and Management of Stage I to IV Pressure Ulcers
- Promoting Continence Using Prompted Voiding (6 homes)
- Least Restraints (3 homes)
- Management of Pain (3 homes)
- Palliative Care (1 home)
- Screening for 3D's (delirium, dementia and depression (1 home)
- Oral care (Oral Health Nursing Assessment and Interventions-guidelines in progress-1 home)

Because the LTC BPG Coordinator role is new, this evaluation study is descriptive and exploratory. Consequently, BPG implementation was not defined at the outset of the study. This phase of the impact evaluation revealed that participant perceptions regarding the degree to which BPGs have been implemented are widely varied and subjective in nature. All groups of stakeholders in this study (BPG Coordinators, DOCs, and frontline staff) agree that implementing BPGs in LTC is a time consuming and slow process that will not occur overnight. The LTC setting is complex with multiple competing priorities and limited resources to take on more than one initiative at a time. BPG Coordinators are stretched with each Coordinator having an average of 77 LTC homes to support in BPG initiatives.

Study participants were asked to comment on the enablers and barriers they have encountered in attempting to implement BPGs in LTC homes. Their comments are organized by theme and summarized below.

Supports/Enablers

The comments from the groups of study participants (Coordinators, DOCs and frontline staff) were combined and are presented by theme.

Leadership and Management Support

Study participants agreed that support from the Administrators and Directors of Care in the LTC homes is critical to the success of BPG implementation. Support was described as providing time for staff (registered and non-registered staff) to participate in appropriate training/in-service education to learn about BPGs; arranging to replace staff when others attended in-services; and listening to staff perceptions regarding the practical aspects of implementing BPGs. If the individuals in these leadership roles are not willing to commit to making changes (e.g. policy and procedures for resident care) to implement BPGs, it is unlikely the process will occur. It is essential to have consistent supportive leadership in the homes in order to move the process forward. One staff nurse commented that if a DOC who is supportive of BPG implementation resigns from his/her role, BPG implementation is impacted i.e. if a new DOC comes in and she/he is not as supportive or as knowledgeable of best practices, other activities may then become priorities and BPGs get less attention. Staff viewed this as both frustrating and confusing. Therefore, the Administrator's, and more specifically, the Dock's, commitment to evidence-based practice has been described as an enabler in implementing BPGs.

One staff participant noted that *"What is mandated... gets implemented."* For example, if the corporation that owns and operates a LTC home(s) has embraced BPGs and mandated their implementation, the Coordinator's job is easier. These homes have made themselves available to the Coordinator. It was also noted that homes belonging to large corporations often have the benefit of having more financial and human resources including support staff, educators and consultants to help with implementation.

Frontline Staff Support

Front line staff input/support/commitment is also essential to move forward with implementing BPGs. Staff buy-in is important and staff members must be able to see the benefits to resident care, and the relevance to their practice. In accordance with this, participating staff indicated they are willing to learn about best practices in order to improve resident care however, they also feel they must be given the time to attend appropriate training sessions/workshops. When training is provided it must be appropriate for the intended audience. Workshops for RNs should include different content than for unregulated staff. Information must be "user-friendly" i.e. educators or those providing training need to make the information meaningful to each level of care provider RN, RPNs and PSW. Staff want to know how BPGs impact their day to day work and what it means for their practice.

Quality of Resident Care

Issues related to the quality of resident care were also noted to drive change in the homes. For example, one LTC home was noted to have concern about pain management for residents. It was identified that staff needed more education and training related to pain assessment and management. This in turn facilitated moving forward with implementing some elements of the Pain Management BPG. Another site mentioned that an increase in resident falls triggered the implementation of the falls BPG as the first one they implemented.

Growing Awareness of BPGs in Long-Term Care

A growing awareness and understanding of BPGs and evidence-based practice in long-term care was also seen as an enabler for BPG implementation because more homes are accepting the BPGs. The general increase in publicity about the BPG Coordinator Initiative was also seen as something that more homes wanted to be a part of. Presenting at conferences and general marketing of the project has enabled access to the homes. A quarterly newsletter that highlights one region's activities has been circulated across all regions, allowing sharing of information and activities within and outside the region. One site mentioned that staff members receive the newsletter stapled to their pay stubs in an effort to disseminate the newsletter to staff.

BPG Coordinators have utilized various methods to engage the homes in implementing BPGs. One method has been the formation of "*Communities of Practice*." These "*Communities of Practice*" have created opportunities for DOCs and other staff from LTC homes to gather in their regions to share resources and knowledge and experience related to BPG implementation. The BPG Coordinators noted that the "*communities of practice*" have facilitated the implementation process within some of the homes and have allowed for networking on other LTC initiatives e.g. Stroke, PIECES and offering collaborative workshops to LTC staff and community agencies.

Other Enablers

Prior education and understanding of BPGs (by DOC and frontline staff) was described as an enabler in implementing BPGs.

Having good information/materials to give to the homes enhances credibility of the coordinators and elicits more positive reception from staff e.g. RNAO BPGs, Newsletters such as the "*BP Blogger*." (a newsletter developed by one of the Regional BPG Coordinators as a tool to share information about Best Practices in LTC that is concise and easy to read.).

One Coordinator described the Compliance Advisor as being very helpful in linking BPGs with other initiatives e.g. Stroke Network, Dementia Network, noting that this increased interest in the agencies and opened a number of doors for the Coordinator.

Barriers

BPG Coordinators, Directors of Care and Frontline staff identified a number of barriers to implementing BPGs in the long-term care sector. Their combined responses are described below:

Workload and Competing Priorities

Frontline staff, DOCs, and Coordinators spoke at length about the impact of workload in long-term care on BPGs. They reported many activities/competing priorities in the homes which have tremendous impact on the workload for DOCs and frontline staff. Participants mentioned examples such as: accreditation, mandatory safety education for all staff (WHMIS), ministry standards, new nursing models of practice, and other projects. One DOC stated: "*People are overwhelmed with standards and paperwork. The*

work increases by 10% but there are no corresponding increases in human resources to take on the additional work”

Staff nurses support the implementation of BPGs to benefit resident care but described their baseline workload as being so high that BPG implementation is very challenging. They specifically commented on the additional time required to complete resident assessments and the related BPG documentation as a barrier.

A resident expressed her concern regarding the paperwork that nurses have to do “People are living longer due to medical care now and medication and stuff like that so they’re coming in later in their life which demands much more and they need much more care ... front line staff now they’re barely holding on, again, with all the ... because they’re standards and so many more issues to be taken care of that...they want all this paperwork so where does that time come from? That time comes away from the resident itself. You can only take so much time away from the residents and pretty soon everything’s falling, the whole organization is falling...”

One registered nurse commented on the nurse to resident ratio and the challenges with that aspect of her workload. *“...I just know for me right now we are taking on a new model of care at our facility and for me, part of it I have to adapt to a unit and a half more than what I was used to caring for so I now have 90 some odd patients that I am trying to complete these forms on. And I having to base a lot of it solely on chart reviews or talking to my PCPs/PSWs just because we are in a transition state that the RPNs are not always able to answer my questions to complete the information that is required. So I am having to base my information on what the PSWs can tell me. Which again is just a learning curve that when hopefully when things settle down it will pick back up.”*

Homes do not always have enough time to work with the Coordinator e.g. ability to free up staff even if they are interested in participating and learning about BPGs

Staffing Issues

Staffing issues were mentioned over and over again as a barrier to implementing BPGs. Frontline staff spoke of having to work short-staffed most of the time and having no one available to replace them to attend education sessions to learn about BPGs. They also mentioned having limited staff available to call in to replace them. *“There simply are not enough nurses out there who want to work in long-term care. LTC has a negative image.”*

At one site the staff spoke of having no staff left to call in as many nurses had recently left the home and relocated to acute care due to the heavy workload. Consequently, their casual pool had been depleted.

Three sites described themselves as being extremely short-staffed so much so that some DOCs have to work on units doing hands on care because there is no staff available to call in.

Staff turnover was also mentioned as a challenge. *“It takes time to educate people about the BPG process. When people leave and new staff come it is like starting over and we can’t move forward very quickly.”* Staff commented that they need regular staff who are knowledgeable about BPGs in order to sustain the desired practice.

The proportion of regulated to unregulated staff in the homes was also mentioned as a barrier because different providers have different knowledge and understanding of BPGs and how they impact resident care.

Content of Written Guidelines

Coordinators, DOCs and frontline staff described the current format/style of the guidelines as barriers. *“They are not easy for practitioners to use...they are too academic and too difficult to implement.”* Other comments suggested the guidelines as currently written are not translatable to residents/family members. There were several comments regarding the guidelines suitability for long-term care and the limited scope that the current guidelines cover. Current publications/resources are primarily in English; this was perceived by some as a barrier and suggestions were made to have some of the resources translated into other languages such as French and Mandarin.

Organization of BPG Coordinator Roles

The BPG Coordinators, DOCs and staff commented that the geographical span of regions is very large and it is impossible for Coordinators to get to all homes in their regions. Some participants felt that all the BPG Coordinator roles should be full time considering the areas they are required to cover. In addition, the weather was noted to be a factor in the northern regions and limited the Coordinators’ travel to some homes.

Other

- Outbreaks e.g. flu season- prohibits entry of Coordinators into homes and then the BPGs get put on the back burner (3)
- The requirement to implement multiple initiatives at the same time e.g. PIECES, MDS and BPGs presents a barrier as they are resource intensive
- Pay discrepancy between acute and LTC –challenge to keep staff
- Resident classification due to the time it takes to complete the paper work
- The funding mechanisms for LTC is viewed as a barrier, as it is perceived by study participants as not accurately meeting resident needs for nursing care (staffing)

Strategies Used by Homes that are Engaged in the Project

Participants were asked to describe what strategies have been used to successfully implement BPGs in the LTC homes in their regions. Their combined responses (Coordinators, DOCs, and staff) are summarized below.

Commitment of Leadership Staff

- Having leaders (Administrators and DOCs) who are committed to the project and have a vision and strategic plan that includes BPGs.

Presence of Support Staff (Educators, BPG Champions)

- Larger homes and those that are part of a larger corporation tend to have more supports i.e. educators or other consultants to help with implementation
- Senior management put in place educators, consultants, NPs to help with the implementation of BPGs
- Having an educator on site to coordinate and assist in the delivery of workshops
- Having BPG Champions in the homes because they advocate for Best Practices

Staff Training and Education

- Staff are given time to attend learning opportunities such as BPG Champion Workshops, in-services and other RNAO events
- Sending staff to BPG Champion workshops and RNAO Summer Institutes increases the knowledge of front-line staff re BPGs. Having a Champion or a resource person attached to specific BPGs makes the project move smoothly-helps to obtain buy-in and keep the momentum for the project going
- Provide rooms for education to take place on site
- Some DOCs commented that they are becoming champions to increase their own knowledge of the BPG process in order to support their staff

Dedicate Staff to Specific Projects

- Nurses are given dedicated time each week to work on their respective BPG projects (capacity building for staff.)
- Designate specific staff to be BPG implementers
- Allow staff nurses (RNs) to take the lead (ownership) on implementing specific BPGs. Staff described this as being empowering, engaging and meaningful to them
- Having someone who is passionate about practice issues e.g. falls, incontinence
- They are innovators and take advantage of opportunities that come their way
- Some homes used the Late Career Nurse Initiative Funding to engage nurses in BPG activities

Support Systems in the Homes

- Establish formal internal committees that are accountable for implementing and evaluating BPGs at the home level
- Involve multi-disciplinary teams as part of the implementation process

External supports:

The project was profiled externally which was seen as a positive strategy to promote the initiative and the implementation of BPGs in long-term care. Examples that were given by participants included:

- OANHSS –highlighted the project at their annual convention and included progress about the project in a newsletter
- BPG Advisory stakeholders provide access to places to showcase the work being done

RNAO

The RNAO was described as being very generous and supportive to the BPG Coordinators. A number of DOCs and staff think Coordinators are RNAO employees because RNAO has been so visible in project related activities such as the BPG Champion workshops, the RNAO BPG Institutes and Conferences. RNAO supported a BPG Open House in one region and has provided funding to create resources.

Staff (RNs and DOCs) were aware of RNAO's role as a supplier of resources (e.g. the guidelines, Champion Workshops) in implementing best practices in long-term care.

MOHLTC

The BPG Coordinators expressed the desire for more support and feedback from MOHLTC regarding the work they have been doing. They expressed their desire to have more regular dialogue with the MOHLTC and recognition from the Ministry on the scope of work the coordinators have accomplished to date.

DOCs and staff from the LTC homes felt that the BPG Coordinator initiative was good and it demonstrated the MOHLTC's support for the LTC sector.

IV Impact on Long Term Care Staff

This section describes awareness of BPGs amongst staff in the LTC homes and summarizes staff responses in regards how the implementation of BPGs has changed their practice and/or the care provided to their residents.

Awareness

The findings from the staff focus groups indicate that some study participants were aware of the Best Practice Guidelines in Long Term Care project and heard of this project through various resources such as the Nursing Secretariat, RNAO, their BPG Coordinator and through in-services by hospital management. Four of the seven sites were able to identify their BPG Coordinator and reported a variety of roles as having worked with the coordinator to provide leadership for the project including the DOCs, nurses' educators, RNs, and the librarian.

RNs were more aware of the project and the terminology related to best practices compared to RPNs and PSWs. Registered staff, RNs, felt more of the responsibility for implementation as they were receiving the education and were taking the lead in many facilities. In addition, the RNs were more involved in the dissemination of the new policies and procedures, based on the BPGs than were RPNs or PSWs. One RN clearly stated the difficulty associated with being the only registered staff on her floor and the enormous responsibility associated with that role. Coordinators, DOCs and RNs commented that some staff (RPNs and PSWs) may be unaware of the term "BPGs". The responses from the PSWs and RPNs confirmed this was in fact true for most sites.

There were also discrepancies noted between the DOC and staff perceptions of the BPG related activities in the homes. In one site, the DOC spoke at length about the frequency of BPG Coordinator visits and her involvement in home activities. In the corresponding

staff focus group, staff indicated they knew their Coordinator's name but had not really met her and indicated that she was only on site once every three weeks to a month. Ironically this site was one of Coordinator "host sites" (see glossary).

Practice Implications

The majority of staff reported an improvement in their practice, including increased staff awareness and focus on patient care, as a result of the BPG project which was indicated in their responses to a question regarding how the implementation of BPGs has changed their practice. For example:

- Improvement in the consistency of interventions
- Enhanced current and on-going best practice guidelines
- Clearer documentation and expectations from staff
- New and updated procedures, forms and assessments (e.g. Braden scale)
- Provided information/rationale and set standards that can be tailored to each patient
- Added equipment for safe practice (e.g. new alarms, belts and restraints)

One RN stated that BPGs made her look at residents differently and thereby provided a holistic view of their care.

"...it makes me look at residents differently on the whole...I got this resident I look at differently. He was falling all the time, right, and it made me look and see all aspects, like the time factor. ... We realized this is why he was falling, and he was falling because he wanted the TV changed at a particular time, at 11 o'clock to watch the price is right. ...a staff would change the TV at that time so that automatically decreased his falls"

A few staff members expressed that some of the perceived challenges/negative effects of the project including increased workload, particularly paperwork and documentation associated with patient assessments. One RN clearly stated that too much time is spent doing paperwork which "takes time away from patient care" and is increasingly difficult due to constant interruptions.

"Well I know I was off for a week but when I cam [back] yesterday ...I stayed for overtime 'cause a lot of the paper work was not getting done. And I stayed and I did straight paperwork for half of a shift and again found it hard to do 'cause you have to do hands on care at the same time 'cause you are constantly getting pulled away"

In general, staff agreed that the quality of care of residents improved as a result of the implementation of BPGs in several ways. For example:

- Improved consistency of standards and procedures
- Improved communication between family members and staff by providing education and a rationale for resident care
- Improved communication among health care professionals by providing a common vocabulary that all levels of providers can understand
- More comprehensive charting and documentation

- More in-services and clinics that provide further education and training resulting in more educated staff
- Integrated or improved systems of tracking outcomes of BPGs,
- Improved outcomes of BPGs such as fewer falls, injuries and pressure ulcers.

One staff member stated that the processes for tracking of incidents such as wounds and injuries and incontinence have improved. Staff were more diligent about reporting such incidents and required tracking was built into quality improvement programs. Another RN stated that policies about transfers requiring two people had changed and equipment such as air mattresses and special dressing supplies were introduced to reduce ulcers as a result of the implementation of BPGs.

Comments from some DOCs reflect what they see as the positive impact of the initiative on the frontline staff. One DOC noted *“The project has been good for staff-it makes them feel empowered when they take on the leadership role on certain practice issues.”*

At another site two staff nurses have set up a wound care committee and are leading a practice group. Their director commented *“they are very enthusiastic about it...They are championing the wound and skin care BPG and are just running with it. It is nice to see their enthusiasm.”*

The project is helping to standardize policies and procedures within individual homes so that all residents in the home receive the same level of care.

In order to ensure continued success of the initiative, staff and DOCs made the following suggestions:

- Need more support from MOHLTC for Coordinator role (i.e. continue to fund the role and consider having more coordinators per region)
- Need more information for staff
- Have more local champions on site
- Provide funding for implementing BPGs directly to the homes and give homes more responsibility for implementing BPGS

V Resident and Family Members’ Awareness of Best Practice Guidelines

This section describes resident and family member awareness of the implementation of BPGs and summarizes their responses describing resident care at their facility and how BPGs have made a difference.

The findings from the resident and family member focus groups indicate the majority of participants were unfamiliar/unaware of the term Best Practice Guidelines. Out of the eight resident focus groups, only 2 groups indicated they were aware of the term BPG. In one home a resident learned of the term through her role as President of Resident Council and attending resident council meetings, and at the other site a family member learned of the BPGs through asking staff.

With regard to the quality of care provided to residents, the majority of participants reported the care provided by staff as average to very good with room for improvement. At all sites residents/family members expressed concerns regarding the lack of staff (from all designations) at their facility. At one site, a resident identified PSWs as particularly lacking. At another site, a resident commented that staff is constantly rushed and have no time for patient care. Residents/family expressed additional concerns about the staff including:

- staff that are unfamiliar/unresponsive to patient needs/care
- a lack of volunteers in the homes
- care issues related to medication administration and daily issues such as toileting
- staff that are overstressed, unmotivated, and overworked
- a lack of communication/knowledge of staff towards both residents and family members

In the two sites that were aware of the implementation of BPGs, one resident noted that staff seemed more educated however staff were still overstressed. Participants at the other site had not heard or noted any difference in their facility. Of the remaining sites, one family member noticed a change in the treatment of his wife in regards to preventing falls. At another site, one respondent reported a change to the use of overhead lifts that seemed to make it easier for staff and residents. The other sites reported no difference as they were unaware of BPGs and residents were new to the facility.

VI Stakeholder Feedback on the Best Practice Guidelines in Long-Term Care Initiative

Participants were asked to comment on the initiative overall and for suggestions as to what would enhance the effectiveness of the Coordinator role.

Suggestions from the Coordinators

- Smaller regions would be helpful (3)
- All coordinators should be full-time roles
- Increase the number of Coordinators (1 per LHIN)
- Need opportunities to keep up to date
- Having a lead coordinator
- Homes have to be the drivers of BPG implementation
- Engaging community partners e.g. stroke networks can help with implementation and sharing of knowledge and resources
- Need a central office of the MOH or Nursing Secretariat with key messaging and dialogue with the Ministry –Coordinators need to understand their (MOHLTC) strategic thinking-need to improve communication with the MOHLTC
- Long-term care cannot handle things fast...needs to be gradual and repetitive
- Could use a central secretary to do minutes from meetings, book flights, photocopy, send out packages etc.
- You can do things in a system that is stressed-simple things can be done to make a difference
- Extend the contracts to 2010 because the work is just getting started

- Staffing is a big issue –has an impact on ability to train staff about BPGs – most homes don't have the staff or money available to replace staff who do attend education sessions

Suggestions from Directors of Care

- Would like to see the program continue
- DOCs, managers and administrators in LTC need to be more informed regarding the BPG process-suggest they all attend the BPG Champion workshops & RNAO Summer Institute to see a bigger impact at the home level
- Need more time and funding to allow staff to attend training and education about BPGs
- Have coordinators on site for educating staff
- Link homes with academic centres and involve students in BPG implementation
- Need clear messages how the project and BPGs can benefit the homes and resident care specifically
- Homes need to continue building partnerships with other homes in their regions to share resources

Suggestions from Front-Line Staff

- Would like to see the program to continue
- more education for all frontline staff (RNs, RPNs, PSWs) on best practice guidelines
- need more time and staff to compensate for educational sessions
- more registered staff to share responsibility
- more funding for educational sessions and incentive to attend including overtime and more resources to implement BPGs
- continuity of guidelines between facilities
- more full time staff and a decrease in staff turnover for more consistent staff
- less paperwork and documentation associated with BPGs
- having MOHLTC have a more visual and participatory role in facilities
- guidelines that are more user friendly for staff, residents and family members and that are more relevant to the long term care environment
- Staff note anecdotally that they are seeing changes in resident care i.e. decreased falls and wounds

DISCUSSION

The discussion that follows is organized according to the Phase objectives which were outlined in the introductory section of this report.

Objective One: Implementation of Specific BPGs in Long-Term Care

From this study, there is evidence that long-term care homes are beginning to implement and incorporate Best Practice Guidelines into practice with the intent of improving resident care. The participating sites reported using various Best Practice Guidelines and most often mentioned guidelines developed by the Registered Nurses Association of Ontario (RNAO). Some sites reported using guidelines developed by other organizations (e.g. IOWA assessment tools), but the RNAO guidelines were the ones being used by most of the homes who participated in this study. The guidelines that have been implemented in the participating sites include:

- Falls Prevention: Prevention of Falls and Fall Injuries in the Older Adult (7 homes)
- Skin and Wound Care (7 homes)
- Risk Assessment and Prevention of Pressure Ulcers
- Assessment and Management of Stage I to IV Pressure Ulcers
- Promoting Continence Using Prompted Voiding (6 homes)
- Least Restraints (3 homes)
- Management of Pain (3 homes)
- Palliative Care (1 home)
- Screening for 3D's (delirium, dementia and depression (1 home)
- Oral care (Oral Health Nursing Assessment and Interventions-guidelines in progress-1 home)

The homes indicate that they choose the guidelines they want to implement based on a combination of resident needs and staff knowledge. For example one home indicated that there had been an increase in the number of resident falls and that this was identified by a combination of staff and compliance officers as an area for improvement. Therefore, the site chose prevention of falls as the first BPG for implementation at their site.

Objective Two: The Extent of BPG Implementation in Long-Term Care

The homes participating in this study are at various stages of implementing BPGs into their practice. Most sites (all but one home) indicated that they have started to incorporate BPGs into their policies and procedures related to resident care. Some homes are further along in this process than others for various reasons. E.g. staff awareness knowledge about BPGs, DOC knowledge, presence of resource staff such as educators, BPG Champions, availability of BPG Coordinator, ability to send staff for education training re BPGs. Other studies refer to a lack of knowledge about BPGs as a potential barrier to implementation (Berta et al., 2005; Colon-Emeric et al., 2007).

As this study included a limited sample of LTC homes in Ontario who participated on a voluntary basis, the investigators cannot generalize the results to estimate how many homes across Ontario have implemented BPGs.

Participating sites have not yet developed formal evaluation tools to measure the impact of implementing BPGs into practice. A number of sites did however, indicate that they have more regular systems in place to track the incidence of resident falls and pressure ulcers as part of compliance audits and that they are seeing decreases in the number of falls and skin ulcers since incorporating aspects of BPGs into their resident care policies and procedures. One site mentioned partnering with an academic institution to assist with this type of evaluation.

DOCs and frontline staff, especially registered staff indicate a growing level of awareness and understanding about BPGs. Unregulated staff indicate a lack of awareness and a limited understanding about BPGs but express interest in learning more about how they impact their specific roles and their day to day work.

Residents and family members in this study had limited awareness and understanding of BPGs. In two out of eight sites the residents/family members had heard of BPGs prior to the focus groups, and those who were aware had learned about BPGs from their participation in resident councils or from a home newsletter. While most were not aware of what BPGs are, they did appreciate the opportunity to participate in the study so that they could learn what BPGs meant for their care. They also felt that it would be helpful if staff shared information about BPG implementation with resident councils on a regular/ongoing basis. They also noted that the information has to be user-friendly so that residents can understand what it means for their care.

Objective Three: Strategies Used to Implement BPGs in Long-Term Care

A number of strategies were identified by participants (staff, DOCs and Coordinators) as being effective and enabling to BPG implementation. These included ensuring the guideline information is “user-friendly” that is, tailored to the appropriate audience using language that they can understand. For practice purposes, this means translating the academic/scientific documents into meaningful information for frontline staff. Those providing the education need to ensure they engage staff participation by translating the guideline so that it makes sense to all levels of care providers. This will contribute to staff buy-in and support of the practices.

Other comments related to the “user-friendliness” of the guidelines referred to the fact that the current resources are produced in the English language only and perhaps some efforts should be directed towards translating the materials into other languages, French and Mandarin were suggested. Additional comments included the fact that the RNAO guidelines were not developed specifically for long-term care and most sites said they do have to do some tweaking to make the guidelines relevant to their particular setting.

When implementing BPGs in LTC homes, staff must be provided with appropriate training that is, time to attend education sessions and staff must be replaced accordingly so that resident care is not jeopardized. In addition, staff and managers require ongoing education to keep up to date with current practice. Other studies also note the need for ongoing and continuing education support when new methods and processes are being taught (Simpson, Stevens, & Kovach, 2007).

Other strategies that were described as being helpful to the implementation process included: 1) effective and ongoing communication of new practices to all staff; 2) using a multi-disciplinary approach; 3) having onsite resources such as educators and BPG Champions to provide leadership and training as the BPGs are implemented; and 4) ongoing commitment and support from nursing management and administration.

Objective Four: Staff/User Feedback on Implementing BPGs in Long-Term Care

DOCs and frontline staff in this study generally support the philosophy and process of implementing BPGs into the long-term care sector and want to provide the best care they can to residents. However, they consistently report the lack of time and competing priorities (workload) as major barriers to the implementation process. They emphasize implementation as a slow process and identify resistance to change as a barrier.

Staffing challenges also play a major role in the ability of the homes to implement BPGs. Being short staffed and unable to find replacement staff are everyday challenges for the DOCs.

Objective Five: Areas of Impact on Resident Care

The implementation of BPGs in long-term care is beginning to have some impact on resident care. Although we may not be able to quantify the impact at this stage, there are many anecdotal reports of how the BPGs are making an impact and for the most part a positive impact.

- Changes in policies and procedures to improve resident care
- BPGs provide rationale for care
- Development of new resident assessment tools leading to more thorough assessments at time of resident admission (but are also time consuming)
- Aspects of BPGs are being included in CQI activities e.g. tracking of resident falls and incidence of pressure ulcers allowed staff to prevent and take further precautions for resident safety
- Standardizing of procedures to ensure consistency of interventions with resident care i.e. All staff do things the same way
- Staff expectations re documentation are more clear
- Change in approach to resident care- look at residents differently, more holistically

- Improved communication between staff and family members. Staff felt they could provide rationale for the care provided to residents e.g. use or no use of restraints, floor mats, hip protectors
- Improved communication between staff as a result of having a common vocabulary
- Charting and documentation are more comprehensive and improving aspects of care such as skin care, pain management and resident safety
- BPGs resulted in changes of equipment required to provide better care for residents such as air mattresses, purchasing of standardized supplies for wound care

CONCLUSIONS

The BPG Coordinators have advanced in their roles and have led a number of activities related to implementing BPGs in LTC homes across Ontario. The activities have ranged from providing resources to staff, facilitating BPG Champion workshops, and facilitating the development of networks and communities of practice within their respective regions. The Coordinator roles have been viewed positively by DOCs and frontline staff from the participating homes in this study. There is an overall consensus that the regions the Coordinators currently are required to cover are too large, and study participants have suggested the MOHLTC consider having more coordinators either by LHIN or within the individual homes.

The LTC homes participating in this study demonstrate an increased awareness about BPGs and have begun to implement aspects of specific BPGs into their resident care policies and procedures. The homes do note that the selected BPGs also coincide with the new Ministry Standards for LTC which participants believe makes implementation easier. Interestingly Berta and colleagues (2005) noted that the clinical practice guidelines most widely adopted by LTC facilities will be those reinforced by regulation. This fact also makes it difficult to evaluate the impact of BPG implementation on resident care when there are co-existing initiatives also in place.

The implementation of BPGs in the participating LTC homes is beginning to have a positive impact on resident care. The guidelines most often referred to were those related to falls prevention, wound and skin care and continence. Staff and DOCs anecdotally report decreases in incidence of resident falls and pressure ulcers. The design of this qualitative study did not involve the collection of quantitative data from the homes to be able to measure the reported differences. Work is being done in some homes to develop more formal evaluation tools and processes to measure the impact of specific BPGs. Further evaluation is required to be able to more specifically describe the outcomes on resident care. This will require the development of tools to measure outcomes as well as further research of a longitudinal nature.

Despite the progress made in raising awareness of BPGs in the long-term care sector, there remain a number of challenges and barriers that have been noted by most study participants. These include the challenges related to staffing, workload and overall

funding for the LTC sector. For change to occur and be sustained on a long-term basis, further investment is required to ensure staff receive required training including the time to attend education sessions. Further research is also suggested to continue to evaluate the impact of BPG implementation on resident care and to determine the best strategies to implement BPGs in the long-term care sector.

Recommendations for the MOHLTC

1. Consider increasing the number of BPG Coordinators per region OR consider funding an on-site BPG Coordinator role in each home.
2. Continue to support (fund) the BPG Coordinators and LTC staff members to attend BPG-specific education and development programs such as the RNAO annual Summer BPG Institute and BPG Champion Workshops within the regions.
3. Provide sustainable funding for the BPG Coordinator in Long-Term Care initiative and continue to evaluate the impact of the implementation of BPGs in long-term care on patient, system, and health provider outcomes.
4. Consider providing funds directly to LTC homes to support additional best practices activities such as continued staff in-services, and supplemental staffing needs.
5. Encourage homes to share information about BPG implementation with resident/family councils on a regular basis.

REFERENCES

Berta, W., Teare, G., Gilbert, E., Soberman Ginsburg, L., Lemieux-Charles, L., Davis D., & Rappolt, S. (2005). The contingencies of organizational learning in long-term care: Factors that affect innovation adoption. *Health Care Management Review, 30*(4), 282-292.

Colon-Emeric, C., Lekan, D., Utley-Smith, Q., Ammarell, N., Bailey, D., Corazzini, K., Piven, M., & Anderson, R. (2007). Barriers and facilitators of clinical practice guideline use in nursing homes. *Journal of the American Geriatrics Society* (OnlineEarly Articles). doi:10.1111/j.1532-5415.2007.01297.x

Simpson, M., Stevens, P., & Kovach, C. (2007). Nurses' experience with the clinical application of a research-based nursing protocol in a long-term care setting. *Journal of Clinical Nursing, 16*(6), 1021-1028.

Appendix A

Interview Guide: LTC BPG Coordinators (Time 2)

- Gender
 - Work Status (full time, part-time, casual)
 - Professional Designation (RN, RPN, BA, etc.)
 - Years in the profession
 - Role prior to BPG LTC coordinator role
 - Years in LTC
 - Education completed (diploma, degree, discipline, etc.)
1. Please tell me what LTC facility serves as your home base?
 2. What geographical area are you assigned?
 3. How many LTC facilities are in your geographical area?
 4. How long have you been in your role as LTC BPG Coordinator?
 5. How would you describe your level of comfort in the role of LTC BPG Coordinator?
 - a) When you completed your orientation:
Comprehensive Adequate Inadequate
 - b) At this point in your term:
Comprehensive Adequate Inadequate
 6. What supports have been made available to you since the start of the project?
 7. What opportunities have you had to network with the other BPG LTC Coordinators?
 8. How did you make contact with the LTC facilities in your area?
 9. How many LTC facilities have supported your outreach to them to date?
 10. What percentage of LTC facilities in your area does # 9 represent? (E.g. 20%, 50%, etc.)
 11. Who has been your primary contact in each of the Homes?
 - DOC
 - Administrator
 - ADOC
 - Other (please name)
 12. What have been the enablers in accessing the LTC facilities and their staff? What have been the barriers?
 13. What have been the enablers in accessing the LTC facilities and their staff? What have been the barriers?

14. In the Homes that are engaged in the project, how has the project been supported? Staff, facilities, etc.
15. Can you describe your specific role/activities in assisting organizations to implement the BPGs?
16. What types of activities have been accomplished in the context of the BPG project in the LTC Homes?
17. Can you identify some common characteristics in the facilities where the program is particularly successful?
18. Has there been an evaluation component to the project in any of the LTC facilities to this point?
19. In view of your experience as a Coordinator to date, are there other supports that you think would help to maximize the Coordinator role?
20. Can you identify any experience or learning to date that has effected a change in how you approach your role?
21. Do you have any reflections or anecdotes that you would like to share related to your Coordinator role at this point?
22. Is there anything else you'd like us to know regarding the BPG LTC project?

THANK YOU FOR PARTICIPATING IN THIS RESEARCH!

Appendix B

Interview Guide: RNAO Project Manager (Time 2)

Demographics:

- *Not captured as there is only one individual to be interviewed*
1. Please describe your understanding of the BPG LTC project's progress to date
 2. How would you describe your role in relation to the project?
 3. Has your role changed since the last interview? If yes, please describe.
 4. Once launched, what has been the role of the RNAO in supporting the work of the coordinators?
 5. What has been the role of the steering committee?
 6. How have Human Resource issues been managed, e.g. replacement of coordinators who resigned, etc.?
 7. Please share with us a brief personal reflection on your experience with the BPG LTC program to date. This may take the form of an overall reflection or one or more specific "stories" or anecdotes.
 8. Is there anything else you'd like to share with us regarding your experience in managing the BPG LTC program?

THANK YOU FOR PARTICIPATING IN THIS RESEARCH!

Appendix C

Interview Guide: MOHLTC Project Liaison (Time 2)

Demographics:

1. *Not captured as there is only one individual to be interviewed.*

1. Please describe the progress of the BPG LTC project to date.
2. What outcomes has the MOHLTC achieved to date?
3. Has your role in relation to the project changed since Time 1? If yes, please describe.
4. Once launched, what has been the role of the MOHLTC?
5. What have been the strengths of the RNAO role with regard to the project?
6. What have been the gaps in the RNAO role with regard to the project?
7. Please comment on the role of the Regional Offices in the project.
8. What feedback have you had to date to indicate the extent to which BPG LTC program has achieved the MOHLTC outcomes?
9. Please share with us a brief personal reflection on your experience with the BPG LTC program. This may take the form of an overall reflection or one or more specific "stories" or anecdotes.
10. Is there anything else you'd like to share with us to inform our research regarding the MOHLTC BPG LTC program?

THANK YOU FOR PARTICIPATING IN THIS RESEARCH!

Appendix D

Letter of Invitation to Directors of Care at Participating Sites (Time 2)

March XX, 2006

Name
Title
Facility
Address
City, Postal Code

Dear [Director of Care]:

In the late summer/fall of 2005 the Ministry of Health and Long Term Care (MOHLTC), through the Nursing Secretariat, launched the "Best Practice Guidelines in Long Term Care" (BPG-LTC) project. This project involved hiring eight (8) BPG LTC Coordinators each of whom was assigned to a specific geographical region. The BPG LTC Coordinator's role was to promote awareness and uptake of best practice guidelines in long term care facilities.

The Nursing Health Services Research Unit (NHSRU) has been asked to design and implement a research study related to the project. This descriptive, exploratory research will take the form of a process evaluation. This letter is to invite you to participate in this evaluation as one of the Directors of Care of a long-term care facility where BPGs have been implemented as since the implementation of the LTC BPG Coordinators' roles. A total of 8 Directors of Care (or their designate) will be invited to participate in the study. There will be one participating site from each region.

Your participation is requested in the form of 2 telephone interviews which will take place in March 2007 and December 2007. The interviews will take approximately 60 minutes and will be arranged at a convenient time in your schedule. The questions to be asked are attached to this letter.

Access to data and confidentiality

All data collected during this study will remain confidential. It is recognized that the personal interview methodology does limit confidentiality. Results will be reported in aggregate and any reference to individuals will be removed in order to preserve privacy and confidentiality; no personal identity will be revealed. The evaluation results will be reported in summary format through scholarly and public publications and presentations. All original interview notes will be stored for seven years in the Nursing Health Services Research Unit's locked data storage unit, after which time the material will be destroyed. You and the information you provide us will be kept confidential according to the Privacy Information Protection and Electronic Documents Act.

Your participation

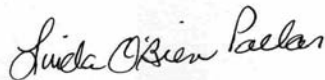
The phone interview will take approximately 60 minutes to complete. You may decline to answer any or all questions. You are free to withdraw from the study at any time without penalty. If you choose to withdraw, the data you have already provided will be preserved. The interview questions are attached for your information. Your willingness to arrange a time for the interview and your participation in the interview will constitute your consent.

A member of the research team will contact you within the next few days to follow-up on this letter. Alternately, please feel free to contact us with your availability (*Sue Bookey-Bassett: 416-946-0193; sue.bookey.bassett@utoronto.ca*).

Beyond the brief period of time required to participate in the interview the researchers are not aware of any risks to you. Neither your day-to-day work nor your overall employment will be affected by participating or choosing not to participate.

There are no direct benefits of participation to you; however, you will gain experience as a research participant. In addition, your participation in this evaluation will make a pivotal contribution to the research. Thank you for your consideration of this request to participate in this study.

Sincerely,



Linda O'Brien-Pallas, RN, PhD
Professor of Nursing
CHSRF/ CIHR Chair in Nursing/ Health Human Resources, and
Co-Director of the Nursing Health Services Research Unit,
Faculty of Nursing, University of Toronto

Encl: Interview Questions

Co-Principal investigator: Barb Mildon, RN, MN
Co-investigator: Gail Tomblin Murphy, RN, PhD, Dalhousie University

If you have any concerns or questions about the study, please contact:
Name: Sue Bookey-Bassett
Title: Research Associate, University of Toronto
Phone Number: (416) 946-0193; Email: sue.bookey.bassett@utoronto.ca

If you have any concerns or questions about the study and do not wish to talk with a member of the research team, please contact:
Name: Marianna Richardson
Title: Assistant Ethics Review Officer, University of Toronto
Phone Number: (416) 978-3165

Source of Funding: Ontario Ministry of Health and Long-Term Care

Appendix E

Interview Guide: Director of Care for Participating Sites (Time 2)

Demographics:

- Gender
- Work Status (full time, part-time, casual)
- Professional Designation (RN, RPN, BA, etc.)
- Years in the profession
- Years in current role
- Years in current LTC facility
- Education completed (diploma, degree, discipline, etc.)

Please tell me your role (DOC or Designate).

Does your facility have professional practice supports such as a clinical educator, resource nurse, nurse practitioner, etc? If so, which one and how many?

Please describe how you heard about the BPG LTC project.

Please describe your understanding of the project.

Was the Medical Director for your facility aware of the project?

How did this project link with your existing processes and resources?

What was the level of awareness/use of BPGs in your facility prior to the project?

What project activities have taken place in your facility to date? (Eg. visits by the Coordinator, education sessions, printed materials, etc.)

How have decisions been made about which activities would be planned and/or implemented?

Who has been involved in the planning and implementation of these activities?

What has made it easy for the project activities to take place?

What has made it difficult for the project activities to take place?

Have specific BPGs been implemented in your facility? If yes, please describe which one(s).

Has there been any evaluation of the BPG LTC related activities in your facility to date?

In your opinion, to what extent has the Coordinator role assisted in the BPG LTC related activities in your facility?

To what extent has the project been helpful to your facility?

Very helpful Somewhat helpful Not at all helpful

What suggestions do you have at this point to make the program more effective?

Has the program been discussed at any regional meetings or external events you have attended? If so, please name them.

If the BPG LTC program were being redesigned, what strategies would you suggest to support awareness raising and uptake of BPGs in LTC facilities?

Please share with us a brief personal reflection on your experience with the BPG LTC program to date. This may take the form of an overall reflection or one or more specific "stories" or anecdotes.

Is there anything else you'd like to share with us regarding the BPG LTC program?

THANK YOU FOR PARTICIPATING IN THIS RESEARCH!

Appendix F

Invitation Letter to Frontline Staff for Focus Group Participants (Time 2)

March XX, 2007

In the late summer/fall of 2005 the Ministry of Health and Long Term Care (MOHLTC), through the Nursing Secretariat, launched the "Best Practice Guidelines in Long Term Care" (BPG-LTC) project. This project involved hiring eight (8) BPG LTC Coordinators each of whom was assigned to a specific geographical region. The BPG LTC Coordinator's role was to promote awareness and uptake of best practice guidelines in long term care facilities.

The Nursing Health Services Research Unit (NHSRU) has been asked to design and implement a research study related to the project. This descriptive, exploratory research will take the form of a process evaluation. This letter is to invite you to participate in a focus group, (at two points in time March 2007, and December 2007) with other direct care providers, to discuss your perspectives and role in the implementation of Best Practice Guidelines in your facility.

Your Participation

The focus group will include 6 to 8 members of the health care team in your facility and may include: RNs, RPNs, Health Care Aides, Personal Support Workers and other health professionals. Each focus group will last approximately 60 minutes. Your participation is voluntary. You may decline to answer any or all questions. You are free to withdraw from the study at any time without penalty. The focus group discussions will be audio-taped and transcribed.

Access to data and confidentiality

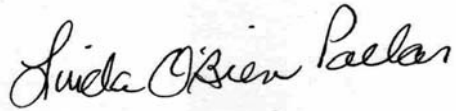
All data collected during this study will remain confidential. Results will be reported in aggregate form and any reference to individuals will be removed in order to preserve privacy and confidentiality will be revealed. The evaluation results will be reported in summary format through scholarly and public publications and presentations. All original interview notes and focus group transcriptions will be stored for seven years in the Nursing Health Services Research Unit's locked data storage unit, after which time the material will be destroyed. You and the information you provide us will be kept confidential according to the Privacy Information Protection and Electronic Documents Act.

Risks to Participants

Beyond the brief period of time required to participate in the focus groups, the researchers are not aware of any risks to you. Neither your day-to-day work nor your overall employment will be affected by participating or choosing not to participate.

There are no direct benefits of participation to you; however your participation in this study will make an important contribution to the research. Thank you for your consideration of this request to participate in this study.

Sincerely,



Linda O'Brien-Pallas, RN, PhD
Professor of Nursing
CHSRF/ CIHR Chair in Nursing/ Health Human Resources, and
Co-Director of the Nursing Health Services Research Unit,
Faculty of Nursing, University of Toronto

Co-Principal investigator: Barb Mildon, RN, MN
Co-investigator: Gail Tomblin Murphy, RN, PhD, Dalhousie University

If you have any concerns or questions about the study, please contact:
Name: Sue Bookey-Bassett
Title: Research Associate, University of Toronto
Phone Number: (416) 946-0193; Email: sue.bookey.bassett@utoronto.ca

If you have any concerns or questions about the study and do not wish to talk with a member of the research team, please contact:
Name: Marianna Richardson
Title: Assistant Ethics Review Officer, University of Toronto
Phone Number: (416) 978-3165

Source of Funding: Ontario Ministry of Health and Long-Term Care

Appendix G

Information Sheet/Consent Form

Focus Group – Frontline Staff (Time 2)

Title of Research Project: Promoting Awareness and Uptake of Best Practice Guidelines in Long Term Care: A Process Evaluation

Investigators: Co-Principal Investigators: Linda O'Brien Pallas, RN, PhD
Barb Mildon RN, MN
Co-Investigator: Gail Tomblin Murphy, RN, PhD
Contact: Sue Bookey Bassett, Research Associate
Phone: (416) 946-0193
sue.bookey.bassett@utoronto.ca

Source of Funding: Ontario Ministry of Health and Long Term Care

Background and Purpose of Research:

In the late summer/fall of 2005 the Ministry of Health and Long Term Care (MOHLTC), through the Nursing Secretariat, launched the "Best Practice Guidelines in Long Term Care" (BPG-LTC) project. This project involved hiring eight (8) BPG-LTC Coordinators, each of whom was assigned to a specific geographical region of Ontario. The role of these coordinators is to promote awareness and uptake of best practice guidelines in long term care homes.

The Nursing Health Services Research Unit (NHSRU) has been asked to design and implement a research study related to the project. This descriptive, exploratory research will take the form of a process evaluation.

Invitation to Participate:

You are being invited to participate in a focus group discussion with other direct care providers at two points in time (March 2007 and December 2007), to discuss your perspectives and role in the implementation of best practice guidelines (BPG) in your facility.

Procedures:

The focus group will include 6 to 8 members of the health care team in your facility and may include RNs, RPNs, PSWs, and other health professionals. Each focus group will last approximately 60 minutes, and will be held on site at your facility. The discussion will be lead by a member of the research team using specific questions as a guide. Notes will be taken to record the points raised, and the discussion will be audiotaped as back-up to the notes, for reference if required.

Voluntary Participation and Early Withdrawal:

Your participation is voluntary. You may choose to respond to or decline any or all questions, and you are free to withdraw from the study at any time without penalty.

Risks/Benefits:

Beyond the brief period of time required to participate in the focus groups, the researchers are not aware of any risks to you. Neither your day-to-day work or your overall employment will be affected by participating or choosing not to participate.

There are no direct benefits of participation to you. However, your perspective is an important contribution to the study.

Privacy and confidentiality:

All data collected during this study will remain confidential. Results will be reported in aggregate, and any reference to individuals will be removed in order to preserve privacy and confidentiality. It is recognized that the focus group format does potentially limit confidentiality in the workplace. However, it is expected that participants will respect the rights to confidentiality of their colleagues (co-participants). All original focus group notes and audiotapes will be stored for seven years in the Nursing Health Services Research Unit's locked data storage unit, after which time they will be destroyed.

Publication of Research Findings:

The evaluation results will be reported in summary format through scholarly publications and presentations. As a participant, you may request a copy of the final report.

You are being given a copy of this informed consent to keep for your own records.

Signature: _____

Date: _____

Printed name: _____

If you have any concerns or questions about the study, please contact:
Sue Bookey Bassett, Research Associate, University of Toronto
Phone: (416) 946-0193 Email: sue.bookey.bassett@utoronto.ca

If you have concerns or questions about the study and do not wish to talk with a member of the research team, please contact:
Marianna Richardson, Assistant Ethics Review Officer, University of Toronto
Phone: (416) 978-3165

Appendix H

Focus Group Guide: Frontline Staff (Time 2)

Demographic information (to be collected from individual participants)

- Gender
- Work status (FT, PT, Casual/relief)
- Designation (RN, RPN, PSW, allied health)
- Years in LTC

What do you know about the Best Practice Guidelines in Long Term Care project?
How did you learn about it?

Who is the Coordinator for your region?

Who has worked with the Coordinator to provide leadership for the project in your facility?

What Best Practice Guidelines have been implemented in your facility?

What activities have been related to the implementation of BPGs?

- Communication
- Educational activities
- Changes in policy and procedure
- Other

How has the implementation of BPGs changed your practice?

Please describe how the implementation of BPGs has influenced the care provided to your residents?

What factors in your work setting have facilitated the implementation of best practices?

What factors have made it difficult to implement best practice?

Appendix I Invitation Letter to Family/Resident Council Focus Group Participants (Time 2)

March, 2007

In the late summer/fall of 2005, the Ministry of Health and Long Term Care (MOHLTC), through the Nursing Secretariat, introduced a project to assist Long Term Care Homes to implement best practices in resident care. The project involved hiring eight (8) coordinators, each assigned to a specific geographic region in Ontario, whose roles are to promote awareness and implementation of best practice guidelines in Long Term Care.

The Nursing Health Services Research Unit (NHSRU) at the University of Toronto has been asked to do a study to evaluate the effectiveness of this project. As part of this study, the research team would like to gather information from residents of Long Term Care Homes, and their family members about how this project has influenced resident care.

This letter is to invite you to participate in a focus group with other residents and family members, to discuss your perspectives on how this project has influenced resident care at

_____ (name of facility).

Your Participation

The focus group will include 6 to 8 residents and/or family members, and the discussion will last about one hour. Your participation is voluntary. You may choose to respond to or decline any or all questions, and you may withdraw from the focus group at any time. The focus group discussions will be audiotaped so that your input can be recorded accurately. A signed consent will be obtained from each participant before beginning focus group discussions.

Privacy and Confidentiality

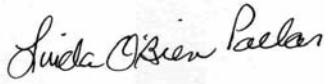
All data collected during this study will be kept strictly confidential. Any reference to individuals will be removed before analysis and reporting of results so that the privacy and confidentiality of all participants are protected. All original focus group notes will be stored in a locked data storage unit for seven years, after which time they will be destroyed.

Risks and Benefits of Participating

The researchers are not aware of any risks to you as a result of participating in the focus group. Your choice to participate, or not, will not affect the care that you (or your family member) receives. There are no direct benefits to you for participating, but your input will provide important information to the research.

Thank you for considering this request to participate in the focus group.

Sincerely,



Linda O'Brien-Pallas, RN, PhD
Professor of Nursing
CHSRF/ CIHR Chair in Nursing/ Health Human Resources, and
Co-Director of the Nursing Health Services Research Unit,
Faculty of Nursing, University of Toronto

Co-Principal investigator: Barb Mildon, RN, MN
Co-investigator: Gail Tomblin Murphy, RN, PhD, Dalhousie University

If you have any concerns or questions about the study, please contact:
Name: Sue Bookey-Bassett
Title: Research Associate, University of Toronto
Phone Number: (416) 946-0193; Email: sue.bookey.bassett@utoronto.ca

If you have any concerns or questions about the study and do not wish to talk with a member of the research team, please contact:
Name: Marianna Richardson
Title: Assistant Ethics Review Officer, University of Toronto
Phone Number: (416) 978-3165

Source of Funding: Ontario Ministry of Health and Long-Term Care

Appendix J
Information Sheet/Consent Form
Focus Group – Family/Resident Council (Time 2)

Title of Research Project: Promoting Awareness and Uptake of Best Practice Guidelines in Long Term Care: A Process Evaluation

Investigators: Co-Principal Investigators: Linda O'Brien Pallas, RN, PhD
Barb Mildon RN, MN
Co-Investigator: Gail Tomblin Murphy, RN, PhD
Contact: Sue Bookey Bassett, Research Associate
Phone: (416) 946-0193
sue.bookey.bassett@utoronto.ca

Source of Funding: Ontario Ministry of Health and Long Term Care

Background and Purpose of Research:

In the late summer/fall of 2005, the Ministry of Health and Long Term Care (MOHLTC) through the Nursing Secretariat, introduced a project to assist Long Term Care Homes to implement best practices in resident care. The project involved hiring eight (8) coordinators, each assigned to a different geographical region in Ontario. The role of these Coordinators is to promote the awareness and application of best practice guidelines in Long Term Care.

The Nursing Health Services Research Unit (NHSRU) at the University of Toronto has been asked to do a study to evaluate the effectiveness of the project. As part of this study, the researchers would like to gather information from residents of Long Term Care Homes, and their family members about how this project may have influenced resident care.

Invitation to Participate:

You are being invited to participate in focus group discussions with other residents and family members at two different times (March 2007 and December 2007) to discuss your perspectives on how this project has influenced resident care at _____ (name of facility).

Procedures:

The focus group will include 6 to 8 residents and/or family members, and the discussion will last about one hour. The discussion will be lead by a member of the research team using specific questions as a guide. Notes will be taken to record the points raised, and the discussion will be audiotaped as back-up to the notes. You will be asked to sign this consent form before the focus group discussion begins.

Voluntary Participation and Early Withdrawal:

Your participation is voluntary. You may choose to respond to or decline any or all questions, and you are free to withdraw from the study at any time without penalty.

Risks/Benefits:

Beyond the brief period of time required to participate in the focus groups, the researchers are not aware of any risks to you as a result of participating in the study.

Your choice to participate, or not, will not affect the care that you (or your family member) receives. There are no direct benefits to you for participating, but your input will provide important information to the research.

Privacy and confidentiality:

All data collected during this study will remain strictly confidential. Any reference to individuals will be removed before analysis and reporting of results so that privacy and confidentiality is protected for all participants. All original focus group notes and tapes will be kept in a secure locked storage area for seven years, after which time they will be destroyed.

Publication of Research Findings:

The evaluation results will be reported in summary format through scholarly publications and presentations. As a participant, you may request a copy of the final report.

You are being given a copy of this informed consent to keep for your own records.

Signature: _____

Date: _____

Printed name: _____

If you have any concerns or questions about the study, please contact:

Sue Bookey Bassett, Research Associate, University of Toronto

Phone: (416) 946-0193 Email: sue.bookey.bassett@utoronto.ca

If you have concerns or questions about the study and do not wish to talk with a member of the research team, please contact:

Marianna Richardson, Assistant Ethics Review Officer, University of Toronto

Phone: (416) 978-3165

Appendix K
Focus Group Guide: Family/Patient Council Participants
(Time 2)

Demographics:

Gender: male female

Age:

Role: family member/relative resident

Preamble about Best Practice Guidelines e.g. what they are and what has been implemented at the specific site.

1. Are you familiar with the term BPG as it applies to resident care?

2. Are you aware of the implementation of BPGs at _____
(name of facility).

3. How would you describe the care provided to residents at _____
(name of facility)?

4. Have you been involved in the implementation of BPGs at
_____(name of facility? If yes, please describe.

5. Can you describe how BPGs have made a difference in resident care?