We Value Your Feedback!

Regional Managers for LTC Team

Hamilton Manager
bsohamilton@sjv.on.ca
Phone - (289) 244 - 3521
Please send referral via Fax – 905-627-2722

Brant & Haldimand-Norfolk Manager
bsohaldimand@sjv.on.ca
Phone - (226) 920 - 8952
Please send referral via Fax – 519-753-7996

Burlington Manager
bsoburlington@sjv.on.ca
Phone - (289) 925 - 3193
Please send referral via Fax – 905-637-7514

Niagara Manager
bsoniagara@sjv.on.ca
Phone - (289) 241 - 0282
Please send referral via Fax – 905-937-7704

I am who I am so help me continue to be me!

"We recognize that each person is unique. Understanding the person behind the disease is imperative to providing person centred care. The more we know about an individual the more we are able to create approaches that are meaningful to them."

BSO Educators, May 2020

BSO Educators/Transitional Lead Managers

Manager for Burlington and Niagara
emartin@sjv.on.ca or call 289-237-3275

Manager for Hamilton, Haldimand-Norfolk and Brant
jplastow@sjv.on.ca or call 905-512-5451

We are person and family centered

For additional resources, please visit:

https://hnhb.behavioursupportsontario.ca/134/Healthcare_Professionals_-_Tools_and_Resources/

Behavioural Supports Ontario

Hamilton Niagara Haldimand Brant Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario de Hamilton Niagara Haldimand Brant

Our LTC Team

RN Regional Manager – Oversees and supports the performance of the LTC team and service delivery at a sub region level. They are responsible for the intake, review and distribution of referrals and relationships with the LTCH. The manager works collaboratively with LTCH leadership teams and community partners to enhance the availability of supports and services to persons living with responsive behaviours and supports clinically where required.

Educators – Responsible for the orientation, education, mentoring and capacity building of our BSO staff. Educators support the Long-Term Care Community of Practice in the collaborative planning of education for all LTCHs and the distribution of therapeutic supplies funded by the MOH.

Clinical Coach (CC) – The CC is a Registered Practical Nurse. The CC uses a team approach to provide person-centered care to the residents living in LTC that have been referred to the BSO Mobile team. The CC uses screening tools, health records and observation to gather information from the resident, Substitute Decision Maker/Power of Attorney (SDM/POA) and staff to help identify underlying issues or triggers of responsive behaviours. Using best practices, the CC works to build capacity with LTC staff by trialing and modeling successful strategies that aim to understand and reduce responsive behaviours.

Behavioural Lead (BL) – The BL is a Registered Social Service Worker. The BL works collaboratively with the BSO Care Support Worker (CSW), the resident, SDM or POA, LTC staff and other supportive services to develop a comprehensive plan of care. The BL supervises the clinical practice, accountability, performance and conduct of their assigned BSO Care Support Worker (CSW). The goal is to reduce frequency and intensity of responsive behaviors. The BL assists with things like:

- Transition and adjustment to LTC
- Setting goals that improve social functioning
- Connecting residents with appropriate community services and social supports
- Promoting self-determination and autonomy
- Coaching communication strategies so that the residents can be actively involved in their care.

Care Support Worker (CSW) – The CSW has a diploma or certificate as a Personal Support Worker from an accredited program. The CSW brings the skills and knowledge of the Personal Support Worker using best practices to develop a therapeutic relationship with the resident and their caregivers. CSWs work to determine the triggers for the residents responsive behavior then trial and model successful strategies to front line staff. The goal is to reduce frequency and intensity of disruptive responsive behaviours.

Transitional Leads (TL) – These Regulated professionals (RN, RSW, MSW, OT, PT) Assist with transition of individuals from community to LTC who are at higher risk for or are currently presenting with responsive behaviours. The goal is to work with the potential residents and their significant others from 2 weeks to 4 months before admission to LTC and then continue support to the 6-week post admission period.

TL's will:

- Collaborate with client, family or SDM through face to face visits in the home from point of referral from Home and Community Care Supports and Services (HCCSS)
- Provide behavioural strategies to optimize the client while waiting
- Collect medical, behavioural care plans and other pertinent information from primary care, specialized geriatrics, health and social service partners, etc., who have supported the client and family in the community
- Conduct complex case conference with partners, Integrated Community Leads and LTC
- Provide the admitting LTC Home with an admission review of the Comprehensive Assessment and Transitional Care Plan (TCP)

Post Transition TL Support (min. 6 weeks)

- Ongoing modelling of care strategies with LTCH staff resident/SDM to support a safe transition
- Updating the transitional care plan and ensuring communication of the same with the care team
- Attendance at 6-week post admission conference

Mobile Social Worker - Our Social Workers provide support to all the homes within their geographic area (Hamilton/Burlington, Brant, Haldimand-Norfolk, Niagara). When making a referral, the resident must be capable and willing to participate in the social work process. To access this service please use the BSO referral form and include details regarding the reason for Social Work support.

The Mobile Social Worker offers task-specific support and/or counselling services. Counselling services are available for 8-10 sessions to support the resident in meeting their specific goal.

Examples of task-specific support:

- Assistance with Public Guardian and Trustee related matters
- System Navigation – connecting with internal/external services and resources
- Assistance with allocating alternate housing or transfer requests
- Advocacy around resident autonomy
- Coaching communication strategies to address interpersonal or behavioural concerns with co-residents, family members or LTC team

Examples of themes explored in counselling services:

- Promoting self-determination
- Mental health and wellness
- Processing thoughts and feelings
- Developing communication strategies and coping mechanisms
- Intimacy and sexuality