Behavioural Supports **Ontario**
Soutien en cas de troubles du comportment en **Ontario**

PCTBSL
Person-Centred Team-Based Service-Learning

A learning & development approach for health care teams supporting older individuals and families with complex health care challenges who have or are at risk of having responsive behaviours

South-East LHIN Behavioural Supports Ontario Capacity Enhancement Working Group

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About This Document

This document provides an overview of the merits of using the PCTBSL framework as a driving methodology for achieving system transformation in the behavioural health sector through capacity enhancement activities associated with the Behavioural Supports Ontario (BSO) project.

An accompanying Facilitator's Guide has been created to help other LHINs and community developers to plan and implement training/education, service-learning and service delivery.

The BSO project's target population is: *older individuals with complex health care challenges who are at risk or have associated responsive behaviours and their caregivers*.

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Part A -
What is Patient-Centred Team-Based Service-Learning (PCTBSL)?

PCTBSL is an overarching framework to guide capacity enhancement/learning activities and service delivery for health care providers working in the behavioural health sector related to the Behavioural Supports Ontario (BSO) project.

The PCTBSL framework is informed by theory and evidence from a variety of models associated with health care education and practice, including:

- Person-Centred Care
- Interprofessional Care
- Improvement Science
- Change Theory
- Service Learning
- Knowledge Translation
- Knowledge Exchange

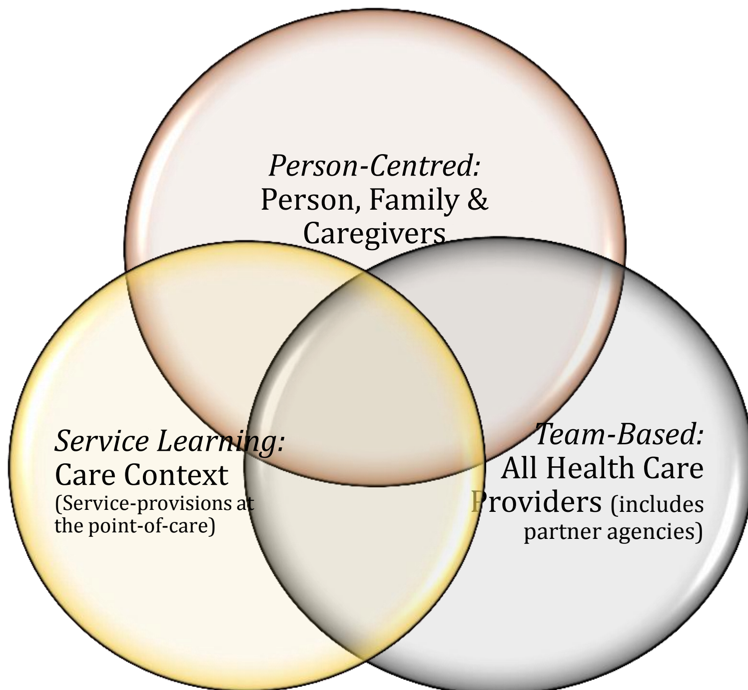
Seven Principles of PTCBSL

The PCTBSL approach is based on seven main principles that are integrated within the design of all capacity enhancement activities and promote care that:

1. Is person and caregiver-directed
2. Involves collaboration with the person, family, health care team and partner services
3. Enables shared solution finding
4. Emphasizes prevention and early detection, minimizes impact of responsive behaviours
5. Ensures that the physical, intellectual, emotional, functional, environmental and social aspects of the responsive behaviour are considered
6. Acknowledges the benefits of collaboration, respecting the unique knowledge of care participants
7. Learning is directly linked to the service provisions i.e. functions at the point of care

Dr. Ken LeClair, 2012

PCTBSL – An Overview



Inherent in the PCTBSL approach is the philosophy that care must be person and family/caregiver-directed. The team is a collaborative partnership involving the person and their family/caregiver and the formal care providers that comprise the person's healthcare team. The literature suggests that the best care is provided through a team approach, and learned through a combination of formal education and situational application, which is a service learning model. Therefore, the learning and development for individuals providing care to this population has to be person-centred, team-based and learned within the context of the services being provided (service-learning).

Benefits of the PCTBSL Framework

Alignment with Client Value Statement

PCTBSL aligns with the South East LHIN client and family value statement, *"Help me, guide me, protect me and understand me"* as this approach enables healthcare teams to better meet the needs of older adults with complex health challenges and associated behaviours.

Promotes and Models the New Culture of Behavioural System Transformation

In order to meet the needs of the growing population of older adults with complex healthcare challenges and associated responsive behaviours, a cultural shift within healthcare is required. This shift acknowledges that the person and family are at the centre, and that decision-making and care processes need to be collaborative.

Aligns with BSO Recommended Core Competencies

Furthermore, this system transformation requires that those involved embody the twelve core competencies as recommended by the BSO Human Resources Working Group. These competencies are a balance of clinical, change management and collaborative/team skills.

Benefits of the PCTBSL Framework versus Other Learning Models

Moving towards a person-centred, team-based service-learning approach is the result of an increasing recognition within health care educators and practitioners that education of best practice does not necessarily lead to better care and outcomes. The education forms a basis but there is also a need for:

- translation of this knowledge into practice
- an understanding and appreciation of the person's environment and context
- an evidence-informed approach (rather than an evidence-based approach) whereby the learner incorporates evidence from the traditional resources (research and literature) and also practice-based evidence and evidence from the lived experience

Other learning frameworks that have been used in healthcare and form the basis of "evidence-based practice" education include traditional/classroom learning and problem-based learning (PBL). A summary table comparing common learning models in health care education follows the description of PBL below.

Problem-Based Learning (PBL)

The PBL framework was originally used in medical education, and was developed from the traditional classroom delivery approach. The purpose of this approach is the identification of the cause of illness or dysfunction so that a treatment can then be prescribed.

Limitations of the PBL Approach for BSO Learning Activities

Unlike person-centred care, PBL has been criticized as perpetuating authoritarian ways of knowing and resulting in reductionism (Fenwick and Parsons, 1997) as it focuses on the disease process and deficits rather than the individual's strengths and remaining capacity.

The whole person, in all their complexities, needs to be understood. Persons with behavioural issues that comprise the BSO target population require a person-centred team approach, as individuals typically have complex changes and challenges in multiple areas i.e. physical, emotional, psychosocial, and environmental risks that need to be understood.

PBL may not adequately prepare service providers caring for an older population to deal with issues faced by this population. Many older individuals have chronic health conditions, and these conditions have multiple causes and effects. Furthermore, there are multiple reasons for the behavior, the reasons for and presentations of behaviours are often atypical, and there may be one condition affecting multiple issues.

Furthermore, a collaborative team-based approach is required to identify barriers to key health determinants in an individual's environment that prevent interaction and lead to decline. Knowledge needs to be surfaced and applied from various bodies of knowledge and provider groups in order to better serve the individuals facing these complex challenges.

A Comparison of Learning Models:

	Traditional Classroom	Problem-Based Learning	Service-Learning
Learning Environment	Classroom	Classroom	On-the job, at the point of service, in the community
Learning Format	Structured Formal, didactic lectures	Semi-structured Apply content through case-based learning, and group work	Semi-structured Applies educational content to real life situations, includes person, family and service team in the learning Learning is experienced through doing and is structured around the client and service being provided
Learning Resources / Sources of Evidence	Primarily research and practice-based evidence: • Literature • Educational experts "Evidence-based practice"	Primarily research and practice-based evidence: • Literature • Peers/colleagues "Evidence-based practice"	Application of formal education Persons/families Team members and mentors Environmental context "Evidence-informed practice" which includes evidence from three areas: • Research/literature • Practice • Lived experience
Unique Benefits	An opportunity to learn educational content and best practices from experts in the field	Enables individuals to use reasoning skills and teamwork	Learning is experiential, may have a greater impact on the learner's memory, and enable change in perspectives and practice Learning is an act of service that benefits the clients, families and other team members Learning is reciprocal, and promotes knowledge exchange and shared solution-finding Recognizes the critical aspects of context and culture.
Potential Limitations	Content is selected by the expert and therefore knowledge is limited to that person's experience i.e. epistemology Typically does not involve the person/caregiver/family perspective May be less engaging for the adult learner as it does not provide an opportunity for application and reflection	Focuses on the disease process or the disability/deficit, rather than the person's strengths and or values Learning is guided by the experience and interaction of the team, key foundational knowledge may be missed	Learning is based on events, therefore limited to that which the individual and/or team is exposed to.

An exploration of the theory, purpose and benefits of PCTBSL can be conducted through a more detailed analysis of the three component parts, which are explained in the next section.

1. Person-Centred Care

a) Definition

Person-Centred care can be defined as care that focuses on the person, rather than the illness, disease or disability that an individual may have. It is inherently empowering as it preserves one's autonomy and individuality, and focuses on one's strengths rather than one's losses or impairment (Epp, 2003; Thornton, 2011). Within this framework the person is at the centre, and the aim is to understand and meet one's physical, psychological, social and spiritual needs (Thornton, 2011). Additionally, it considers the importance of the individual's personal context, such as family, marriage, culture, ethnicity and gender (Epp, 2003).

b) Components and Characteristics

Components of Person-Centred Care (Thornton, 2011) include:

1. *In-depth knowledge of the person*
2. *Inclusion of family and/or significant others in care*
3. *Individualized communication*
4. *Meaningful occupation/activity*
5. *Supportive individualized environments*
6. *Active involvement in community*

Other positive interactions and characteristics of person-centred care have been described by Kitwood (1999) and cited in Epp (2003):

Positive Interactions in Person-Centred Dementia Care	
Social Interactions	
Recognition	Individual known as a unique person by name; involves verbal communication and eye contact
Negotiation	Individual consulted about preferences, choices, needs
Collaboration	Caregiver aligns him/herself with care recipient to engage in a task
Play	Encouraging expressions of spontaneity and of self
Stimulation	Engaging in interactions using the senses
Celebration	Celebrating anything the individuals finds enjoyable
Relaxation	Providing close personal comfort (e.g. holding hands)
Psychotherapeutic Interactions	
Validating	Acknowledging person's emotions and feelings and responding to them; Empathy
Holding	Providing a space where the individual feels comfortable in self-revelation
Facilitation	Enabling the person to use their remaining abilities; not emphasizing errors

c) Benefits

- **Better Outcomes, Lower Cost**

One of the most compelling reasons for person-centred care delivery is that several studies have demonstrated that it can deliver superior outcomes at lower cost. A study by Olsson et al (2009) compared costs and outcomes for a person-centred integrated care pathway with those of a usual care group for patients post-hip fracture receiving rehabilitation. The results demonstrated a 40% reduction in average total cost in the person-centred group versus the usual care group. Also, clinical outcomes were better for the pathway group; 75% of participants were successfully rehabilitated versus only 55% in the usual care group.

- **Benefits for Persons With Dementia**

Using a person-centred approach is inherently an ethical system of care, and has become synonymous with the delivery of best quality care (Thornton, *2011*).There are many additional benefits to using a person-centred approach, related to persons with dementia (Epp, 2003):

- enhances quality of life
- decreases agitation
- improves relationships with caregivers
- enables better sleep

1. Team-Based Learning and Care

a) Definition

Effective healthcare teams are collaborative networks of individuals who put the needs of the person and family at the centre of care. Interprofessional communication and trans-professional care are required to meet the needs of individuals who have complex health care challenges. Team based learning brings multiple perspectives and may help to maintain a standard of care that is holistic, person-centred and effective.

b) Components and Characteristics

c) Benefits

Research suggests that both learning and working in a team can result in optimal care for persons and their families. “The best care comes from when people know each other and have relationships with each other” (Weinstock, *c 2011*).

Weinstock (c 2011) and the World Health Organization (2010) cites the following benefits of team-based learning and care:

- Promotes a culture of safety
- Increases information sharing and knowledge exchange
- Promotes a culture of trust and accountability
- Encourages mutual performance monitoring
- Provides opportunities for feedback and encourages self-correction
- Increases individuals’ willingness to admit mistakes and accept feedback
- Results in higher levels of patient satisfaction and health outcomes
- Improves access and coordination of services and the appropriate use of specialists
- Decreases tension and conflict among care-givers
- Decreases healthcare costs

2. Service-Learning

a) Definition

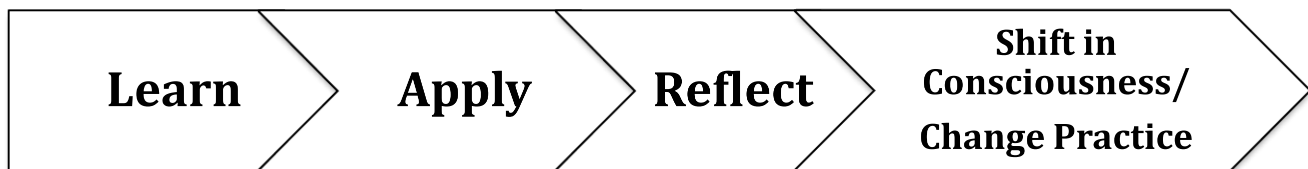
Service-learning is a learning model whereby an individual applies knowledge in a real life context. The setting for service learning is the service setting itself rather than the traditional classroom environment. The theory of service-learning offers a framework in which healthcare professionals combine content knowledge, situational experience, team collaboration and exchange and active reflection (Stallwood and Groh, 2011; Reynolds, 2009). Additionally the learning is experienced through reciprocal relationships, knowledge exchange and a shared experience (Ivey, 2006;).

b) Components and Characteristics

The service-learning model is different from other approaches as it has a reflective component that may be a catalyst for social change. It is a "critical approach" that enables the learner "to see themselves as agents of change and excites within them a passion to use their experience of service to address and respond to injustices in their communities, particularly when dealing with vulnerable populations" (Gillis and Mac Lellan, 2010). The learning experience strengthens relationship among teams/partners in care, and typically results in a shift in consciousness and/or change in practice. Service learning has the following characteristics:

- Combines content knowledge with situational experience
- Promotes team collaboration and exchange
- Requires pre-determined learning objectives
- Involves an active reflection component
- Provides catalyst for social change, especially on behalf of vulnerable populations
- Learning happens "on the job", at the point of service (as opposed to in the classroom)
- Reciprocal, shared learning (versus learning only experienced by service recipient)

The following model demonstrates how practice change and shifts in consciousness arise from service learning opportunities.



c) **Benefits**

- **Promotes Knowledge to Practice**

The PCTBSL model utilizes a service learning approach in the form of mentoring, coaching and shared learning on the job at the point of service. This form of service learning moves knowledge to practice through the delivery of the service across team members and organizations.

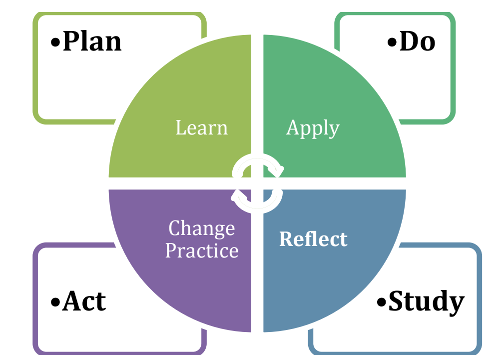
- **Increases Individual and Team-Based Skills**

Service learning seeks to increase the learners' understanding, skill and confidence through learning that involves simultaneous mentoring, modeling and discovery of knowledge together (Vogt, Chavez and Schaffner, 2011). This approach is a methodology for teaching skills such as group collaboration, team building, participatory leadership and advocacy.

- **Congruent with Quality Improvement Methodology**

Service learning is congruent with a quality improvement approach. In the spirit of QI, service learning takes a Plan-Do-Study-Act approach as individuals learn through the process of doing, reflecting and then integrating that learning into practice, and/or changing practice. The modern healthcare environment needs leaders, champions of change who function as knowledge brokers with a quality improvement approach. This will ensure that the needs and values of the persons stay at the centre of care and that processes are value added to persons, families and the greater community.

The following diagram demonstrates how the service learning approach mirrors the Plan-Do-Study-Act approach, and vice versa – a factor that makes both methodologies compatible and augmentative.



Part B –
Operationalizing the PCTBSL Approach

(For more information on incorporating the PCTBSL into BSO training and development activities, please refer to the Facilitator's Guide that accompanies this document.)

PCTBSL can be used as the driving methodology for all capacity enhancement activities designed for individuals and/or agencies that provide services for persons with complex health care challenges and associated responsive behaviours and their families.

Target Learners

PCTBSL considers the persons, their family/caregivers, and formal care providers (direct and indirect care providers, consultative practitioners, community agencies and organizations) as all part of the person's health care team. Thus, they are all considered target learners of this approach. Formal care providers include the following individuals or groups:

Desired Outcomes

PCTBSL-driven learning and development activities are designed to achieve one or more of the following outcomes:

- building relationships with persons and family, and other providers across the system
- modeling desired skills and behaviours through a coaching and mentoring approach
- promoting shared solution-finding and team-based collaborative care
- creating a culture of continuous quality improvement
- encouraging the practice of active reflection

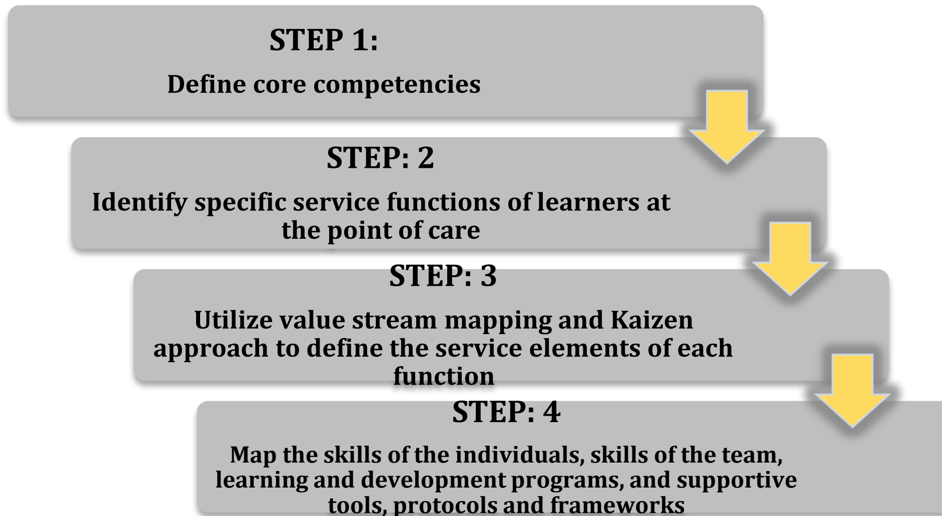
BSO Recommended Core Competencies

In addition to meeting these desired outcomes, the design of learning and development activities embeds the 12 Core Competencies, as identified by the BSO Human Resources Working Group, and described below.

(12 Core Competencies - Capacity Building Roadmap, February 2012, p. 2)

Targeting Knowledge and Skill Development to Service Functions and Elements

Successful operationalization of the components of the PCTBSL and the core competencies, is a four-step approach.



This four-step approach includes the identification of specific person-centred service functions at the point of care (step 2) and description of service elements of each function as created at dedicated value stream mapping and kaizen events (step 3). From this analysis, the specific individual and team-based learning needs with respect to knowledge, skills and supportive tools, protocols and frameworks can be mapped.

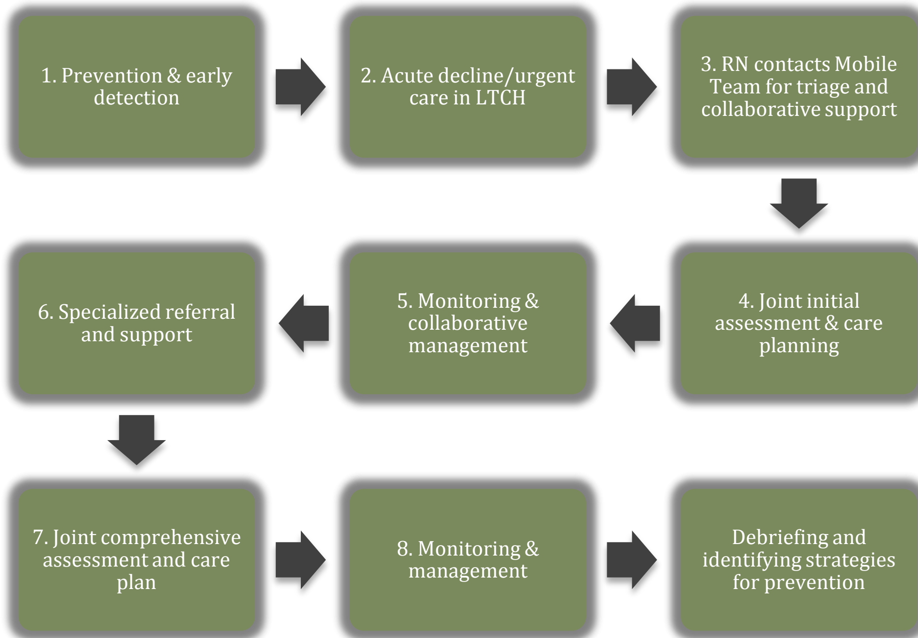
In its entirety, this is a template that assists in the planning of individual and team learning and development activities that are customized to each service event.

Example - Functions for a mobile team in a LHIN

STEP: 2

Identify specific service functions of learners at the point of care

Service Functions from Acute Decline/Urgent Care Process Map (created at SE LHIN Mobile Team Kaizen Event, December 2011)



STEP: 3

Utilize value stream mapping and Kaizen approach to define the service elements of each function

Each Process Map is then broken down into specific functions, in which the learning and development can be anchored to support.

STEP: 4

Map the skills of the individuals, skills of the team, learning and development programs, and supportive tools, protocols and frameworks

Finally, this template is used to map the required individual and team skills as well as supportive tools, protocols, and educational supports are identified.

Acute Decline/Urgent Care In the LTCH	
Skills of the Team	
Skills, Knowledge & Behaviour of Individual Members	
Common Assessments,Protocols and Tools	
Education & Learning Programs	

Other Possible Functions for the Mobile Teams

Other specific service functions for the mobile teams have been identified by the design and implementation team. These include:

- Palliative and End of Life, Pain
- Admission Support
- Urgent Response and Follow-Up
- Post-Crisis Follow-Up
- Prevention & Early Intervention
- Family Education and Support
- Transition Support

The processes, skills and associated resources for capacity enhancement for each of these service functions will be further explored in future Kaizen events.

This paper is intended as a discussion paper, and continues to evolve as the concepts are implemented and evaluated by the design team.

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