nova scotia association of health organizations

Secure and Special Care Unit Inventory
Final Report – December 2009

Produced by NSAHO on behalf of the Continuing Care Council of Nova Scotia



Partnering for a Better Health System

This report summarizes the key findings of the Secure and Special Care Unit Inventory Project (Spring 2008 to Fall 2009). If you have any questions or concerns about the information contained herein, please feel free to contact NSAHO staff as follows:

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Introduction

Background

In response to concerns being expressed in the sector, Nova Scotia's Continuing Care Council approached the Department of Health, Continuing Care Branch, regarding the need to develop a common definition and understanding of secure and special units in long term care in the province. The Department supported the development of a Working Group to develop definitions for secure and special care units as they currently exist in Nova Scotia, to provide clarity in the environmental requirements, programming, target populations, staffing, and policies for each of these units. The end goal was to build a common understanding of these units in the sector, and to assist the Department of Health with placement decisions for long term care.

As outlined in the Secure and Special Care Unit Working Group's final report (2007), the objectives of the project *'Defining Secure Units in Long Term Care in Nova Scotia'* included:

- Creating operational definitions of secure and special care units in long term care;
- Developing consensus in the sector on definitions and unit criteria;
- Identifying recommendations for the Department of Health, Continuing Care Branch regarding the definitions; and
- Identifying issues that may impact the implementation of the recommended definitions.

The working group identified criteria for the various unit categories in five key areas: Target Population, Environment, Programming, Staffing, and Policies (e.g. admission and discharge policies). Determination of a unit's category is based on the degree to which it meets criteria in each of these five key areas. Making modifications in any one area alone (e.g. physical environment) without addressing criteria in the other key areas would not necessarily result in an environment which ensures safe and effective care for residents with dementia and/or responsive behaviours. Appropriate resources are required to provide safe and effective, resident-centred care to all clients.

In October 2007, the Secure and Special Care Unit Working Group finalized the document *Defining Secure and Special Care Units in Long Term Care in Nova Scotia*. This report outlines the characteristics of secure and special care units as they currently exist in the province. One of the recommendations emanating from this work was to create an inventory of existing units in long term care facilities across the province (for the purposes of this inventory, the term long term care facility refers to a Department of Health funded nursing home). The report was submitted to the Department of Health, Continuing Care Branch for review, with advisement of NSAHO's intent to follow-up with an inventory of existing units in the province.

In the Spring of 2008, the Department of Health, Continuing Care Branch sent their response to the Working Group's final report, indicating that, while not prepared to accept the definitions proposed in the report at the time, the Department was interested in the inventory results when available.

On behalf of Nova Scotia's Continuing Care Council, NSAHO agreed to conduct an inventory of secure and special care units across Nova Scotia, using the definitions and criteria developed by the Secure and Special Care Unit Working Group, as presented in its final report. The intent is that the information will be used as a tool for placement, to assist the Department of Health Placement Office to better understand the purpose of each unit, with the end goal of facilitating the placement of individuals into units that best meet their needs. This inventory could be one of the many tools in a provincial tool-kit to support the placement process in Nova Scotia.

The inventory will provide clarity on the types of units that actually exist, the current distribution of units across the province, and will further validate the definitions developed by the Working Group. Knowing what currently exists is an essential first step to be able to plan for a system that meets the needs of all residents. This project is in no way intended to promote the adoption of any one approach over another. The intent is solely to provide a snapshot of "what is", so as to support more informed health policy decision-making.

Framework:

The Secure and Special Care Units Inventory is based on a framework which categorizes units based on their capacity to manage their intended population with regard to two key concepts: 1) Risk; and 2) Need. Please see the unit categories and diagrammatic representation below. Proposed revisions to the categories and diagrammatic representation can be found in the conclusions section of this report. A more detailed description of the framework and the category criteria can be found in the revised report of the Secure and Special Care Unit Working Group (2009).

Secure and Special Care Unit Assessment Categories

1. **General Unit**
   Risk – Low
   Need – Low

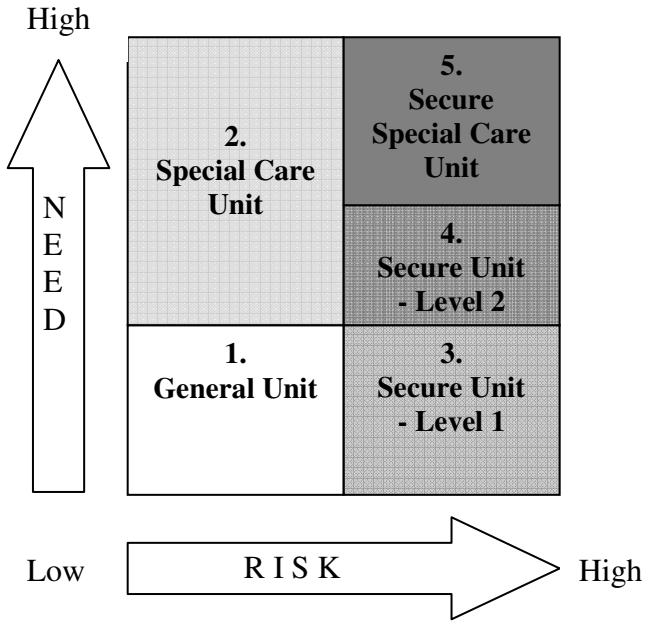
2. **Special Care Unit**
   Risk – Low
   Need – High

3. **Secure Unit – Level 1**
   Risk – Elopement
   Need – Low

4. **Secure Unit – Level 2**
   Risk – Elopement and/or Medium
   Need – Medium

5. **Secure Special Care Unit**
   Risk – Elopement and/or Medium to High
   Need – High

Figure 1: Categorization of Specialized Units Based on Risk and Need



Continuing Care, like the health care industry in general includes elements of risk. However, for the purposes of this assessment, the general environment in long-term care facilities will be used as a base-line, and therefore categorized as "low risk".

Methodology

Development Phase:
The initial secure and special care unit inventory assessment tool was developed by NSAHO staff in the spring of 2008, based on the category definitions and criteria presented in the original Secure and Special Care Unit Working Group Report (2007). At that time, information was obtained from the Department of Health (DoH) Placement Office, listing the long term care facilities in each DHA, that were identified as having a "secure" or "special care" unit.

To further assist with refinement of the assessment criteria for the Secure and Special Care Unit Inventory, a tour of the Rocmaura Nursing Home in New Brunswick was arranged. This facility has four distinct "modular care" units; one of which is a secure dementia care unit. This experience provided direction in the refinement of the assessment tool, as it provided context around implementation of the criteria in long-term care facilities, and further confirmed the validity of the criteria chosen.

Testing Phase:
Over the summer 2008, interviews were conducted at a total of four test sites that had a "secure" unit as outlined in the DoH lists previously provided. The tool was further refined according to the results achieved at each site to reflect the feedback given.

Tool Validation with Sector Experts:
Throughout this process, it became apparent that some modifications to the original definitions developed by the Secure and Special Care Unit Working Group were required in order to enhance the clarity of language used. A new framework to categorize units based on "risk" and "need" was developed, and the Working Group was brought together in December of 2008 to provide their feedback and approve the changes.

On the recommendation of the Continuing Care Council, a Focus Session with long term care representation was held in February/March 2009 to test and obtain feedback on the report and assessment tool from a clinical perspective. The revised Secure and Special Care Unit Working Group Report (2009) was approved by the NSAHO Continuing Care Council in the winter of 2009. The final version of the assessment tool can be found in Appendix A.

Implementation Phase:
A notice was sent out to long term care facilities across Nova Scotia in March 2009, advising of the inventory and inviting all facilities with one or more secure or special care units to participate. Facilities that have an Integrated Population were not included in this inventory.

The inventory process can be divided into three distinct phases:

1. *Interviews:* were arranged with each participating organization. The interview generally took between 1 ½ to 3 ½ hours, during which time the NSAHO researcher completed the secure and special care unit inventory assessment tool with one or more individuals who were familiar with the operations of the unit (e.g. Director of Care, Administrator, etc.).
2. *Assessment Summary:* Following each interview, an assessment summary was created. This summary includes the unit category assessment, and outlines the main criteria which resulted in the final category decision. Participants were asked to review their assessment results, and to advise of any inaccuracies.
3. *Validation:* When satisfied with the accuracy of the summary information, participants were advised to sign and return the validation sheet at the back of their summary.

Of the 40 long term care facilities listed in the DoH information as having a secure or special care unit, four indicated that they did not actually have one. One other participant, listed as having a "secure unit" in the DoH information, completed an interview but the results indicated that it was a secure facility with an integrated population, as opposed to a secure unit. Their facility is therefore not included in the inventory results listed below – though their comments are still included in Appendix C of this report.

In addition, one long term care facility listed as offering "dementia care" but no specialized unit in the DoH information was interviewed and assessed as having a "special care unit".

For the purposes of this inventory, only "secure" and "special care units" intended for a dementia population are included (i.e. chronic care units, palliative care units, children's units, etc., are not part of this inventory).

In total, 37 interviews were scheduled. One facility had to cancel, and will be rescheduled for the fall, 2009. The report will be updated to reflect their data at that time.

Tool Reliability Re-Testing:

In order to test the reliability of the assessment tool/process, the focus group suggested that one facility be re-tested after several months and the results compared. A re-test was arranged, however, the secure unit at the facility chosen for re-testing underwent significant human resource and other changes during the five months between testing. These changes may have been influenced in part by the dialogue regarding the framework and proposed unit definitions which took place during the focus group session in February 2009. The re-assessment resulted in a change in category for this unit.

A second re-test was arranged with another facility, where unit operations had remained more or less stable during the months between assessments. As expected, there were minor differences in some of the information gathered during the interview process, however, the final assessment results remained stable over time. These findings provide support for the reliability of the assessment tool and process.

Inventory Results

Number of participating long term care facilities: 37

Interviews:		Assessment Summaries:		Validations:	
# Completed	*# Remaining*	*# Completed*	*# Remaining*	*# Completed*	*# Remaining*
37	0	37	0	20	17

Preliminary Results (not validated)

Category Legend:
E = Elopement Risk M = Medium Risk H = High Risk

DHA 1:

3 facilities	*# of Units*	*# of Beds*
Secure Unit Level 2 – E	(2)	30
Secure Unit Level 2 – EM	(1)	15

DHA 2:

4 facilities	*# of Units*	*# of Beds*
Secure Unit Level 1	(1)	10
Secure Unit Level 2 – E	(3)	63

DHA 3:

3 facilities	*# of Units*	*# of Beds*
Secure Unit Level 1	(1)	18
Secure Unit Level 2 – E	(2)	37

DHA 4:

2 facilities	*# of Units*	*# of Beds*
Secure Unit Level 2 – E	(1)	49
Secure Unit Level 2 – EM	(1)	30

DHA 5:

1 facility	*# of Units*	*# of Beds*
Secure Unit Level 2 – E	(1)	28

DHA 6:

3 facilities	*# of Units*	*# of Beds*
Secure Unit Level 1	(2)	26
Secure Unit Level 2 – E	(1)	15

DHA 7:

5 facilities	*# of Units*	*# of Beds*
Secure Unit Level 1	(1)	24
Secure Unit Level 2 – E	(2)	24
Secure Unit Level 2 – EM	(2)	32

DHA 8:

7 facilities	*# of Units*	*# of Beds*
Secure Unit Level 1	(2)	36
Secure Unit Level 2 – E	(4)	100
Secure Special Care Unit – EH	(1)	24

DHA 9:

8 facilities (one with 2 distinct units and one with 3 distinct units)	*# of Units*	*# of Beds*
Special Care Unit	(1)	33
Secure Unit Level 1	(1)	42
Secure Unit Level 2 – E	(7)	179
Secure Unit Level 2 – EM	(2)	86

Overall:

Unit Category	**Number of Units**	**Total Beds**
Special Care Unit	1	33
Secure Unit Level 1	8	156
Secure Unit Level 2 – E	23	525
Secure Unit Level 2 – EM	6	163
Secure Special Care Unit – EH	1	24
Total:	**39**	**901**

Summary

The revised final report of the Secure and Special Care Unit Working Group (2009) identified six distinct unit categories: 1) General Unit; 2) Special Care Unit; 3) Secure Unit – Level 1; 4) Secure Unit – Level 2; 5) Secure Special Care Unit; and 6) Responsive Behaviours Assessment Unit. It was recommended in the report that "beds in each of these categories, with the exception of the *Responsive Behaviours Assessment Unit*, be available in every district, based on population need". Category 6, the Responsive Behaviours Assessment Unit, is outside of the scope of this inventory.

While the preliminary inventory results suggest that all districts do have at least one secure unit, the majority of secure and special care units in the province (84%) are not

designed to provide resident security beyond the basic protection required for residents who are at risk of wandering/elopement (Secure Unit Level 1, and Secure Unit Level 2 – E). These units generally focus more on meeting the special needs of the dementia population (e.g. providing a quiet environment, with a flexible approach to care and individualized and/or dementia-specific programming), and provide additional security to ensure the safety of individuals with cognitive impairment/dementia (e.g. secure exits, bed alarms) as opposed to security measures and special approaches to de-escalate aggressive responsive behaviours and protect against resident aggression.

There are a number of units designed to manage mildly aggressive responsive behaviours (Secure Unit Level 2 – EM), though they are located in only four of the nine District Health Authorities. Not all districts have access to secure/special care units designed to manage aggressive responsive behaviours (i.e. Level 2 – EM or higher). In fact, there is only one unit in the province which rated at the highest level (Secure Special Care Unit – EH). That unit is located in DHA 8.

Six of the 36 long term care facilities interviewed are scheduled for replacement. This may have an impact on the number of secure and special care units which will be available in the near future, as some of the new facilities have opted not to include a secure/special care unit in their plans – either because they are not funded to operate a secure/special care unit, or because they have chosen to move to an integrated resident population.

Discussion:

This report is focused on the perspective of placement – what is the capacity to take in individuals displaying responsive behaviours, and what issues will impact admission? There is a difference between identifying an appropriate referral, and having the ability to be responsive to the needs of individuals with dementia (e.g. to manage responsive behaviours associated with dementia should it become necessary). Additional work is needed to examine the issue of responsive behaviours from other perspectives (e.g. what is the capacity to manage behaviours which develop slowly over time? And how best are we able to meet the needs of individuals?).

Throughout the inventory assessment interviews with the various long term care facilities, it became apparent that no unit will fit perfectly into one of the pre-defined secure and special care unit categories. For example, funding provided to secure and special care units in Nova Scotia does not currently differ based on the level of care required by residents. As assessed in this inventory, a Secure Unit Level 2 may or may not receive additional funding from the Department of Health. Also, the unit category assessments presented in this inventory do not differentiate units based on the age of their infrastructure. For example, many “newer” units are able to offer single rooms. Beyond simply looking at the assessed unit category, it is important to recognize and understand these individual limitations when determining what types of referrals can and cannot be managed in a particular unit environment. Each facility has its own set of strengths and

challenges which impact the type, severity, and frequency of behaviours that can be safely and effectively managed.

A close relationship with the Department of Health Placement Office is needed to ensure a better understanding of these unique units, in order to ensure safe and high quality care that meets the individual needs of all residents living in the facility. For the purposes of this report, NSAHO staff has attempted to assess the "most appropriate fit" in terms of the unit type for admission purposes. The validated assessment summaries will supply additional context that may assist the Department of Health Placement Office in making placement decisions. Therefore, a report containing the validated inventory summaries will be provided separately to the Placement Office.

While the majority of secure and special care units in the province were designed to manage non-aggressive responsive behaviours associated with cognitive impairment/dementia (e.g. wandering, rummaging, undressing), most of these units could successfully care for one or two individuals displaying mildly aggressive responsive behaviours as well. Ability to safely and effectively manage aggression is dependent on the severity of the behaviour, and interaction with other residents on the unit. Unpredictable behaviours are much harder to manage.

In general, units that have been successful in effectively managing resident aggression attribute their success to the dedication and expertise of their own staff (staff education has been very helpful in assisting staff to modify their approach to resident care), management commitment (e.g. supporting staff education, risk management meetings, commitment to care planning and team meetings), and strong relationships with community supports (e.g. Senior's Mental Health, Mental Health, volunteer groups).

Throughout the inventory interview process, participants identified a variety of strategies/practices that they have implemented in order to better respond to the special needs and safety requirements of residents with dementia and responsive behaviours. Providers expressed interest in learning more about other strategies being used within the sector. To assist in the sharing of these practices, this report includes an inventory of current/leading practices for dementia care and the management of responsive behaviours in long term care facilities in Nova Scotia, as identified during the interview process (See Appendix B).

Participants also noted the importance of communication and a collaborative approach to care at all levels. Long term care facilities across the province are one part of a larger system. Positive relationships with all stake-holders are essential (residents, families, other long term care providers, the DoH placement office, CB Resource Consultants, acute care providers, etc).

Any work to support the continuing care sector as it strives to provide safe and effective care for clients with dementia and/or mental health issues will have a positive impact on all components of the health care system (e.g. more appropriate use of emergency departments). The information highlighted in Appendix C of this report represents some

of the system level issues that were identified. These issues are beyond the scope of individual facilities but need to be addressed in order for the long term care sector, and specifically secure and special care units in Nova Scotia, to operate as intended and ultimately provide the optimum quality of care.

Conclusion

The definitions and criteria presented by the Secure and Special Care Unit Working Group (2009) are a "first step" toward attaining clear and consistent criteria for long term care facilities across the province. This work is meant to assist with placement decisions to ensure the selected placement has the resources required to meet the unique needs of the individual being referred, and to inform future work within the continuing care sector. Changes in provincial policy may result in the decision to move forward in a different direction (e.g. integrated populations). This project is in no way intended to promote the adoption of any one approach over another. The intent is solely to provide a snapshot of "what is", so as to support more informed health policy decision-making.

Should the province decide to adopt the definitions of secure and special care units as proposed, further work to increase the clarity of the criteria should be ongoing.

Through the assessment process, it became apparent that additional modifications to the assessment tool are needed, in order to reduce any remaining ambiguity in language and to ensure the continued accuracy, validity and reliability of the criteria chosen.

The titles of the unit categories could be further simplified, so that the names of the units more appropriately reflect the type of care provided (i.e. secure unit level 2 may provide similar care to a special care unit with additional security – the name should reflect this). Also, the diagrammatic representation of the unit categories (figure 1 above) should be modified to reflect feedback from the sector with regard to variations in the level of risk inherent in each unit type (i.e. the diagram should reflect the potential for increased risk in a special care unit, and should show the gradient as the potential for risk increases at each level of secure unit). The following modifications to the framework are therefore recommended:

Proposed Revisions to the Secure and Special Care Unit Assessment Categories

1. **General Unit**
   Risk – Low
   Need – Low

2. **Special Care Unit**
   Risk – Low
   Need – Medium to High

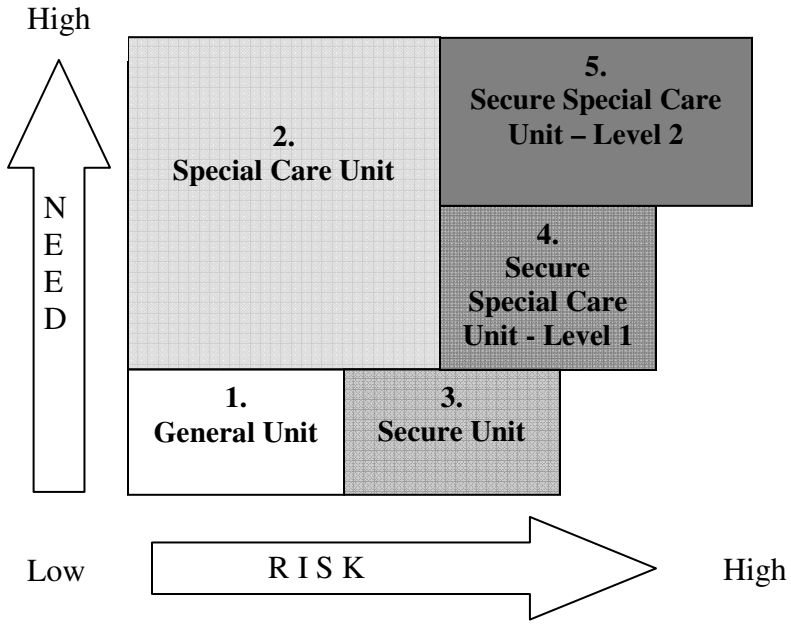
3. **Secure Unit**
   Risk – Elopement
   Need – Low

4. **Secure Special Care Unit – Level 1**
   Risk – Elopement and/or Medium
   Need – Medium

5. **Secure Special Care Unit – Level 2**
   Risk – Elopement and Medium to High
   Need – High

6. **Responsive Behaviour Assessment Unit** (Not within the scope of this inventory)

Proposed Revisions to the Diagrammatic Representation



Recommendations Following the Interview Discussions

The following key themes emerged during the Secure and Special Care Unit Inventory interview process. These issues are perception based, and reflect feedback provided by the sector during the assessment interviews. They are not presented in order of importance. The recommendations for each theme have been developed to support long term care facilities to provide resident centred care for residents on secure and special care units. Please see Appendix C for more detail.

Defining Units and Behaviours:

The system has acknowledged there are a number of issues that have arisen as a result of lack of clarity regarding the requirements for, and clients served by, "secure units". The final report of the Secure and Special Care Unit Working Group (2009) recommended definitions and criteria to build a common understanding of care provided to clients in secure and special care units in long term care.

- **Recommendation 1**: The secure and special care unit assessment categories developed by the Secure and Special Care Unit Working Group (2009) should be adopted by the Department of Health and the sector, and used to help place residents.
- **Recommendation 2:** Work with the sector to develop a template for admission and discharge criteria for units to promote consistency across the province.

There are diverse opinions regarding the philosophy of specialized units as opposed to integrated populations. Some inventory participants expressed concerns that the rights of other clients could be violated if clients with cognitive impairment/dementia wander into their rooms and invade privacy or take personal belongings. There are further concerns related to increased risk for injury to others with an integrated population, and funding to accommodate to the specific care needs of clients with dementia or 'acquired brain injury'. There are other organizations that have been very successful in an integrated approach to resident accommodation. Participants believe there is a need to investigate the pros and cons of integrated populations at a provincial level.

- **Recommendation 3**: Support facilities in their decision to adopt and maintain a specific model – integrated population or special care units.

Complexity of Care:

Across the province, participants expressed concern that the complexity of care in long term care facilities is increasing due to an aging population, varying needs and diagnoses, and delayed entry related to improved access to home care. Appropriate standards/tools are essential to create an accurate baseline for future decision making with regard to resource allocation.

- **Recommendation 4**: In consultation with the sector, review current tools/instruments to assess accuracy in denoting complexity of care, intensity of care needs for individuals, and consistency in use/practice provincially.
- **Recommendation 5**: Improve access to provincial data and reporting on trends, in order to assist with facility, and sector-wide planning.
- **Recommendation 6**: Inclusion of 'acquired brain injury' in all future processes related to secure and special care unit studies, funding, planning, and education. It is a specialty area different from, but relevant to the secure and special care unit inventory.

Assessment and Placement:

The majority of long term care facilities indicated that they have received referrals for placement to their secure/special care unit that do not fit with their internal admission criteria or unit capability. In partnership with long term care facilities, the placement process should take into consideration responsive behaviours and individual client needs in order to determine the right fit to meet the needs of the resident.

- **Recommendation 7**: Adopt the proposed secure and special care unit project categories for secure and special care units, and use this as one of the tools to consider in making placements.
- **Recommendation 8**: Care Coordinators need to have tools, procedures, and practices in place to help them determine the needs of complex cases in the system. This includes familiarity with the units in their districts.

As a resident's condition progresses, timeliness of information is key to proper placement that meets the individual's needs. Many respondents state that the assessments of residents needing placement are outdated, missing information or inaccurate at the time of placement request.

- **Recommendation 9:** Revisit assessment and placement protocol to ensure client and long term care facility have accurate information to make informed decisions about the best fit for the client.
    - Ensure resident assessments be within three months prior to placement.
    - Ensure information between placement personnel and facility personnel be timely, accurate, transparent, and honest.
    - Ensure fostering of therapeutic and effective relationships between placement personnel and facility personnel.

Once a resident is admitted into a long term care facility, external assessments are no longer conducted. Should the need arise for the resident to be transferred to another level of care, a process for assessment by a care-coordinator is needed.

- **Recommendation 10**: Create a process for reassessment to determine the need for alternative placement to best meet the client's needs after admission to a long term care facility.

Access to Consult/Support:

Residents of long term care should have access to all services available in the community. However, responsive behaviours may increase in unfamiliar environments and during over stimulation, therefore some residents may have difficulty when leaving the unit for off-sight specialist appointments.

- **Recommendation 11**: Funding/resources related to oral care, dentistry, foot care, senior mental health, physician, occupational therapist, nutritionist, hearing and vision assessments, etc., need to create flexible delivery methods whereby clients can be treated on the secure/special care unit, in a familiar environment and with skilled staff to assist in treatment delivery.

Programming:

Participants expressed concern that they do not have adequate time and resources for programming. Programming on secure/special care units should reflect current research on leading practice.

- **Recommendation 12**: Ensure human and financial resources are available to promote individualized programming that reflects the resident's personal and cultural preferences. Review funding and increase programming staff on secure and special care units to help residents achieve a sense of purpose and to develop and maintain their socialization. All aspects of care need to be client centred.

Environment:

The environment offered on specific units across the province may differ dramatically depending on the infrastructure, number of residents, philosophy of care, and resident complexity.

- **Recommendation 13**: Review current best/leading practice for secure and special care unit environments and plan/fund upgrades as required. Facilities should have access to resources that foster positive approaches for dementia care, and facilitate risk management associated with responsive behaviours.

There are many types of risk which must be managed in a long term care environment. The ability to accept/manage risk will depend on staff training, ratio of staff to residents, access to resources, and approach to care.

- **Recommendation 14**: Acknowledging specific risks, ensure each facility has policies and practices in place to minimize the risks. This includes training for staff and volunteers, adaptations to the physical environment, admission and discharge criteria for the unit.

Staffing:

Staffing for secure and special care units needs to support a safe, resident centered approach.

- **Recommendation 15**: Ensure staffing requirements on special care units support a person centered care approach. This includes staffing ratio, education, and staff complement with regard to an interdisciplinary team.

Education:

Staff require continual education to deal effectively and provide specialized care to residents

- **Recommendation 16**: Funding and management support is required to provide staff with the opportunity for continual education so they can provide safe/leading practice care.

Strategic/System Planning:

The majority of participants indicated that they would be interested in evolving their unit(s) to meet the needs of the current resident population. The concept of "evolving" the unit involves more than managing responsive behaviours and includes changing current delivery models to better serve the needs of all residents.

- **Recommendation 17**: Establish provincial level planning and commitment for funding in support of implementing best/leading practices in person-centred care. Once best/leading practices are identified, adopt guiding principles for care delivery on secure and special care units. This includes creating an inventory of the resources currently available in communities for facilities to draw on.
- **Recommendation 18:** Implement Phase III of the Department of Health's Challenging Behaviour Program with the creation of a Responsive Behaviour Stabilization Unit.
- **Recommendation 19:** Review of statistics to determine need for future secure and special care units in specific regions identified. This would lead to a proactive approach to future planning of secure and special care unit bed allocation.

Glossary of Terms

Best Practice: Strategies and programs demonstrated through research and evaluation to be effective. Best practice models include program models that have been shown, through rigorous evaluation and replication, to achieve target outcomes. (Adapted from the Kentucky Juvenile Justice Advisory Board, accessed on November 6, 2009 at: http://www.jjab.ky.gov/terms.htm)

Leading Practice: Continuing care organizations may identify leading or exemplary practices which they find to be commendable examples of high quality leadership and service delivery. These practices are worthy of recognition as organizations strive for excellence in their specific field, or commendable for what they contribute to health care as a whole. They may have been identified as a leading practice in a particular geographic region, or for a particular service delivery area or health issue. Some of these commendable practices are ingenious in their simplicity. Often they are implemented by organizations with limited resources, showing how innovative strategies can be achieved at a minimal cost. (Adapted from information contained on Accreditation Canada's website, accessed November 6, 2009 at: http://www.accreditation.ca/knowledge-exchange/leading-practices/)

Department of Health (DoH) Placement Office: Using information supplied by the care coordinators, the Placement Office coordinates appropriate long term care placement in Nova Scotia.

Integrated Population: Residents with dementia are admitted into general nursing units (i.e. the long term care facility accepts referrals for clients with dementia, however there are no secure or special care units).

Participants/ Participating Organizations: Long term care facilities who have indicated that they have one or more secure/ special care unit(s), and would like to take part in the inventory.

Secure Unit Focus Session Participants

A number of focus sessions were held with sector representatives to review the draft inventory report and provide feedback. Their insight has been invaluable in shaping the final report/appendices.

Focus Group Participants:

Barry Granter, Administrator, Harbour View Haven
Darlene Cook, Director of Care, Tideview Terrace
Dawn Ryan, Director of Resident Care, Parkstone Enhanced Care
Debbie Wilson, Administrator, Parkstone Enhanced Care
John Budgell, Administrator, North Queens Nursing Home
Joy Boyle, Director of Care, North Queens Nursing Home
Linda Bird, Director, Programs and Services, Alzheimer Society of Nova Scotia
Rebecca Dorey, Director of Resident Care, Harbour View Haven
Tim McAuley, Assistant Director of Care, Harbour View Haven

NSAHO Support Staff:

Brandy McIntosh, Researcher, Policy, Planning and Decision Support
Janet Simm, Director, Policy, Planning and Decision Support
Barb Baker, Policy Analyst, Policy, Planning and Decision Support

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