Clear Webinar Series:
Managing Pain

November 22, 2018

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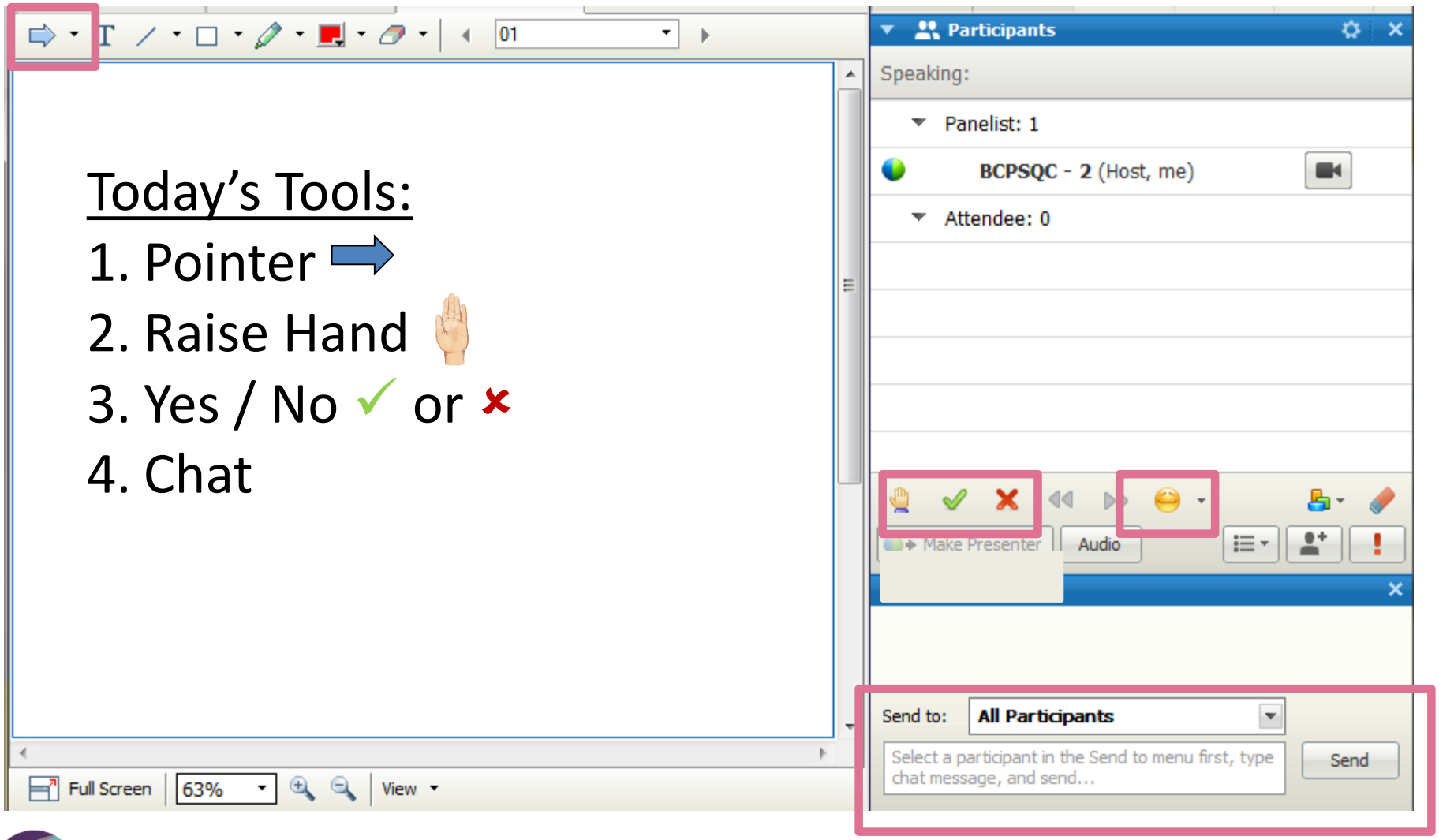

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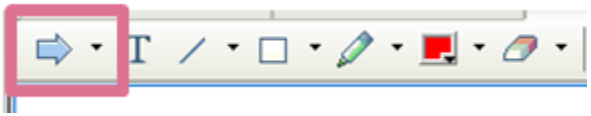

Who's Online?

- ❑ Aberdeen Hospital
- ❑ Augustine House/Haven House
- ❑ Beacon Hill Villa
- ❑ Bevan Lodge Residential
- ❑ Comox Valley Seniors Village
- ❑ Cumberland Lodge
- ❑ Dufferin Care Centre
- ❑ Elim Village, The Harrison/Harrison West
- ❑ Glacier View Lodge
- ❑ Good Samaritan Wexford Creek
- ❑ Gorge Road Hospital
- ❑ Guildford Seniors
- ❑ Heritage Square
- ❑ Jackman Manor
- ❑ Kamloops Seniors Village
- ❑ Kiwanis Village Lodge
- ❑ Louis Brier Home and Hospital
- ❑ Maple Ridge Seniors Village
- ❑ Nanaimo Seniors Village
- ❑ Nanaimo Traveller's Lodge (Eden Gardens)
- ❑ Peace Villa
- ❑ Powell River General Hospital
- ❑ Qualicum Manor
- ❑ Renfrew Care Centre
- ❑ Richmond Lions Manor Bridgeport
- ❑ Rosemary Heights Seniors Village
- ❑ Rotary Manor
- ❑ Royal City Manor
- ❑ Selkirk Place (Selkirk Seniors Village)
- ❑ Shorncliffe
- ❑ Simon Fraser Lodge
- ❑ Stanford Place
- ❑ The Pines
- ❑ The Residence at Morgan Heights
- ❑ The Residence in Mission
- ❑ Valhaven Rest Home
- ❑ Valleyhaven
- ❑ Waverly-Grosvenor House Ventures
- ❑ Willingdon Creek Village
- ❑ Woodgrove Manor
- ❑ Yucalta Lodge

Don't see your name? Use the text tool to tell us in the Chatbox!

Quick Reminder…
Monthly Reports & Data

Learning Objectives

1. Review the experience of pain in long-term care homes.
2. Examine how the pain experience impacts people living with dementia.
3. Review tools you can use to screen and assess for pain.
4. Identify one thing you will take away to your practice.

Kimberley Smith, BHSc, RPN, MSc

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The Pain Experience and the Person with dementia

VCH Residential Care Practice Team

November-22-2018

Vancouver Coastal Health

Learning objectives

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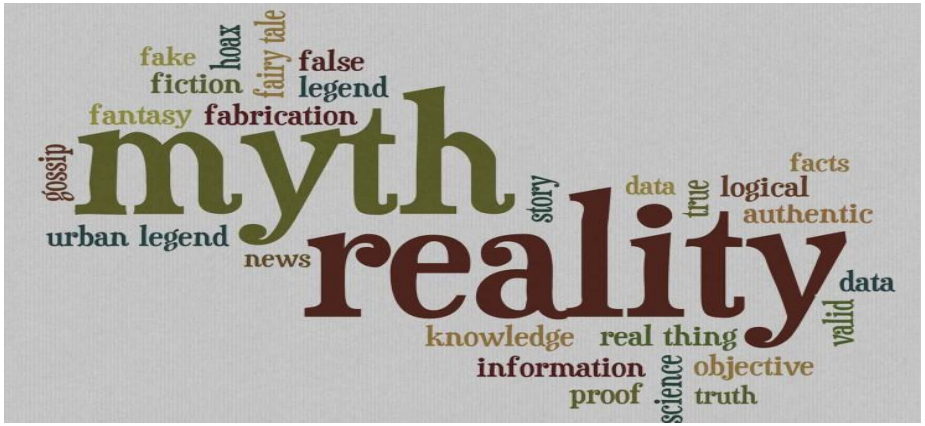
Pain is…



1) Something to get used to

A) TRUE
B) FALSE

2) A physical problem only

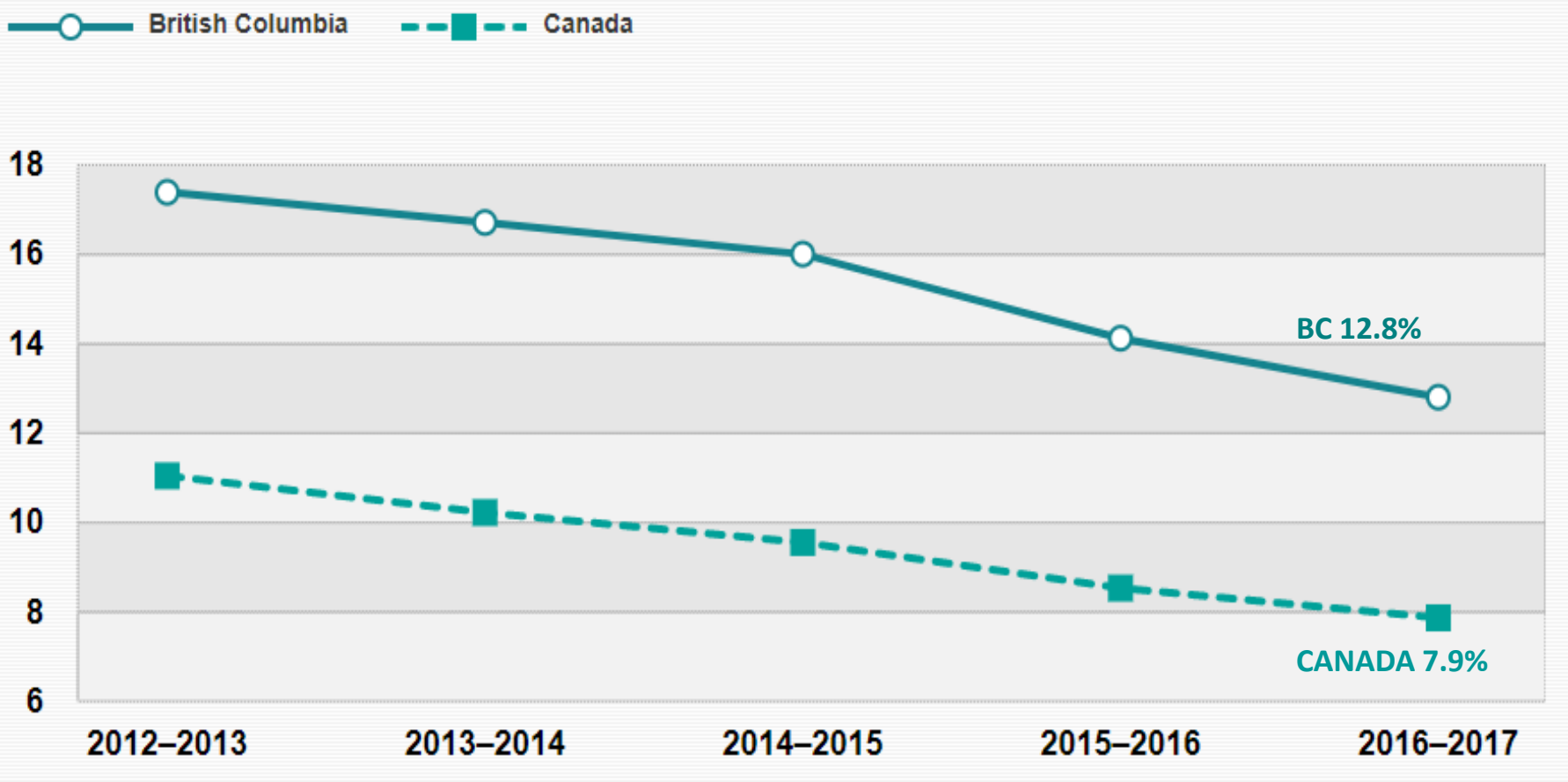
A) TRUE
B) FALSE

3) Something people with cognitive changes cannot reliably report

A) TRUE
B) FALSE

Percentage of Residents Experiencing Pain

(Daily Moderate Pain OR Any Horrible/Excruciating Pain)



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Percentage of Residents Experiencing Pain

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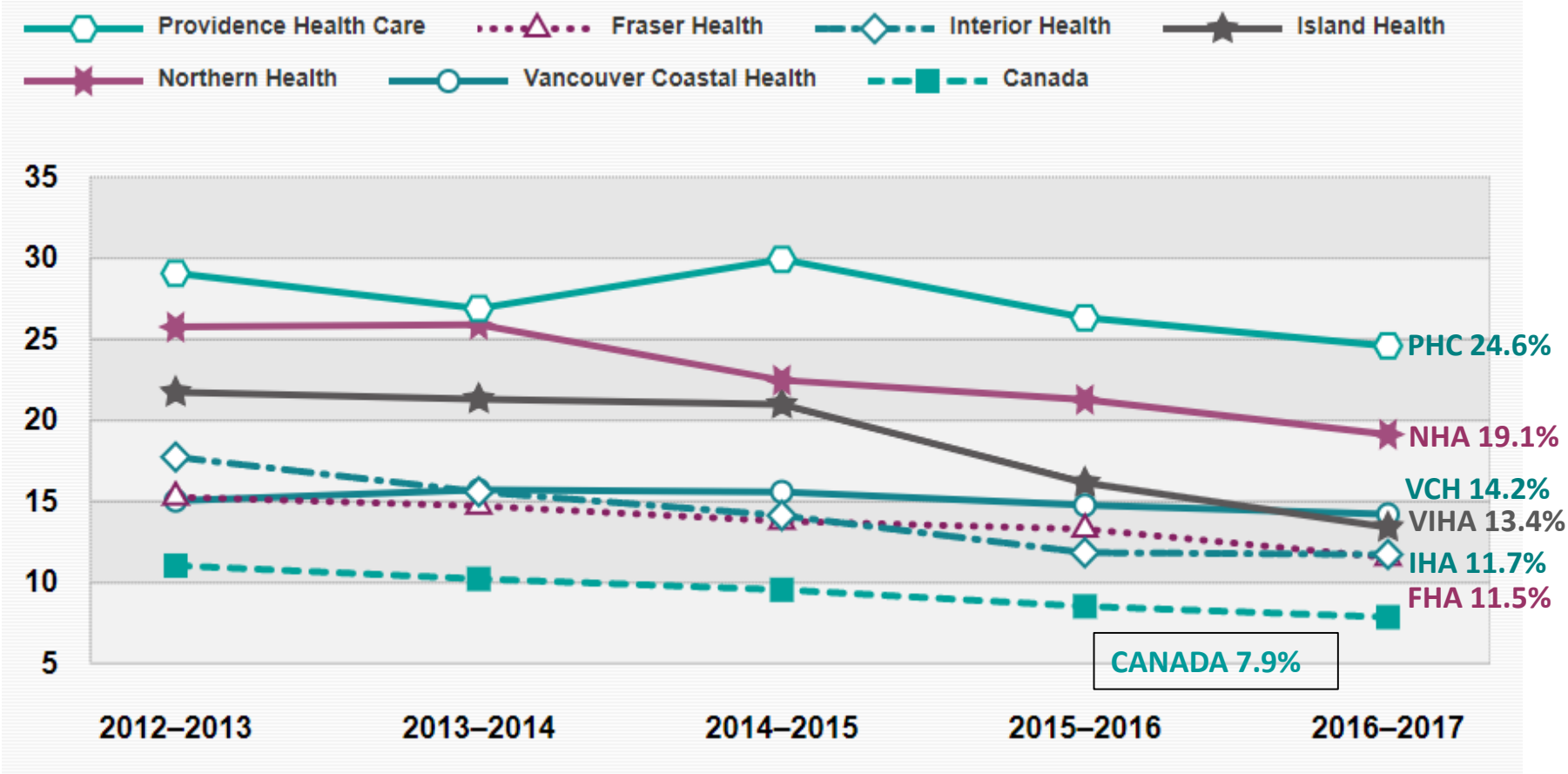

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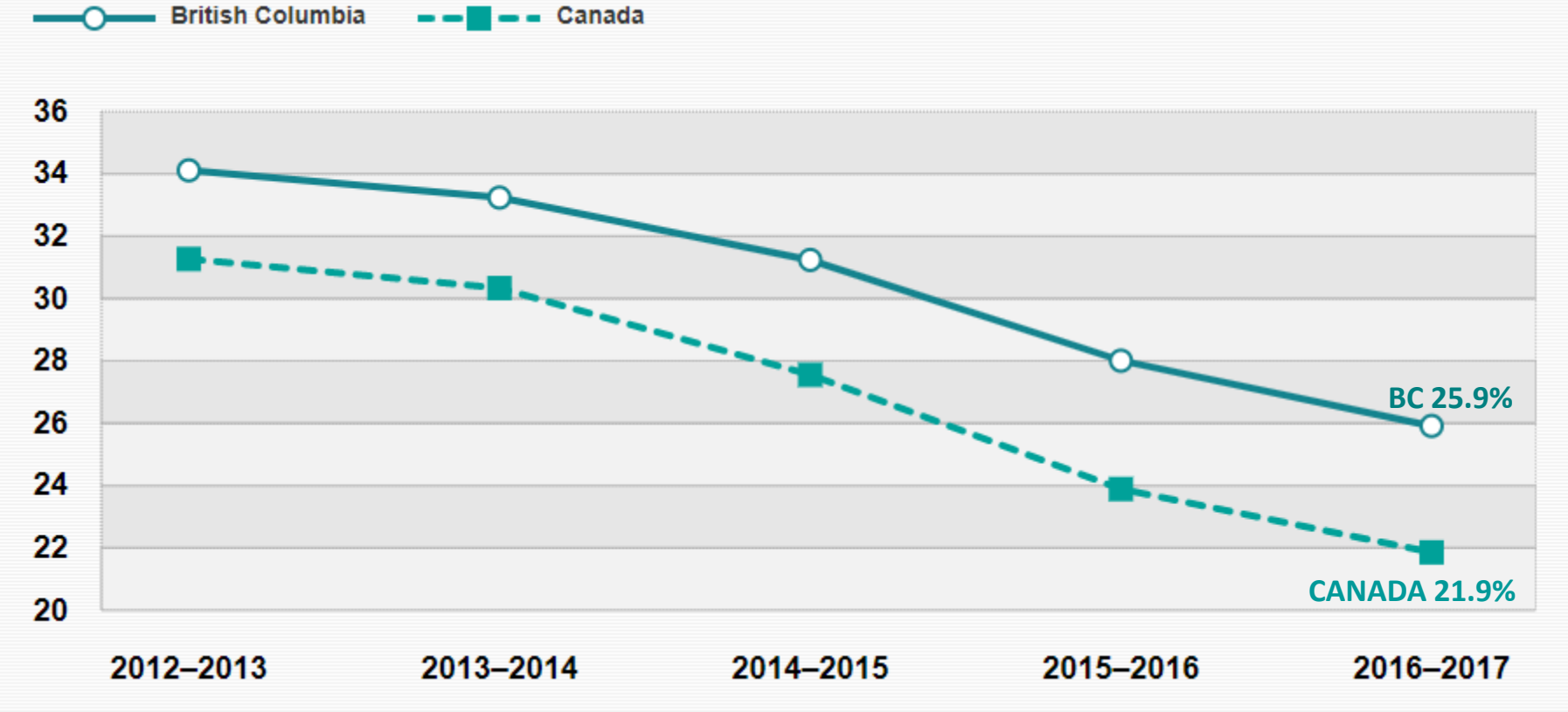
Potentially Inappropriate Use of Antipsychotics

(Without a Diagnosis of Psychosis)



Vancouver Coastal Health

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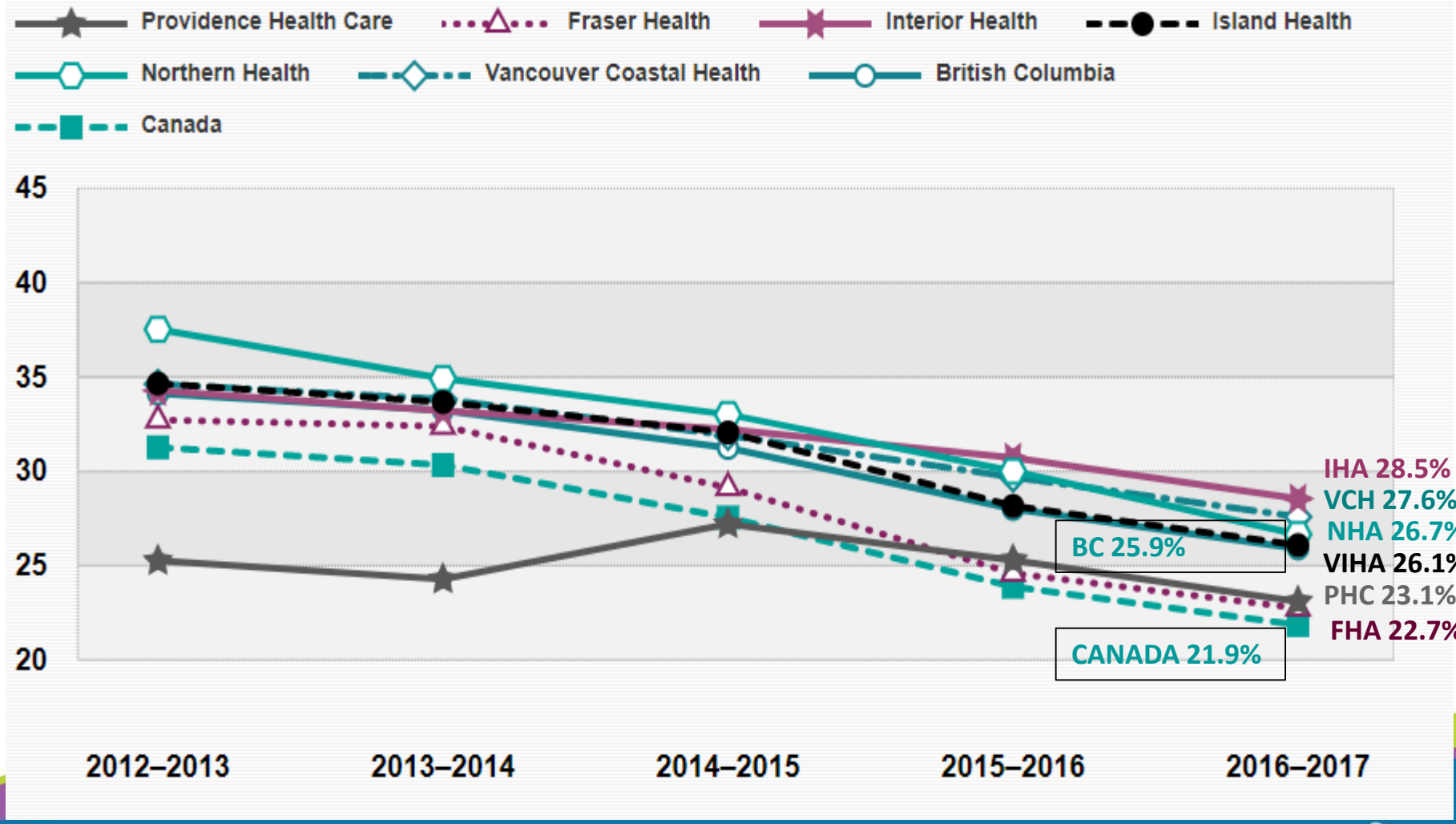

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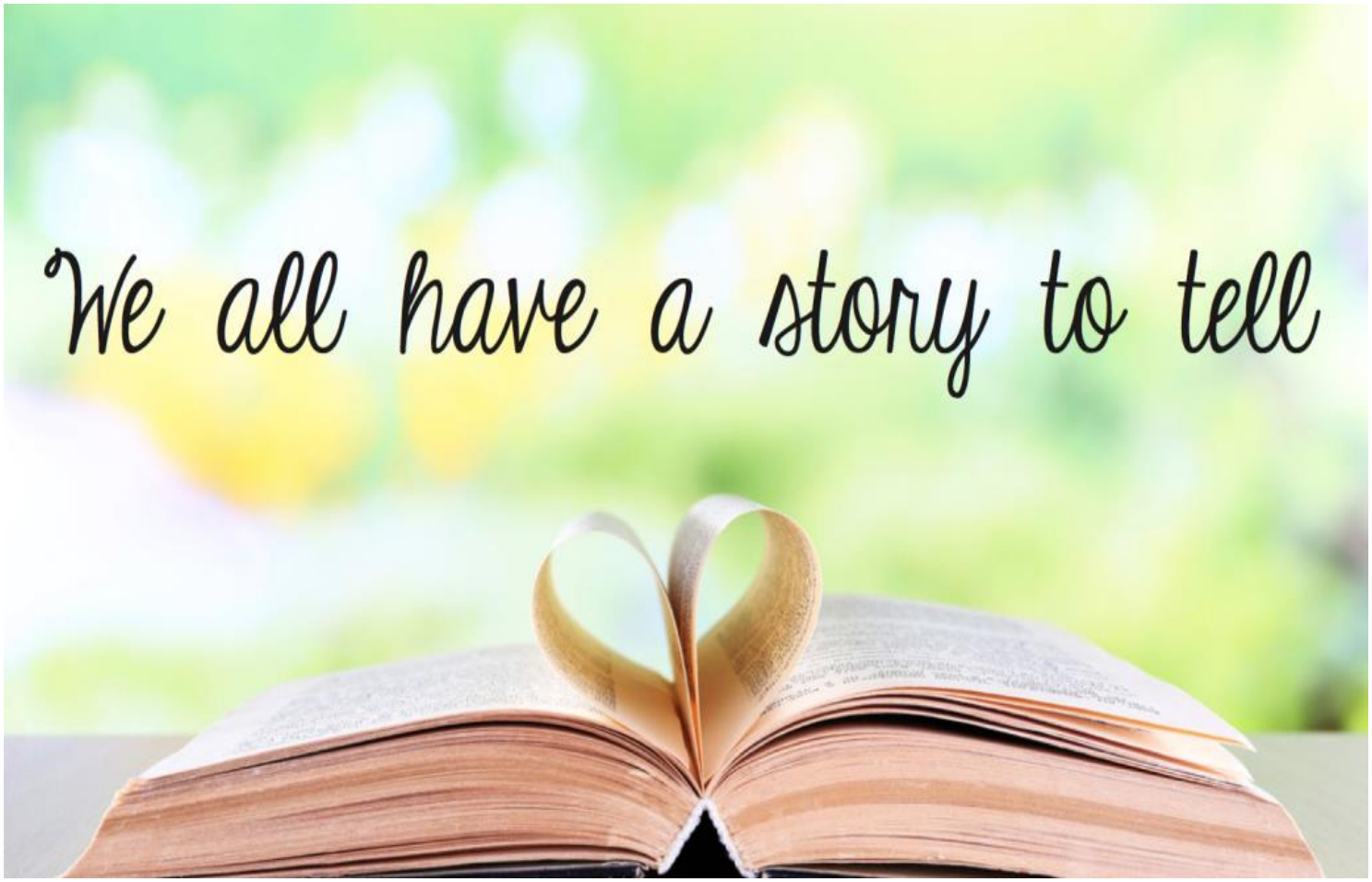


Vancouver CoastalHealth

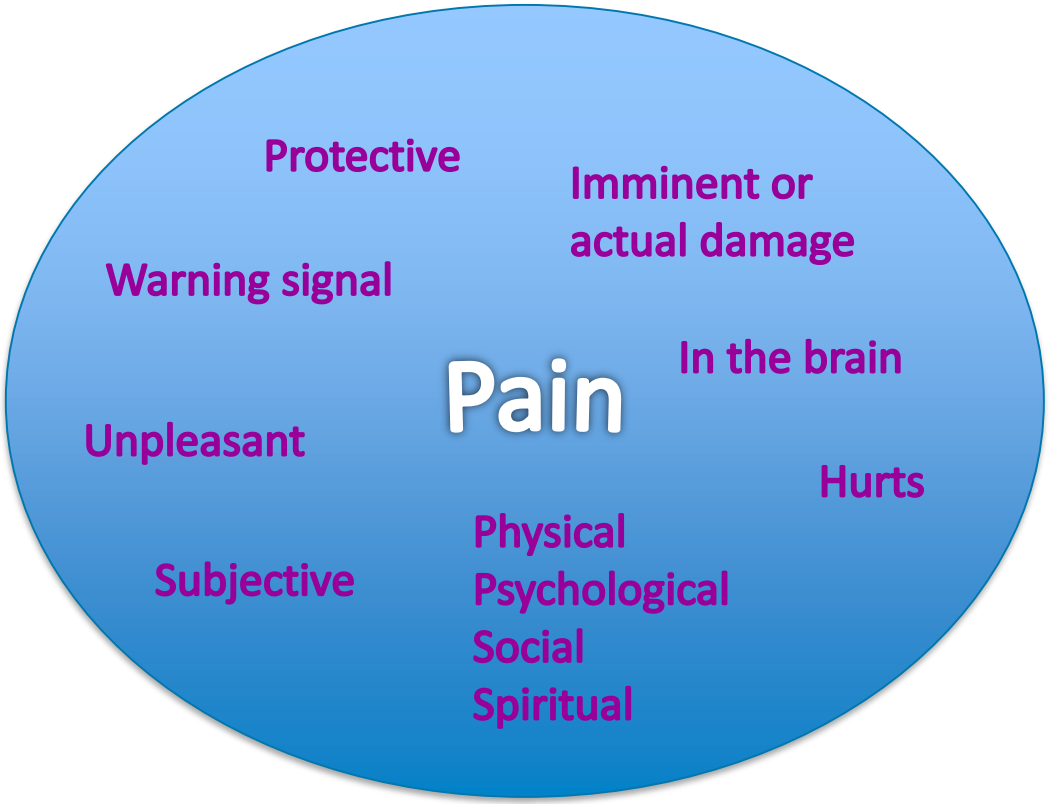
"My father was screaming during the day, during the night, a lot of the time. It was incredibly upsetting and initially I thought that this must just be part of his dementia. I was getting to the stage where I felt completely helpless, as did the care staff. The care home team had tried different medications, including Quetiapine, an antipsychotic, and Ativan, an antianxiety, but nothing stopped his screaming. Then, I started to think there was more to this when, one day, I tried to move my father into a more comfortable position when not only did he scream even louder, but he tried to hit me-something he never had done before. Suddenly I remembered my dad's bad back- the back that kept him off of work for months at time and sometimes left him lying on the floor while the family ate dinner at night. I asked for the care team to assess if my father was in pain.

I was told that this would be hard to do since my father has dementia and can't tell people what hurts. I pointed out that, although limited in his speech, my father does respond to 'yes' and 'no' questions and that the care staff might be able to tell what hurt by looking at my father's facial expression.

How do we tell if a person with dementia is in pain? Sometimes we can push gently on an area and ask if it hurts. Another way is to check for changes in facial expression. Behavioural changes and even fast breathing may be signs of discomfort. The current generation of older adults, raised in an era when it was not appropriate to complain, may also not acknowledge discomfort.

Just because someone cannot talk does not mean everything is ok. Just because someone is screaming doesn't mean it's their dementia causing it. My father's dementia makes it hard for him to tell me he is in pain, but the dementia itself doesn't make him scream-I believe the pain does. It is important for families and care staff to work together to make sure people are monitoring and treating pain in people with dementia. We can't cure the dementia, but we can alleviate some of the suffering." ~ Family Member

What is Pain and the Pain Experience?



What is Pain and the Pain Experience?

What is Pain and the Pain Experience?

Why does pain matter?

1. The occurrence of chronic pain in older adults living in long-term care homes may be as high as:

A) 25%

B) 45%

C) 60%

D) 80%

2. Predictors of responsive behaviour include:

A) Psychosis

B) Interpersonal relationships

C) Delirium

D) Pain

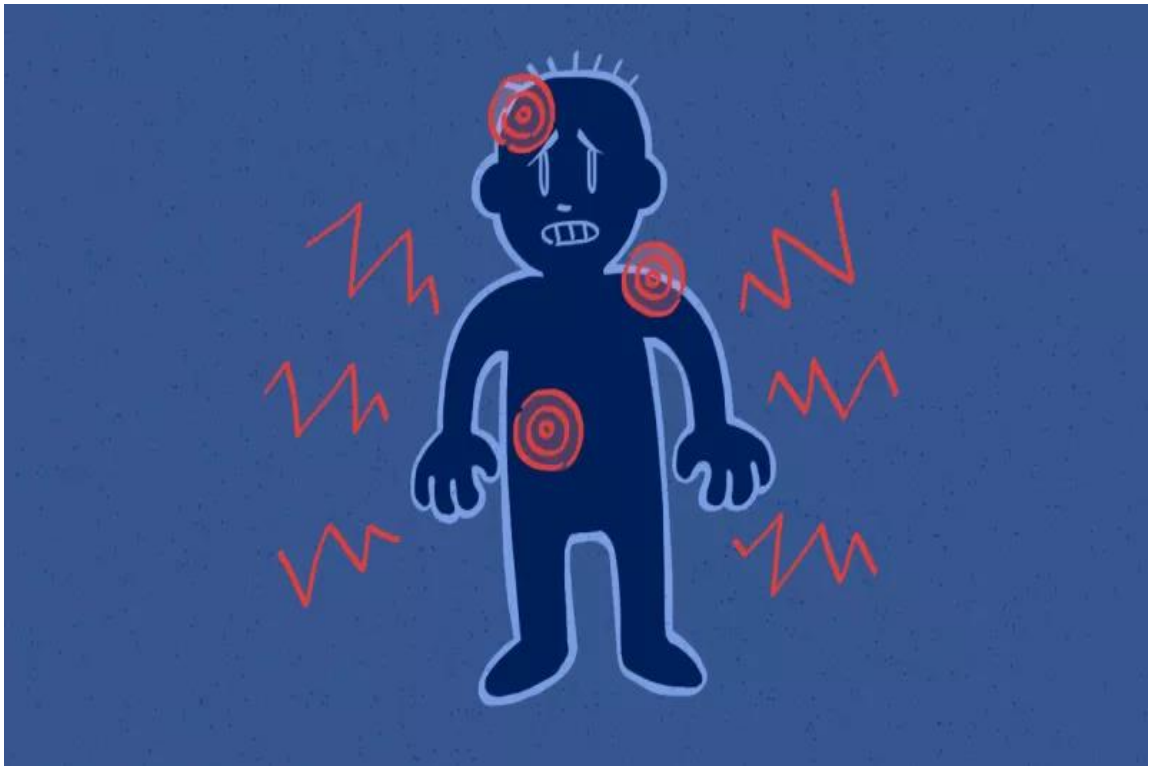
E) All of the above

3. 'Responsive behaviours' are directly a result of dementia.

A) True

B) False

The Pain Challenge for the Person with dementia



Not reporting pain is not the same as having no pain.

Learning to read the clues . . .
When words are hard to find

- “No, I don’t want to get up today”
- “No, no, no”
- “No, I am not hungry”
- “Leave me alone”
- “Help me”
- “I don’t feel good today”
- *&$% off

Learning to read the clues . . .

When words can't be found

Facial Expressions	- Slight frown; sad, frightened face - Grimacing, wrinkled forehead - Rapid blinking	- Closed or tightened eyes - Any distorted expression
Verbalizations, vocalizations	- Sighing, moaning, groaning - Grunting, chanting, calling out - Noisy breathing	
Body movements	- Rigid, tense body posture, guarding - Fidgeting - Increased pacing, rocking	- Restricted movement - Gait or mobility changes
Changes in interpersonal interactions	- Physical responsiveness - Decreased social interactions or social withdrawal	- Socially disruptive behavior - Refusing assistance with care
Changes in activity patterns or routines	- Refusing food, appetite change - Sleep, rest pattern changes	- Sudden cessation of common routines - Restlessness, inability to relax
Mental Status changes	- Crying or tears - Increased confusion - Irritability or distress	

American Geriatric Society Panel on persistent pain in older persons (2009)

Learning to read the clues . . .

‘Get to Know’ the Person

1. Ask the Person
- What is their preferred routine?
- What is known about their life & health that impacts their present?
- How do they tend to express themselves…when happy, sad, angry?
- What helps them feel well?

2. Observe the Person for cues & clues
- Facial expressions are most sensitive and reliable in pain estimation

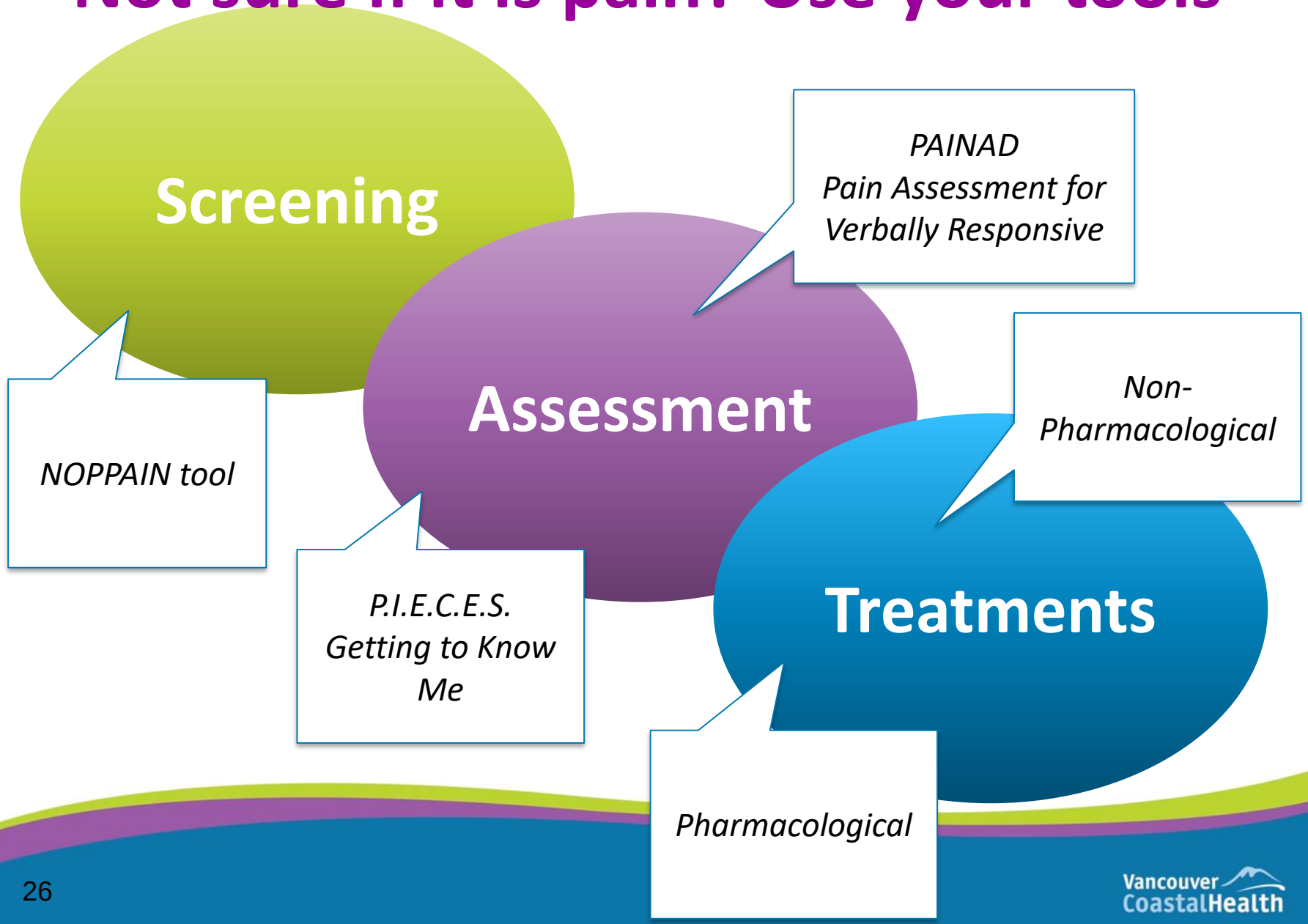
3. Ask the Person’s family & friends
- Encourage family to report what they notice

4. Read supporting documents & assessments

5. Involve the interdisciplinary to develop a holistic perspective

Consider from the information gathered if there is anything in the person’s story that links to the potential for experiencing pain.

Not sure if it is pain? Use your tools



NOPPAIN TOOL

Make notes & circle the option that applies

Appendix E – Observation for Non-verbal Responsive Residents

...N)

...itive Patient's Pain Assessment Instrument)
...rt Check List

Name of Evaluator _____
Name of Resident: _____
Date: _____
Time: _____

DIRECTIONS: Nursing assistant should complete at least 5 minutes of daily care activities for the resident while observing for pain behaviors. This form should be completed immediately following care activities

	Did you do this?	Did you see pain when you did this?
(a) Put resident in bed OR saw resident lying down	☐ YES ☐ NO	☐ YES ☐ NO
(b) Turned resident in bed	☐ YES ☐ NO	☐ YES ☐ NO
(c) Transferred resident (bed to chair, chair to bed, standing or wheelchair to toilet	☐ YES ☐ NO	☐ YES ☐ NO
(d) Sat resident up (bed or chair) OR saw resident sitting	☐ YES ☐ NO	☐ YES ☐ NO
(e) Dressed resident	☐ YES ☐ NO	☐ YES ☐ NO
(f) Fed resident	☐ YES ☐ NO	☐ YES ☐ NO
(g) Helped resident stand OR saw resident stand	☐ YES ☐ NO	☐ YES ☐ NO
(h) Helped resident walk OR saw resident walk	☐ YES ☐ NO	☐ YES ☐ NO
(i) Bathed resident OR gave resident sponge bath	☐ YES ☐ NO	☐ YES ☐ NO

REMEMBER: Make sure to **ASK THE PATIENT** if he/she is in pain!

Pain Response/Responsibility (What did you see and hear?)

Pain Words? "That hurts!" "Ouch" "Cursing" "Stop that"
☐ YES ☐ NO
How intense were the pain words? 0 1 2 3 4 5

Pain Faces? -grimace -wince -furrowed brow
☐ YES ☐ NO
How intense were the pain faces? 0 1 2 3 4 5

Bracing? -rigidity -holding -guarding (especially during movement)
☐ YES ☐ NO
How intense was the bracing? 0 1 2 3 4 5

Pain Noises? -moans -groans -grunts -cries -gasps -signs
☐ YES ☐ NO
How intense were the pain noises? 0 1 2 3 4 5

Rubbing? -massaging affected area
☐ YES ☐ NO
How intense was the rubbing? 0 1 2 3 4 5

Restlessness? -frequent shifting -rocking -inability to stay still
☐ YES ☐ NO
How intense was the restlessness? 0 1 2 3 4 5

Locate Problem Areas

Please "X" the site of any pain
Please "O" the site of any skin problems

FRONT BACK

Snow AL, O'Malley K, Kunik M, Cody M, Bruera E, Beck C, Ashton C. Developed with support from the US. Veterans Affairs Health Services Research & Development Service and the National Institute of Mental Health. For more information, contact Dr. Snow at asnow@bcm.tmc.edu. *(This document may be reproduced*

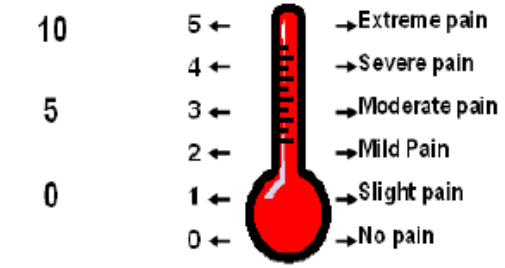
NOPPAIN (2nd Page)

Non - Communicative Patient's Pain Observation Instrument Activity Chart Check List

Name of Evaluator _____
Name of Resident _____
Date: _____
Time: _____

Rate the Resident's pain at the highest level you observed during care. (circle your answer)

Pain Thermometer Scale

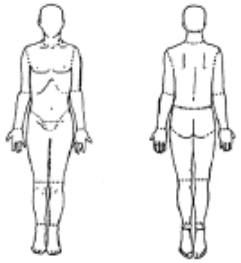


Appendix D – Pain Assessment Tool for the Verbally Responsive

NAME _____ ***DATE*** _____

1. Where is your worst pain? (point to the spot) _____

2. Where else do you have pain or discomfort? _____



Pain Assessment Tool

10

5

0

3. *Onset* – When did the pain start? _____

4. *Pattern* - What makes the pain(s) better? _____ worse? _____

5. *Quality* - How would you describe your pain(s)? – Throbbing ☐, shooting ☐, numbness ☐, stabbing ☐, sharp ☐, dull ☐, aching ☐, burning ☐, pins and needles ☐, grinding ☐.
6. *Radiating* - Does the pain(s) spread to other areas? _____

7. *Severity* - How would you rate your pain(s), 0-10, 0-5 scale ☐ Descriptions ☐ Faces ☐

8. *Timing* - Is the pain(s): Constant? ☐ Come and go? ☐ Only with movement? ☐

9. *Understanding* - What do you think causes the pain(s)? _____

10. *Value* – What is your acceptable comfort level? _____

11. What medications do you use? _____
Do they help? _____

12. What have you used in the past? _____
14. Does your pain(s) affect your: Sleep ☐ Appetite ☐ Activity ☐ Mood ☐ Other ☐
15. Do you have any concerns about taking pain medications? Yes ☐ No ☐
If yes, describe: _____

H651 – January 2011. Vancouver Coastal Residential Hospice Team

Pain Assessment Tool for the Verbally Responsive

PAINAD

Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

Behavior	0	1	2	Score
Breathing Independent of vocalization	• Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	• Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	• No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
			TOTAL SCORE	

(Warden et al., 2003)

Scoring:

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

Source:

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *J Am Med Dir Assoc*. 2003;4(1):9-15.

PAINAD Item Definitions

(Warden et al., 2003)

Breathing

1. *Normal breathing* is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. *Occasional labored breathing* is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. *Short period of hyperventilation* is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. *Noisy labored breathing* is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. *Long period of hyperventilation* is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. *Cheyne-Stokes respirations* are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization

1. *None* is characterized by speech or vocalization that has a neutral or pleasant quality.
2. *Occasional moan or groan* is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. *Low level speech with a negative or disapproving quality* is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. *Repeated troubled calling out* is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. *Loud moaning or groaning* is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. *Crying* is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression

1. *Smiling or inexpressive*. Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. *Sad* is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. *Frightened* is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. *Frown* is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. *Facial grimacing* is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language

1. *Relaxed* is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. *Tense* is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. *Distressed pacing* is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. *Fidgeting* is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. *Rigid* is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. *Fists clenched* is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. *Knees pulled up* is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. *Pulling or pushing away* is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. *Striking out* is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. *No need to console* is characterized by a sense of well-being. The person appears content.
2. *Distracted or reassured by voice or touch* is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. *Unable to console, distract, or reassure* is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

TREATMENTS

Non-Pharmacological	Pharmacological
Relaxation techniques	Acetaminophen
Exercise and paced activity	NSAID's
Massage	Mild Opioids
Music Therapy	Strong Opioids
Heat or cold packs	Adjuvant medications
Gentle stretching	Other?
Specialized cushions/mattresses	
Regular repositioning	
Splinting	
Physiotherapy	
Distraction techniques	
Cognitive-behavioural therapy	
Other?	

Monitoring and Reassessment

- Are the interventions working?
  - if not, what is your next step?
- Do we need to make some changes?
- Have we adjusted the care plan?
- Have we communicated with the family? How do they want to be involved in the care plan?
- Keep an eye out for what's changed for the person- for better and for worse.

Read the following story and then try to answer the questions that follow.

Tom is a 64-year-old man who is in the advanced stages of Alzheimer's disease. He has been an insulin-dependent diabetic since he was 19 years old and has developed necrotic ulcers on his heels and toes as a result. His left great toe was amputated 2 weeks ago. He was a life long soccer player and has developed osteoarthritis in his knees. Tom speaks in repetitive, indistinguishable words. He needs assistance to transfer and change position. Tom enjoys eating when he is able to focus on doing so.

Usually Tom is easy going and social. He loves music, especially Queen and the Beach Boys. He has a big laugh that lights up everyone around him. Today when you are trying to help Tom remove his socks and shoes at bed time, you notice that he does not look happy, he does not smile at you or laugh with you as he normally does and is bending over, holding his knees. When you try to remove his shoes and then his socks, he loudly yells " No" and almost head butts you, but you move away quickly enough.

You decide to leave his shoes and socks on for now and help him into bed.

In the morning, your colleagues find Tom to be awake, but not easy to engage; he doesn't make eye contact and does not go along with their requests as he normally does. He seems quiet and withdrawn.

1. List the ways in which Tom's behaviour has changed.
2. Think of possible reasons for the change(s) in behaviour.
3. Choose a pain tool use. Why did you choose this tool?
4. What might you do to try to help Tom?

In Summary

- Pain is an experience: No two people are the same, no two reactions to pain are the same, and people do not respond to the same treatments in the same ways.
- Be aware of making assumptions, particularly for people who do not communicate their pain specifically and clearly. Dementia does not alter the fundamental experience of pain.
- Know the Person you are caring for: Every person has a story that influences how they experience and express pain.
- Every person's behavioural expression has meaning:
  - Use your tools. Find out what the meaning is as it may be pain related.
  - Find out what makes the person comfortable and keep doing it!


CHALLENGE!

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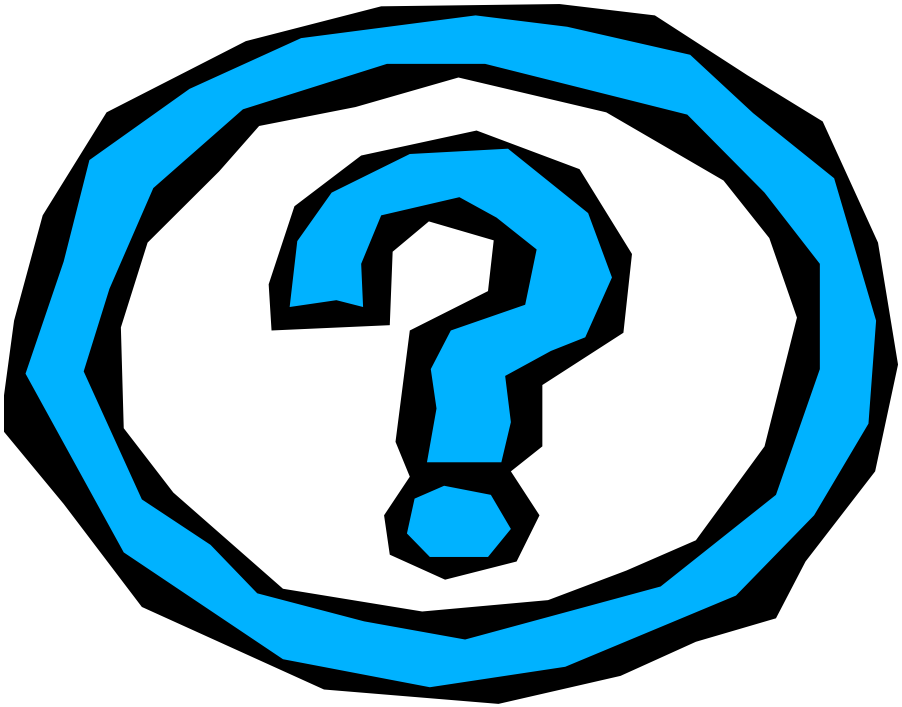
Questions?



What is one thing you heard today that you may start to use by next Tuesday?

Changes/PDSAs

Clear

Poll!

Are you or your team trying any small changes?

A. We have been running a change for a month or more
B. We just started a change
C. We are thinking of a change to start next week or month
D. We have too much going on, maybe we will look at a change in Jan 2019

Clear

Why Test?

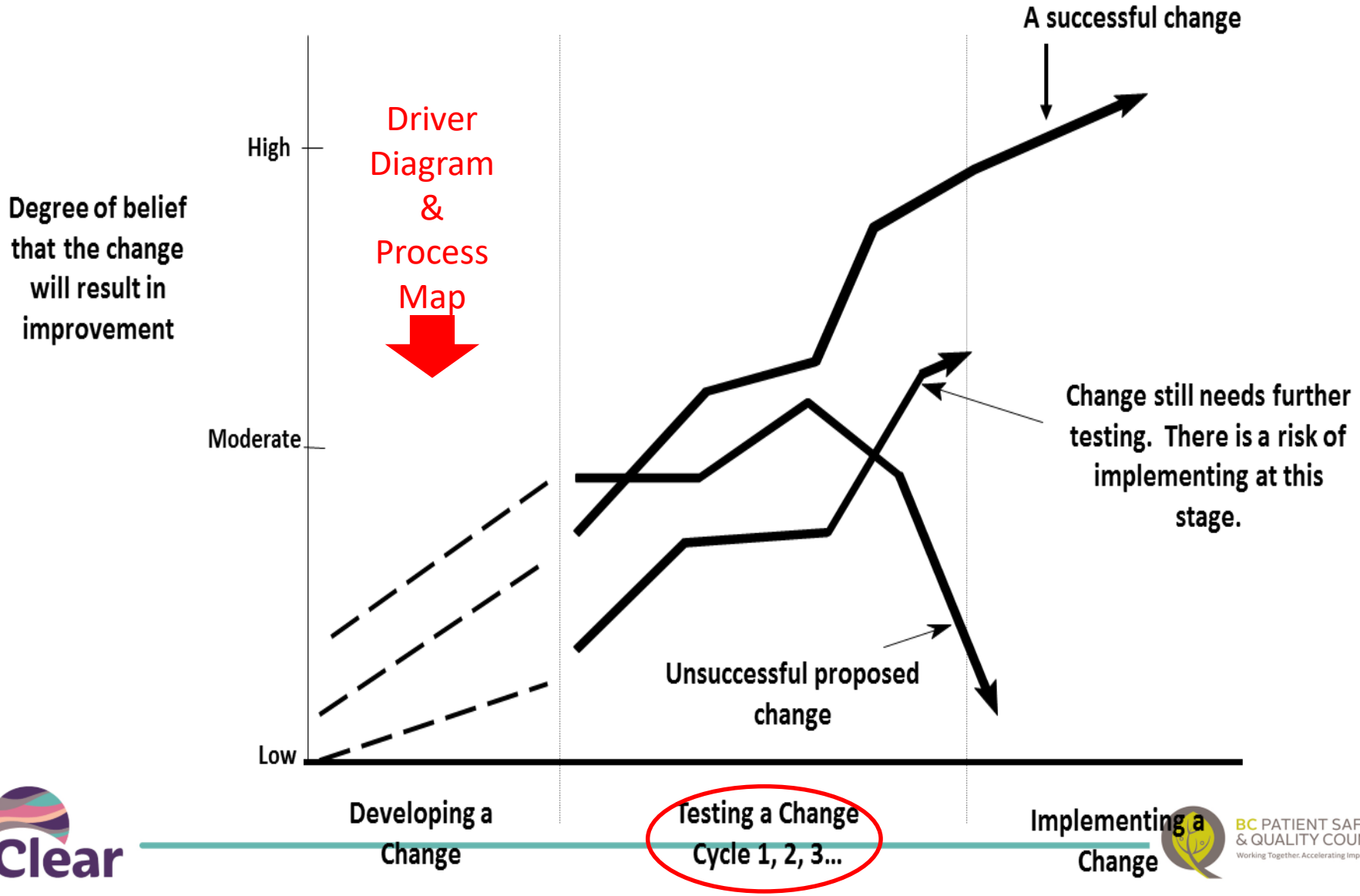
- Increase belief that a change will result in improvement
- Document how much improvement can be expected
- Learn how to adapt changes to local conditions
- Evaluate costs and effects of the change
- Minimize resistance upon implementation

Why Do We Need PDSA Cycles?

Because we don't know:

- How well an idea will work
- How the idea is best delivered
- If it will work in all conditions
- When it won't work
- How it will affect other parts of the system

Develop, Test, Implement a Change



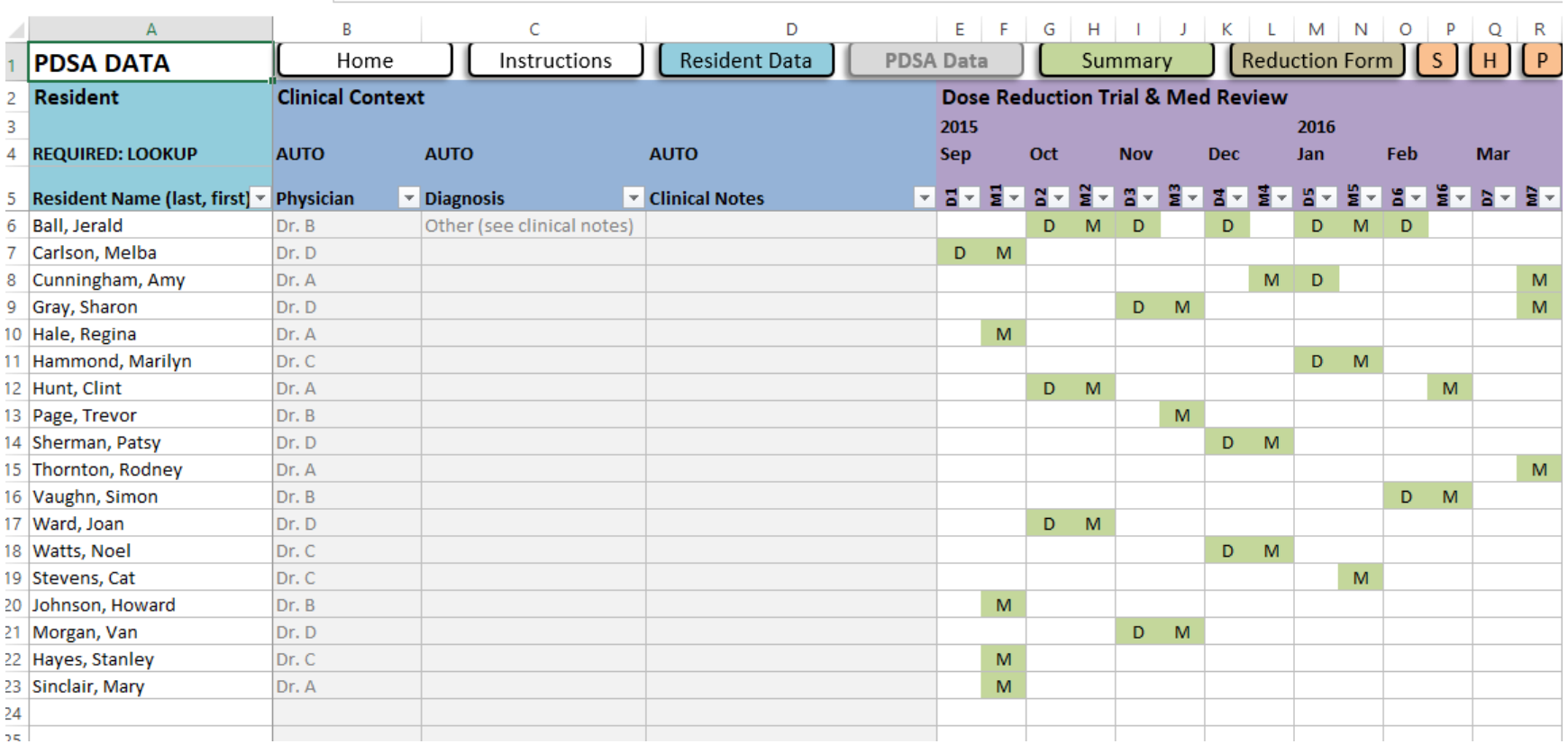
“Failed” Tests

- Expected and important
- Reasons for “failed” tests
  - Change not executed well
  - Support processes inadequate
  - Hypothesis/hunch/theory not useful for conditions
  - Change executed but did not result in local improvement
  - Local improvement did not impact safety or specific aims in the Charter
- Collect data during the Do Phase of the Cycle to help distinguish between these different reasons.

Lessons Learned From Previous Teams

- Change takes time, but can be achieved with little steps
- Time is often the main constraint
- Data collection strategies can change throughout the initiative depending on the focus
- Qualitative and quantitative data are invaluable for storytelling and motivation

Collecting PDSA Data in Excel – Quick Demo



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
1	PDSA DATA	Home	Instructions	Resident Data	PDSA Data		Summary		Reduction Form				S		H		P	
2	Resident	Clinical Context			Dose Reduction Trial & Med Review													
3					2015								2016					
4	REQUIRED: LOOKUP	AUTO	AUTO	AUTO	Sep		Oct		Nov		Dec		Jan		Feb		Mar	
5	Resident Name (last, first)	Physician	Diagnosis	Clinical Notes	D1	M1	D2	M2	D3	M3	D4	M4	D5	M5	D6	M6	D7	M7
6	Ball, Jerald	Dr. B	Other (see clinical notes)				D	M	D		D		D	M	D			
7	Carlson, Melba	Dr. D			D	M												
8	Cunningham, Amy	Dr. A										M	D					M
9	Gray, Sharon	Dr. D							D	M								M
10	Hale, Regina	Dr. A				M												
11	Hammond, Marilyn	Dr. C											D	M				
12	Hunt, Clint	Dr. A					D	M								M		
13	Page, Trevor	Dr. B								M								
14	Sherman, Patsy	Dr. D									D	M						
15	Thornton, Rodney	Dr. A																M
16	Vaughn, Simon	Dr. B													D	M		
17	Ward, Joan	Dr. D					D	M										
18	Watts, Noel	Dr. C									D	M						
19	Stevens, Cat	Dr. C												M				
20	Johnson, Howard	Dr. B				M												
21	Morgan, Van	Dr. D							D	M								
22	Hayes, Stanley	Dr. C				M												
23	Sinclair, Mary	Dr. A				M												
24																		

Clear

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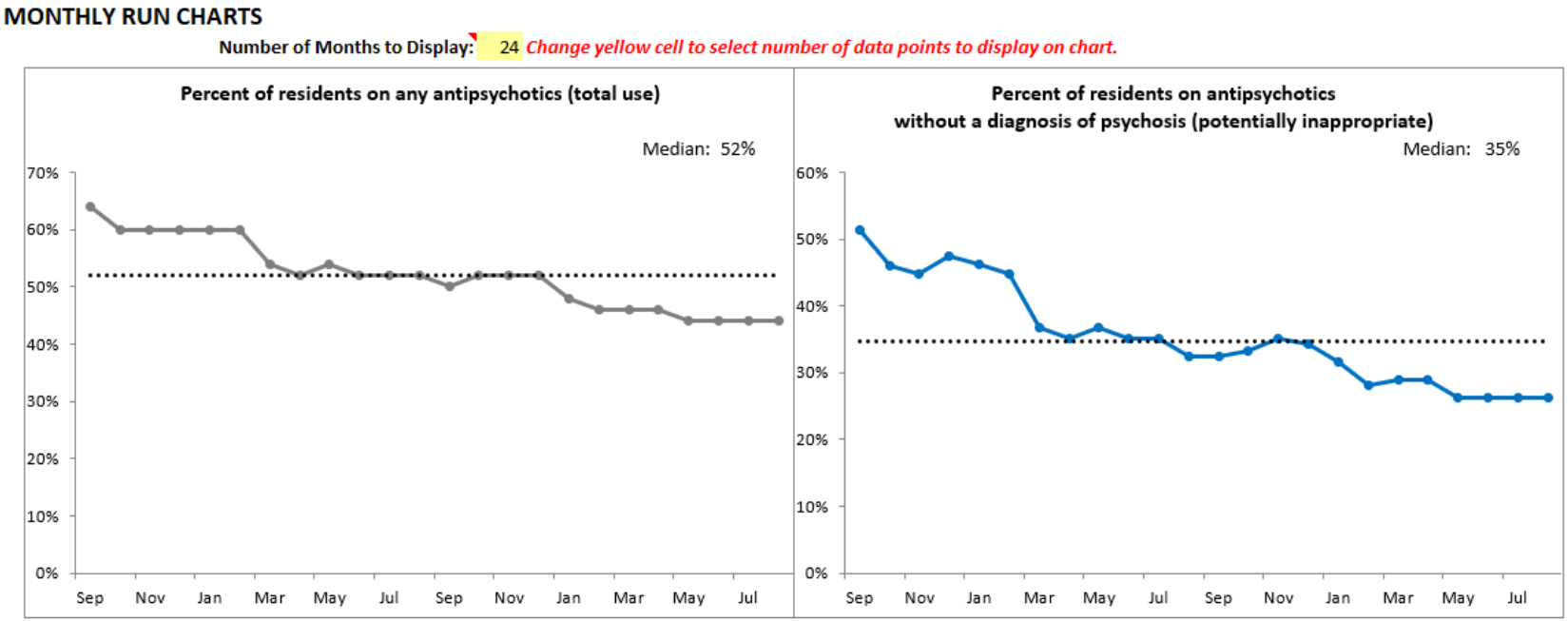
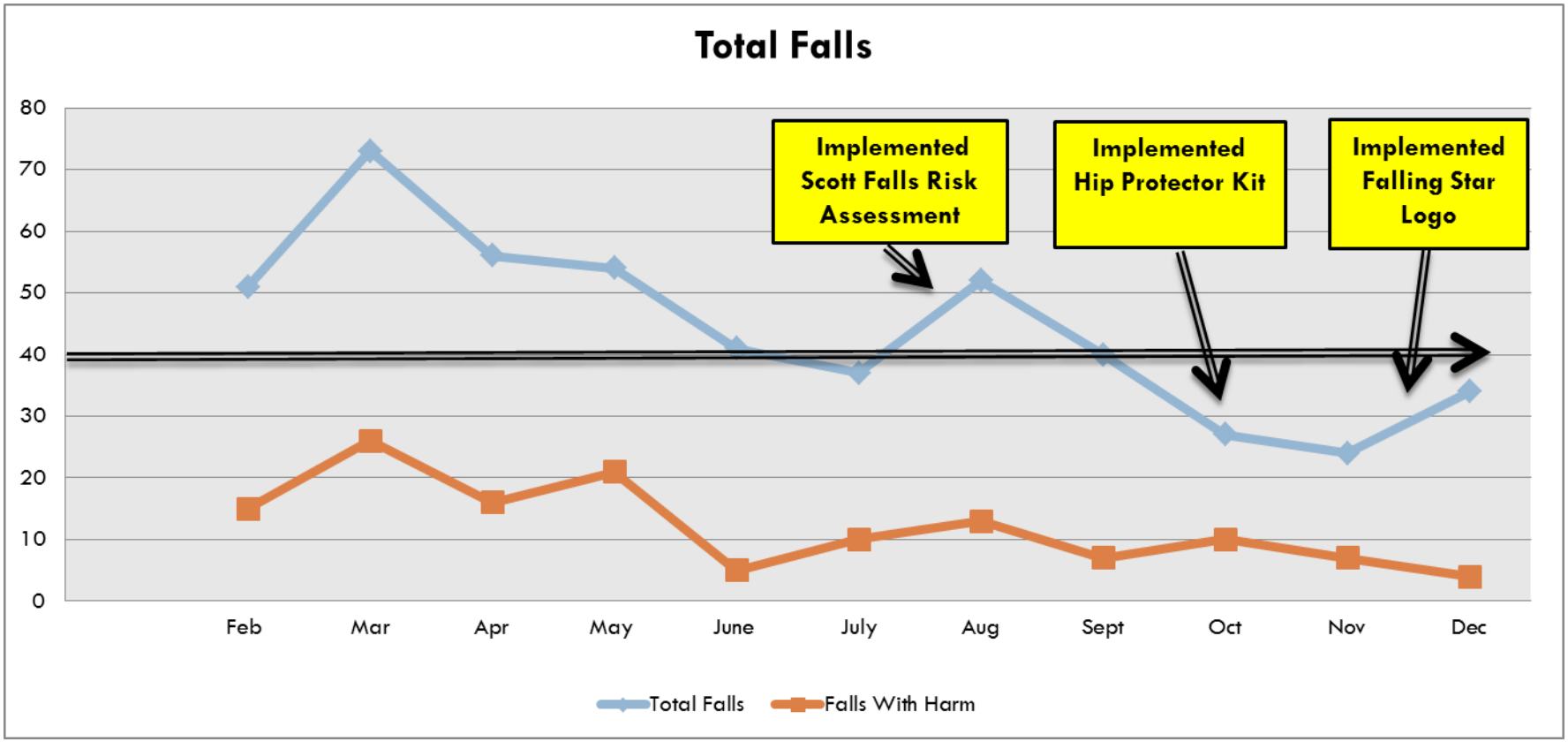
Types of Measures

- **Outcome Measures**: Show if changes are leading to improvement and achieving the overall aim of the project
- **Process Measures**: Show whether a specific change is having its intended effect
- **Balancing Measures**: Help ensure that changes to improve one part of the system are not causing new problems in other areas

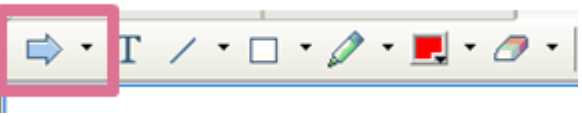
Printing a Chart from a the Summary Tab – Quick Demo



Annotated Run Chart - Example



Source: A Saskatchewan Falls Collaborative Team



Who would find a powerpoint/poster on antipsychotics for educating teams helpful?

- ❑ Aberdeen Hospital
- ❑ Augustine House/Haven House
- ❑ Beacon Hill Villa
- ❑ Bevan Lodge Residential
- ❑ Comox Valley Seniors Village
- ❑ Cumberland Lodge
- ❑ Dufferin Care Centre
- ❑ Elim Village, The Harrison/Harrison West
- ❑ Glacier View Lodge
- ❑ Good Samaritan Wexford Creek
- ❑ Gorge Road Hospital
- ❑ Guildford Seniors
- ❑ Heritage Square
- ❑ Jackman Manor
- ❑ Kamloops Seniors Village
- ❑ Kiwanis Village Lodge
- ❑ Louis Brier Home and Hospital
- ❑ Maple Ridge Seniors Village
- ❑ Nanaimo Seniors Village
- ❑ Nanaimo Traveller's Lodge (Eden Gardens)
- ❑ Peace Villa
- ❑ Powell River General Hospital
- ❑ Qualicum Manor
- ❑ Renfrew Care Centre
- ❑ Richmond Lions Manor Bridgeport
- ❑ Rosemary Heights Seniors Village
- ❑ Rotary Manor
- ❑ Royal City Manor
- ❑ Selkirk Place (Selkirk Seniors Village)
- ❑ Shorncliffe
- ❑ Simon Fraser Lodge
- ❑ Stanford Place
- ❑ The Pines
- ❑ The Residence at Morgan Heights
- ❑ The Residence in Mission
- ❑ Valhaven Rest Home
- ❑ Valleyhaven
- ❑ Waverly-Grosvenor House Ventures
- ❑ Willingdon Creek Village
- ❑ Woodgrove Manor
- ❑ Yucalta Lodge

Don't see your name? Use the text tool to tell us in the Chatbox!

Clear

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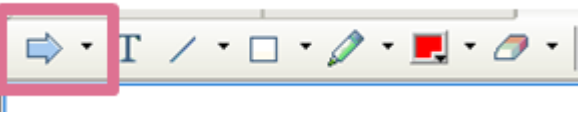
New Website!

Mid-Initiative Survey: Monday, Nov 26!

Last Webinar before 2019!!

- December 13 – Chatting about Change
  - ‘Success strategies’ and ‘common barriers’ – themes from the Regional Workshops and what you need from us for 2019
  - There’s a twist!
- January 31 – what do you want to kick off the year with?



Who thinks that someone from their team can attend the December 13th webinar?

- ❑ Aberdeen Hospital
- ❑ Augustine House/Haven House
- ❑ Beacon Hill Villa
- ❑ Bevan Lodge Residential
- ❑ Comox Valley Seniors Village
- ❑ Cumberland Lodge
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Thank You

Participating Teams

Faculty

Support Team

Guest presenters

Evaluation!

Please complete the evaluation of the webinar after you close WebEx.