



Name:
DOB (dd/mm/yyyy):
HCN:
Other ID:

MY TRANSITIONAL CARE PLAN DURING THE COVID-19 PANDEMIC

A supportive tool to plan and facilitate my move from one place to another.

My Support System and/or Care Team Leading up to and on the Day of My Move:

Substitute Decision Maker (SDM):	Phone #:
Transitional Support Lead:	Phone #:
Additional Supports: (e.g., community team, mobile LTC team, etc.)	

Current Location: Hospital Private Dwelling (house, apartment) Retirement Home Other	Destination: Date & Time of Move:
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Transportation Plan:	Arrival Plan: SDM able to enter Home: Yes No Have screening protocols been reviewed with SDM: Yes No
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My Personhood Summary: Full Personhood Tool Attached: Yes No	My Typical Daily Routine: (e.g., wake up time, sleep time, eating preferences, showers/baths)
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My Smoking/Alcohol/Other Substance Use Plan <i>(if applicable)</i> :	

My Room Set-Up:

In advance	On the day of the move	Unable to bring personal items into the home
Who will set up my room:		
Key/favourite items to make my room feel like home:		

My Isolation Care Plan Strategy Summary: (including activities that promote social, sensory, kinesthetic and intellectual needs) Isolation Care Plan attached: Yes No	My COVID-19 PPE & Swabbing Support Strategies:
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Isolation activity kit: Yes No If yes, delivery plan:	PPE Strategies: (e.g., mask reminders in writing, verbal cueing): Swabbing Strategies: (e.g., reducing background noise, providing blanket, redirection/distraction techniques):

Responsive Behaviours/Personal Expressions¹ <i>(please check all that apply and describe the behaviour(s)/expression(s) and context in which they occur [e.g., during personal care])</i>	COVID-19 Risks & Strategies
Vocal Expression(s):	Risks: <i>(e.g., ability to adhere to IPAC measures, etc.)</i> Strategies: <i>(e.g. 'Do Not Enter' signs, verbal reminders)</i>
Motor Expression(s):	
Sexual Expression(s) of Risk:	
Verbal Expression(s) of Risk:	Other Identified Risks: Falls Suicidal Ideation Other
Physical Expression(s) of Risk:	
Please be Mindful that the Following May be a Cause of Stress/Discomfort for Me: <i>(e.g. chronic pain, loud noises, not being able to see a family member in person, staff use of masks/shields)</i>	
You Can Help to Validate My Feelings by: <i>(e.g. redirection strategies, reminiscence, specific approaches to care)</i>	

¹ DOS Working Group (2019). [Behavioural Supports Ontario-Dementia Observation System \(BSO-DOS©\) resource manual: Informing person and family-centred care through direct observation documentation](#). Behavioural Supports Ontario Provincial Coordinating Office, North Bay Regional Health Centre, Ontario, Canada.

My Assistive Devices: *(please check all that apply)*

Cane/Walker	Wheelchair	Dentures	Glasses	Hearing Aids
Other:				

I May Need Help/Reminders for the Following Tasks:

<u>Hygiene/Personal Care:</u>	Independent	Set Up Only	Assistance	Full Assistance
<u>Toileting Needs:</u>	Independent	Reminder/Routine Toileting		Incontinent
<u>Ambulation/Transfers:</u>	Independent	Supervision	Full Assistance	
<u>Nutrition/Eating:</u>	Independent	Set Up Only	Full Assistance	<u>Diet Ordered:</u>
<u>Medication Administration:</u>		Whole	Crushed	
Recent Changes:				

My Family Connections & Social Supports: *(i.e., how will family/friends connect with me following my move?)*

	Time Frame:	
	During Isolation	Post Isolation
Virtual Visit(s):		
Phone Call(s):		
In-Person Visit(s): Indoors Outdoors		
Window Visit(s):		
Other:		

The Following Reports are Available to Assist in Getting to Know Me Better: *(e.g., BSO Assessment, Seniors/Geriatric Mental Health Assessment, Medication List, Vaccination List.)*

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The Following Clinician(s)/Team(s) are Available to Support Me Following My Move:

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Completed by <i>(please print):</i>	
Contact number:	
Organization:	

Signature: _____ **Date (dd/mm/yyyy):** _____

This transitional care plan was developed based on the individual's presentation in their environment at time of transition. This plan may require adaptation in the new environment as differing behaviours may present themselves throughout the transition period.