Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

brainXchange

MY TRANSITIONAL CARE PLAN DURING THE COVID-19 PANDEMIC

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

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

1. 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:
Transportation Plan:	Arrival Plan: SDM able to enter? ☐ Yes ☐ No Screening protocols reviewed? ☐ Yes ☐ No

Section 1 completed by:

2. My Personhood Summary:

Full Personhood Tool Attached: ☐ **Yes** ☐ **No**

My Typical Daily Routine: (e.g., wake up time, sleep time, eating preferences, showers/baths)

My Smoking/Alcohol/Other Substance Use Plan *(if applicable):*

Section 2 completed by:

3. 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:

Favourite items to make my room feel like home:

Section 3 completed by:

4. My Isolation Care Plan Strategy Summary: (including activities that promote social, sensory, kinesthetic and intellectual needs)

Isolation Care Plan attached: ☐ **Yes** ☐ **No**

Isolation activity kit: ☐ Yes ☐ No

If yes, delivery plan:

My COVID-19 PPE & Swabbing Support Strategies:

PPE Strategies: *(e.g., mask reminders in writing, verbal cueing)*:

Swabbing Strategies:*(e.g., reducing background noise, providing blanket, redirection/distraction techniques):*

Section 4 completed by:

Adapted by: The Behavioural Support Integrated Teams Collaborative
From: North East Behavioural Supports Ontario/Seniors' Mental Health Regional Consultation Service (2020, Apr). My Transitional Care Plan. *North Bay Regional Health Centre.*
Version 2.2 (December 2021)

5. Responsive Behaviours/Personal Expressions[1] (*please check all that apply and describe the **behaviour(s)/expression(s) and context** in which they occur [e.g., during personal care]*)	**COVID-19 Risks & Strategies**
☐ **Vocal Expression(s):**	**Risks:** *(e.g., ability to adhere to IPAC measures, etc.)*
☐ **Motor Expression(s):**	**Strategies:** *(e.g. 'Do Not Enter' signs, verbal reminders)*
☐ **Sexual Expression(s) of Risk:**	
☐ **Verbal Expression(s) of Risk:**	**Other Identified Risks:** ☐ **Falls** ☐ **Suicidal Ideation** ☐ **Other**
☐ **Physical Expression(s) of Risk:**	

Sections 5 completed by:

6. Please be Mindful that the Following May be a Cause of Stress/Discomfort for Me: *(e.g. chronic pain, loud noises, not being able to see a family member in person, staff use of masks/shields)*

You Can Help to Validate My Feelings by: (*e.g. redirection strategies, reminiscence, specific approaches to care)*

Section 6 completed by:

[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.

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7. 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:

Hygiene/Personal Care: ☐ Independent ☐ Set Up Only ☐ Assistance ☐ Full Assistance

Toileting Needs: ☐ Independent ☐ Reminder/Routine Toileting ☐ Incontinent

Ambulation/Transfers: ☐ Independent ☐ Supervision ☐ Full Assistance

Nutrition/Eating: ☐ Independent ☐ Set Up Only ☐ Full Assistance Diet Ordered:

Medication Administration: ☐ Whole ☐ Crushed

☐ Recent Changes:

Section 7 completed by:

8. My Family Connections & Social Supports: *(i.e., how will family/friends connect with me following my move?)*	**Time Frame:**
☐ **Virtual Visit(s)/Phone Call(s):**	**During Isolation** ☐ **Post Isolation/Isolation Not Required** ☐
☐ **In-Person Visit(s):** ☐ Indoors ☐ Outdoors	**During Isolation** ☐ **Post Isolation/Isolation Not Required** ☐
☐ **Other:**	**During Isolation** ☐ **Post Isolation/Isolation Not Required** ☐

Section 8 completed by:

9. 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.)

The Following Healthcare Provider(s)/Teams are Available to Support Me Following My Move:

Section 9 completed by:

10. The Following Healthcare Providers/Individuals Have Contributed to This Transitional Care Plan:

Name:	Designation:	Organization:	Lead:	Date: (dd/mm/yyyy)	Signature:
			☐		
			☐		
			☐		
			☐		
			☐		

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.