Behavioural Supports Ontario
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Critical Elements & Guiding Checklist

Supporting Successful and Sustainable Transitions into Long-Term Care for Older Adults with Responsive Behaviours/Personal Expressions

Created by the Behavioural Support Integrated Teams (BSIT) Collaborative • Part of Ontario's Best Practice Exchange
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References

Behavioural Supports Ontario (2011)
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The Behavioural Support Integrated Teams Transitions Model: A Discussion Paper.

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REPORT BACKGROUND

In the fall of 2017, the Behavioural Supports Integrated Teams (BSIT) Collaborative began to gather information on **critical elements for supporting transitions for the Behavioural Supports Ontario (BSO) target population[1] into long-term care (LTC) homes**. Drawing on the themes that emerged from the September 2015 Ontario's Best Practice Exchange Catalyst Event, at each monthly meeting the collaborative members shared their perspectives on critical elements for supporting person and family-centred transitions from their professional and/or lived experiences. Using the Behavioural Support Integrated Teams Transition Framework, members discussed and determined essential components throughout the experience of transitioning from either the community or hospital into a LTC home which were incorporated into a guiding checklist. All identified critical elements were grounded in the philosophy of person and family-centred care; including creative strategies implemented by various BSO teams and their key collaborators to overcome potential barriers and challenges.

Report Purpose

This report is intended to act as a compendium of critical elements for supporting successful and sustainable transitions for those who fall within the BSO target population as they move from either community or hospital into LTC Homes. The critical elements are presented in the form of a guiding checklist that can be used by professional care providers across the spectrum of care to support individuals and their families in the transition into LTC. These care providers include front-line staff, management, allied health team members and other relevant partners including those from the organization that is sending the individual (i.e., community partners or hospital partners) and those at the receiving end (i.e., at the long-term care home). The critical elements identified in this report capture emerging, promising and best practices that have been implemented at both small and large scales across Ontario. Many of these elements may also be used to inform quality improvement activities aimed at improving transitions into LTC and to aid in the selection of relevant provincial and regional-level tools and resources to improve these complex transitions.

Family

In this document, the term 'family' refers to individuals who are related (biologically, emotionally, or legally) to and/or have close bonds (friendships, commitments, shared household/family responsibilities, and romantic attachments) with the person receiving care. A person's family includes all those whom the person identifies as significant in their life (e.g., partner, children, caregivers, and friends) (Registered Nurses Association of Ontario, 2015).

[1] The BSO Target Population includes older adults presenting with or at risk for responsive behaviours due to dementia, complex mental health, substance use and/or neurological conditions. In addition to providing direct support to the older adults, BSO teams also support family care partners and professional care staff.

What is a Transition?

In the context of this report, transitions refer to a set of actions designed to ensure the safe and effective coordination and continuity of care as a person experiences a change in physical location. All transitions should be facilitated based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment/care goals, preferences, and health or clinical status. They include logistical arrangements and education of the person and their family, as well as coordination among the health professionals involved in the transition. In this report, supporting transitions specifically into LTC is the primary focus in order to highlight specific critical elements that are unique to this often complex transition.

About the Behavioural Support Intregrated Teams (BSIT) Collaborative

The Behavioural Support Integrated Teams (BSIT) Collaborative is a part of Ontario's Best Practice Exchange and supported by BSO and brainXchange. Its overarching goal is to bring forward emerging and best practices related to facilitating safe, successful and sustainable transitions across sectors for individuals with or at risk for responsive behaviours/personal expressions. The BSIT Collaborative is made up of a group of health care professionals, leaders and individuals with lived experience who meet on a monthly basis to:

- Identify the critical elements that enable successful transitions of various types; using a combined team approach across sectors and across providers from the perspective of persons with lived experience and providers within health care teams.

BSIT Collaborative Members

An integral part of the BSIT Collaborative is the participation and contributions of individuals with Lived Experience. In addition to members with Lived Experience, the following organizations are represented within the collaborative:

- Alberta Health Services
- Alzheimer Niagara Region
- Alzheimer Society Chatham Kent
- Baycrest Health Sciences
- Behavioural Health Services Thunder Bay
- BSO - Central East
- BSO - Central West
- BSO - Erie St. Clair
- BSO - HNHB
- BSO - Central
- BSO - South East
- BSO - South West
- BSO - Mississauga Halton
- Centre for Education and Research on Aging and Health (CERAH)
- CMHA Waterloo Wellington
- Family Councils Ontario
- Home and Community Care (Central East)
- Huron Perth Healthcare Alliance
- LOFT Community Services
- North Bay Regional Health Centre
- Ontario Association of Resident's Councils (OARC)
- Providence Care Behavioural Support Services
- Schlegel Villages
- St. Joseph Healthcare London
- Sunnybrook Health Sciences Centre

RELEVANT THEORETICAL FRAMEWORKS

The following frameworks were selected to serve as the key frameworks to inform the development of the Behavioural Support Integrated Teams Transitions (BSITT) Model.

Saint Elizabeth, 2016

Person and family-centred care is an approach that acknowledges that those receiving care, their family, and their care providers all bring expertise and experience to the relationship. As such, this approach is essential in ensuring that care reflects a person's individual needs and goals.

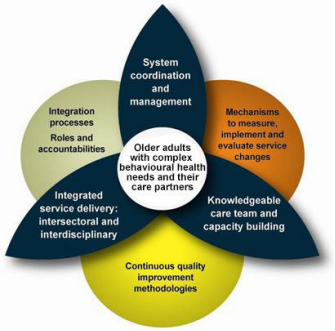
A Person and Family-Centred Approach:

- Focuses on the whole person as a unique individual and not just on their illness or condition.
- Places the person and their family at the centre of their care.
- Puts the person and their family at the heart of every decision and empowers them to be genuine partners in their care.
- Fosters respectful, compassionate and culturally appropriate care that is responsive to the needs, values, beliefs, and preferences of the person and their family.
- Supports mutually beneficial partnerships between the person, their family and health care providers.
- Shifts providers from doing something to or for the person to doing something with the person.
- Ensures that services and supports are designed and delivered in a way that is integrated, collaborative, and mutually respectful of all persons involved.

Ministry of Health & Long-Term Care, 2015

Patients First: Action Plan for Health Care Framework is an Ontario transformational health care strategy. The Framework is based on 4 key priorities:

1. Protect: protect universal public health care system – making decisions based on value and quality
2. Access: improve access – providing faster access to the right care; and
3. Connect: delivering better coordinated and integrated care in the community, closer to home
4. Inform: support people and patients – providing the education, information and transparency they need to make the right decisions about their health.



Behavioural Supports Ontario, 2011

The **BSO provincial framework** was developed as a catalyst to realign and enhance care for older adults with responsive behaviours and their care partners. It is based on three foundational pillars:

- Pillar 1: System coordination and management (coordinated cross-agency, cross-sectoral collaboration and partnerships)
- Pillar 2: Integrated service delivery (interdisciplinary outreach and support across the service continuum)
- Pillar 3: Knowledgeable care team and capacity building (strengthen capacity of service providers, older adults and families through education and continuous quality improvement).

PUTTING IT ALL TOGETHER: HOW DO THE FRAMEWORKS CONNECT?

The BSO Integrated Teams Transitions (BSITT) Model

The BSO Integrated Teams Transitions (BSITT) Model aims to serve as a best practice to improve the way people access safe quality care as they move across different care settings and different care providers. It is grounded on the founding principles of person and family-centred care, the original BSO Framework for Care and the Patients First Action Plan. It envisions an integrated health system in which providers across all sectors - long-term care, acute care, primary/home and community care - are coordinated and collaboratively work together. They actively involve the older person with complex behavioural health needs and their care partners to provide high quality care across sectors and across the disease continuum. BSITT is a health model premised on the belief that 'teams supporting teams' in collaborative transitional care equals better care and health outcomes, better value and lowered risk. Improving the quality of transitional care requires an integrated, person and family-centred, planned approach to care. This necessitates cross-sector interprofessional teams working together as a key driver to improve timely access to the right care from the right provider closer to home.

Using the BSITT Model to Develop a Transitions into LTC Guiding Checklist

Identification of Critical Elements to support Transitions into LTC

The BSITT Model was used to frame discussions related to critical elements for supporting transitions into LTC. Following the development and presentation of the model, Collaborative members engaged in a knowledge exchange of critical elements that are necessary for supporting a person's journey of moving from Community and/or Hospital (i.e., acute care) into LTC. Discussions pertaining to the surfacing of these elements were separated into three time frames:

In addition to the hosting of conversations based on the three time frames, multiple perspectives were also taken into consideration in order to ensure that the end product would reflect the needs of the person, their family care partner(s) and professional care partners at both ends of the transition.

The identified critical elements for supporting complex transitions into LTC at all stages were:

- Involvement of the person and their Substitute Decision Maker/Family at each stage of the transition;
- Communication and information sharing between the 'sending site' and the 'receiving site';
- Development of an individualized transition plan which includes the person's preferences, goals, identified responsive behaviours/personal expressions and strategies to reduce incidence of behaviours/expressions; and
- Identification of a Lead for each stage of the transition who will act as the primary contact for matters pertaining to the transition and initiate activities to support the transition.

Following the surfacing of these critical elements, the primary focus of the Collaborative's discussions was to identify how these critical elements have been or could be successfully actioned in the Ontario context. Activities that were deemed a promising or best practice were then grouped by timeframe (i.e., before, during or after the day of transition) and then transformed into a guiding checklist for easier translation of knowledge into practice. Each of the elements included in the guiding checklist is associated with one or more of the three components of the BSITT Model. This alignment is demonstrated in **APPENDIX A**.

Trialing the Checklist

Following the creation of a draft checklist, five pilot sites volunteered to trial the checklist with future patients who would be soon be transitioning from either community or hospital into LTC. Feedback from the pilot sites was collected via an online survey, directly on the form and/or during regularly scheduled Collaborative meetings. Feedback from the sites was then incorporated into the final document to ensure that the activities included were relevant to current practices amongst teams supporting the BSO population.

Case Study Example: Using the Checklist

The following case study was submitted by one of the pilot site participants; demonstrating the use of the checklist to support a transition from the community into LTC:

Patient is a 74 year old female with primary Parkinson's disease and mild dementia who was followed by our Seniors Mental Health Consultative Service and was assessed by our Care of the Elderly physician. The patient's spouse, who has a diagnosis of Lewy Body Dementia, was deemed 'crisis for long term care' due his frequent attempts to leave their home. He was placed initially and she was then deemed 'crisis' for spousal reunification at the LTC home that he moved into.

After her spouse moved in, I utilized the ***before a bed offer is made*** *section of the BSIT checklist which promotes overall preparedness for patient/family. As the identified lead for this stage of supporting the transition, I met with the patient and her family to complete a concise transitional behavioural care plan which focused on the patient's care preferences, capabilities and person centred strategies/interventions. I also provided information both verbal and written, as suggested by the checklist, regarding the upcoming transition. We were expecting a quick bed offer and therefore at the family meeting we also discussed transportation arrangements, items to bring, the admission paperwork process and the importance of bringing over the counter medications that the patient was taking regularly (Voltaren and Advil for pain) to have them ordered by the receiving facility. Once the* ***bed offer was received*** *I liaised with the in-house BSO team at the LTC home and shared a copy of the completed transition plan to the receiving facility as the patient previously signed consent to share personal health information.*

As the identified Lead ***on the day of the transition****, I linked with the LTC home team to review the transition care plan to ensure the staff were familiar with patient's preferences and care needs. This patient was willing to move, and was looking forward to being reunited with her spouse, which was especially helpful as we did not have to plan for scripting or redirection strategies.*

A few days after the transition*, I visited the LTC home and met with the embedded BSO team as well as checked in with the new resident. I linked with the physiotherapy and recreation therapy teams to review the new resident's needs and advocate for involvement in their programs. I also spoke with family to provide an update and to follow up regarding any of their questions or concerns. Ultimately, the resident had a successful transition to LTC and she and her family felt well prepared and supported throughout.*

Overall, the checklist helped to flag me to complete action items and to consider various resources and options to help support a seamless transition. Not all actions are required for every transition, depending on the patient/family/level of cognitive impairment, however it serves as a guide for staff to support best practices in transitional care support. It also helps to promote enhanced communication between care providers to ensure the timely transfer of key person centred information and to support the family through a very stressful time as care partners.

GUIDING CHECKLIST:

Supporting Transitions from Acute/Community into Long-Term Care (LTC)

Behavioural Support Integrated Teams (BSIT) Collaborative

The purpose of this Guiding Checklist is to provide a set of activities to guide teams in actioning critical elements for supporting successful and sustainable transitions for older adults presenting with, or at risk for, responsive behaviours/personal expressions as they move from either community or hospital into LTC Homes. The actions listed in the guiding checklist capture promising and best practices that have been successfully implemented at both small and large scales across Ontario for facilitating complex transitions. In addition to using the checklist to facilitate complex transitions, it may also be used in quality improvement activities aimed at improving transitions into LTC and to aid in the selection of relevant provincial/regional tools and resources to improve complex transitions.

The critical elements for supporting transitions from community/acute care into LTC include: the involvement of the person and their Substitute Decision Maker/Family at each stage of the transition; communication and information sharing between the 'sending site' and the 'receiving site'; the development of an individualized transition plan which includes the person's preferences, goals, identified responsive behaviours/personal expressions and strategies to reduce incidence of behaviours/expressions; and the identification of a Lead for each stage of the transition who will act as the primary contact for matters pertaining to the transition and initiate activities to support the transition.

Given that the identified Lead may change throughout the transition from one organization to another or one team member to another, **the Guiding Checklist includes a space whereby the Lead can be identified.** In this space, Checklist users may identify a specific person or organization that will act as the primary contact and initiator of supporting actions at each stage of the transition (e.g. Home & Community Care Coordinator, Transitions Clinician, Geriatric/Seniors Mental Health Clinician, BSO Embedded/Mobile Support Team Member etc.).

In using the checklist to support an individualized transition, it is essential to note that the intention of this checklist is for it to be used as a guide and therefore, it is not necessary to complete all items in the checklist, nor to complete them in the order listed in order to facilitate a successful transition.

PART A-1: Before Transitioning into LTC

Before a Bed Offer is Made

Team Lead Name:	Contact Information:
Actions for Team Lead to consider in initiating with Team Members and other Health Service Providers	**Actions for Team Lead to consider initiating with Person and SDM/Families & Resources to provide**
☐ Develop and implement a transitional behavioural care plan in collaboration with the person, Substitute Decision Maker (SDM)/Family and other community care providers. Consider interventions that will also be implementable once in LTC. ☐ Ensure community care providers within circle of care are aware of completed personhood tool and behavioural care plan, including where information can be found and how to use the information.	☐ Compile a personhood tool suitable for the community sector. ☐ *Resources:* General LTC Home Pamphlets, Photos & Links to Videos Online ☐ *Resources:* LTC Overview & Moving into LTC Checklist ☐ Visit LTC Homes being considered and consider bringing this LTC Inspection Checklist. ☐ Consider coaching the Substitute Decision Maker (SDM)/ other family members on strategies to discuss the move into LTC with the person via open dialogue. If refusal to move is anticipated, consider coaching the SDM on other effective strategies such as not announcing the move. ☐ Speak with friends/family members that live in LTC or have a loved one in LTC about their experiences. ☐ If it is known which LTC home the person will move into, consider a referral to the home's Social Worker to discuss cost and financing logistics.

PART A-2: Before Transitioning into LTC

After the Bed Offer is Accepted

Team Lead Name:	Contact Information:
Actions for Team Lead to consider in initiating with Team Members and other Health Service Providers	**Actions for Team Lead to consider initiating with Person and SDM/Families & Resources to provide**
☐ Determine who will act as the Lead in supporting the transition at the LTC Home. ☐ Liaise with LTC Home Lead to determine whether a BSO Team Member/other staff is able to visit the person while in the community/hospital. ☐ Organize a multidisciplinary care conference with discharge setting to discuss the person's behavioural care plan and what has worked well in the community/hospital. ☐ Share a copy of the current transitional behavioural care plan. Ensure full circle of care is aware of plan, including available information related to the person's personhood that may be relevant in the first few days following the move. ☐ Consider the person's personhood and whether meeting with a current resident of the LTC Home (in-person, via videoconference or over the telephone) may be helpful. If so, initiate this process with the LTC Home Lead. ☐ Support and/or lead the medication reconciliation process; including information regarding recent medication changes relevant to current responsive behaviours.	☐ *Resource:* Moving Day Checklist ☐ Offer a meeting to develop a plan with the SDM for the move. ☐ Complete paperwork that can be done in advance of the day of the move. ☐ Bring in familiar items into the person's room before the day of the move. ☐ Determine on what day and time the person is often at their best and discuss preferred transition time and rationale with the LTC home. While a holding fee may be charged, a bed can be held for 5 days before it is required that the person move in. ☐ Consider coaching the SDM/ Family Members on strategies to discuss the move, including techniques to address anticipated reluctance such as scripting or using fiblets. ☐ Discuss with SDM/Family Members the potential of bringing an additional person alongside on the day of the move to stay with the person while SDM completes paperwork. Discuss what strategies may be helpful for leaving the home following the move.

PART B: On the Day of the Transition

Before Leaving to Travel to the LTC Home

Team Lead Name:	Contact Information:
Actions for Team Lead to consider in initiating with Team Members and other Health Service Providers	**Actions for Team Lead to consider initiating with Person and SDM/Families & Resources to provide**
☐ Confirm with the LTC Lead that they are prepared and confirm contact details to be provided to person and family. ☐ Plan to have a familiar face for both the new resident and family upon arrival at the LTC Home.	☐ Review Moving into LTC Checklist & Moving Day Checklist. ☐ Ensure person has taken all necessary medication and that pain is managed. ☐ Ensure adequate time to travel to LTC Home, including potential planned stopped required to comfort the person.

After Arriving at the LTC Home

Team Lead Name:	Contact Information:
Actions for Team Lead to consider in initiating with Team Members and other Health Service Providers	**Actions for Team Lead to consider initiating with Person and SDM/Families & Resources to provide**
☐ Introduce person and family to LTC BSO Staff Member/Team ☐ Schedule touch points with Substitute Decision Maker based on LTC home's policies.	☐ Recommend to SDM when might be the best time to complete final paper (e.g., when person is engaged in an activity, having a meal, etc.) ☐ *Resource:* Residents' Bill of Rights ☐ *Resource:* (if available) one-page resource consisting of names, titles and/or photos of key LTC contacts, including the Administrator, Director and Associate Director of Care, Residents' Council Representative, Family Council Representative, BSO Staff, etc.

PART C: Following the Transition

In the First few Days

Team Lead Name:	Contact Information:
Actions for Team Lead to consider in initiating with Team Members and other Health Service Providers	**Actions for Team Lead to consider initiating with Person and SDM/Families & Resources to provide**
☐ Review the Transitional Behavioural Care Plan initiated in the community for adaptation into LTC. Consider initiating a DOS and/or CMAI to determine the impact of the transition (i.e., change of environment and surroundings) has impacted the presence and severity of behaviours. Remember P.I.E.C.E.S.! ☐ Determine how to best communicate and/or display information related to the resident's personhood. ☐ Ensure that the staff who are supporting the resident receive information and training on particular approaches and techniques to be used with the resident. ☐ Encourage other LTC staff to introduce themselves to the new resident and welcome them to the home (e.g., activation, dietary, maintenance, etc.) ☐ Ensure Residents' Council Leader is introduced to new resident. Suggest that Resident Council Leader provide person with a calendar of events and Residents' Council meeting schedule. When appropriate, encourage Residents' Council Leader to establish a 'buddy system' with another resident with whom the new resident may have elements of personhood in common. ☐ Prepare for first 'Touch Point' Meeting 5 days post admission; liaise with other LTC Staff Members to gain a current status of the new resident.	☐ *Resource:* Tips for Settling in ☐ Review information on personhood form to ensure that it remains accurate; updating necessary sections based on person's capabilities, change in interests, etc. ☐ Ensure Family Council Leader is introduced to Family/Substitute Decision Maker and is provided with meeting schedule.

Following a few weeks

Team Lead Name:	Contact Information:
Actions for Team Lead to consider in initiating with Team Members and other Health Service Providers	**Actions for Team Lead to consider initiating with Person and SDM/Families & Resources to provide**
☐ Monitor the residents' responsive behaviours over time using P.I.E.C.E.S. and modify the behavioural care plan as needed. Ensure staff are made aware of changes being made to the behavioural care plan. ☐ Prepare for second 'Touch Point' 6-12 days following the admission; liaise with LTC Staff Members to gain a current status on the resident. Discuss discharging of resident from Community Caseload at this time.	☐ Ensure Family is aware of ongoing support available through Alzheimer Societies and various Online Groups.

HYPERLINKED RESOURCES IN CHECKLIST:

Part A-1: Before a Bed Offer is Made:

- 'Personhood tool suitable for the community sector' Behavioural Supports Ontario Lived Experience Advisory (2018) Recommendations to enhance the use of personhood tools to improve clinical care across sectors. Available at: https://tinyurl.com/yxcb46mq
- 'LTC Overview' Government of Ontario (Apr 2019) Long-term care overview.
  Available at: https://tinyurl.com/y3jaop2u
- 'Moving into LTC Checklist' Alzheimer Society of Canada (Nov 2017) Finding the right home.
  Available at: https://tinyurl.com/y2x3bs5w
- 'LTC Inspection Checklist' Concerned Friends (2007) Long term care homes checklist.
  Available at: https://tinyurl.com/y6koq6jc

Part A-2: After the Bed Offer is Accepted:

- 'Moving Day Checklist' Alzheimer Society of Canada (July 2016) Handing moving day.
  Available at: https://tinyurl.com/y2rk9968

Part B: On the Day of the Transition:

- 'Moving into LTC Checklist' Alzheimer Society of Canada (Nov 2017) Finding the right home.
  Available at: https://tinyurl.com/y2x3bs5w
- 'Moving Day Checklist' Alzheimer Society of Canada (July 2016) Handing moving day.
  Available at: https://tinyurl.com/y2rk9968
- 'Residents Bill of Rights' Advocacy Centre for the Elderly & Community Legal Education Ontario (2008) Every resident: bill of rights for people who live in Ontario long-term care homes.
  Available at: https://tinyurl.com/y3uwpv3l

Part C: Following the Transition:

- 'Tips for Settling in' Alzheimer Society of Canada (Aug 2018) Tips for settling in.
  Available at: https://tinyurl.com/yysgmt7a

APPENDIX A

Critical Elements' Alignment with BSITT Model

Timeline	Critical Element	System Coordination & Management	Integrated Service Delivery: Intersectoral & Interdisciplinary	Knowledgeable Care Teams & Capacity Building
Before a Bed Offer is Made:	Discuss with person and family why transition into LTC is necessary via an open and respectful dialogue.	✓		✓
	Develop and implement a transitional behavioural care plan in collaboration with the person, family and other community care providers. Consider interventions that will also be implementable once in LTC.	✓	✓	
	Ensure community care providers within circle of care are aware of completed personhood tool and behavioural care plan, including where information can be found and how to use the information.		✓	✓
	Resources: General LTC Home Pamphlets, Photos & Links to Videos Online			✓
	Resources: LTC Overview & Moving into LTC Checklist			✓
	Visit LTC Homes being considered and consider bringing this LTC Inspection Checklist			✓
	Call Concerned Friends (1-855-489-0146) to discuss LTC homes being considered. This organization can provide information related to inspection report findings over recent years.	✓		✓
	Speak with friends/family members that live in LTC or have a loved one in LTC about their experiences.			✓
	Compile a personhood tool suitable for the community sector.	✓		✓

Timeline	Critical Element	System Coordination & Management	Integrated Service Delivery: Intersectoral & Interdisciplinary	Knowledgeable Care Teams & Capacity Building
After the Bed Offer is Accepted:	Reinitiate conversation regarding the necessity of the transition with the person and their family. Consider any changes to capacity, cognition and capabilities.* Determine who will act as the Lead in supporting the transition at the LTC Home.	✓		
	Determine who will act as the Lead in supporting the transition at the LTC Home.	✓		
	Liaise with LTC Home Lead to determine whether a BSO Team Member is able to visit the person while in the community.		✓	
	Organize a multidisciplinary care conference with discharge setting to discuss the person's behavioural care plan and what has worked well in the community/hospital.	✓		✓
	Share a copy of the current transitional behavioural care plan and modify if necessary.		✓	
	Consider the person's personhood and whether meeting with a current resident (in-person, via videoconference or over the telephone) may be helpful. If so, initiate this process with the LTC Home Lead.	✓	✓	
	Ensure medication reconciliation process is completed.	✓		
	Resource: Moving Day Checklist			✓
	Complete paperwork that can be done in advance of the day of the move.	✓		
	Bring in familiar items into the person's room before the day of the move.	✓		
	Determine on what day and time the person is often at their best and discuss preferred transition time and rationale with the LTC home. While a holding fee may be charged, a bed can be held for 5 days before it is required that the person move in.	✓	✓	

Timeline	Critical Element	System Coordination & Management	Integrated Service Delivery: Intersectoral & Interdisciplinary	Knowledgeable Care Teams & Capacity Building
Before Leaving to Travel to the LTC Home:	Confirm with the LTC Lead that they are prepared and confirm contact details to be provided to person and family.	✓		✓
	Plan to have a familiar face for both the new resident and family upon arrival at the LTC Home.		✓	
	Discuss with Substitute Decision Maker and Family potential indications for when may be the best time and strategies to leave the LTC Home once the person has moved in.	✓		✓
	Review Moving into LTC Checklist & Moving Day Checklist			✓
	Ensure person has taken all necessary medication and that pain is managed.	✓		
	Ensure adequate time to travel to LTC Home, including potential planned stopped required to comfort the person.	✓		
After Arriving at the LTC Home:	Introduce person and family to LTC BSO Staff Member/Team.			✓
	Provide LTC Lead with completed personhood tool and/or ensure that Staff (including Primary Personal Support Worker) are familiar with the person's background, interests, likes and preferences.	✓	✓	✓
	Schedule touch points with Substitute Decision Maker, LTC Lead and BSO Staff Member/Team (1) 5 days following the move; (2) within 6-12 weeks following the move; and (3) 6 months following the move.	✓	✓	✓
	Recommend to Substitute Decision Maker when might be the best time to complete final paper (e.g., when person is engaged in an activity, having a meal, etc.)	✓		✓
	Resource: Residents' Bill of Rights	✓		✓
	Resource: (if available) one-page resource consisting of names, titles and/or photos of key LTC contacts, including the Administrator, Director and Associate Director of Care, Residents' Council Representative, Family Council Representative, BSO Staff, etc.			✓

Timeline	Critical Element	System Coordination & Management	Integrated Service Delivery: Intersectoral & Interdisciplinary	Knowledgeable Care Teams & Capacity Building
In the First few Days:	Review the Transitional Behavioural Care Plan initiated in the community for adaptation into LTC. Consider initiating a DOS and/or CMAI to determine the impact of the transition (i.e., change of environment and surroundings) has impacted the presence and severity of behaviours. Remember P.I.E.C.E.S.!	✓	✓	
	Determine how to best communicate and/or display information related to the resident's personhood.		✓	✓
	Ensure that the staff who are supporting the resident receive information and training on particular approaches and techniques to be used with the resident.		✓	✓
	Encourage other LTC staff to introduce themselves to the new resident and welcome them to the home (e.g., activation, dietary, maintenance, etc.)		✓	✓
	Ensure Residents' Council Leader is introduced to new resident. Suggestions that Resident Council Leader provide person with a calendar of events and Residents' Council meeting schedule. When appropriate, encourage Residents' Council Leader to establish a 'buddy system' with another resident with whom the new residents may have elements of personhood in common.	✓		✓
	Prepare for first 'Touch Point' Meeting 5 days post admission; liaise with other LTC Staff Members to gain a current status of the new resident.	✓		✓
	Resource: Tips for Settling in			✓
	Review information on personhood form to ensure that it remains accurate; updating necessary sections based on person's capabilities, change in interests, etc.		✓	
	Ensure Family Council Leader is introduced to Family/Substitute Decision Maker and is provided with meeting schedule.		✓	✓
Following a few weeks:	Monitor the residents' responsive behaviours over time using P.I.E.C.E.S. and modify the behavioural care plan as needed. Ensure staff are made aware of changes being made to the behavioural care plan.	✓	✓	✓
	Prepare for second 'Touch Point' 6-12 days following the admission; liaise with LTC Staff Members to gain a current status on the resident. Discuss discharging of resident from Community Caseload at this time.	✓		✓
	Ensure Family is aware of ongoing support available through Alzheimer Societies and various Online Groups.		✓	✓