Behavioural Supports Ontario
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Guiding Checklist

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

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