MYTHS VS. FACTS

My Transitional Care Plan© (MTCP)

Myths	Facts
The MTCP is to time-consuming to complete and does not improve the efficiency or quality of care.	Completing the MTCP before the transition saves time by clearly communicating the patient's/resident's immediate needs and functional status, and more, enabling efficient and effective person-centred care. Information from the MTCP can also be transferred to permanent care plans, further streamlining the process.
Using the MTCP, and identifying current responsive behaviours/ personal expressions, needs etc. might result in a long-term care home admission refusal/ decline.	The MTCP includes space to identify and describe responsive behaviours, along with successful strategies and helpful tips to prevent and/or respond. The MTCP is intended to support the individual's care and transition, and does not impact eligibility or decisions regarding long-term care home admissions.
The MTCP does not benefit the resident/patient; it is simply an additional form to complete.	The MTCP consolidates a summary of essential information from existing care plans into a single document to be shared between care team members at both the current and new location. This continuity of care facilitates a smoother transition and increases person-centred care during the transition into the long-term care home.
Only one PRC or BSO team member can/should complete the MTCP and care partners/ Substitute Decision Makers (SDM) have no role in the completion of the MTCP.	All BSO team members and healthcare providers involved in assessment or care planning can use the MTCP. Multiple contributors are encouraged, each signing their section. Users should collaborate with team members, the patient/resident, and their care partners/ SDM (if applicable) to obtain the most accurate information.