KnowledgeBITE

PSYCHOGERIATRIC NEWS AND INFORMATION FOR PRIMARY CARE PRACTITIONERS

Editor's remarks: *This is the 15th issue of the PRC-PC Newsletter, providing quick tips and useful information to fit your fast-paced work environment and to help you in the care of patients with dementia. As the seasons change and we make our transition to fall I would like to dedicate this issue to transitions in particularly transition to Long Term Care. Families struggle with this emotionally laden and conflicting transition which can be traumatic for their loved one with dementia. In this issue we discuss the use of decision resources and the provision of guidance to support this complex transition* (Einat Danieli – OT.Reg. Ont; PRC-PC).

GOOD TO KNOW ABOUT

The Reitman Centre CARERS Program at Mount Sinai Hospital, now offers caregiver services for caregivers who their family members are in Long Term Care follow the link above for more information.

TIP OF THE MONTH

LTC transition tips you can share with families:

1. There is a lot of paper work involved in the transition – it is best to start early and gradually collect all the necessary forms and information.
2. Learn as much as you can about the home in advance
3. Suggest the family use the about me booklet about the PWD to enable the staff to learn their history and serve them better
4. Some Nursing homes host day programs. Try and have the PWD attend the day program to help them become familiar with the facility and the staff
5. Bring familiar and meaningful objects/furniture to the room such as: A favorite chair, pictures, books; etc. Consider bringing these items gradually and not all at once to avoid confusion.
6. Suggest that the family discuss with the home prior to the PWD's transition into the home regarding the person's ability to accept support with personal care in the first days and create a plan to support that and set expectations accordingly from both the PWD and the staff. There should also be some discussion about how often the family/POA should be visiting in the first few days and weeks.

OUR DEMENTIA 'TOOLBOX'

The Alzheimer's Society of Ottawa has a number of guides and modules that can support families in planning a transition to LTC. See more in this Link.

STORIES FROM THE PRC-PC CONSULT SERVICE

The following case represents a composite of several recent transitions

Situation: *An 80 years old woman with dementia has become increasingly unsafe and dependent in her self-care. Her niece who is her only relative and POA for treatment and personal care, turned to the physician and informed that she would like to place the patient in a Long Term Care (LTC) facility as she feels overwhelmed with care needs and that the patient cannot be cared for safely at her home. The niece is concerned about her aunt's reaction to the transition and that she will not agree to come willingly.*

Background: *The patient was diagnosed with dementia 4 years earlier and was receiving some support from personal support workers but is refusing their assistance. She was assessed by CCAC for capacity to LTC and was found incapable and her POA was invoked. Since that time. She has become increasingly dependent on her niece. Her niece has a full time job and young children and she is feeling torn between her multiple responsibilities and can no longer keep her aunt safely at home. Until about a year ago the patient was receiving some support from Personal Support Workers (PSWs) at home but gradually became suspicious of the PSWs and refused their assistance. Several months ago a LTC application was filed and CCAC now estimates that a bed may become available within the next week.*

Knowledge To Practice Assessment: ***Things to consider and suggestions***:

Whether the person is incapable or not it is important to try and follow their wishes but in some situation it may not be realistic and the decision should balance everyone's involved needs including the caregiver. In these types of situations where the person has no insight into their challenges and is incapable of making LTC decisions, we need to consider the pros and cons of letting the patient know in advance that he/she will be going to a LTC facility. Usually once a LTC bed is offered the decision has to be made within 24 hours and the transition within the week so there is very little time for planning. Here are some resources to consider and involve in the transition to make it a better one:

- Help the niece decide on whether advanced discussion will be helpful
- Encourage completion of the All About Me booklet of the Alzheimer's Society and assist in completing it as relevant
- Suggest engaging the LTC-Home social worker in planning the transition
- Encourage the LTC-Home to engage a Psychogeriatric Resource Consultant for transitions assistance

Here are some resources to consider and involve in the transition to make it a better one:

- Have the LTC home Social Worker involved by compiling collateral information about the patient and coordinating a planning meeting between the family ,community care team and the LTC-Home staff to coordinate transition.
- Consider asking if the LTC home has a Psychogeriatric Resource Consultant that can consult on transition planning
- If responsive behaviours are anticipated especially when transition is done against one's own will it would be important to have the Behaviour Support Outreach in LTC team involved in supporting everyone involved throughout the transition.
- See more tips for transition in our Tip of the Month Section on the left.

For additional information, support, resources or case-based consultation, please contact your PRC-PC directly at: 416-586-4800 ext. 5251 or edanieli@mtsinai.on.ca or visit our website at www.mountsinai.ca/reitman/prc-pc

Baycrest INNOVATIONS IN AGING

Ontario Toronto Central Local Health Integration Network

PRCP psychogeriatric resource consultation program of toronto

MOUNT SINAI HOSPITAL Joseph and Wolf Lebovic Health Complex
The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer's Support and Training

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