

Improving Long-Term Care Now and Beyond the Pandemic for People Living with Dementia:

Submission to the Ontario
Long-Term Care COVID-19
Commission

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Key Recommendations:

1. Commit to a minimum level of dementia-specific education and training for all LTC staff, including as part of ongoing professional development.
2. Guarantee safe, ongoing access of care partners to their supported resident at all times.
3. Mandate that homes allow access to activation support for new residents, especially those living with dementia, as they transition from the community or hospital to LTC including during any required period of post-admission self-isolation.
4. People living with dementia are to be free from discrimination of any kind. They have a right to care and must not be discriminated against when needing to move into LTC based on their diagnosis of dementia.

About the Alzheimer Society

The Alzheimer Society is a Federation of 29 community support providers, operating in every corner of Ontario. We support over 85,000 clients each year, including both caregivers and people living with dementia both in the community and long-term care. We provide education and training to physicians and other health and long-term care professionals, as well as the general public. With hundreds of staff and thousands of volunteers, we seek to alleviate the personal and social consequences of Alzheimer's disease and other dementias, and promote research into a cure and disease-altering treatment.

Introduction

The COVID-19 pandemic has shaken every aspect of our day-to-day lives. For most this has taken the form of isolation, loneliness, and delayed life milestones, as our society presses pause to combat this virus. No where have the negative repercussions of COVID-19 been more severe, more pronounced than in our long-term care (LTC) homes. We have failed to protect our most vulnerable, around the world and especially in Canada. Homes where people should feel safe and welcome have been turned into places of confinement, with many residents passing the days without interaction or stimulation—and far too many spending their final days this way.

Compared to other OECD countries, Canada has the highest proportion of COVID-19 deaths occurring in LTC homes.³ Ontario is one of three provinces to have seen over 70% of its COVID-19 fatalities occur in LTC homes.³ These devastating figures are not normal, not acceptable, and we owe it to those who have lost their lives to ensure they are never again repeated.

The rapid spread and detrimental toll in Ontario's LTC homes highlights many pre-existing issues of the LTC system. Chronic understaffing, inadequate living accommodations, and leadership and communication issues are just some of the long-standing challenges that were exacerbated once COVID-19 entered Ontario LTC homes.

Dementia and long-term care are inseparable. With two-thirds of LTC residents in Ontario living with a diagnosis of dementia,^{7,18} any meaningful reform in LTC homes must recognise and prioritise the unique needs of residents living with dementia. The Alzheimer Society of Ontario is committed to alleviating the personal and societal consequences of dementia, both in the community and LTC. We are grateful for the interim recommendations put forward by the Commission, and for the opportunity to bring forward concerns expressed by our staff and clients. We thank the Commission for considering our recommendations, which we put forward in the sincere hope that they will contribute to a more

dignified, person-centred, and compassionate LTC system. LTC residents deserve better, and we must do better.

1. Education and Training in LTC Staff

Recommendation: Commit to a minimum level of dementia-specific education and training for all LTC staff, including as part of ongoing professional development.

1.1 Supporting Needs in Dementia Care

People with a diagnosis of dementia currently make up nearly two-thirds of residents in Ontario's LTC homes^{7,18}—many of whom live with other advanced medical conditions and over 85% displaying responsive behaviours as the disease progresses.^{7,13} Caring for residents with a diagnosis of dementia requires more time and attention from staff to assist with complex needs that may be challenging at times due in part to decreasing mental acuity, responsive and reactive behaviours, and higher risk of injuries as the disease progresses. Chronic understaffing in LTC homes has worsened since the start of the pandemic, resulting in further declines to staffing levels due primarily to isolation requirements after virus exposure, challenging working conditions such as access to personal protective equipment (PPE), fear and anxiety of contracting COVID-19, and government orders prohibiting staff from working at multiple homes.^{13,14} Such shortages have made providing basic care for residents living with dementia even more challenging as staff are now also monitoring residents for COVID-19 symptoms¹⁴ and trying to follow new IPAC protocols.

When staff are educated and trained to support ongoing complex needs through evidence-informed dementia interventions, best practices, and therapies there can be a direct improvement to the daily quality of life for residents living with dementia.¹³ The quality of care and the quality of life for LTC residents depends on an adequate supply of skilled and qualified staff available to meet the complex clinical, social, and daily living needs for residents living with dementia. It is important and necessary that staff recruitment efforts address the requirement for up-to-date training and education in dementia care and make this part of the minimum standard in LTC staffing in order to fully meet the care needs of residents in LTC.

1.2 Supporting Staff in Their Work

Education and training in dementia care are not only important for the residents living with dementia but are important for the staff working in long-term care as well. When staff lack proper education and training in dementia care, they may feel insufficiently prepared and/or supported to care for residents, which in turn may negatively impact their mental health and emotional well-being at their place of work.¹³ Recent staffing studies show that there are disparities between educational experience and the working environment.¹³ Educators tend to teach the ideal environment, while the pace and nature of work in LTC can be more challenging than what students are prepared for in training.¹³ Part of this can be attributed to the rising complexity of resident needs and staffing shortages, both of which have worsened in the wake of the pandemic. As a result, some LTC staff such as PSWs may be assigned increased responsibilities that fall outside of their scope of practice due to lack of staff on shift, risking potential harm or injury to the resident if improper care techniques are performed.² Unpreparedness and increased pressure at work may lead to higher staff turnover, ultimately having negative impacts on the residents who will lack continuity of care—a challenge affecting many residents living with dementia

who need consistency in their care plans.¹³ Low staff to resident ratios, an improper mix of staff skill sets, and higher staff turnover creates environments with little resilience to adverse events such as the COVID-19 pandemic, leaving LTC residents to exposed to unnecessary risk.⁹

Knowledge of how dementia can impact behaviour and care needs is essential for any staff member in an LTC home. This understanding will help frontline and supervisory staff work as a team to develop individualised support strategies for residents living with dementia, and promotes a common knowledge base, values, language, and approach to care among all staff responsible for a resident's wellbeing. Integrating specialised in-home resources, such as Behavioural Supports Ontario (BSO), can further help LTC staff to manage the steady growth in resident complexity by providing residents with individualised care, particularly as it relates to responsive behaviours. BSO teams use a coaching approach to teach LTC staff how to better communicate with residents and family members, gain a deeper understanding of behavioural responses, and help to identify ways to reduce resident distress.²⁶ According to a 2019 report, half of Ontario's LTC homes do not currently have in-house BSO resources to help manage responsive behaviours among LTC residents.²⁴ These specialised in-home resources provide meaningful, round-the-clock support to an increasingly complex resident population while also enhancing the knowledge and skills of LTC staff.

During the pandemic, BSO staff embedded within some LTC homes have been diverted away from their specialised role and assigned to duties usually fulfilled by a PSW or other frontline staff without a BSO designation. While an acceptable last resort to respond to a temporary, one-time staffing crisis (for example, an unforeseeably high number of sick days taken), BSO staff cannot be requisitioned as a long-term solution to address operational staffing shortages. This is a waste of training, and negatively impacts residents that would benefit from an individualised care plan and assessment, as well as all other LTC home staff who are being deprived of the knowledge exchange offered by an embedded BSO staff member. BSO staff must be free to fill the crucial role for which they have been trained.

It is necessary and essential that ongoing up-to-date education and training in dementia care be required for LTC staff to feel supported and equipped in their role, and for residents to feel they are receiving the compassionate and dignified care they expect and deserve. Recognising that staffing levels are already well below what is acceptable, and homes often lack the resources to cover a staff member who misses one or more shifts to attend vital training, the Ministry of Long-Term Care should provide backfill support to ensure homes are not penalised for offering development opportunities and education for both frontline and supervisory staff.

1.3 Education and Training Moving Forward

In early November, the Ministry of Long-Term Care announced the launch of a new recruitment program to support the LTC sector.⁶ While seeking individuals to join LTC staff, the Ministry of Long-Term Care is encouraging those who are unemployed or displaced from work, specifically from retail, hospitality, administration, and students to enter the workforce to help those living in LTC. The announcement expressed that this work will be personally satisfying and greatly improve the quality of life of Ontarians living in LTC by helping our front-line staff.⁶ The new role of Resident Support Aides will assist with activities of daily living, including assistance during mealtimes and nutrition breaks or with the coordination of visits and support with technology or recreational activities. Individuals interested in the program will be screened, trained, and matched with a LTC homes in need of support.

To ensure proper training, candidates will be asked to complete online modules focusing on IPAC, PPE, and to “review an overview of long-term care and seniors care”.⁶ In Ontario, PSWs must graduate from a certified program at an Ontario college to attain their credentials, a process that takes several months or, in some programs, over a year. As previously noted, nearly two-thirds of residents in LTC live with a diagnosis of dementia and require trained and experienced staff to provide proper and appropriate care. A “review” of an “overview” on caring for residents in LTC, many of those with complex needs, is not sufficient for neither the resident nor the new staff member. Staffing shortages experienced in homes where many of these new workers will be assigned will inevitably result in aides being asked to perform duties they are not qualified to perform – as has already been the case with other care aides offering assistance. While extra hands may provide some relief to LTC staff, there are also risks associated with undertrained and inexperienced staff that could result in injury—a scenario unfair to both the worker and to the resident. Caring for our most vulnerable must be a duty entrusted only to those with the proper training for their specific role. We caution that these temporary measures may become permanent, resulting in further care disparities in our LTC system. The Alzheimer Society supports the principle of staff positions dedicated primarily to resident activation and engagement, such as the new RSA role, however we feel strongly that LTC homes require the right mix of staff who are properly trained and educated to fill the duties of their role. The Alzheimer Society is one of several organisations that offers education and training suitable for LTC home staff. We strongly suggest that the Commission insist on a minimum standard of education and training for LTC home management and staff which includes a requirement for dementia specific education, and that this requirement not be waived for any resident-facing staff—including RSAs and similar positions.

2. Social Isolation

Recommendation: Guarantee the safe, ongoing access of care partners to their supported resident at all times.

2.1 Impacts of Social Isolation on People Living with Dementia

To date, over 80% of COVID-19 deaths in Canada have occurred amongst older adults in LTC settings.^{3,16} Learning from the first wave, these settings have better prepared themselves upon entering the second wave. Despite these preparations, many LTC homes continue to restrict access once again to outside visitors and family care partners.¹⁴ These measures create renewed concerns about how this will further continue to negatively impact the health and wellbeing of residents.

Older adults who are clinically vulnerable, such as those with a diagnosis of dementia, are more susceptible to severe effects of COVID-19, either directly by the infection or indirectly due to strict social isolation measures enacted in LTC homes.^{12,23} While the Ministry of Long-Term Care has made attempts to recognise the necessity of care partners in LTC while also addressing risks of crowding and IPAC measures, compliance with directives on access and visitation has been found to be inconsistent with many homes who continue to place their own restrictions on visitors and care partners.¹⁶ Results of these restrictions paired with severely understaffed homes have meant that some residents have been isolated for months, spending all day and every meal trapped alone in their rooms.⁴ Residents remain victims of policies that fail to take a person-centred approach to care, leaving them physically and emotionally distressed. Such policies are out of touch with the needs of residents and are causing irreversible damage²³ that some residents and their families claim are more harmful than the virus itself.⁸

LTC residents are older and more frail than in the past. A third of residents rely entirely on staff for activities of daily living, with a diagnosis of dementia adding an additional layer of complexity for higher-needs residents.¹⁰ As resident complexity increases, staffing resources have not kept pace with the changing demographics inside LTC homes.¹⁰ Coupled with the ongoing pandemic, staffing shortages within LTC homes has reached a crisis level. Prior to the pandemic, family care partners have often made up for this shortfall by providing countless hours of care and socialisation to their loved ones¹⁴—essential to their quality of life. Approximately two out of three care partners for someone living in an LTC home say homes see them as playing a critical role in the care team, especially for those with dementia whose care partners provide more hours of care on average than those providing care to adults without dementia.^{17,20} By limiting care partner access to residents we will continue to indirectly deprive the residents of their basic care needs,²³ which for some could be the difference between a full meal or the ability to get out of bed in the morning—while also violating the Resident’s Bill of Rights.¹¹

While LTC homes have made necessary adjustments embracing new technologies to allow residents to virtually visit with families and participate in activities, some homes have not been able to offer the appropriate person-centred alternative to these essential visits and video conferencing is not always suitable for people with moderate to advanced dementia.⁵ Some residents may lack the technical proficiency to use such devices or residents may lack access to communication technology as many homes struggle to provide each resident with ongoing access to sufficient resources.⁴

Prolonged isolation and loneliness resulting from restricted care partner access risks irreversible emotional and physical harm to the resident, especially those living with dementia, including decreased mobility, depression, increases in responsive behaviours, and deterioration in functional and cognitive ability.^{5,12,16} Family and friends provide crucial social support, from hands-on assistance to ensuring that staff understand who a resident is as a person: each with their own unique life history and health care needs. It is important that when implementing IPAC measures in LTC homes, that policies stray away from a one size fits all approach as this is neither optimal nor practical. We must use an approach guided by equity and based on the individual care needs of each resident to promote health, well-being, and quality of life.

2.2 Social Isolation Implications for Communication

Addressing care partner access is only one of many steps needed to improve quality of care for LTC residents. Reports from the Patient Ombudsman identified that communication between homes and families of residents was severely compromised in many homes across the province during the pandemic. Additionally, some staff reported inadequate and inconsistent internal communication in their homes, resulting in poor hand-offs and compromised care for residents.²¹ Given the inability to visit residents paired with rapid spread of the virus and understaffed homes, care partners reported that the lack of communication was very distressing and many felt significantly less informed about the health of the person they are caring for than before the outbreak began.^{20,21} For residents living with dementia, lack of communication takes a more detrimental toll on their health. Many of these residents have care partners or substitute decision makers (SDMs) who are responsible to make important health care decisions when the resident themselves is not able to do so. With decreased communication, many are left unable to see and speak with their family member or friend. They are left in the dark, unable to make well-informed decisions in the best interests of the person for whom they are caring.²¹

Poor communication has been noted as the root of many complaints over the past several years of Patient Ombudsman operations.²¹ Since the pandemic, communication concerns have been exacerbated. There simply is not enough staff or resources to manage adequate communication. This long-standing issue violates the Residents' Bill of Rights, which guarantees residents the right to communicate in confidence without interference.¹¹ As noted by the Patient Ombudsmen, this right does not include any specific rights for the family members or SDMs of the residents. While people living with dementia account for a majority of residents in LTC homes across the province, with many unable to make care decisions in the absence of a care partner or SDM, we suggest that LTC homes implement a policy related to ongoing and effective communication with care partners or SDMs, recognising that these partners in care play a crucial role in care planning and delivery for many residents in LTC homes. Furthermore, homes should be proactive and transparent by establishing a communication plan that includes regular updates to families and care partners. It is important to share with families and care partners what the home is doing in terms of screening, outbreaks, and status of their loved one and the home.

3. Transitioning to LTC

Recommendation: Mandate that homes allow access to activation support for new residents, especially those living with dementia, as they transition from the community or hospital to LTC including during any required period of post-admission self-isolation.

3.1 Transitions to LTC

Residents living with dementia—who constitute a majority of residents in Ontario LTC homes—are more vulnerable to breakdowns in care compared to residents without dementia, and thus have greater need for transitional care services.¹⁵ Studies suggest that lack of planning and poor “handoff” of these older adults from their current care setting, be it community or hospital, to LTC is linked to adverse events, low satisfaction with care, and higher rates of hospital re-admission.¹⁵ Other factors that contribute to gaps in care during transitions to LTC include poor communication between staff, care recipients, and care partners; incomplete transfer of information; inadequate education and skills of dementia care by staff; and the absence of a single point person to ensure continuity of care.¹⁵

Factors such as those previously listed are not new and have long existed within Ontario's LTC system. The current climate of the COVID-19 pandemic has exacerbated these long-standing issues, resulting in greater adverse events and lower satisfaction in care. Many documents have been developed in light of these shortfalls to help provide guidance to staff and volunteers in LTC homes to assist in transitions and activation for residents while isolation protocols are in effect.¹⁸ However, while these guidance documents offer excellent care options, especially for those living with dementia who require increased activation support, LTC homes are challenged with severe staffing shortages and may not have the necessary resources nor time available to spend with new residents as they transition to their new care setting. For a person living with dementia who is already more likely to experience responsive behaviours from a change in routine or environment, this could mean they go hours alone in their new care setting without the crucial support to assist in daily tasks that promote quality of life—a situation that may leave them feeling confused, stressed, helpless, and abandoned. We strongly encourage the addition of activation aid roles in LTC for transitioning residents to provide much needed continuity and reassurance during this period of extreme stress. Such roles support the Alzheimer Society's recommendation to enact regulatory changes under the *Connecting Care Act, 2019*, whereby we suggest

including LTC homes as an eligible setting for home and community care services. Expanding service locations to include LTC is one way to alleviate some staff burdens in LTC homes and reduce avoidable hospital visits following a move to LTC. While not replacing the role of LTC staff in providing intensive support to a resident, the home and community care sector is well positioned to support residents in the crucial two-weeks following a move to LTC. Home and community care staff would be a familiar face among a changing environment, as they have already established a relationship with the resident and have been shown to make a positive difference in their life.

3.2 Program Success

Transitioning to LTC is a traumatic experience for both the resident and those closest to them. The stress of an entirely new and unfamiliar environment is compounded by severe restrictions on a resident's right to see family, friends, and care partners, including mandatory two-week isolation periods immediately following admission—the timeframe when residents most need support, and are at highest risk of re-admission to hospital. While isolation continues to be an effective way to reduce transmission and spread of the virus, it can be a challenging situation for someone who has just moved to a new environment, especially for those living with dementia who may not fully understand the rules around isolation. Compounded by staffing shortages, new residents are not experiencing the same type of one-on-one care they require when moving to a new care environment leaving many with increased fear, anxiety, loneliness and lack a sense of belonging. Procedures around PPE are also limiting how some staff interact with residents in isolation; rather than “gown up” to enter a resident's room, some of our clients report that staff will stand at their doorway and verbally check on them, an approach that is not only cold and impersonal but also risks missing some risks to physical health such as signs of a recent fall the resident may not consider serious.

The High Intensity Needs Fund provided by the provincial government has allowed some organisations to plan and implement new pilot programs to support the needs of those they serve. A notable project developed by the Alzheimer Society of Sudbury-Manitoulin North Bay and Districts and the North East BSO LTC integrated team, in partnership with the North East LHIN, has had recent success in helping those living with dementia transition from their current care environment to LTC by providing enhanced one-on-one activation support to those requiring a 14-day self isolation period. This project recognises that moving to LTC is stressful, especially when moving in a short period of time to a new environment with many new faces and surroundings. With coordination of the care team (e.g. LHIN manager, BSO lead and the administrator of the LTC home, the new resident and their care partner) an assessment and transitional care plan is developed for the person moving to LTC. A transitional support worker employed by the Alzheimer Society is partnered with the individual for the 14-day self-isolation period to assist with daily tasks and ease the transition to the home. It is important to note that a transitional support worker is not there to provide personal care duties assigned to staff from the LTC home.

Requirements to fulfill transitional support roles respond to staffing shortages by offering positions to people working outside of home and community care who are qualified to perform activation work for people living with dementia and come from backgrounds such as social support workers, occupational therapy assistants, physical therapy assistants, and health promotion. Further details regarding this project and its mapping process can be found in Appendix A of this document. It should be noted that this is currently only a pilot project with limited funding until March 2021. However, while only implemented in November, uptake of this project has been very successful with outstanding client

feedback. In a letter from one client's family writing about their experience with the project, they stated that "the hours that [transition aids] have spent with our mother were the best gift that anyone could have ever given her or us during these hard days" and that the transition aids "made mom feel loved, cared for, and given her a sense of belonging" and "have given her the time to make certain little decisions in her clothes, walks, what she would like to eat and redirecting her so lightly when she is confused".

A move to LTC is the last resort for most families, with the final decision taken only when no other options remain. The new resident and their family and friends are emotional and vulnerable during this time, and depriving them of all contact and stimulation for any length of time post-admission risks a rapid decline in condition that may result in an unnecessary hospitalisation. Home and community care providers have a proven track record of activation support, and innovative solutions such as transitional support from HCC staff should be expanded where initial results show great potential.

4. Right to Care

Recommendation: People living with dementia are to be free from discrimination of any kind. They have a right to care and must not be discriminated against when needing to move into LTC based on their diagnosis of dementia.

The COVID-19 pandemic has disproportionately affected long-term care residents,²³ especially those living with dementia, highlighting many areas of the LTC system that remain broken and ill equipped to care for our most vulnerable friends and neighbours. Numerous stories have been shared by families, staff, and residents—many of which violate the rights of people living with dementia, highlighting instances in which they have been deprived of the care to which they are entitled. Families, residents, and members of care teams have raised concerns around limited access to care resources for people living with dementia. Access to care should not prioritise individuals based on least amount of care needed, and a diagnosis of dementia must never prevent someone who is otherwise eligible from being placed in a long-term care bed. The COVID-19 pandemic has only magnified long standing issues of discrimination and stigma that this population experiences when trying to access the care they need. It is paramount that these issues be addressed so that people living with dementia can live fully with dignity and respect.

4.1 Admission to LTC

Frontline staff and the clients they support across the province have indicated that individuals living with dementia who are seeking admission to LTC have been denied a bed for which they are eligible. The justification for refusal is that such residents are unlikely to be able to comply with COVID-19 restrictions regarding IPAC and isolation due to their increased risk of wandering in the home, or a lack of staff resources to support the client's level of need. Certain homes throughout the province have been noted to be "cherry picking" their new admissions based on those with the fewest behavioural problems—in effect, a moratorium on new admissions of people living with dementia especially those with a noted history of wandering and/or exit seeking. These situations identified from around the province are discriminatory, distressing, and immoral.

In 2018, the Alzheimer Society supported a group of people with lived experience who put forward seven rights to empower self-advocacy for people living with dementia under the Canadian Charter of

Right for People with Dementia.¹ Included in this is the right to be free from discrimination of any kind, and the right to access support so that one can live as independently as possible. Being refused an LTC bed due to a medical diagnosis violates these rights that people living with dementia indicated are most important to them.

Long-term care homes are the last resort of families in crisis. When anyone, especially someone living with dementia, is placed on a crisis waiting list for LTC admission, it is because all other options have been exhausted. For homes to use the pandemic as justification to choose clients based on ease of care rather than urgency and need is a devastating setback for the rights and dignity of this population. We urge the Commission to draw attention to this issue, and work with the Ministry of Long-Term Care to ensure pandemic-related capacity constraints do not result in the most complex clients being refused care for which they are eligible. Such clients have no where else to turn; if we are truly all in this together, we cannot turn our backs on vulnerable people in desperate need of a LTC bed.

Conclusion

The ongoing COVID-19 pandemic has laid bare the neglect and chronic challenges that have long besieged the province's LTC system. Due to years of inaction, Canada—and Ontario specifically—failed in its duty to protect our most vulnerable friends and neighbours, to an extent almost unrivalled anywhere else in the world. As we turn to confront the second wave, and look forward with hope and optimism to the widespread availability of effective vaccines, we are grateful to the Commission for its role in ensuring lessons are learned from the unspeakable tragedies that have occurred in the province's LTC homes.

Dementia and long-term care are inseparable. With two-thirds of residents in Ontario living with some form of dementia, any impactful changes must establish the unique needs of this population as a top priority. The Alzheimer Society of Ontario is grateful for the opportunity to share our recommendations amplifying what we have heard from residents, staff, and care partners, and we would welcome and invite an opportunity to discuss this submission with the Commissioners.

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Appendix A: NE BSO High Intensity Needs Transition Pathway

Created by J Wallenius; S Denton; M Bretzlaff; S LeClair

The following table was derived from the NE BSO High Intensity Needs Transitional Pathway. This table is to be used as a reference example outlining the Transitional Support Pilot Project for a new resident entering long-term care required to self isolate for 14 days.

Step 1: IDENTIFY: LHIN/Acute Care/BSO Integrated Team Identify patients who may benefit from 14-day transitional support	
Patient Experience: I need help transitioning from one environment to the next	
Process Step:	Consider patients who are currently presenting with or at risk of responsive behaviours that may benefit from enhanced activation/1:1 care during isolation period. Needs may vary from 'roaming about' to a combination of complex behavioural and function needs
Step 2: PLACEMENT: LHIN Manager/ BSO Lead to connect with administrator of LTCH	
Step 3: ENGAGEMENT OF TRANSITIONAL SUPPORTS: Coordinated by BSO	
Patient Experience: navigating who best to engage and ensure continued open communication, inclusive of patient/family care partner	
Process Step:	BSO already engaged; If this is not the case, urgent referral needed from BSO clinical lead
Process Step:	BSO Central Intake to complete comprehensive review and clarification of transitional needs
Decision Point:	Appoint transitional support lead to guide transition support planning
Process Step:	Communication with all care partners involved in the circle of care
Step 4: BSO ASSESSMENT AND RECOMMENDATIONS TO FACILITATE TRANSITION	
Patient Experience: Getting to know me and helping others know what is best for me with shared engagement from me and my family care partners.	
Documents required:	PIECES Assessment, Personhood Tip Sheet, K2P tool, LTC Ethical Framework
Process Step:	Medication reconciliation
Process Step:	Develop personalised activation kits
Process Step:	Develop transitional care plan during COVID-19
Step 5: PLANNING A MOVE	
Patient Experience: moving is stressful, especially within a short period of time to a brand-new environment with many new faces and surroundings	
Process Step:	Meet with partners: BSO, acute care, Alzheimer's society, LHIN, LTCH BSO
Process Step:	Identify leads from each partnering agency
Process Step:	support informal care partners
Process Step:	Share assessment and recommendations with transitional partners

Process Step:	Transitional partners to complete bi-weekly/weekly routine COVID-19 testing or as required according to current LTCH designation
Process Step:	Develop transitional support schedule for 14-day isolation period
Process Step:	Consider pro-attention plan (all hands-on deck)
Process Step:	Consider ideal time and day of week for transition based on person & team
Step 6: MOVING DAY	
Patient Experience: ensure intensive proactive support regarding adjustment	
Process Step:	Support receiving clinical team, client and care partners.
Documents required:	Documents required: transitional care plan during COVID-19
Step 7: SUPPORTING TRANSITION	
Patient Experience: continuing to adjust to my new home	
Process Step:	Scheduled touch points with transitional leads during 14-day period (suggesting day 1, 4, 7, 14)
Process Step:	Link with unit/home area lead with updates
Process Step:	Daily touch points between family, transitional supports, and in-house BSO
Documents Required:	Initiate BSO Dementia Observation System Worksheet
Documents Required:	Initiate Infection control and Isolation care plan
Process Step:	Review of shared documentation, meetings with BSO, LTCH, Alzheimer's Society, and key transitional leaders/stakeholders
Decision Point:	Consider opportunities to adjust level of support as needs decrease or increase
Decision Point:	Consider opportunities for staff education to support care post 14-day isolation
Process Step:	Engagement of PRC
Step 8: DISCHARGE	
Patient Experience: seamless support for warm hand-over to embedded BSO team	
Process Step:	Meet with transitional leads to review outcome and ongoing plan; facilitate quadruple aim qualitative evaluation and analysis
Decision Point:	Community BSO team to discharge to in-house BSO: clinical decision (guiding framework)
Decision Point:	Should there be a change in status, refer to BSO Central Intake to access additional supports

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