NEW FOR 2024!

Making the Move to Long-Term Care

A Practical Navigation Guide for Ontario Families

Family Councils Ontario

version: 001.6

If you find yourself in need of assistance please contact any of the following resources:

Ontario Caregiver Organization Helpline:

Available 24/7
Phone: 1-833-416-2273

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211 Ontario is a helpline that connects people to social services, programs, and community supports:

Phone or text: 211
Web: 211ontario.ca/search

Ontario Health at Home:

Available 7 days/week
Phone: 310-2222 (No area code needed)
Web: ontariohealthathome.ca/contact

MAKING THE MOVE TO LONG-TERM CARE

A Practical Navigation Guide
for Ontario Families

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SPECIAL THANKS TO

Ontario Ministry of Long-Term Care, Ontario Caregiver Organization,
Ontario Health atHome, Ontario Association of Residents' Councils,
Ontario Centres for Learning, Research, and Innovation in Long-Term Care,
Retirement Homes Regulatory Authority, Family Council Network 4 Advocacy,
Ontario North Family Council Network, Champlain Region Family Council Network,
Réseau Francophone des Conseils de Familles Ontario, Elderado, Depresribing.org,
The Elliot Community Guelph, Deborah Bakti, Carol Lemen,
and all of our focus group participants.

ABOUT FAMILY COUNCILS ONTARIO

Family Councils Ontario (FCO) works with long-term care home residents' families, Family Councils, and home staff across Ontario to enable them to cultivate positive relationships, build effective Family Councils, and improve the long-term care experience. Our mission is to lead and support families in improving the quality of life in long-term care. Through working with families, long-term care home staff, and sector partners, we strive to create a safe, vibrant, inclusive, and respected long-term care system.

For more information visit FCO.NGO

Family Councils of Ontario is a registered, charitable nonprofit, funded by the Ontario Ministry of Long-Term Care. Registration number 828934190 RR0001.

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FOREWORD

by Sam Peck, FCO Executive Director

For many years, I made a joke at the presentations I did for Family Councils. When I discussed the challenges, many families had when their residents moved into an LTC home, I asked "By a show of hands, how many of you received the 'what to expect in long-term care' resource?" Inevitably, there was a pause followed by laughter as Council members realized that I was joking about how unprepared many people felt during the transition and the lack of information available before the move to LTC. Now, thanks to FCO's Making the Move to Long-Term Care I will no longer be able to make this joke. It looks like I need to come up with new material for my presentations!

In all seriousness, it's been a problem for many, many years that caregivers have felt unprepared, uninformed, and unsupported as they navigate the transition to LTC and navigate through a new part of the healthcare sector. Information about LTC exists but it is fragmented, can be hard to find, and is not always written with caregivers in mind. When so many caregivers join the LTC community during a time of crisis, all this new information can be overwhelming and cause even more stress to an already overburdened and burnt-out caregiver.

> *"I wish I had known what an emotional roller coaster it was going to be for me and for my mother."*
>
> *~Focus Group Participant*

Our new guide *Making the Move to Long-Term Care* will help to prepare, inform, and support caregivers as they support their person in their new home. Our guide exists to reassure caregivers that they can continue to be caregivers to their person in this new home and help them understand their new role.

Our goal with this guide is to prepare caregivers ahead of time for the reality of LTC and help them not only understand the system but also how they can be involved in their resident's LTC home. We hope that if caregivers are better informed and prepared for the reality of LTC, they can ease into the new environment a lot quicker. By feeling more at ease and feeling part of the LTC community a lot sooner, our hope is that it will prepare them to be an effective family council member. When caregivers are informed and supported, they can have incredible impacts on their resident's new homes. As we work closely with Councils and home staff to improve the quality of life in long-term care, we see this guide as an important tool to help caregivers understand their new role and how they can be effective advocates for change in LTC. Knowledge is power.

This guide was created with caregivers and Family Council members every step of the way. We surveyed Family Council members to ask what they wish they knew before their resident moved into an LTC home, held focus groups to dive deeper into what we heard in the survey and to hear their stories about what transitioning to and navigating the LTC system, and solicited feedback on a draft version of this document. We couldn't have done it without their support, and we thank them for their input.

This will be a 'living' document in that we will be updating it as new information becomes available or changes. As you read it, if you think of something we have missed, please contact us at info@fco.ngo. We welcome your feedback.

We are also creating other resources to go with this guide: a promising practices resource to help LTC homes improve their move-in process to better onboard and welcome new caregivers to the home and a resource for Councils that they can use to better support their new peers. These documents will also be created in partnership with Councils and home leaders, so please share your ideas with us.

Our vision is that all people in long-term care have a vibrant experience and the best care. By reading this guide before their care recipient moves into LTC, we hope that caregivers will have the vibrant experience they deserve.

SAM (SHE/THEY) IS PASSIONATE ABOUT HELPING PEOPLE AND GROUPS ACHIEVE THEIR GOALS. IN HER 16 YEARS WITH FAMILY COUNCILS ONTARIO SHE HAS SUPPORTED THOUSANDS OF FAMILY MEMBERS AND LONG-TERM CARE HOME STAFF IMPROVE THEIR WORK TO ACHIEVE THE BEST POSSIBLE OUTCOMES AND MEANINGFUL IMPACTS.

SECTION ONE:

WHERE DO I START?

LEARNING OBJECTIVES

- *Understand the need for this guide.*
- *Recognize how other caregivers have navigated the LTC system.*
- *Identify the eligibility for applying to LTC.*
- *Compare and Contrast the services and supports available to residents in a Retirement Home and LTC.*

The decision to move someone you care about into a long-term care home is not easy. Understanding, navigating, and finding the answers to your questions within healthcare and senior services can be an added stress in an already overwhelming situation. Long-term care is not a subject that we like to think about or a welcome topic of discussion over dinner. But it's a necessary conversation when a member of our family experiences a health crisis or the progression of a chronic disease that makes long-term care an impending reality. Transitioning into long-term care is a life-changing event for everyone involved. It is filled with a mix of emotions including grief, fear, anxiety, guilt, and relief. We hope this guide will help to relieve some of that tension and make that discussion with family a little easier. And even more, we want to educate and empower you to make clear and confident decisions every step of the way.

A GUIDE FOR ONTARIO FAMILIES

Once the decision is made to apply for a bed* in long-term care, family members may choose to pursue resources and information as they wait to create a plan for the inevitable move-in day, to help them feel prepared. They may also want to connect with organizations focused on supporting caregivers to take in all that's happening and come to terms with the repercussions of this decision. Despite best efforts to plan and prepare, when move-in day arrives, they are often overwhelmed. Heightened emotions make it challenging to process information and remember details about policies and procedures shared by staff.

On top of this, families and residents often join a long-term care community with misconceptions that can impact the relationship they develop with home staff. For example, family members are often frustrated when their phone call to the home to check in on their resident is unanswered. In reality, the care routine and life in LTC is highly scheduled and staff may be unavailable to answer the phone as they are involved in providing care to residents.

Caregivers also often express a fear of retaliation from staff if they raise concerns or make a formal complaint on behalf of the person they support in an LTC community. We hope this resource and the additional resources suggested in this document serve to eliminate these misconceptions and others about LTC.

Despite the ongoing efforts to use the feedback shared by family members of residents to improve the LTC move-in process, many continue to experience confusion, frustration, and anger when attempting to navigate the Ontario long-term care system. Family members begin their journey with limited knowledge of LTC. They rely on the expertise of Ontario Health at Home (OHAH) and the roles of the many staff in the community at OHAH and hospitals to help them begin the process of applying for a bed in long-term care and all of the additional steps that follow.

As part of its vision to ensure "people in long-term care have a vibrant experience and the best care," FCO decided it would be beneficial to create this resource, Making the Move to Long-Term Care: A Practical Navigation Guide for Ontario Families, to help guide families of new residents through the process and answer frequently asked questions to help prepare them for move-in day and beyond. The primary goal of this resource is to support you, the families and caregivers, throughout your loved one's transition to becoming a member of an LTC community. The specific content included in this document comes from feedback collected by the FCO team in 2023 through a survey of five focus groups, as well as our FC360 Needs Assessment Survey.

As we examined the results of the survey and perspectives shared during the focus groups, we gained a wealth of valuable insights which offering a deeper understanding of reality of navigating the move into LTC. These insights have helped our team develop the key themes and areas of focus that will be woven throughout this guide. The following series of quotes demonstrate the extent of feedback shared with our team and helps set the tone for the remainder of this document.

***NOTE:** IN THIS GUIDE, WE USE THE TERM "BED" TO ALIGN WITH THE LANGUAGE OF THE APPLICATION PROCESS AND DOCUMENTATION. WHILE WE RECOGNIZE THIS DOESN'T FULLY REFLECT PERSON-CENTERED LANGUAGE, WE ACKNOWLEDGE THAT LONG-TERM CARE HOMES ARE MUCH MORE THAN JUST THEIR PHYSICAL ENVIRONMENT.

SURVEY & FOCUS GROUP HIGHLIGHTS

With limited knowledge of the system before the process of applying to LTC, one participant noted families are "sitting ducks" at the mercy of the system and those with extensive knowledge of policy and procedures.

> *"Family members are kind of sitting ducks in a way in terms of lack of knowledge and information going in, in terms of the information you have on hand. You know nobody explains to look at the public reporting site to see whether they've been noncompliant or the kinds of inspection reports there are against a particular home you might be interested in—nobody tells you that ahead of time so you don't have that kind of information to help you make choices or to even feel a little bit confident that you're doing the right thing and you're working towards a good decision."*

It is a steep learning curve, and because of the limited knowledge about the LTC system heading into move-in day, it is normal to question if you are making the right decision. But as you do some research and spend time in the LTC community talking to staff and other caregivers, you may come to realize just how far you've come. As one participant noted:

> *"We look back and we think maybe we didn't make the right decisions because we just didn't have the knowledge, and we didn't understand the long-term care system, but since then, you know, my knowledge is grown, my family's knowledge is grown."*

FIGURE 1.1:
WORD CLOUD FROM FOCUS GROUPS AND SURVEYS

While this resource will provide information about the process of moving into LTC, it is important to note that your experience will be unique from the experiences of others going through the same transition. Rich, vibrant family life in the community is filled with memories and experiences that you will bring into the LTC community. One participant noted:

> *"The needs of families based on the residents and situations coming in will be so unique."*

As a caregiver, you have, and will continue to experience the unique nature of each journey supporting someone in the community before starting the transition into LTC. Participants in the focus group highlighted the unique nature of the caregiver and incoming resident shaping the process of transition. Experience is also shaped by the environment they are transitioning from, whether it's the community, Retirement Home or the Hospital.

> *"What a huge transition it was from retirement living!"*

Moving into LTC is a process filled with frustration and limited control for caregivers who are at the mercy of current policies and the demands on the system. However, our focus group discussions highlighted that during the process of applying and supporting someone as they move into LTC, knowledge is power.

> *"Every little thing they could possibly need to know about long-term care will help them guide them and support them during this transition of moving a loved one into long-term care and making that day a little less scary and giving them the courage the confidence of knowing the decision they made was one that needed to be done and that they are going to know what questions to ask when it comes to the admission day for their loved one to that long-term care home."*

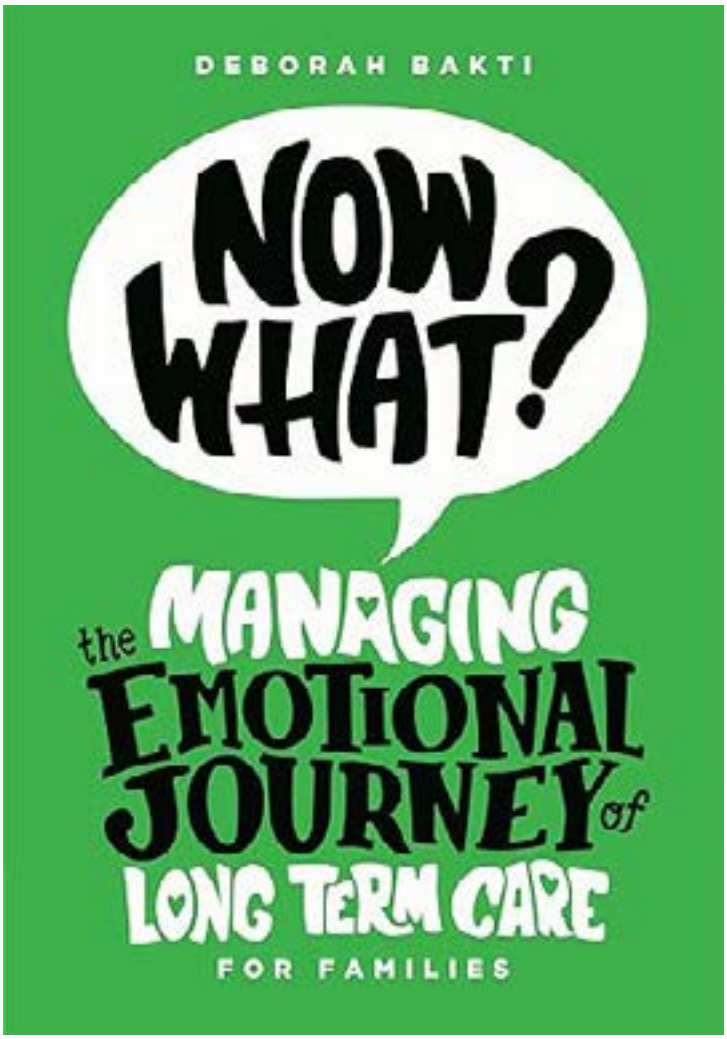
Discussion between participants in our focus groups frequently revealed their shared frustration with the inconsistency of the process when move-in day arrived. Even those who supported multiple family members or close friends through their transition into an LTC community noted the importance of recognizing the unique nature of each person's move into long-term care. Insights shared by caregivers highlighted the importance of a successful move-in day as a source of reassurance that they are making the right decision for their loved ones. We hope that this resource presents a one-stop shop for all the information you will need to guide your discussions throughout the process of transitioning into LTC from application to move-in day.

REFLECTIONS ON THE EMOTIONAL JOURNEY OF LONG-TERM CARE

The following is an excerpt from Now What? Managing the Emotional Journey of Long-Term Care for Families by Deborah Bakti

"When I get old and can't take care of myself, I want to live in a nursing home with a bunch of people I don't know."

~ Said no one. Ever.



Let's face it, the idea of "ending up" in a nursing home ourselves can influence how we feel about moving a loved one into long term care. It's not usually the option we run to –instead, it typically becomes the only viable option.

Long term care (LTC) is a key part of our health care system; it's a much-needed service. But it's not always a solution we want for our loved ones.

You may be asking yourself, "Now what?" Wherever you are on your journey—whether that's considering LTC, or you've already made the decision and are waiting for availability, or you've already joined the "Resident's Family Member Club"—this book is for you.

Think of this as a playbook of sorts: It's not so much about "How does the system work?" but more "How do I make this work for me and my family?" This book will help prepare and equip you with the knowledge and tools you need to navigate through the various stages, including acceptance and appreciation. All without wearing yourself out physically and emotionally.

I understand what you're going through. I've been there myself.

I first became a resident's family member when my dad was admitted into LTC in early 2011, followed by my husband three months later, then my mom several years after that. Ironically, I was also working in seniors' care as a Vice President with a company that operated over 100 long term care homes in Canada. I had inside knowledge of how things worked in the LTC system and thought I had the upper hand.

During this time, I had my own hands full working full-time and raising two kids. At 62 years of age my husband Ty was diagnosed with an extremely rare disease called Erdheim-Chester disease (ECD). It was so rare in fact, that it took 18 months for doctors to identify his illness. At the time, only 400 people in the world had also been diagnosed with ECD.

We were also told that Erdheim-Chester was degenerative, incurable, and fatal. At this point, because of the decline in Ty's health and abilities, he was receiving home care twice a day, five days a week, in addition to attending an adult day care centre two to three times a week.

Ty was then admitted into LTC just a few of months after my dad in April 2011. For many months following, I oscillated between visiting my dad in his home on one side of the city, and my husband in another on the other side of the city. It was emotionally draining and incredibly surreal, to say the least.

Perhaps you've already been through the wringer in coming to terms with your loved one's health changes and the degree that they now require the care and support of an LTC home. You may also be feeling conflicting emotions – sadness, frustration, guilt, anger, worry – now that a team of caregivers are taking care of them. You may also feel some guilt about feeling relieved.

Or maybe you are wondering if, or when, it will be time to consider LTC for your loved one. Perhaps you're watching your parents continue to live in their home, but are struggling with their daily activities., Or they're having memory issues, and you worry about their safety and well-being.

You are not alone.

In Canada, almost 400 families go through this life-changing experience every single day, as a loved one is admitted into LTC. That's close to 7,500 families every single month who walk through the doors of an LTC home feeling a myriad of emotions.

This is a huge life change for you and your family. If you have never stepped foot in a home before now, it can feel like a scary transition.

This is a new arrangement, one that requires new relationships. You'll be meeting many care team members on different shifts who are all responsible for taking care of your loved one, who is now their new resident. You'll visit the home to spend time with your loved one, where you'll meet other residents and their family members.

IMAGE: DEBORAH AND TY

Making this new reality work isn't always easy. Integrating this into your life can be challenging.

That's why I wrote this book. This is the book I wish I had when I became a family member. I want to help ease some of the emotional distress you may be feeling.

We hear negative stories in the media about LTC. Perhaps you've also heard stories from other people about their own experiences. Maybe your loved one made you promise to never send them to an "old folks' home," only you are now unable to keep up with the growing demands of their care. Or they've been living in a retirement home, but now need additional help and care. Others are referred to LTC after a lengthy hospital stay.

Whatever path you're on, it's challenging to accept this new reality, or to even know what to do next. You may be asking yourself, "Now what…will their lives be like? Now what…will MY life be like?"

Some of you may feel moving to an institutional setting isn't the ideal place you imagined for your loved one. For others, it may be your only choice. The impact on family members doesn't typically get discussed. The focus tends to be on the resident. After all this is a big life change for them. And yet, families are profoundly affected too.

In this book, I'll share my own admission day experience and shed some light on your new identity as a resident's family member. You'll also learn about the emotional journey through the Seven A's – from awareness to appreciation. There is a chapter written by Edy Nathan, who is a licenced therapist and author of It's Grief: The Dance of Self-Discovery Through Trauma and Loss. Edy shares her insights on how to "Dance with the Grief." I provide perspective from another vantage point of your admission day experience – the people who work in long term care. You'll read about some common misconceptions that other families have shared. My hope is they will help increase your knowledge, clarify expectations, and minimize disappointment. I've also written a chapter on the three different types of "family flavours" to help you reflect on what your family flavour may be.

IMAGE: DEBORAH AND TY

Being a practical person, I wanted to provide useful tips and tools that will assist you with the changes in your life, so you're able to create the best possible relationships with the care team members. After all, they are the ones who are now largely responsible for providing quality care, compassion, and support to your loved one.

You will find this book helpful if you're feeling:

- Worried that your loved one is going to dislike living in long term care, or is upset with you because of it
- Judged by friends and family who ask why you couldn't keep your loved one at home
- Wishful that it didn't have to come to this point
- Grief and guilt for making this decision
- Worried about how the people working in the home are going to take care of your loved one
- Concerned the care providers don't know you, your family, or your loved one

My motivation for writing this book is to help you along the journey you're now on. When I became a family member I was working in seniors' care. That should have given me an advantage, yet I still struggled with the emotional roller coaster and physical impact it had on me as a spouse, a mother, and daughter. It was through this very personal journey, with operational insight, that I created the framework we'll explore in this book.

It's normal to feel some resistance, even resentment, about this new reality. You likely have questions or may not even know what you don't know. If your concerns are keeping you up at night or if you're questioning your decision to place your loved one into LTC, then this book can help.

This book is for and about you. Your experience. Your emotions. Your ability to journey through the Seven A's and manage this experience as a resident's family member as best you can. I want this book to help expand your ability and your resilience throughout this emotional journey as a family member

As the title suggests, it IS a journey. How you perceive, experience, and relate to yourself and others may change – from that first admission day to the final day. I hope this is a book you can come back to, re-read sections, and gleam something helpful or meaningful from as you continue in your journey.

Victor Frankl, author of "Man's Search for Meaning" said:

> **"When we are no longer able to change a situation, we are challenged to change ourselves."**

With insight, encouragement, and the right tools, you can take the lead in influencing what you can – which is you!

You can find Deborah at

DeborahBakti.com.

SCAN ME!
TO VISIT THIS WEBSITE

DEBORAH (SHE) IS A SENIORS CARE CONSULTANT, COACH, SPEAKER AND TRAINER WHO HELPS TO BUILD POSITIVE AND HEALTHY CONNECTIONS WITH RESIDENTS FAMILIES IN SENIORS' CARE HOMES.

THE DAY MY DAD MOVED-IN

by Liane Pelissier, FCO Client Services Manager

As a Resident and Family Services Coordinator, I have been assisting families moving their loved ones into long-term care for 15 years. I knew the processes, the paperwork involved, and everything there was to know about long-term care. But when it came time to bring my dad to his long-term care home, I found I lost all sense and was completely overwhelmed with emotion.

Here is my story.

This is my dad. He was everything to me. We had such a close relationship and he taught me so many valuable life lessons.

My dad was a fun-loving, gentle, soft-spoken man. He loved music and movies. He was a musician and played in a band for about 25 years. He was also a charted accountant and was a genius in math. His family was very important to him.

When my dad got sick and was diagnosed with dementia, it was devasting to our family. Having the experience of supporting residents with dementia and seeing the progression on a daily basis, made me so sad and scared for my dad's future.

I had to use my skills and training to communicate with my dad and also teach my mom and family how to better communicate and respond to my dad as his dementia progressed.

The day came when my mom could

IMAGE 1.2: LIANE AND HER DAD

no longer look after him safely at home, and we had to make the very difficult decision of moving my dad to a long-term care home. That is a day I will never forget. It was a pivotal moment in both my personal and professional life.

As we drove my dad to his new home my heart was racing, my mind was full of uncertainty and fear. I was caught off guard by these emotions. After all, this is what I did for a living, this was my job. I welcomed residents and families into long-term care on a weekly basis. But this was so different, this was my dad, this was my family. I was now a family member. Wow! What a reality check that was.

My dad's move-in day was filled with the all-so-familiar paperwork, sharing of information, and meeting new staff. I remember standing in my dad's room, watching him putter and fidget, looking confused and lost. I could hear my mom crying in the background, not at all registering what was happening. There were many staff that came to my dad's room that day to introduce themselves. I saw them, I knew they were talking, but I did not hear one word they said. I was so overwhelmed and lost. I know that I signed many forms that day, I knew those forms like the back of my hand, but that day, I had no clue what I was signing.

My mom and I left my dad in his now home, in his shared room. We told him that the doctor wanted him to stay because they needed to do some tests. He couldn't understand why he couldn't leave with us. At that moment, my two worlds collided. I was a Resident and Family Services Coordinator, who was

IMAGE 1.3: LIANE AND HER DAD

responsible for the move-in process at the home I worked in. But on this day, I was a daughter and the emotion of it all was overwhelming. I felt completely lost.

I literally sat in my car for about a half hour and cried. I couldn't drive. I needed to get back to the home where I worked and continue my day of supporting residents' families and staff. Once I gained some composure, I vowed in that moment that I would do things differently. I would engage, respond, and empathize differently. Although I often spoke the words, I never knew the impact, the deep emotional impact of moving a loved one into long-term care.

It's funny, I told my colleagues that I didn't want to be one of "those" family members. I knew the sector; I was educated and skilled. But let me tell you, there were times when I was in that spicy, jalapeño family.

I totally got it! I was so overwhelmed, tired, stressed, sad, and grieving, that my response to certain situations was not ideal. I can guarantee you that there were times when staff scattered when they saw me coming. I am not a malicious person. I often caught myself slipping because, after all, this was my dad, and I loved him beyond words. Many times, I needed to step back, take a deep breath, and reflect on the situation at hand. I needed to problem-solve and have a conversation with the nurse about how my dad's care plan could be adjusted to ensure that his particular needs were met. I needed to put trust in the staff that were looking after my dad and that they were doing everything they could to care for him. But watching him deteriorate was heartbreaking and I didn't always know how to cope.

The good days, however, were to be celebrated. My dad had some great moments, and days of clarity. He loved to joke with the staff, play his air guitar and sing Elvis tunes. He would tip his hat and greet people as he walked the corridor — this was my dad.

Going through the ups and downs of being a caregiver to a loved one in long-term care has helped put things in perspective for me and that shared lived experience helped me completely understand what families go through on that move-in day. Families need so much support, empathy, guidance, and understanding.

IMAGE 1.4: LIANE AND HER DAD

LIANE (SHE) CARES DEEPLY ABOUT MAKING A DIFFERENCE AND HELPING OTHERS, BUT MOST PARTICULARLY THOSE LIVING, WORKING AND FAMILY MEMBERS IN LTC. SHE HAS 19.5 YEARS OF EXPERIENCE OF WORKING IN A LTC HOME AS A RESIDENT AND FAMILY SERVICES COORDINATOR, HELPING SUPPORT RESIDENTS AND FAMILIES AS THEY TRANSITIONED INTO LTC.

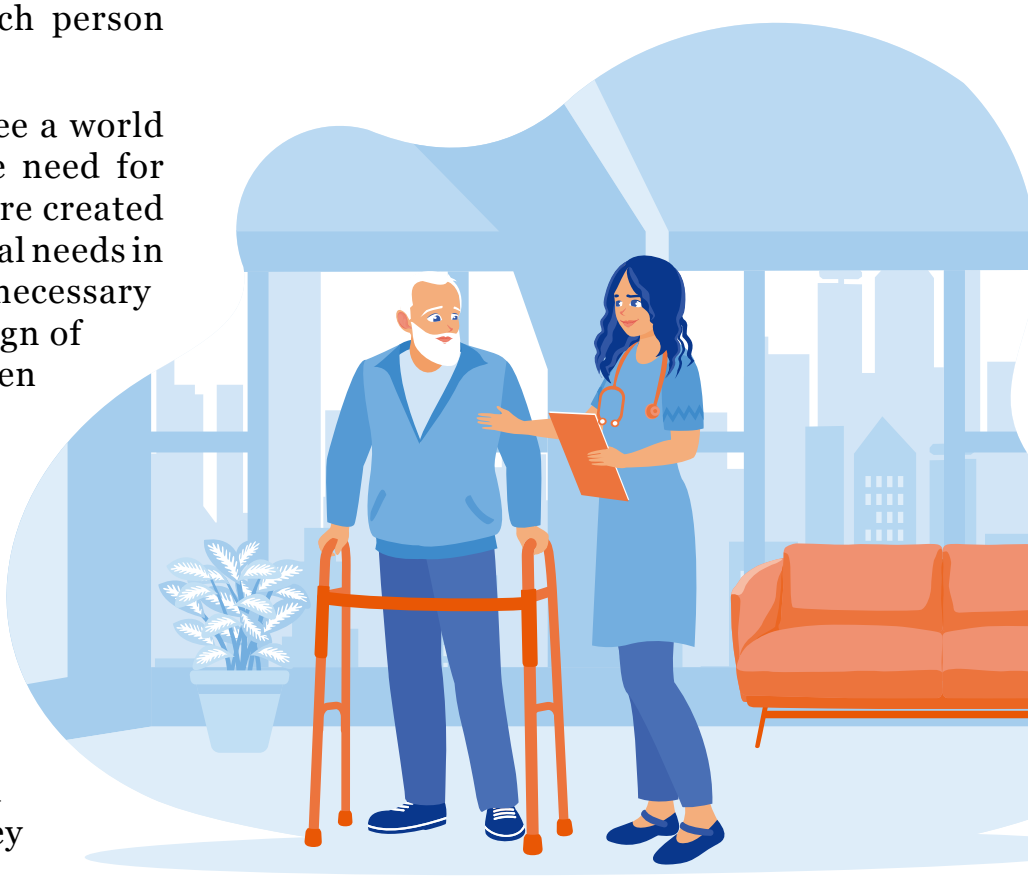
WHAT IS LONG-TERM CARE?

A long-term care home is a setting where people with complex health care needs, like diabetes, arthritis, Alzheimer's disease or other forms of dementia, live (Canadian Institute for Health Information, N.D.). In Ontario, LTC is funded and regulated by the Government of Ontario through the Ministry of Long-term Care.

The MLTC issues a license or permit to operate a home to a municipality, a not-for-profit, or a for-profit organization. MLTC also provides subsidies for lodging, food, and staff to provide a range of health and support services. The goal of the services and supports provided by staff in LTC is to promote as much independence as possible for as long as possible and to ensure the best possible quality of life for each person living there.

As much as we would like to see a world where we have eliminated the need for long-term care homes, they were created and continue to exist to meet vital needs in our province. LTC homes are necessary because often the physical design of homes in the community—even with expensive renovations—is unsuitable to provide the required level of care to support those living with complex needs. Caregivers often take on responsibilities that take up time, energy, finances, and other resources. If they ignore their own mental and physical health needs, they may find themselves unable to provide adequate care for their loved ones, or worse, needing their own specialized care.

Since many medical conditions are progressive, they may find the care they are required to provide is beyond their knowledge, skills, or abilities. The increasing prevalence of cognitive impairments and chronic conditions, often managed with multiple medications and interventions, underscores the need for LTC homes where skilled care and consistent daily support are readily available. Above all, LTC homes are needed to ensure that both caregivers and care recipients are safe and healthy (Armstrong & Armstrong, 2022).



KEY TERMS

There are several terms you will encounter early in the process.

Long-Term Care: According to the National Institute on Aging (NIA), long-term care refers to a range of preventive and responsive care and supports, primarily for older adults, that may include assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) provided by a non-for-profit or a for-profit provider, or unpaid caregivers in settings that are not location specific, including designated buildings, or in home and community-based settings (Flanagan et al., 2023).

Activities of daily living (ADLs): Basic ADLs (BADL) or physical ADLs are those skills required to manage one's basic physical needs, including personal hygiene or grooming, dressing, toileting, transferring or ambulating, and eating.

Instrumental Activities of Daily Living (IADLs): This includes more complex activities related to the ability to live independently in the community. This would include activities such as managing finances and medications, food preparation, housekeeping, and laundry.

Resident: A resident in Long-Term Care (LTC) is an individual who lives in a facility designed to provide 24-hour care and support due to chronic health conditions, physical or cognitive impairments, or the need for assistance with daily activities.

Culture Change: As you learn more about long-term care you hear the term culture change, defined as the knowledge of best practices in LTC to promote quality of life and opportunities for meaningful interactions to continue to grow. Culture change refers to an approach to care that focuses on the people who receive care, and the relationships between those who provide care and those who receive care (Best-Martini, 2011).

Person-Centred Language: The care provided in LTC takes a resident-centred approach, focused on the needs and goals of the resident. Resident and family satisfaction is measured through assessments, using surveys and other feedback to improve services. The language in that feedback is used as an essential element of culture change. To learn more about person-centred language please visit clri-ltc.ca/resource/pcl

Models of Care: There are several models of care associated with the implementation of culture change in LTC, including the Meaningful Care Matters (Butterfly Model,) Greenhouse Model, Eden Alternative, Dementia Villages (Dutch Model), and Montessori Method. The table below provides a summary of each approach to care (Welsh, 2021). Additional details about these models for culture change will be shared later in this resource on page XX.

Model of Care	Description
Meaningful Care Matters (Butterfly Model)	Emotion-focused interactions between residents and staff
Green House Model	Meaningful life through opportunities to engage in activities, make choices, and form relationships in a small home
Eden Alternative	Caring for the human spirit along with the physical body, and resident-directed routines and care to reduce boredom, loneliness, and hopelessness
Dementia Villages (Dutch Model)	People with dementia are free to move about the community, their safety is supported by the staff
Montessori Method	A strength-based approach focused on residents' capabilities, providing opportunities and choices in how they engage with their environment in meaningful activities

Equity, Diversity, and Inclusion: EDI is a framework which seeks to promote the fair treatment and full participation of all people, particularly groups who have historically been underrepresented or subject to discrimination on the basis of identity or disability.

SUPPORTING EQUITY, DIVERSITY, AND INCLUSION IN LONG-TERM CARE

The Ontario CLRI at Bruyère, supported by the Ontario CLRI at RIA, collaborates on the Equity, Diversity, and Inclusion in LTC (EDI) project. This initiative builds workforce capacity and fosters person-centred care through the identification, development, and spread of information and resources that support the diversity and inclusion of residents, family and friends (care partners), and team members.

To help inform our EDI approach, the program draws on the expertise and learnings from our EDI Advisory Committee and our EDI in LTC Community of Practice. This Community of Practice brings together LTC home representatives, researchers, and LTC sector partners for engaging discussions, such as presentations from Ontario-based LTC homes about their EDI journey.

A suite of EDI resources is promoted and shared to support LTC homes in their efforts to be more inclusive and affirming places. These resources include a Toolkit, posters, eLearning course, a newsletter and the opportunity to participate in knowledge exchange events.

Our Diversity and Inclusion Calendar has been used extensively. It provides a comprehensive listing of cultural, religious, and spiritual days of significance and health promotion days. Many have shared with us that our EDI Calendar is their "go-to resource" to keep track of and learn about days that may have special meaning for LTC residents, families, and team members.

As the Ontario CLRI continues to prioritize and expand our EDI efforts, we are guided by our goal that everyone has the right to feel safe in the place they live and work.

ONTARIO CLRI Centres for Learning, Research & Innovation in Long-Term Care

BAYCREST • BRUYÈRE • RIA

WHO IS ELIGIBLE FOR LONG-TERM CARE?

The number of people living in LTC is steadily growing with the increased aging population in Ontario. The people who live in LTC are referred to as "residents." Prior to their move to LTC, some residents may have lived in a community with care provided by a combination of family or friends and home care staff. Some residents are preparing to be discharged from the hospital. People living in LTC pay a fee set by the government based on the type of accommodation chosen (e.g. basic/standard, semi-private, or private). To become a resident, they meet the following criteria of eligibility:

- Over the age of 18
- Have a valid Ontario health card (OHIP)
- Requires help with tasks like eating, bathing, or getting dressed
- Requires on-site monitoring for their safety and well-being
- Unable to return home when discharged from the hospital
- Requires available, on-site nursing care 24 hours a day, 7 days a week

HOW IS LONG-TERM CARE FUNDED?

Long term care homes are regulated and funded by the provincial government.

People living in a home pay a fee for accommodation, which is set by the government and is based on the type of accommodation chosen (e.g. basic/standard, semi-private or private). Long term care homes can operate either on a not-for-profit (municipal, charitable, non-profit nursing home) or for-profit basis (Advantage Ontario). All LTC homes, regardless of operator type (municipal, charitable, nonprofit, or for-profit) receive the same amount of funding.

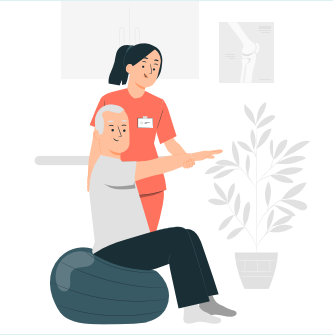
All long-term care homes in Ontario are regulated by the Ministry of Long-Term Care, and are inspected at least once a year. In addition, not-for-profit homes are accountable to their governing body which is either a non-profit board or Municipal Council for the community to adhere to the specific mandates determined by the governing body.

SERVICES AND SUPPORTS AVAILABLE TO RESIDENTS

In a long-term care home, residents have access to a comprehensive range of services designed to support their well-being and help them thrive in a safe, nurturing environment. These homes are equipped to meet the diverse needs of residents, offering personalized care that promotes health, comfort, and quality of life. Here are some quick examples of the types of care provided.

Personal Care

Residents in LTC receive help with activities like eating or bathing. This personal care is provided by a personal support worker (PSW) who, at times, must work under the supervision of a registered health professional (RHP) when performing certain tasks.



Physical Care

Physiotherapists and restorative care aides provide individual or group programs to help residents maintain or regain strength, and improve balance, coordination, and mobility.

Dietary Needs

Meals are prepared on-site and served three times a day by members of the food service team to residents in dining rooms. While residents provide input on the menu, a registered dietician ensures high-quality, appropriate foods are provided to residents.

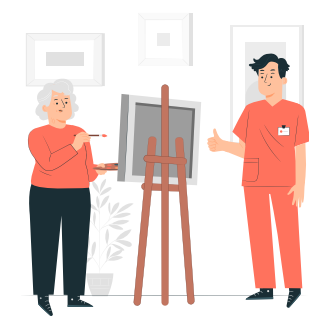
Health Care

A registered nurse (RN) and registered practical nurse (RPN) are examples of RHPs who provide health care, assess residents for illness, provide treatments, and administer medication. Each home will also have a doctor on call 24 hours a day who serves as the medical director.

According to the Ontario Long-Term Care Association (OLTCA), "75% of individuals moving into LTC have 3 or more medical conditions and take at least 8 different medications" (OLTCA, 2024).

Support Services

Housekeeping aides clean resident rooms and common areas. Laundry aides provide in-house laundry for bedding and residents' clothes. And maintenance staff ensure the building, walkways, and equipment used to provide care are safe and in good repair.



Recreation

Recreation programs are provided to residents by members of recreation departments who provide services in small activity rooms or large common areas. Residents are invited to participate in one-on-one, small group, and large group programs to meet their emotional, spiritual, intellectual, social, and physical needs.

NOTE: FIND OUT MORE ABOUT SERVICES IN SECTION 4.

WHAT IS THE DIFFERENCE BETWEEN A RETIREMENT AND A LONG-TERM CARE HOME?

While both are places where older adults can live, there are many differences between a retirement home and a long-term care home.

Retirement Home

Retirement homes are privately owned and focus on providing their residents with independence and flexibility in the services provided to them. Residents have their own private suite. They create their daily routine and have the freedom to go out in the wider community as they please. They can participate in social programs, exercise classes, or outings planned by the recreation manager. Residents can buy groceries and prepare their meals to eat in their suite or they can enjoy prepared meals with other residents in the dining room. It is important to note that retirement homes do not receive funding from the government. Residents in a retirement home pay the full cost for their accommodation and for the services they receive.

Policies and procedures for retirement homes are governed by the Retirement Homes Act (2010) under the guidance of the Retirement Homes Regulatory Authority (RHRA). The RHRA is an independent, self-funded, not-for-profit regulator established in 2011 and mandated by the government of Ontario to protect and ensure the safety of all residents living in retirement homes across the province. Staff at the RHRA oversee inspections of retirement homes to ensure they are following the Retirement Homes Act, respond to resident or family concerns, and address reports of risk or harm to residents.

Types of Retirement Home Care

There are four different types of care offered to individuals in retirement communities: independent supported living, assisted living, dementia or memory care, and short stays (orcaretirement.com, 2024).

Independent Supported Living

In independent supported living, residents live in a private unit similar to an apartment or condominium. They can cook their meals or opt for meals prepared by the staff in the dining room. They can take care of their housekeeping or they can have staff come in and regularly clean their unit. Depending on their health care needs they can opt-in to purchase additional services to help them with their ADL (activities of daily living) like bathing, getting dressed, or managing their medication. Residents in independent supported living may still own a personal vehicle and are often actively engaged in activities in the community outside of their retirement home.

Assisted Living

In assisted living, residents live in a private unit and receive additional support focused on their health care needs. These additional services are included in the fees they pay and they can request additional support as needed.

Dementia or Memory Care

Dementia or memory care is a specialized living area of a retirement community. The physical environment is designed to support those individuals with dementia. Staff working in these areas of the community receive specialized training focused on communication and supporting independence and autonomy for people with dementia. Access to this area of the community is often restricted to ensure the safety of the residents.

Short Stay

Areas of retirement homes dedicated to short stays allow those who are unsure if they want to commit to independent or assisted living the opportunity to “try before they buy.” They can commit to moving into the community for a limited time (i.e. one month) before they decide to make a permanent move. This approach allows the new resident to get to know the staff and other residents in the community, and the opportunity to learn more about the potential benefits of moving into this retirement community ahead of time. Short stay is also an option for some individuals following surgery who require a safe, accessible space to live as they recover. If, during their recovery, it would be impossible for them to return home, moving into a retirement community will provide them with access to services and support to help them in their rehabilitation.

Long-Term Care Home

Long-term care homes function differently than retirement homes, though they offer many of the same types of programs and options. Because they are part of the health care system, LTC homes are regulated and funded through the Ministry of Long-Term Care (MLTC). The provincial government provides funding for the staff and supplies related to nursing and personal care, social and recreational programs, support services, and food. The programs and services offered to residents in LTC are shaped by the Fixing Long-term Care Act (FLTCA), 2021.

LTC homes also receive additional funding for specialized programs like fall prevention and pain management. Residents living in LTC are housed in a variety of living arrangements from private to semi-private and pay a fee set by the MLTC for their room. These fees are used to pay for expenses like electricity, water, property taxes, mortgages, building maintenance, and non-care staff.

The MLTC guides the education and training requirements for all staff working in LTC. Staff in the MLTC are also responsible for the recruitment and training of LTC inspectors and enforcing the findings of inspections. All homes are required to submit an annual plan for how they will work to improve the quality of life for residents based on the needs and experiences of residents. All long-term care homes have a resident's Council.

> *"I think family support is important. The first couple of days a family member should be with the resident. This is so family can gauge the group dynamics of the residents. Also, ask questions to staff and cognitive residents. I think it's important the resident doesn't feel abandoned.*
>
> *Don't lie to them as to having a choice. Exception is if [the long-term care home] is not their first three choices. Then keep them on the list."*
>
> *~Steven, Resident*

WHAT IS THE DIFFERENCE?

LONG-TERM CARE vs RETIREMENT HOME

PRICE

Set by the Ministry of Long-Term Care
As of July 2024: $2,036.40 - $2,909.36

Set by each retirement home
Prices range from $1,500 - $10,000+

ADMISSION

Ontario Health atHome assesses eligibility and priority

Homes assesses eligibility based on vacancy and care needs

LEVEL OF CARE

A resident will be admitted to a home that can provide the necessary level of care

Level of care varies by home and can impact the price

CARE PLAN

Residents receive an individual plan of care that is reviewed at least every 6 months

Residents receive an individual plan of care that is reviewed at least every 6 months

COUNCILS

Residents' Council & Family Council

Residents' Council

REGULATOR

Ministry of Long-Term Care

Retirement Home Regulatory Authority

Learn more at www.elderado.ca

SECTION TWO:

APPLYING TO LONG-TERM CARE

LEARNING OBJECTIVES

- *Gain a clear understanding of the Long-Term Care (LTC) application process.*
- *Explore the various assessments used during the transition into LTC.*
- *Demonstrate strategies to discuss the move to LTC with your loved one.*
- *Understand key legal steps and requirements involved in applying for LTC.*
- *Develop a list of questions to consider when selecting a LTC home.*

Applying to long-term care can be a complex and emotional process, involving multiple steps and important decisions that impact both the potential resident and their caregivers. This section will guide you through the application process, offering insights on eligibility criteria, the paperwork required, and the factors to consider when selecting an LTC home. Whether you're just starting the application or awaiting a placement, understanding the journey ahead will help you navigate it with confidence and clarity.

HOW DO I KNOW WHEN IT'S TIME TO APPLY FOR LONG-TERM CARE?

IMAGE: A LONG-TERM CARE RESIDENT FILLING IN PAPERWORK WITH THE HELP OF A LOVED ONE.

We all hope there will be time to have those all-important discussions about someone's wishes before we begin to support them through a chronic illness. It is a challenging decision to apply for long-term care, made jointly by the individual and their family members. There are several factors to help you know when it's time.

- Their ongoing care needs exceed the services available in the community, family (or friends), or current residence.
- They need help with tasks like getting dressed, eating, or bathing.
- They need constant monitoring for safety and well-being.
- They are unable to return home after a hospital stay.
- They need nursing care available 24 hours a day. One of the biggest clues to help you know when to apply for LTC is the declining health of not only the care recipient but the caregiver as well. Sometimes the need to apply to LTC is propelled by a sudden, unexpected event like a fall leading to a broken hip, a stroke, a significant decline in cognitive function, or the loss of a spouse.

Unfortunately, most people have little knowledge about the long-term care sector and its systems, which contributes to the myths that shape what we think about LTC. These myths shape how we think and feel heading into the application process. One such myth is that residents are "dumped" into homes by their families.

NOTE: YOU CAN FIND MORE INFORMATION TO HELP YOU HAVE A PRODUCTIVE CONVERSATION WITH YOUR LOVED ONE ON PAGE 40.

HOW DO I APPLY TO LONG-TERM CARE?

In Ontario, the application process for moving into an LTC facility involves several steps, each requiring careful consideration and coordination. For many caregivers, navigating this complex system can be overwhelming and stressful, as it often involves gathering extensive documentation, understanding eligibility requirements, and making difficult decisions about care options. The emotional weight of transitioning a loved one into long-term care, combined with the logistical challenges, can make this journey particularly daunting. This guide will walk you through each essential step, providing clear instructions and practical advice to make the journey smoother.

THE NARRATIVES FOUND THROUGHOUT THIS GUIDE

These narratives aim to illustrate the practical impact of various processes and decisions on individuals and their families. By sharing these stories, we hope to provide a deeper understanding of the emotional and logistical aspects of navigating long-term care.

Contact Ontario Health atHome

If you're caring for someone who now needs long-term care, you'll need to reach out to Ontario Health at Home (OHAH) in your community to start the process.

You can call
310-2222
for service in English
or
310-2272
for service in French

You will then be assigned a care coordinator who will become your main point of contact at OHAH throughout the application process. The care coordinator will speak with you and discuss the application process. They will explain the steps of the assessment and collect necessary medical information to ensure your loved one is eligible to apply for long-term care.

If you are a caregiver supporting someone preparing to be discharged from the hospital and the complexity of their medical needs means they are unable to return home, hospitals will have a care coordinator (employed through OHAH) who can help start the application.

Documentation

Certain information and documents are needed to complete the application for LTC and the move-in process. To help expedite the process, you will want to make sure that the following documents are available and up to date:

- ☐ A valid Ontario health card (OHIP)
- ☐ Power of Attorney for Care and Property (see page 48)
- ☐ Notice of Assessment (NOA) Summary received from Canada Revenue Agency once yearly income tax is filed
- ☐ Updated list of medications
- ☐ Advance Care Plan (see page 90)
- ☐ Insurance benefit information or veterans benefit information
- ☐ A void cheque
- ☐ Proof of up-to-date vaccinations (COVID-19, Tetanus, Diphtheria, Flu)

THE APPLICATION PROCESS

Applying for long-term care (LTC) can seem complex, but understanding the process makes it easier to navigate. It typically involves determining eligibility, completing necessary forms, and choosing the right LTC home for your needs or the needs of your loved one.

Step 1: Referral

The LTC application process starts with a referral. This can be done by the person seeking a bed or, if they have a cognitive impairment, a substitute decision-maker (SDM) can make the referral and decisions about LTC on their behalf. If needed doctors, nurses or social workers can also initiate the referral process.

A care coordinator from OHAH will receive the referral and will speak with the potential resident or their SDM to determine eligibility for LTC. Once OHAH staff confirm that they are eligible, they will begin the application process. At this stage, it is important to have an open and honest discussion about applying for LTC with the potential resident. We will share details about how to have a conversation with a potential resident later in this resource.

NOTE: YOU CAN FIND MORE INFORMATION TO HELP YOU HAVE A PRODUCTIVE CONVERSATION WITH YOUR LOVED ONE ON PAGE 46

IMAGE 1.5: STEPS ADAPTED FROM ONTARIO HEALTH AT HOME GUIDE TO PLACEMENT IN LONG-TERM CARE HOMES (HEALTHCAREATHOME.CA)

Step 2: Home Visits and Selection

Once OHAH confirms your eligibility, you will be asked to submit a "Home Preference Form." This form allows you to indicate your preferred choices for long-term care residences. As you explore different homes, consider the following factors:

- **Location and proximity**: Consider how close the residence is to where the individual currently lives and where you, as the caregiver, are located.
- **Cultural or religious preferences:** Ensure the home can accommodate any specific cultural or religious needs.
- **Programs and activities:** Look into the types of programs and activities offered to residents to ensure they align with the individual's interests and needs.
- **Past experiences:** Reflect on any previous interactions with the home, such as volunteer work or having a family member or friend who was a resident.
- **Types of accommodations:** Review the available living arrangements to find the best fit for comfort and lifestyle preferences.

Next, you will want to contact the homes that are of interest and arrange a tour. Spending time in the home will help you and the potential resident get a feel for the community. You can talk to some of the residents to see what they enjoy about their home and get to know the staff before making the decision to join the community.

You can use the following resources (available in the Appendix) to give you some things to examine during your tour:

- Ontario Ministry of Long-Term Care Checklist: Visiting a long-term care home
- Checklist of Items to Consider when Selecting a Long-Term Care Home (Concerned Friends of Long-Term Care)
- Asking the Right Questions (Eden Alternative)
- **ontario.ca/page/choosing-long-term-care-home#section-2**
- **concernedfriends.ca/choosing-a-ltc-home**

NOTE: TO IDENTIFY LOCATIONS OF HOMES IN YOUR AREA OR IN THE COMMUNITY WHERE THE RESIDENT LIVES, VISIT **ONTARIO.CA/PAGE/LONG-TERM-CARE-ONTARIO**.

Resources to help you find and select a home:

ELDERADO.CA

Elderado is a website created to help caregivers find a retirement or long-term care home. It was founded by Daniel Clarke after his experience finding elder care for his Grandmother following her hospitalization. The tools that are available through this website were created to guide caregivers in navigating the current long-term care landscape.

Step 3: Assessment and Form Submission

Once you have confirmed that LTC is the right decision for the person you support, you will work with the OHAH care coordinator to complete the assessments and additional paperwork for an application. The care coordinator will determine the eligibility of the potential resident to apply for a bed in LTC. There are two outcomes to this assessment:

- If the care coordinator confirms that the person you care for is eligible for LTC, they will ask you to complete a Home Selection Form, where you'll list your top five choices for residences. Staff at each selected LTC home will review the application to assess whether they can meet the needs of the potential resident. If a home determines that its care team is unable to meet those needs, the application will be declined. In such cases, the care coordinator will reach out to discuss alternative options and help you choose another LTC home.
- If the potential resident is deemed ineligible for LTC, the care coordinator will explain the reasons and assist you in exploring alternative solutions to meet their needs. You will then be connected with local organizations to arrange services such as meal delivery, friendly visiting, or day programs, all designed to help the person you care for continue living comfortably at home.

  If you disagree with the decision, you can arrange a meeting with your care coordinator to discuss your current situation as a caregiver. The care coordinator will then work with you to address your concerns.

REPORTS ON LONG-TERM CARE HOMES

You may also want to search the public reporting on facilities to view inspection information and findings.

publicreporting.ltchomes.net/en-ca/Search_Selection.aspx

Step 4: Waitlists and Wait times

Unfortunately, there is often a waiting period between the application, selection, and move into an LTC home. Wait times can vary significantly from one home to another and are influenced by factors such as the type of accommodation requested and the specific care needs of the potential resident. We understand that this waiting period can be stressful for caregivers. During this time, the care coordinator will continue to offer support and ensure that your needs are met while you await a bed offer. They can also provide you with up-to-date information about the current wait times for the homes you selected on your Home Selection Form.

If you remain on the waitlist for an extended period, your care coordinator may need to reassess the potential resident and your caregiving situation. If you require urgent support, you may be encouraged to consider an LTC home with a shorter wait time. If you decide to move the resident into a home that wasn't on your initial selection form, they will remain on the waitlist for your original choices and can transfer to one of those communities when a bed becomes available.

If the potential resident is waiting for an LTC bed while in the hospital, their care team will work with you to develop the best possible immediate and long-term plan. One key difference between waiting for a bed in the community and waiting from the hospital is the additional support provided by the hospital team. Due to the increasing demand for hospital beds, you may be encouraged to consider temporary LTC homes with shorter waitlists.

Step 5: Bed Offer

When a bed becomes available at one of the homes on your preference form, the care coordinator will reach out to you. You will then have 24 hours to decide whether to accept or decline the offer.

Because of the demand for beds in LTC, if you accept the offer your family will have five days to move into the home. Once the bed is accepted, you will pay a pro-rated cost for the five days. If the bed that is offered is not your number one choice on the list, you can also request to keep the resident's name on the waitlist. Unfortunately, while you can remain on the waitlist, your priority for the other choices will change when you accept a bed in another home.

If you are providing care to the potential resident in the community and you reject an offer of a bed for an LTC home, OHAH will close your file and the potential resident will be removed from the waitlist. As a caregiver, you will not be able to submit another application for LTC for 12 weeks.

If you are supporting a potential resident who would be transferred to LTC from the hospital and reject an offer of a bed, the potential resident will remain on the waitlist for LTC. The team at the hospital will be informed that you have declined the offer and you will be charged $400.00/day if the resident remains in the hospital but no longer needs acute care, as per the More Beds Better Care Act.

NOTE: What is Bill 7?

Bill 7, the More Beds Better Care Act of 2022, is another factor shaping wait times for LTC. To make sure residents get the care they need in the right place, the healthcare team can initiate some steps in the application process for LTC without the consent of the patient or their SDM. They can also initiate the transfer process from a hospital to an LTC without the consent of the resident. When transferred to an LTC home while waiting for a bed available at a home of their choice, they will remain on the waitlist with priority status. Individuals who require chronic care and permanently live at the hospital may be required to pay a chronic care co-payment. The maximum co-payment is $63.73 a day and the majority of the fees cover the cost of meals and accommodation. As of November 20, 2022, patients who have been discharged from the hospital and asked to transfer to an available LTC bed but choose to remain in the hospital will be charged a fee of $400.00 per day.

Step 6: Move-in Day

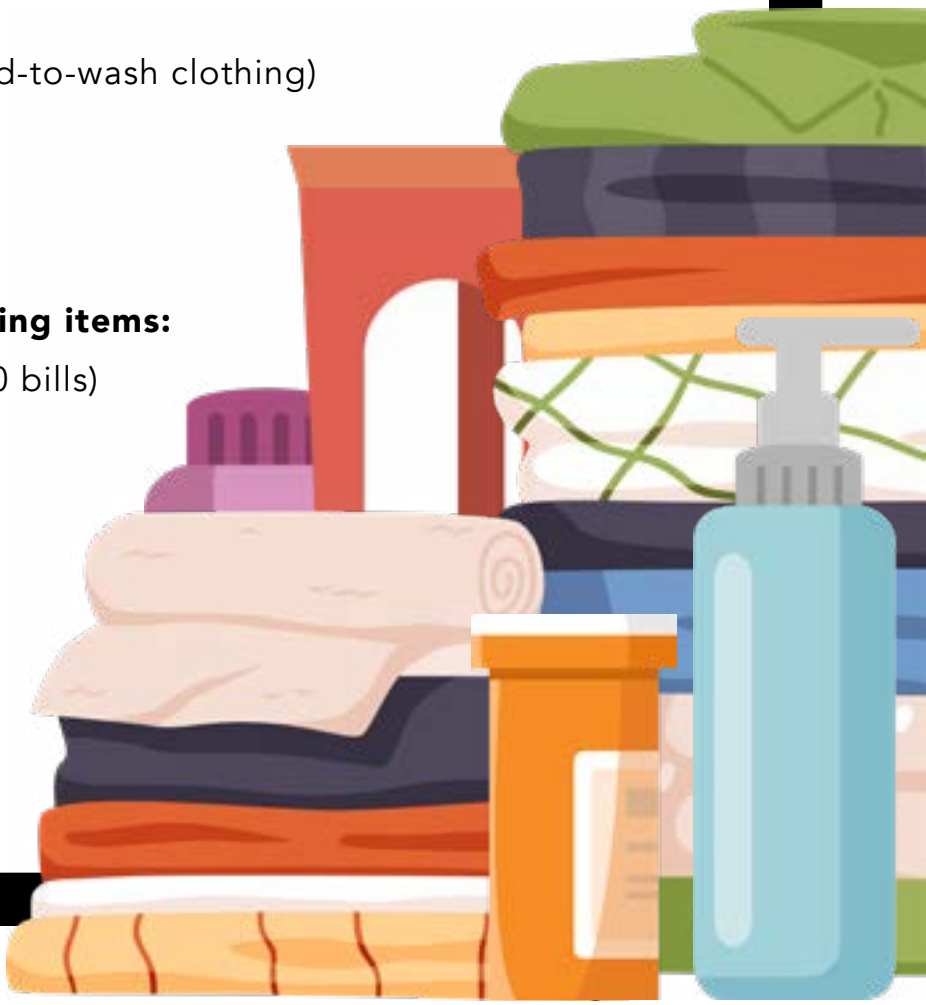
Once you accept a bed, you will be responsible for paying all expenses and arrangements for moving personal belongings for incoming residents. You will need to complete additional forms (listed below) before move-in day and bring them with you to the LTC home.

We have provided a detailed checklist of the items to bring with you for move-in day. You will also need to bring the following with you:

- ☑ A list of the names and quantity of all prescribed medications
- ☑ The resident's OHIP card
- ☑ Completed Family Information Assessment Form
- ☑ Power of Attorney for personal care and property (if applicable)
- ☑ Income Tax Notice of Assessment (basic accommodation rooms only)
- ☑ Assistive devices (i.e. mobility aids, such as wheelchairs, scooters, walkers, canes, crutches, prosthetic devices, and orthotic devices)
- ☑ Glasses or other sight-assistive devices
- ☑ Hearing aids and extra batteries
- ☑ Machine washable clothing (avoid bringing delicate or hard-to-wash clothing)
- ☑ Toiletries
- ☑ Dentures
- ☑ Personal items

You <u>should not bring</u> the following items:

- ☒ Large sums of money (i.e. $100 bills)
- ☒ Jewelry (i.e. a diamond ring)
- ☒ Family heirlooms
- ☒ Food that is not kept in closed containers
- ☒ Sharp objects (i.e. scissors)



WHAT ASSESSMENTS ARE PART OF THE APPLICATION PROCESS?

We mentioned assessments earlier when we outlined the process of applying for LTC. An assessment refers to the systematic process of collecting and analyzing information about a person to understand their needs, strengths, and preferences when it comes to their health and care. This information is also used to guide decisions about details in their care plan.

For long-term care, assessments are focused on the individual. As described in Section 1 of this guide, this person-centred approach considers the unique perspectives of each resident, their families, and communities. It ensures that health care and services are delivered in response to the specific needs and preferences of those involved, including anyone who benefits from these services.

Person-centred care requires families of residents to educate themselves on how to effectively support their role in decision-making and actively participate in the care process (World Health Organization, 2016). A person-centered approach to assessment means that residents and families understand the role of the assessment and share information with members of the care team to help them create a care plan that reflects their unique needs and goals in LTC.

To get a well-rounded understanding of a potential resident, the assessments will examine their mental and physical health, social supports, and everyday activities of daily living like eating and dressing. If you have been involved as a caregiver supporting someone living in the community, you may already have experience with assessments.

Marie's Assessment: A Path to Personalized Care

Marie sat quietly in her armchair, watching as a nurse from Ontario Health at Home arrived with a laptop and clipboard. The nurse was there to conduct an Inter-RAI assessment, a tool used to gather detailed information about Marie's health and abilities. Angela, Marie's niece and Power of Attorney, sat beside her, ready to help.

The nurse explained that the Inter-RAI assessment is used to evaluate the care needs of seniors like Marie and to support decisions about home care, Long-Term Care (LTC) placement, and hospital admissions. It collects a wide range of data, including physical and cognitive abilities, mental health, and medical conditions.

STORY CONTINUED ON THE NEXT PAGE

Inter-RAI

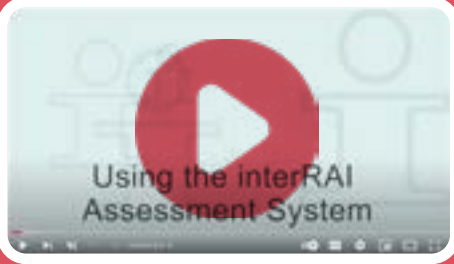
In Ontario, OHAH uses the Inter-RAI assessment to provide support for decisions related to the home care services and support provided in the community.

Inter-RAI is an international collaborative network of researchers in 32 countries to support the care provided to seniors in the community and predict the need for LTC placement or hospitalization. They are a non-profit group dedicated to improving the care of disabled or medically complex individuals through collaborative research and development of high-quality assessment tools. They have rigorous standards to ensure tool reliability and validity and offer assessment systems in various care settings.

Inter-RAI has pioneered a set of standardized tools to collect information about physical and cognitive abilities, mental health, and medical complexity. These tools are used across Canada and the information collected can support care planning and resource allocation, and guide quality improvement.

In LTC, Inter-RAI is one of the assessments used for the move-in process. It helps to establish the baseline status of residents when they move into the home. Residents will be re-assessed each year or when they experience a significant change in their health. The information gained is incorporated into the care plan.

VIDEO:
USING THE INTER-RAI ASSESSMENT SYSTEM



YOUTU.BE/5NAWOML4904

"Don't worry, Marie," the nurse said. "This assessment will help us understand what you need so we can create a care plan that's right for you."

By the end of the assessment, the nurse had gathered a comprehensive picture of Marie's health and care needs. The information would be used to help Angela decide whether Marie could stay in her retirement community with extra support, or whether she would need to move to LTC.

Marie felt tired but relieved. "It wasn't so bad," she said with a small smile. Angela squeezed her hand. "No, it wasn't, Aunt Marie. Now we know what you need, and we'll make sure you get the right care."

Capacity Assessment

Consent and capacity are both important factors informing the delivery of health care and support provided to residents in LTC. In Ontario, it is a legal requirement that the consent of a potential resident is obtained before they can move into LTC. Unfortunately, for many seniors, a cognitive impairment may cause a decline in their memory, reasoning, or judgement. Due to these cognitive changes, they may not recognize their need for placement in LTC.

Capacity refers to the ability to make decisions based on awareness and understanding of the consequences tied to their actions (Best-Martini, 2011). There are several types of capacity including the ability to make decisions about finances and managing property, personal care, and health care.

In Ontario, it is assumed that anyone over the age of eighteen is capable of making decisions until it is proven otherwise (Ontario, Mental Capacity). Thus, if incapacity is suspected, then there is a need to assess the potential resident's capacity for consent. This assessment is conducted by a capacity assessor who has undergone specialized training. The following professionals may serve as a capacity assessor:

- Doctor
- Nurse
- Psychologist
- Social Worker
- Occupational Therapist

Carlos's Assessment: A New Chapter

After Carlos's stroke, his son Jose began to worry about his father's ability to make informed decisions regarding his care. Carlos had been showing signs of confusion and frustration, and while he often understood his immediate surroundings, there were moments when his memory and judgement seemed to falter.

During the assessment, Carlos was asked a series of questions to evaluate his understanding of his health condition, his care needs, and the consequences of refusing or accepting long-term care placement. The assessor observed his reasoning, memory, and ability to weigh the benefits and risks of the decision. It became evident that, while Carlos had moments of clarity, his reasoning was impaired, particularly when it came to understanding the long-term effects of his stroke and mobility challenges.

The assessment concluded that Carlos lacked the capacity to make fully informed decisions about his care. As a result, Jose, acting as his Power of Attorney, would need to take on the responsibility of making decisions on his behalf. This decision wasn't easy for Jose, who felt the weight of taking over such a crucial part of his father's life, but he knew it was necessary for Carlos's well-being.

Functional Assessment

A functional assessment refers to the evaluation of physical and cognitive abilities that are needed to support independence. This assessment will measure a potential resident's physical health including their ability to complete activities of daily living (ADLs) and instrumental activities of daily living (IADL).

ADLs represent activities that are a part of someone's ability to function in their everyday life. Examples of ADL are bathing, dressing, toileting, eating, transferring (movement from one place to another), and grooming. IADLs differ as they are activities needed to live independently in the community. Examples of IADLs are grocery shopping, cooking, baking, cleaning the house, using the phone, making medical appointments, taking medications as prescribed, banking, and working or volunteering.

Behavioral Assessment

Many people living in long-term care homes experience changes in behaviour called the behavioural and psychological symptoms of dementia (BPSD). The valid and reliable assessment of BPSD is essential to guide treatment and monitor the effects of interventions. Behavioural assessment tools, in particular a direct observation tool, are widely used in clinical care in LTC homes. Education, enhanced resources, leadership support, and applications of technology represent opportunities to improve their use.

Leo's Assessment: Understanding His Needs

The assessor, a healthcare professional from Ontario Health at Home, visited Leo in the hospital to carry out the evaluation. The process began with assessing Leo's Activities of Daily Living (ADLs), such as his ability to perform basic self-care tasks. The assessor observed whether Leo could transfer from his wheelchair to his bed, bathe, dress, and eat independently. Due to his deteriorating health and reliance on the ventilator, Leo needed significant assistance with these tasks. He struggled with transfers and required help with grooming and feeding, highlighting his need for round-the-clock care.

Next, the assessor focused on Leo's Instrumental Activities of Daily Living (IADLs), which included more complex tasks necessary for living independently, such as managing medications, preparing meals, and handling finances. Since Leo was now dependent on Noor for many of these activities, his functional assessment confirmed that he could no longer perform IADLs without substantial support.

The results of the functional assessment were vital in determining Leo's eligibility for LTC and informed the creation of a tailored care plan that would ensure he received the appropriate level of assistance.

HOW DO I KNOW WHEN TO HAVE "THE TALK"?

If you're unsure about how or when to have "the talk" with a potential resident about the need to explore additional care options, you're not alone. Our sense of hesitation to initiate this conversation is connected to our emotions, including anxiety and fear, about how our loved ones may react to the topic. We may assume they will be in denial of the decline in their health and ability to meet their needs within the community. It is important to overcome these barriers caused by our apprehension and work to involve all potential residents, including those with cognitive impairments, in the discussion about their need to move into LTC.

Getting the potential resident involved is important to allow them the opportunity to share their feelings. They may feel nervous, afraid, or angry about the need to move into LTC (Silin, 2001). If you have served as a support to them as a caregiver, they may express a fear of being abandoned during the move to LTC, accompanied by a sense of resentment towards you. When you do decide to talk with them about the need to begin the process of applying for a bed in LTC, here are some things you can do to help you prepare for "the talk."

Take a broad approach to the conversation

One way to frame the conversation is to have them examine the "big picture" and anticipate what will happen in the future. If you live with them and serve as their main caregiver, initiate the discussion by sharing, "I've been thinking about what we would do if something happened to me." Recognizing the extent they depend on you to provide them with support and the uncertainty about your ability to continue in that role may help them understand the importance of moving into LTC. It is important to plan for continuity in their care regardless of your role and presence in their life. Confirming this may even make someone feel less apprehensive.

Signs It's the Right Time to Have the Talk

Unfortunately, many chronic conditions and cognitive impairments are progressive. Most people postpone the talk about moving into LTC until they experience a crisis, which triggers the immediate need to have "the talk." The urgency of the discussion can make the decision-making process feel rushed. Heightened emotions during a crisis may leave you feeling overwhelmed by the information shared with you. Even during a crisis, once you decide to apply for a bed in LTC, and depending on the community where you live, the size of the waitlist may mean you will need to wait for an available bed.

To help you avoid being overwhelmed by information about LTC, you should be proactive. To make sure you are planning ahead, pay attention to the following warning signs that a crisis may be coming (Silin, 2001):

WARNING SIGNS

Your physical health is suffering because of your role as a caregiver.

You are burnt out (feel hopeless, overwhelmed).

Your loved one's health is suffering (no longer eating, challenges in taking medication, open wounds or bed sores, resistance to care).

Your loved one's safety is at risk.

You can no longer provide them the care they need (i.e. lifting/ transferring them, helping them get dressed, helping them go to the bathroom).

You have limited patience and are easily frustrated by their actions.

Health care professionals or staff from community agencies have told you that "it's time."

Community agencies are unable to meet their current needs for care through available programs and services.

You hide the extent of their physical or cognitive impairment from your family and friends.

Ask them to share their understanding of what you said in the discussion

To confirm that they understand what it is you discussed, ask them to share what they heard. In asking them to reflect on the subject matter of the conversation, they may identify the emotions tied to this discussion. They may also voice their questions and concerns about the process of applying or moving into LTC. Take the time to provide them with emotional support and share information with them to help ease their concerns and feel confident with the decision you are making together.

Unfortunately, due to unexpected changes in their health, you may have to have "the talk" with your loved one's doctor, nurse, or social worker present as well. There is an upside if this happens, though. The benefit of a professional initiating the conversation is that it allows you as a caregiver to take a more supportive role in the discussion. You can focus on providing emotional support.

What do I do if they refuse to accept moving into an Long-Term Care home?

In Ontario, if someone does not have a cognitive impairment and has the capacity to make their own decisions, you cannot force them to apply to LTC. If after you have "the talk" they do refuse to acknowledge the challenges in meeting their needs at home, one can consider setting boundaries (Silin, 2001). When it comes to providing care and support them, you can set limits on the time you can dedicate to care, and the activities you are willing to do. By backing off from your role as caregiver, they may understand the extent of care they need. Setting clear boundaries will allow you to focus on yourself and your needs, which can help you avoid burn out.

“How to have “the Talk”: Jose and Carlos

Jose: Dad, I’ve been thinking about something… I know things have been tough since the stroke, and I can see how frustrated you’re getting here in the hospital.

Carlos: It’s just hard, Jose. I hate being stuck here. I want to go back home.

Jose: I know, Dad. Believe me, we all want that. But the thing is… our house just isn’t set up for everything you need now. The wheelchair, the renovations—it’s all going to take time. And I don’t want you stuck waiting for months while we figure it all out.

Carlos: So what are you saying? You don’t want me at home anymore?

Jose: No, it’s not that at all. We love having you at home. It’s just—your health is different now, and we want to make sure you’re getting the care you need. The doctors and social worker here at the hospital, they’ve mentioned something… about maybe applying for Long-Term Care.

Carlos: I don’t want to be a burden, Jose. I hate the thought of leaving my family.

Jose: You’re not a burden, Dad. We just want what’s best for you. This way, you’ll have people looking after you 24/7, especially when things get hard.

Carlos: I don’t like it… but I guess I understand. I’ll need time to think.

Jose: Of course, Dad. We’re not rushing anything. Let’s take this one step at a time, okay?

LEGAL MATTERS

Before transitioning into long-term care, it's crucial to address a variety of legal matters to ensure a smooth and secure move. These discussions can help protect the rights and interests of the potential resident and provide peace of mind for both the individual and their loved ones. Key topics include establishing or reviewing powers of attorney, understanding consent and capacity laws, and ensuring that all necessary legal documents, such as wills and advance directives, are in order. Addressing these legal aspects early on can help avoid complications down the road and ensure that the resident's wishes are respected.

What is a Power of Attorney?

A power of attorney (POA) is a legal document giving someone you trust the right to make financial or health care decisions for you. This person does not need to be a lawyer or an attorney. There are two types of power of attorney: **Personal care, and property.**

Who can serve as a POA?

When deciding who will serve as your POA it is important to choose someone you know and trust. The following people may be a good choice:

- **Children**
- **Grandchildren**
- **Spouse or partner**
- **Long-time friend**

Before finalizing your decision about a POA it is best to take the time to have a focused conversation with them to ask how they feel about the role and if they would be willing to take on the responsibilities. This is also a great time to share your wishes with them and let them know how you would like your financial affairs and personal care to be handled. When choosing someone to serve as your POA it is important to recognize that you should never feel pressured to choose a specific person. Some people are uncomfortable choosing a family member or friend to take on this responsibility. In these cases, those people opt to appoint a lawyer or a trust company as their POA.

What is a Substitute Decision Maker?

A substitute decision-maker (SDM) is a person designated to make decisions on behalf of someone unable to make decisions about their care. This includes making decisions for someone about what they eat, where they live, their healthcare, and medical treatment.

Who can serve as an Substitute Decision Maker?

An SDM can be anyone you trust to carry out your wishes, including:

- **Spouse or partner**
- **Child**
- **Grandchild**
- **Sibling**
- **Life-long friend**

According to the Health Care Consent Act (1996), the SDM needs to meet the following criteria:

- **Understand the information about the treatment or intervention, including the potential consequences of their decision**
- **Over the age of sixteen**
- **No legal documents that would prevent their access to the person they would be making decisions for** (i.e. court order/separation agreement).

It is possible for someone to appoint more than one SDM. However, in this case, one of the people named as an SDM would also need to sign a POA of personal care.

How do I make a Power of Attorney?

To create a POA for personal care or property, you need to meet the following criteria:

- **Mentally capable** (capacity to make decisions)
- **Over the age of eighteen for POA of property**
- **Over the age of sixteen for POA of personal care**

You can make your own POA document or you can have one created for you by a lawyer. If your personal or business affairs are complicated it is advised that you talk to a lawyer. This is important if you:

- **Run or own a business**
- **Have complicated family dynamics**
- **Are considering giving someone a POA for the property through your bank**
- **Own assets in another province, territory, or country**

Why it's important to have a POA for Personal Care

Having a Power of Attorney (POA) for personal care is critical because it gives someone you trust the legal authority to make important decisions about your health and personal well-being if you become incapable of doing so. Without a POA, your family may face limitations in making these decisions. Here are three key examples of why a POA is necessary:

Medical Treatment Decisions: Without a POA, family members can make some basic decisions but may not have the authority to make crucial medical choices, such as consenting to or refusing life-sustaining treatments.

Living Arrangements: While family members can often express opinions, they may not have the legal power to decide where you live (e.g., moving into a long-term care facility). A POA allows your chosen person to make appropriate decisions about your living situation that align with your wishes, ensuring you receive the necessary level of care and support.

Consent for Personal Care Services: If you need assistance with daily activities such as bathing, dressing, or receiving home care services, your family may not be able to consent on your behalf without a POA.

Why it's important to have a POA for Property

Power of Attorney for property grants someone the authority to manage your financial affairs if you become unable to do so. This legal document can provide peace of mind knowing that your financial matters are being handled by someone you trust. Here are expanded tasks a POA for property can perform on your behalf:

Pay Bills: They can ensure that all your bills, such as utilities, mortgage payments, insurance premiums, and other recurring expenses, are paid on time.

Collect Money Owed to You: The attorney can pursue and collect any outstanding payments or debts owed to you, including pensions, benefits, rental income, or refunds.

Maintain or Sell Your Home: If necessary, the attorney can make decisions regarding your real estate, including maintaining the property, paying for repairs, handling tenants if it is a rental property, or selling the property if needed.

Manage Investments: The attorney can oversee your investments, including monitoring and adjusting your portfolio as needed.

If you do not have a POA for property, your family, including your partner or spouse, cannot automatically step in to make financial decisions for you. They may need to go to court to become a court-appointed guardian.

RESOURCES

If you want to understand more about the role of an SDM, you can access the SDM resource guide available through **Advance Care Planning Ontario**.

advancecareplanningontario.ca/substitue-decision-makers

They also have videos to explain the details about an SDM and a "My Substitute Decision-Maker Card" that you can complete online.

advancecareplanningontario.ca/acp/acp-workbook/substitute-decision-maker

The Ontario Palliative Care Network has also created a great resource providing answers to frequently asked questions about Advanced Care Planning, Goals of Care, Treatment Decisions, and Informed Consent. This resource will include additional details about SDMs in Ontario.

ontariopalliativecarenetwork.ca/sites/opcn/files/2021-01/OPCNGocFAQ.pdf

The Ontario Caregiver Organization provides additional resources for caregivers about Health Privacy and Consent in Ontario as well as information about frequently asked questions on privacy and consent for caregivers supporting someone incapable of making their own decisions.

ontariocaregiver.ca/wp-content/uploads/2021/08/Understanding-health-privacy-and-consent-in-Ontario-a-guide-for-caregivers-and-providers-Aug4.pdf

ontariocaregiver.ca/wp-content/uploads/2021/08/FAQs-on-Privacy-and-Consent-for-Caregivers-Supporting-Someone-Incapable-of-Making-Their-Own-Decisions-Aug4.pdf

If you want to create your own POA, you can use the following toolkit available through the Government of Ontario.

publications.gov.on.ca/300975

You can also use the Guided Pathway to prepare a POA created by Steps to Justice
stepstojustice.ca/guided-pathways/wills-and-powers-of-attorney-preparing-a-power-of-attorney/

HOW TO CHOOSE A LONG-TERM CARE HOME

One of the required forms when applying for LTC is the Home Preference Form. As you do your research and explore LTC homes in your community, you will want to arrange a time to visit each of these homes. As Pat Armstrong states, "The conditions of work are the conditions of care." When touring LTC communities, this means looking beyond the physical appearance of the facility. Look at how the staff interact with residents. How do the residents respond? How do the staff interact with each other? Do they seem exhausted? Are they constantly on the go?

> *"It was great to go visit the homes because you walk in a building, you get a sense in thirty seconds if this is the place you would like to live. You hear other people interact, things you hear, things you smell, etcetera. You get a sense of the culture of the building."*

Another thing that a virtual tour can't show is the dynamics between staff hierarchies (administration and PSWs), plus the relationships between staff and family members.

> *"It is the administration and the core team, the management team, that sets the attitude to make sure there isn't them versus us in terms of family members being the problem and creating barriers. Versus where you can have great collaboration between management, residents, and family members. And they [administration] treat family members as consultants. [A] lot of homes will do this, they will create that collaborative environment and ensure that all staff know that that's part of the culture."*

Questions to ask yourself while touring Long-term care homes

If you know someone—a family friend or a neighbour—who lives in a potential LTC home you are considering, it could be a great opportunity for you to pay them a visit or two. As you spend time in the LTC community it is important that you ask a variety of questions to help you understand the philosophy of care guiding the delivery of care to residents. Below is a list of questions you can ask yourself as you visit a potential LTC.

Resident Lifestyle and Daily Routines:

Are the residents dressed in clean, tidy clothing?

Is the resident's hair brushed?

Are the interactions between residents and staff natural or forced?

What are the residents doing when you visit?

How do residents interact with each other?

How are residents involved in creating the activity calendar and menu?

What is the residents' role in quality improvement?

How do they manage residents with responsive behaviours?

What opportunities exist for residents to spend time outdoors?

How do they support residents' choice to smoke cigarettes or consume alcohol or cannabis?

Are the programs offered on the monthly calendar varied?

Are there programs offered to meet different levels of skill?

Are families invited to join in programs?

How can residents continue to be involved in their community outside the LTC home?

Does the home have an active residents' council?

YOUR NOTES:

Staffing:

What is the staffing level in the home during (a) daytime, (b) evening, and (c) weekends?

How often does the home require agency staff to support full-time regular staff?

What training do staff receive and complete?

Can the family participate in training with staff?

What do staff wear as they work?

Where are the staff workstations located in the areas of the home?

How are staff communicating with each other?

Dining:

Is there a place where you can prepare a meal with the resident?

Does the food served to residents look appetizing?

What does meal service look like in the dining room?

How do they accommodate specialized diets?

When are meals and snacks served to residents?

Will staff help residents who need support with feeding?

Can residents choose to dine in their rooms?

What happens if a resident misses mealtime for an appointment?

YOUR NOTES:

Philosophy of Care:

What words describe the approach to care?

How are staff encouraged to build relationships with residents?

How are residents encouraged to make choices in their daily lives?

What are the policies for visiting?

Are there any limitations to the care they can provide?

Physical Environment:

Are the private and shared spaces in the home well-lit?

How many residents live in each neighbourhood of the home?

How many working elevators are in the home?

Does the LTC home have air-conditioning?

Are the emergency exits identified?

Is the emergency plan posted?

Is the following information posted in the lobby of the home?

- Mission and Vision
- Residents' Bill of Rights
- Emergency Plan
- Accreditation
- Quality Improvement Plan
- Complaints process
- Residents' Council meeting minutes
- Family Council meeting minutes

YOUR NOTES:

SECTION THREE:

WHAT CAN I DO WHILE I WAIT FOR A BED OFFER?

LEARNING OBJECTIVES

- *Explore activities that help you prepare for the transition to Long-Term Care.*
- *Learn the "P.I.E.C.E.S." method for organizing for organizing the resources you need as a caregiver.*
- *Assemble a personalized life story to help staff get to know a resident.*
- *Develop a plan to build and strengthen your circle of support.*

ACTIVITIES FOR CAREGIVERS TO PREPARE

Unfortunately, it is rare to receive an immediate offer of a bed in LTC. While you cannot control how long you wait, you can control what you do while you wait. This section provides suggestions to help you prepare for when you receive the call for a bed. We also include some points to consider about the logistics of move-in day. Finally, we highlight important legal and financial documents to gather while you prepare.

Making use of the time while you wait will help to minimize your stress during the move-in process. In managing your own emotions you will be able to focus on supporting your loved one and meet their specific needs. Don't forget to seek assistance from the people in your circle of support to help you with your feelings at the end of move-in day, after you leave the LTC community.

Planning the Logistics of the Move

We know that you can't bring all the resident's belongings and furniture with them once they move into LTC. While you are waiting, you can decide what to do with the items that are not going to make the trip. If you live together, it's easier to choose which items to keep at home for them to enjoy when they visit.

If they live in their own home or apartment, you will need to decide what to do with all the furniture they can't bring with them when they move. If they are hesitant to part with their belongings, there are several strategies to navigate the process of downsizing and honouring their life. As you begin to discuss their possessions, make sure you avoid being judgmental (Tamblyn-Watts, 2024). The items in their home or apartment are theirs and reflect their preferences and life story. There are stories attached to each item and while you may not feel emotional about the thought of getting rid of these items, your family member might.

As you start the process of downsizing, you will need to share your expectations about the process. How are you going to work together? What items do they feel are important to them and their identity? How do they feel about the process? How have they felt about moving in the past? How can you help them with the process? Depending on the information you gain through this discussion, you may realize you are not the best person to support them in downsizing. Once you come to this realization, talk with them about other family or friends who can support the process.

If you do decide to take an active role in the process, you will need to get the following tools (Tamblyn-Watts, 2024):

- Measurements of their room in LTC
- Measuring tape
- A smart phone or digital camera
- Boxes and bags for storing items
- Labels for the following categories (absolutely keep, maybe keep, storage, give away, and throw away)
- Bubble wrap
- Rope
- Sharpies
- Something to eat and drink
- A "No Questions Box"

onesourcemoving.ca

You may also want to use a company like **ONESource Moving** Solutions that offers a one-stop shop for all things tied to downsizing and moving.

If the resident will be moving to LTC form the hospital or you are unable to drive them safely in your vehicle you will need to make a plan for how you will get them to the home on move in day.

Some options for arranging transportation include

Rapid City Transportation rapidcitytransport.com

or

RNR Patient Transfer Services rnrpt.com

What is a "No Questions Box"?

A "No Questions Box" is a designated box where you will put items that the person moving into LTC wants to keep. They can choose to put any item in this box and you will not ask them any questions, will not argue with their choice, and will not judge what they decide to include. Your choice of the size of the box is connected to the size of the space in their new home. The "No Questions Box" is a great strategy to help remind the person moving that they have control and power in the process (Tamblyn-Watts, 2024). This sense of control can be empowering and keep the process moving.

For the personal belongings that will be kept, you can plan how you will move these items to the home. Will everything fit into the vehicle you will be taking? If you are taking public transportation, then how will these belongings get there? You may need to arrange transportation.

Financial and Legal Preparations

Just like any other move, you will need to notify the bank, Canadian Revenue Agency, family doctor, and any other important contacts about the address change.

When you arrive on move-in day, some of the conversations with the care team will be centred on the kind of care or level of treatment the new resident would want to receive. This is a question you will be asked in the admission meeting so it is important that you take the time to discuss their wishes beforehand, while you are waiting for a bed offer, if you have not already. Some of this information will also be found in their Power of Attorney for Personal Care or a living will. You will want to gather legal documents like their Power of Attorney for Property and their Power of Attorney for Personal Care. You will want to be familiar with both of these documents and aware of who is appointed to make financial and personal care decisions on behalf of the resident if they are unable to make those decisions themselves.

You will need to organize their OHIP card, banking information, insurance benefit information, and Revenue Canada Notice of Assessment. Make sure to have them stored together and ready to bring with you the day of your move.

You will be expected to provide the first-month's co-payment and extra services fees (phone, cable, internet). To ensure you're prepared when you receive the call, consider setting aside some money in advance while you wait.

Resources to Help You Prepare

Caregivers have access to a wealth of valuable resources designed to support them in their challenging and rewarding roles. These resources span a wide range of topics, from practical tools and educational materials to emotional support and financial guidance.

One that can help you prepare for move-in day is the **Empathy Exchange Podcast *** and this article about **admission anxiety by Deborah Bakti ***. You can also read her book Now What to help you prepare for your new role as a partner in care in LTC.

deborahbakti.com/admission-anxiety

healthyagingcore.ca/resources/podcast-lets-talk-about-aging-parents-1

Another great book to read as you navigate the process of supporting someone as they move into LTC is **Let's Talk About Aging Parents by Laura Tamblyn Watts ***.

***NOTE:** *YOU CAN FIND LINKS TO ALL OF THESE RESOURCES IN SECTION 9.*

GATHERING THE P.I.E.C.E.S.

To help you prepare for the conversations you will have with the care team on move-in day, you can use the P.I.E.C.E.S. approach. This method was developed by the Ontario Strategy for Alzheimer's and Related Dementias team in 1997. It is grounded in best practices and evidence-based principles. P.I.E.C.E.S. is an acronym that stands for Physical, Intellectual, Emotional, Capabilities, Environment, and Social Self (Burke, 2019).

P - Physical health

Gather all the information about the individual's medical history and current health concerns (sight, hearing, mobility)

I - Intellectual abilities

Take note of the individual's issues with their memory, speech, problem-solving, and making decisions.

E - Emotional well-being

Share any strong feelings about certain events in their life or losses that may be triggered by the move. Memories may also be triggered by photos, music, or when they receive personal care.

C - Capabilities

Think about how much help your family member needs for things like getting dressed, going to the bathroom, taking a bath, and eating.

E - Environment

Think about what can be done to help them feel a sense of continuity between their new room in the LTC and their current living environment. What will help make them feel comfortable? What are any anticipated issues they may experience in their new home (i.e. noise, light)?

S - Social Self

This would include the details in their life story, their likes, dislikes, and significant events in their life, both positive and negative.

Write it Down

You may have already started to keep a journal to help you in your journey as a caregiver in the community. If you already have a journal, start to write down any questions you may have about LTC as you come across information about the home, including the Resident and Family Guidebook. If you can find answers in advance of move-in day, it will help in managing your emotions and expectations. It's also a great way to keep you organized (Cumming & Milne, 2019).

CREATING A LIFE STORY BOOK

One of the easiest things to do while you wait is to create a life story for your loved one. It shares details about their likes, dislikes, accomplishments, and major life events with staff at the LTC home. Creating a book to highlight the history of experiences they bring as they transition into the LTC community will help members of the care team understand your family members better. This information is also helpful to support conversations during the care team meeting that will occur after they move into LTC.

Whether you have an artistic flare or not there are lots of ways to build a life story book.

1. Scrapbooking

Traditional scrapbook: Gather photos, letters, memorabilia, and keepsakes to create a tactile and visually appealing scrapbook. Use decorative paper, stickers, and other embellishments to personalize each page.

Themed pages: Consider organizing the scrapbook by themes, such as childhood memories, family traditions, hobbies, and achievements. Each page can tell a different part of their story.

2. Online Book Printing Services

Digital photo books: Use online platforms like Kindred books (lovekindred.com) or storyworth (storyworth.com) to create a professional-quality photo book. Upload photos and captions, choose a layout, and customize the design to reflect the resident's personality.

Interactive options: Some services offer interactive features like adding video clips or voice recordings, which can make the story book even more engaging. Remento (remento.co) has interactive video recording features.

3. DIY Binder or Album

Customized binder: Create a story book using a three-ring binder, which allows for easy updates and additions over time. Include printed photos, typed stories, and personal reflections. You can also use plastic sleeves to protect and preserve original documents or fragile photos.

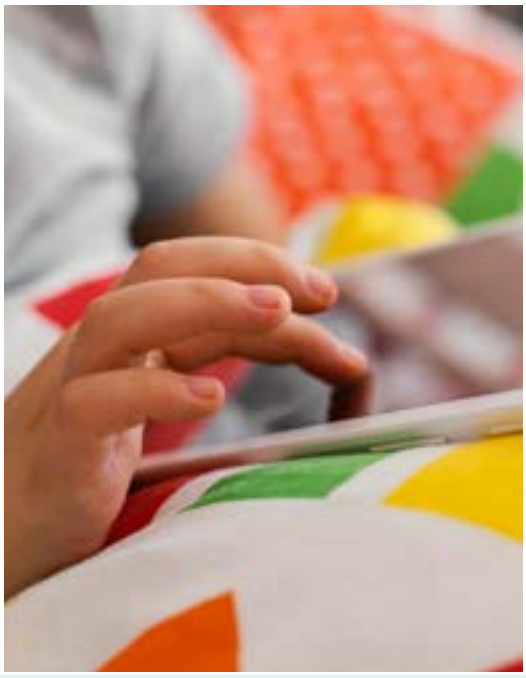
Accordion file: An accordion-style file can hold different chapters or stages of life, allowing for easy access and organization.

4. Collaborative Projects

Family contributions: Involve family members in the creation of the story book by asking them to contribute stories, photos, and memories. This can be a wonderful way to bring generations together and ensure the book reflects the perspectives of many loved ones.

Group effort: Engage friends, caregivers, and the residents themselves in the process, making it a collective project that strengthens connections.

5. Multimedia Options



Video life story: If the resident enjoys watching videos, consider creating a digital version of their life story using video editing software. Combine old home movies, voiceovers, and photo slideshows to bring their memories to life.

Audio recordings: Record the resident sharing their memories, which can be included as part of the book or as a standalone audio version.

Tips for Creating a Meaningful Life Story Book

Focus on joyful memories: Highlight positive and joyful memories that bring happiness to the resident.

Include personal details: Incorporate favourite quotes, songs, recipes, or anything that holds special significance to the resident.

Be flexible: The life story book can evolve over time. Keep it open-ended so new memories and experiences can be added.

Share the Joy: You can read the Life story book you create when visiting with your loved one in long-term care.

YOUR CIRCLE OF SUPPORT

We know that move-in day is overwhelming for both resident and their family members. To help you prepare for the move-in day, you will want to build a circle of support (Cumming & Milne, 2019). Identify people who know you and who you are comfortable sharing your thoughts and feelings with. Beyond family and friends, you can also explore additional supports available for caregivers including the local Alzheimer's Society, the Ontario Caregiver Organization, and if there is an active family council at the LTC. If there is a family council, ask if there is a mentoring or buddy system that would connect you with a family member who has already navigated the move-in process for that home. If you are unsure if your LTC has an active family council, feel free to explore our council directory on our website (fco.ngo).

Building a Circle of Support

Your circle of support should include trusted family members, close friends, healthcare professionals, and possibly even neighbours or community volunteers. These individuals should be people you can rely on for emotional, physical, and practical support as you navigate the challenges of caregiving.

Your support circle can help in various ways: Providing emotional support through regular check-ins, assisting with day-to-day tasks such as grocery shopping or meal prep, offering respite care to give you a break, and helping with medical appointments or decision-making. Each person in your circle might contribute differently based on their strengths and availability.

To prevent overwhelming your support circle, be mindful of how often you ask for help and ensure that you're not relying too heavily on one person. Distribute tasks evenly among your supporters and encourage open communication so they can express when they need a break. Additionally, consider expanding your circle by connecting with local support groups or professional caregiving services to share the load.

Showing gratitude is key to maintaining a strong support circle. Express your thanks through heartfelt notes, small gifts, or simply taking the time to verbally acknowledge their help. Regularly check in with your supporters to see how they are doing and offer your support in return when possible. A little appreciation can go a long way in strengthening these vital relationships.

Long Term Care Building A Circle of Support: Angela's Experience

Dealing with change of any kind is stressful. Accepting change is one of the biggest challenges in dealing with failing health and loss of independence related to aging. Caregivers too often bear the brunt of responsibility for making important decisions on behalf of loved ones facing significant change in their ability to deal with new, less than ideal situations when it comes to their health. Overwhelmed, they struggle to maintain balance between personal responsibilities at home and work. Seeking information from correct sources, and building a circle of support can help prepare the way to a less stressful transition from home or hospital to an appropriate long term care facility.

Things have been going well for Angela. Following her aunt Marie's diagnosis of Alzheimer's Disease, she had long, extended conversations with her aunt's wishes when it came to her care and end of life. Marie shard that when the time came to move from her retirement to long-term care home, she wanted Angela to choose a home that was easily accessible via public transportation so that the members of her Church and friends from her retirement home could easily visit her at her new home.

Knowing little about Dementia, Angla sought out the knowledge and support of the medical professionals who were trained to deal with assessments and interventions for Alzheimer's Disease. Relying on their opinions required time to process the information they shared with her at each appointment, as well as on-going communication with them to foster trust based on the guidance provided after each visit. The doctors also encouraged Angela to connect with the local Alzheimer's Society and explore the programs and supports available to caregivers. Angela was delighted to learn about a local caregiver support group and would attend monthly meetings.

The pressure from the staff at the Retirement Home about her aunt's growing need for additional supports prompted the sudden need to decide about her aunt's transition to a Long-term care community. During her monthly support group meeting Angela shared how her decision-making was impacted by the undue stress about affordability and suitability of long term care homes that matched her aunt's wishes. It was at this point where thought it would be helpful to expand on her established circle of support. Beyond the existing support of from the Alzheimer's Society and medical professionals supporting her aunt, Angela made connections with the social worker and registered nurses at long-term care homes on her aunt's preference list. After accepting a bed, she introduced herself to the social worker and nurses when she arrived to set up her aunt's room to establish effective communication regarding expectations for communication about her aunt's care needs. She also made connections with some of the family members in the neighborhood where her aunt would be moving. The Chair of the home's Family Council also gave her a call to introduce themselves and explain the role of the Council in the home. They let Angela know about the next date of the Council meeting and invited her to join if she was available.

HOW LONG WILL I NEED TO WAIT TO MOVE INTO LONG-TERM CARE?

Several factors influence the amount of time spent waiting for an offer for a bed in LTC. Different homes have different length waiting lists, so it all depends on which homes you gave preference to.

Another factor shaping your wait time is the urgency, also referred to as a crisis. The more urgent your need or crisis, the higher your placement will be on the wait list for a "crisis admission."

Other factors are also considered in how long you wait, including spousal or partner reunification, ethno-cultural or religious factors, the level of care required, and if the individual waiting is a veteran.

As the number of seniors in Ontario continues to grow, it is not surprising there is also an increase in the demand for beds in LTC. Currently, in Ontario, there are about 40,000 people on the wait list for LTC, which is more than 50% of the 78,000 beds in LTC (OLTCA, 2024). On average, a person on the list will wait 149 days until they receive an offer of a bed in LTC.

What Is a Crisis?

We know that while on the waitlist, someone can experience a change in their health or in the health of those providing care for them. This sudden change or turning point in a chronic disease is called a crisis. In these situations, difficult or important decisions need to be made quickly to address the needs of the person receiving care.

A crisis placement means there is an immediate need to move into LTC. When this occurs, wait times are reduced. Once a bed is available and offered, you have 24 hours to accept and must move in within 5 days. Below are the different classifications for crisis placement (Fixing Long-Term Care Act, 2021; Ontario Regulation 246/22: General).

Crisis Category 1

Someone who requires immediate admission to LTC and cannot have their needs met at home. People who are in a hospital experiencing a crisis. A current resident of an LTC that is closing within twelve weeks.

Crisis Category 2

Someone who meets the criteria to move into LTC and needs to be reunited with their spouse or partner who is currently living in LTC.

Crisis Category 3A

Someone waiting for an available bed in an LTC community that serves members of a specific religion, ethnicity, or cultural group. People with a high degree of care needs can remain at home with additional services in place until a bed is available. People waiting for an offer of a bed while in the hospital. Someone who lives in an LTC home but is waiting for an available bed at a home from their preference list submitted to OHAH.

Crisis Category 3B

People waiting for an LTC home serving those of a particular religion, ethnicity, or culture. Their care needs are currently being managed at home with support. Wait times for individuals in this category are much longer because of the limited number of culturally specific LTC communities.

Crisis Category 4A

Someone whose current needs for care are met in the community through services and support until a bed is available. Wait times for people in this category are much longer as it is possible to manage their care needs in the community.

Crisis Category 4B

People with care needs who are currently managing at home with support. Wait times for people in this category are much longer as it is possible to manage their care needs in the community.

Veteran

Individuals who are veterans of the Canadian military with care needs who are currently managing at home with support. Their wait times are shaped by the availability of beds in LTC communities with Veteran Priority Access Beds (i.e. SunnyBrook, Pearley).

SECTION FOUR:

MOVING INTO A LONG-TERM CARE HOME

LEARNING OBJECTIVES

- *Identify the next steps when accepting or rejecting an offer of a bed in LTC.*
- *Understand the daily routines in LTC.*
- *Prepare for Move in Day.*
- *Demonstrate a conversation to let someone know they are living in LTC.*
- *Plan for what to expect as a Caregiver after move in day.*

SO YOU'VE BEEN OFFERED A BED - NOW WHAT?

After finalizing all the paperwork with your Care Coordinator through OHAH, there will most likely be a waiting period until they contact you. With limited LTC accommodations and increasing demand for beds across Ontario, things can move quickly once a spot becomes available. Your Care Coordinator will contact you as soon as a suitable bed becomes available at one of the LTC homes on your preference list. At this point, you will have 24 hours to make the decision to accept or reject the offer of that bed in the LTC home. Take the time to speak with your family members and others in your circle of support who are involved in assisting you and the person you care for while you decide.

Participants in our focus group vividly recalled the sense of urgency they felt when it came time to make a decision. This pressure often heightened their anxiety, as they struggled to balance the need for a timely choice with the desire to make the best possible decision for their loved one. The rush to secure a spot in a long-term care facility, coupled with the emotional weight of the situation, left many feeling uncertain and stressed:

> *"What we see is crisis situations in long-term care and you don't really have time to shape your decision. As you said, it's very quick. You have twenty-four hours [and] your loved one is in crisis"*

Although the decision must be made quickly, caregivers can find reassurance in knowing that if a bed becomes available in a preferred home later on, a move is still possible.

> *"A medical condition can change very quickly, so there's not always time to get to where you are on the waiting list. It just doesn't happen always that way. You're fortunate enough to get that call ... you're up now. You get to pick one of the [homes] that you picked and there's a spot available. Often it's done as it was described to us in a crisis situation. Where you don't have very much time and you have to pick ... It may not be the top of your list but you still retain the right to have the move later on."*

ACCEPTING A BED OFFER

If you choose to accept the bed offer, you will be required to move in within five (5) days of acceptance. Due to high demands for long-term care homes, the Ministry cannot hold "vacant" beds. Regardless of when you move in, you will need to pay the pro-rated accommodation cost for each of the five (5) days. If the bed offered to you isn't your first choice, you can opt to keep your name on the waiting list for your other preferred options. However, please be aware that your priority on those waitlists may change once you accept a bed offer.

NAVIGATING UNCERTAINTY: ACCEPTING A BED AT A NON-PREFERRED LONG-TERM CARE HOME

It's been a month since the Coordinator at Ontario Health atHome worked with Isabella to submit an application to LTC for Carlos and Isabella finally gets a phone call with an offer for a bed. Since Carlos is considered a Category 3A Crisis admission, the bed is in a Long-term Care Community that was not on one of his preferences. Knowing Carlos will be discharged next week, Isabella ask what will happen if she accepts the available bed. The Care Coordinator assures her that if she accepts the current offer, then Carlos will still be eligible to remain on the wait list for his preferred homes. When a bed is available in one of these homes, he can opt to stay in his current home or he can move to the home on his preference list when a bed is available. Isabella accepts the offer and is told she has 5 days to help Carlos complete his move to the home. She begins by calling the home and asking for the important documentation she will need to bring with her on move in day. She also receives a copy of the Resident & Family Handbook for the home and spend some time reading and learning about the home community. Since Jose is away on a route for his job, Isabella takes the time to speak with Carlos and let him know that he will not be coming home when he is discharged from the hospital. She shares the Hanbook with him and asks him if there is anything form home he would like to see brought with him and displayed in his room when he moves into the LTC home.

FACING NEW CHALLENGES: ANGELA'S GROWING CONCERNS FOR MARIE'S CARE

It's been a month since Angela helped her aunt Marie complete her application for a bed in Long-term Care. She's starting to get impatient and concerned about the progression in her aunt's responsive behaviors, most recently being disruptive to other residents overnight, entering their rooms and rearranging their personal belongings or napping on their beds. The Retirement home indicated an immediate need for 1:1 support and she felt like she was going to have a panic attack when they shared the increase in her monthly payment. Angela calls her contact at Ontario Health at Home to share the changes in her aunt's needs. They discuss the options available to support Angela and ensure Marie has the best quality of life.

Refusing a bed offer when waiting at home

If you decide to refuse a bed offer, your file will be closed and you will be removed from the wait list for all the homes you selected on your preference form. You will be required to wait twelve (12) weeks after the day you are removed from the waiting list to re-apply for LTC. Exceptions to this rule are made if there is a change in your condition or circumstances. Since these exceptions are limited, it's important to discuss your situation with your Care Coordinator.

Refusing a bed offer when waiting in the hospital

If you decline a bed offer from a long-term care home while waiting in the hospital, you will continue to remain on the waitlist for the long-term care homes you and the placement coordinator have selected. However, if you turn down a bed offer, whether the home was chosen by you or the placement coordinator, the hospital discharge team will be notified.

If you no longer require acute medical care but choose to stay in the hospital after being discharged while waiting for a more suitable long-term care setting, the hospital will charge you a daily rate of $400.

Rejections From a Long Term Care Home

There are only two criteria that allow an LTC home to reject an application: the physical environment and nursing expertise.

The Physical Environment:
An LTC home may reject an application if the physical environment of the facility is not equipped to meet the specific needs of the potential resident. This could include limitations related to mobility, accessibility, or specialized equipment that the resident requires. For example, if a resident needs a bariatric bed or a room with certain modifications that the home cannot provide, the application may be declined on these grounds. Ensuring that the physical layout and facilities can accommodate the resident's needs is crucial for their safety and comfort.

Nursing Expertise:
An application may also be rejected if the LTC home determines that their nursing staff does not have the expertise or capacity to adequately care for the potential resident. This could involve cases where the resident requires specialized medical care, such as complex wound management, advanced dementia care, or certain types of therapy that the home is not equipped to deliver. The home must ensure that they can meet the medical and personal care needs of the resident with the available resources and trained staff.

These criteria are in place to ensure that residents receive the appropriate care and support in an environment that can safely and effectively meet their needs. Each home has someone designated to review Long Term Care Applications for the home. Once reviewed, the home determines if the resident's needs can be met.

If a home cannot accept a potential resident due to issues with the physical environment or nursing expertise, the home will notify both the client and Ontario Health atHome, providing an explanation for the refusal. Ontario Health atHome has the option to challenge the refusal if necessary.

LEO'S SETBACK: NAVIGATING NEW OPTIONS

It's been a week since Leo and Noor submitted an application for a bed in Long-term Care. This morning as they were eating breakfast they received a call form their Care Coordinator. While Leo met the criteria to apply for a bed in Long-term Care, all of the homes have rejected his application. Unfortunately, due to the use of a ventilator to support his breathing the LTC homes Leo was rejected for the reason of "Nursing Expertise". The Care Coordinator shares additional options including contacts for staff at Long-term Ventilation programs within their community.

What happens when a spouse enters Long-Term Care?

If you are married to the person moving into LTC, you will need to complete and submit an involuntary separation form. This form is NOT a divorce, it simply lets the Federal and Provincial Governments know to calculate your annual income separately. This will shape their eligibility for support to help them pay for the cost of their accommodations in LTC. Once you also meet the criteria for eligibility to live in LTC, your Care Coordinator will discuss the Spousal Reunification Process. This is a special provision that would allow you to apply for a bed and move into the same LTC community as your partner. You would be assigned to Category 2 on the waitlist and have a priority placement when a bed is available at that LTC home.

NOTE: Category 2 – Spouse or partner reunification: When a client is eligible for an LTC home and their spouse or partner has been admitted to an LTC home, that client can be assigned as a Category 2 on the waitlist of the LTC home where their spouse or partner is now living. The goal is to try to reunite the couple as quickly as possible.

LINDA'S NEW CHAPTER: LIFE AFTER TOM'S MOVE TO LONG-TERM CARE

When Tom moved into Long-Term Care, it was an emotional and challenging time for Linda. Although she understood that his condition required specialized care, the separation weighed heavily on her heart. As they navigated Thomas's transition, Linda had to complete an involuntary separation form. This form informed the government that their incomes would now be assessed separately, which was essential in helping Thomas qualify for financial support to cover his stay in the LTC home.

Despite focusing on these practical matters, Linda felt the emotional strain of living apart from Thomas for the first time in years. The Care Coordinator, however, reassured her that they could consider the Spousal Reunification Process in the future. Should Linda become eligible for LTC, she could apply to move into the same community as Thomas, where she would receive priority placement on the waitlist.

In the meantime, Linda visited Thomas regularly, making sure he was comfortable. Although their daily lives had changed, the hope of one day being reunited in the same home gave Linda peace and something positive to hold onto.

What does a typical day in long-term care look like?

As you are waiting for a bed offer in LTC you may want to know a bit more about what daily routines will look like once you move in. One of the unique aspects of life in LTC is that residents have access to support with activities of daily living (ADL) 24 hours a day, 7 days a week at the level of support they need. Staff can help residents get dressed, eat, take a shower or bath, get into and out of bed, As the residents' needs change, the level of support provided by staff in LTC will also change.

Residents receive care from a team of staff that consist of nurses, personal support workers (PSW) who work in shifts to provide 24 hour support. Meals are provided by Dietary aides who offer residents a choice of what they eat. If needed, PSWs will provide support in feeding residents. After mealtime, residents spend time in the common area watching TV or talking with other residents. This is a great time for a visit. You are also welcome to join residents as they attend any of the programs listed on the detailed activity calendar. If you have questions about any of the activities listed on the calendar you can speak with a member of the recreation team.

MARIE'S NEW ROUTINE: CARE, AND COMMUNITY

Marie's PSW, Julie, quietly enters her room, greeting her with a warm smile. Together, they work through the morning routine. Juile helps Marie with personal grooming—combing her hair, assisting with her favorite lavender-scented lotion, and helping her get dressed for the day. As they finish up, Julie ensures Marie takes her morning medications.

By 8:00 AM, the hallways hum with the clatter of breakfast trays. Marie sits at a table with a few other residents she has grown close to, enjoying her scrambled eggs and toast while chatting about the weather and the day's plans.

Today, she has signed up for a crafting session with the recreation staff, a chance to flex her creativity by making seasonal decorations for the dining hall. As the clock nears noon, Marie decides to take a brief walk in the garden with one of the volunteers.

At noon, lunch is served—soup, a sandwich, and a soft dessert. Next, the physiotherapist works with Marie on exercises that focus on improving her balance and mobility. It's hard work.

Afterward, she takes a well-deserved break at 3:00 PM, enjoying a refreshing drink. Sitting in the common room, she enjoys her time reading quietly.

Dinner begins at 5:00 PM— a comforting rice dish, just like her daughter used to make.

Tonight, it's a music hour, where a local volunteer musician will play some of the old songs that bring memories flooding back to Marie.

Around 7:00 PM, her PSW returns to help Marie prepare for bed. They chat about the day, and Marie shares her thoughts on tomorrow's activities. After washing up and getting into her nightgown, Marie settles into bed.

Sample Schedule for a Day in Long-Term Care:

TIME	ACTIVITIES	STAFF INVOLVED
6:30- 8:30 AM	Wake Up, Personal Grooming, Get Dressed, Wound Care, Take Medications	PSW, Registered Nurse
8:00- 9:00 AM	Breakfast	Dietary Aides, PSW
9:00 - 12:00 PM	Attend Programs, Spend time with Visitors	Recreation Staff, Spiritual Care Team, Volunteers
12:00 – 1:00 PM	Lunch	Dietary Aides, PSW
1:00 – 3:00 PM	Attend Programs, Restorative Care	Recreation Staff, Physiotherapist, Kinesiologist
3:00 – 4:00 PM	Refreshments, Take Medications	Dietary Aides, PSW
5:00 – 6:00 PM	Dinner, Take Medications	Dietary Aides, PSW, Registered Nurse
6:00 – 7:00 PM	Evening Program, Visiting	Recreation Staff
7:00 PM –	Personal Grooming, Bedtime	PSW

NOTE: Remember: All homes are unique and operate differently. Everyone's move-in experience and day to day activities will be different based on personal needs and preferences.

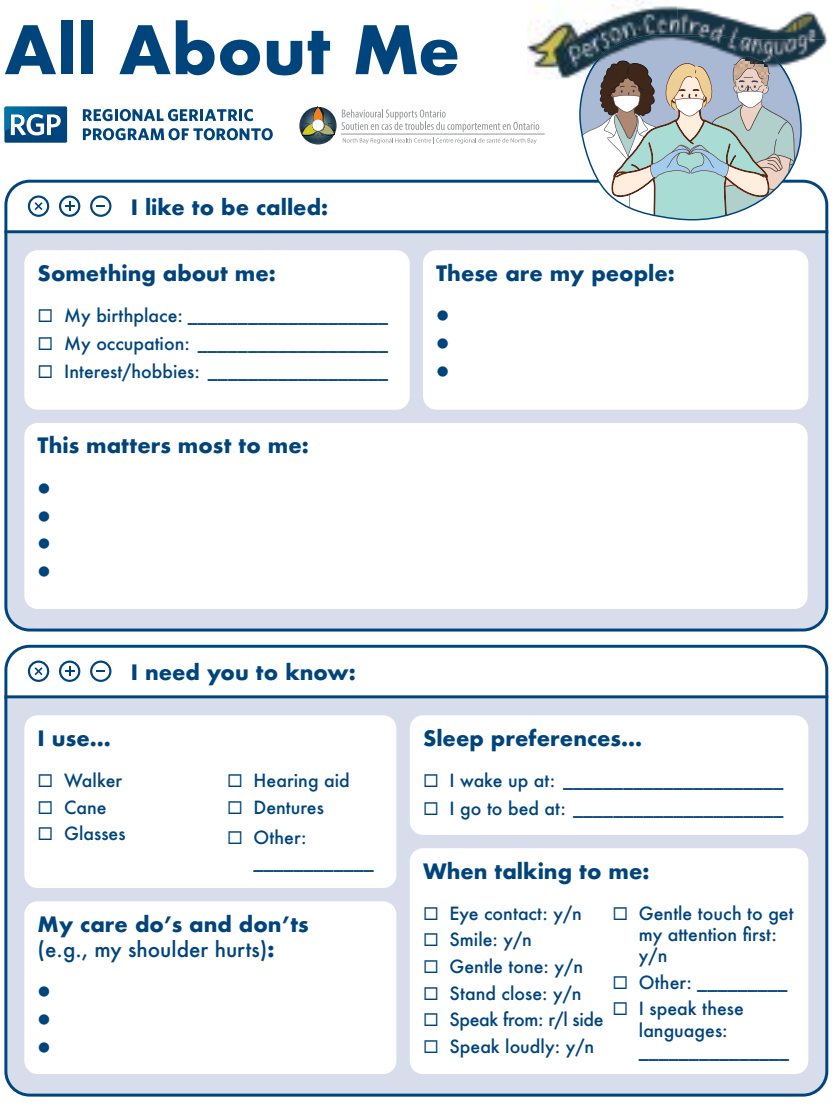
WHAT TO EXPECT ON MOVE IN DAY

Regardless of the information shared to help you prepare, it is important you realize that move in day will be long and highly emotional. Expect the day will be busy. When you arrive at the home, you will sign in and be greeted by the receptionist. There may also be a representative from the Family Council and Residents' Council there to greet you and escort you to the room the resident will be moving into. This is where you will get to see the room and for those in basic or semi-private rooms meet the other resident living in that room.

You will meet a lot of new people who work in the home including the Nurse and Personal Support Workers (PSW). Staff will meet with you both and ask questions to help them get to know you and the specific needs of the resident. The intent of the information shared in the discussion is to help them feel comfortable in their new home. Examples of questions they ask include if the resident prefers to have a bath or shower. You will have the opportunity to ask these staff questions.

The nursing staff will be conducting mandatory assessments and tests on your loved one. These include, a Mini Mental test to assess their cognitive abilities, Weight and height, assessing their needs for support in transfers and a feeding assessment to meet their dietary needs. They will also choose (if possible) when they would prefer their bath day and if they prefer a bath or shower. Your loved one's medication will need to be obtained by the home's pharmacy with orders received from the Home's physician.

The home may ask that you fill out an "All About Me" document in order to develop a person-centered Care Plan and help the staff in getting to know your loved one better.



All About Me

RGP REGIONAL GERIATRIC PROGRAM OF TORONTO

Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Person-Centred Language

I like to be called:

Something about me:
- ☐ My birthplace: _____
- ☐ My occupation: _____
- ☐ Interest/hobbies: _____

These are my people:
- •
- •
- •

This matters most to me:
- •
- •
- •
- •

I need you to know:

I use...
- ☐ Walker
- ☐ Cane
- ☐ Glasses
- ☐ Hearing aid
- ☐ Dentures
- ☐ Other: _____

Sleep preferences...
- ☐ I wake up at: _____
- ☐ I go to bed at: _____

My care do's and don'ts (e.g., my shoulder hurts):
- •
- •
- •

When talking to me:
- ☐ Eye contact: y/n
- ☐ Smile: y/n
- ☐ Gentle tone: y/n
- ☐ Stand close: y/n
- ☐ Speak from: r/l side
- ☐ Speak loudly: y/n
- ☐ Gentle touch to get my attention first: y/n
- ☐ Other: _____
- ☐ I speak these languages: _____

Your loved one will need to get swabbed for Covid 19 as well as receive a nasal and rectal swab to test for MRSA and other communicable diseases.

To break up the day and give a break from the volume of information and questions being asked, you will recieve a tour of the resident living areas for the neighbourhood including the dining room, nursing station, recreation room and any areas available for visiting.

Some homes invite residents and their family to enjoy a meal together at lunch to help them feel comfortable in the home. This is also a great way to get to know other residents and their families.

After lunch, staff will discuss important information about the policies and procedures in the home. In this meeting they will discuss the home's specific complaint process, procedures for safety and security including fire information and evacuation policies.

They will discuss accommodation fees including the basic car, programs and services included in the fees, you will hear about rate reduction programs and discuss the fees for resident absences/leaves. You will set up a trust account and discuss the additional fees for optional services like phone and cable. They will give you a copy of the resident and family handbook and encourage you to spend time after the meeting reviewing the contents.

SETTLING IN: CARLOS' FIRST DAY IN LONG-TERM CARE

Carlos' first day moving into Long-Term Care was bittersweet. The process of packing his belongings had been more difficult than expected. He carefully chose his favorite clothes and he made sure to bring along his most cherished personal items too—a framed photo of him and his late wife, a small wooden carving from his hometown in Portugal, and a record player to play his beloved fado music.

Upon arriving, the staff welcomed him warmly and helped him settle in. His schedule for the day was already outlined—starting with a tour of the facility with his PSW, followed by lunch in the dining room where he met some of the other residents.

After lunch, Carlos had some time to himself. He unpacked his things and arranged his room just the way he liked it, making sure the record player was set up to play his favorite songs in the evening. Later, he attended a brief orientation meeting with the recreation staff to learn about the various programs and activities available to him. He was especially excited to join the weekly music sessions.

By dinner time, Carlos was feeling a bit more at ease, though the weight of the transition was still heavy. The smells of the comforting rice dish served at dinner brought back memories of home, and as he sat in his room later, listening to his old records, he realized this new chapter might not be so bad after all.

WHAT TO BRING ON MOVE-IN DAY

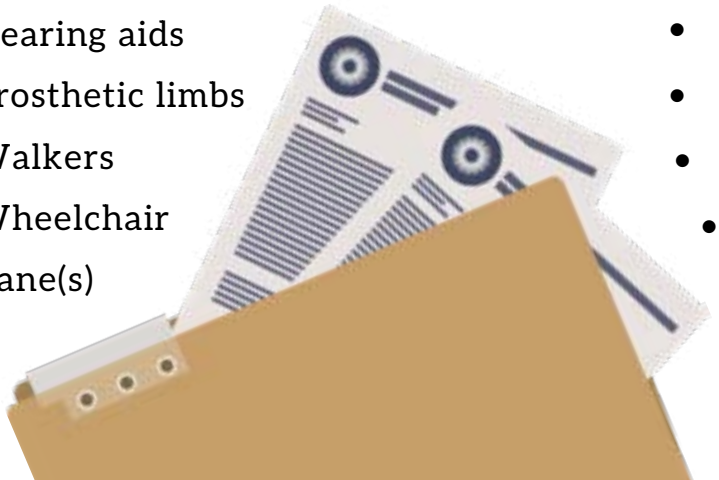
On move-in day, it's important to bring not only practical essentials, such as clothing and toiletries, but also personal items that can help make the new environment feel more like home. This guide will help you ensure that you've packed everything needed.

Personal Items

Everyone has their own preferences and things that are important to them. Most homes encourage that you bring personal items that are comforting to the resident and that will reflect "Person-Centered" Choices.

Examples of Items to Personalize the Room

- Photographs/paintings to hang on the walls
- Personal moments to display in the case in front of the room
- Photo albums
- Digital photo frame
- Favorite movies, music CDs or books
- Plants
- Clock
- Calendar
- Hangers for clothing
- Comforter/quilt/bed spread
- Glasses
- Hearing aids
- Prosthetic limbs
- Walkers
- Wheelchair
- Cane(s)



Labeling Personal Items

Labeling personal items for residents in long-term care (LTC) is essential for maintaining their dignity, comfort, and sense of ownership. With many individuals living in close quarters and sharing common spaces, it's easy for belongings to become misplaced or mixed up. Properly labeled items help ensure that residents' personal possessions, from clothing to cherished mementos, remain with them, reducing the risk of loss and confusion.

Documentation

When preparing to move into long-term care (LTC), it's crucial to have all necessary documentation in order. Proper documentation ensures a smooth transition and helps the LTC home provide the best possible care.

- OHIP Card
- List of current medications
- Power of Attorney for Personal Care
- Power of Attorney for Property
- Executor Information
- Void Cheque
- Immunization Record
- Canadian Revenue Agency Notice of Assessment

Toiletries

Long Term Care Homes are stocked with certain toiletries provided by the Ministry of Long-Term Care. However, you can still choose to bring in your loved ones preferred products.

Examples of Toiletries:

- Toothbrush and Toothpaste
- Body lotion
- Body wash and Shampoo
- Deodorant
- Denture cleaner
- Denture adhesive
- Hairbrush
- After shave (for men)
- Electric razor
- Cosmetics
- Box of Kleenex
- Sunscreen
- Moisturizer
- Soap
- Scent free detergents and softener

Clothing

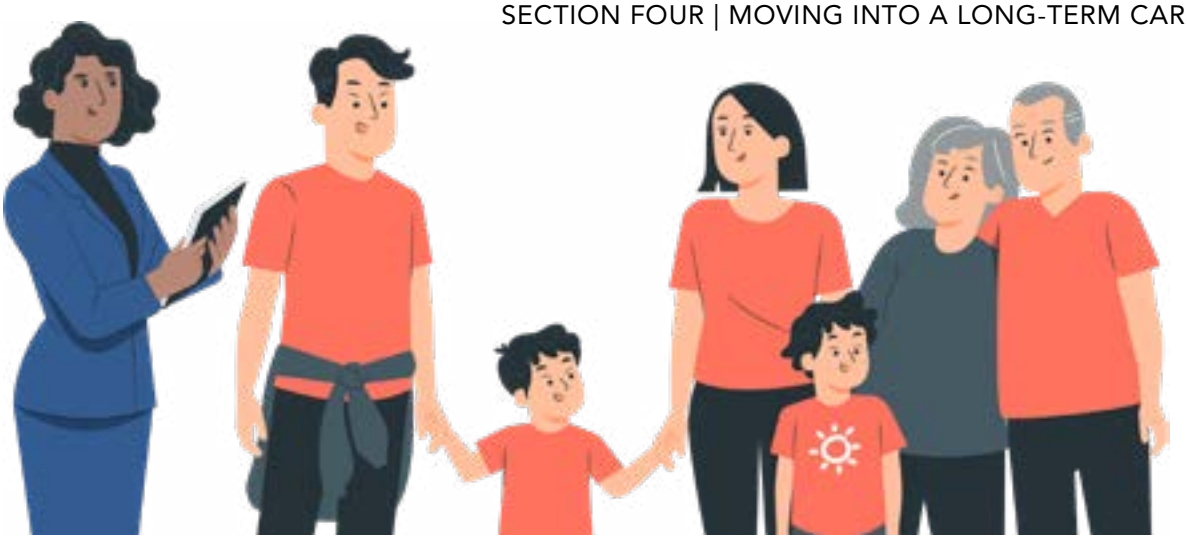
When it comes to choosing clothing for your loved one it is important to remember that all clothes need to be labelled with a commercial labeller as clothes will be washed in high temperature water with a commercial type of washer and dryer. Be mindful of materials as well as easiness to put on and take off. Many families choose loose comfortable or adaptive clothing.

Here are some examples of Clothing:

- 5-10 pairs of pants and/ or 5-10 dresses
- 18 pairs cotton underwear
- 5-10 t-shirts
- 12 shirts (polyester blend)
- 6 sweaters (acrylic knit)
- 12 pairs of socks (cotton)
- 1 robe
- 2 outfits for special occasions
- 2 pairs of non-slip sturdy shoes
- 2 pairs of slippers or flip flops
- 2 hats (1 for summer/1 for winter)
- 2 coats and 1 winter coat
- 2 track suits
- 4 night gowns and/or 4 pajamas

Sample Schedule for a Day in Long-Term Care

TIME	ACTIVITY	LOCATION
10:00 AM	Arrival, Meet Resident/Family Council Spokesperson Drop off laundry to be labelled Take the resident's picture	Lobby
10:05 – 11:00 AM	New Admission Meeting Meet the Care Team Nurses (RN & RPN), Take resident vitals Collect medical information and history Discuss resident preferences for care (bathing schedule)	Business Office
11:00 – 11:15 AM	Coffee or Tea Break	Common Area
11:15 AM – 12:00 PM	New Admisison Meeting Meet with Business Manager or Family Support Services Staff member Review and Sign Notice and Consent Sign New Admission Meeting Acknowledgement Review and Sign Accommodation Agreement	Business Office



Sample Schedule for a Day in Long-Term Care (Continued)

TIME	ACTIVITY	LOCATION
12:00 – 1:00 PM	Lunch	Dining Room
1:00 – 1:30 PM	Tour of the LTC Meet other Residents & Families Meet staff	Common Areas of the Home
1:30 – 2:30 PM	New Admission Meeting Review and Sign Purchase of Services Agreement Complete application for subsidy	Business Office
2:30- 3:00 PM	Coffee Break	Common Area
3:00 PM –	Unpack and Settled into Resident Room	Resident Room

NOTE: Remember: All homes are unique and operate differently. Everyone's move-in experience and day to day activities will be different based on personal needs and preferences.

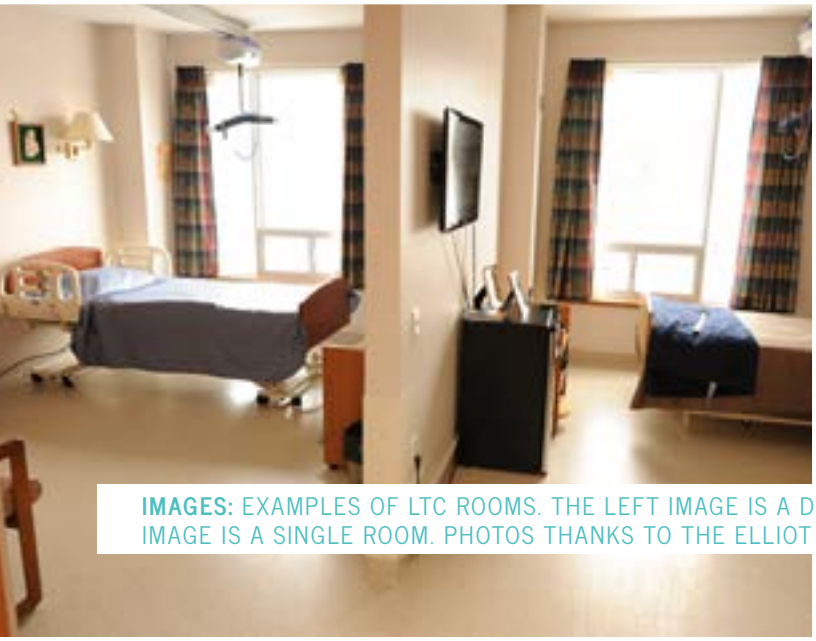
COMMON RESIDENT AND FAMILY HANDBOOK POLICIES

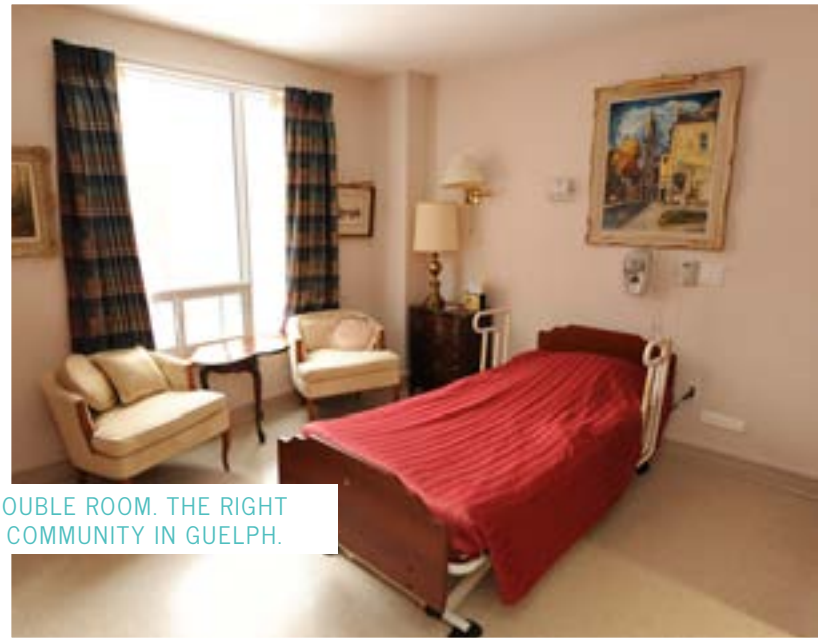
Understanding the common policies found in a Resident and Family Handbook is essential for navigating life in a long-term care (LTC) home. These policies provide crucial guidelines on daily routines, resident rights, and expectations for both residents and their families. They cover areas such as visitation, meal plans, safety protocols, and personal care procedures, ensuring that everyone is informed and prepared for the LTC experience. Familiarizing yourself with these policies will help you and your loved ones feel more comfortable and confident in your new environment, promoting a smooth transition and fostering a positive living experience.

The following are some of the most common policies found in LTC Home Handbooks:

Accommodation

On move in day, if you are the Power of Attorney for Property you will be asked to sign an Accommodation Agreement. This agreement will explain your rights and responsibilities. Residents living in Basic Accommodations in LTC can apply for the rate reduction program. The process to apply for a rate reduction is explained in section five of this resource.





IMAGES: EXAMPLES OF LTC ROOMS. THE LEFT IMAGE IS A DOUBLE ROOM. THE RIGHT IMAGE IS A SINGLE ROOM. PHOTOS THANKS TO THE ELLIOT COMMUNITY IN GUELPH.

Absences from the Care Home

In the Regulations for LTC in Ontario, residents can be away from their home. There are 4 different categories of resident 'leave'. The Ministry of LTC sets the maximum amount of time a resident can spend on this leave. If they are away for a pro-longed period on a leave, they will be discharged from the home and will need to go through the application process for possible re-admission. You will still be charged your fees for accommodations as well as fees for additional services (phone, cable, internet)

Casual leave refers to brief periods of time away from the home for up to 48-hours a week. This type of leave occurs throughout the year and is different from vacation or medical/psychiatric leave. Once a resident moves into LTC, if you plan on taking a resident out in the community for a family event or a medical appointment, please make sure to connect with the Care team in advance of the anticipated date. The team will make sure you are up to date about care routines and ensure medication requirements can be met.

Vacation leave refers to time residents spend away from the LTC on vacation. Residents are entitled to 21 days of vacation leave per year.

Medical leave refers to periods of hospitalization for up to 30 days at a time. The use of Medical leave does not reduce Casual or Vacation leave for residents.

Psychiatric leave refers to assessment, treatment and stabilization of psychiatric conditions. Residents are entitled to up to 60 days of psychiatric leave per year.

Nutrition and Meal Services

All residents' preferences and special dietary needs are considered when planning meals. Efforts are made to provide them with choice and alternatives during meals and at snack times. The specific timing for meals and snacks varies from home to home. Residents' dietary needs are assessed by the Registered Dietician and will be discussed and part of their individualized care plan.

BREAKFAST	LUNCH	DINNER
Poached Eggs	Vegetable-Beef Soup	Tomato Soup
Oatmeal	Caesar Salad	Garden Salad
Bacon	Grilled Chicken and Root Vegetables	Smoked Sausage with Red Beans and Rice
Fruit Salad	Steamed Rice	Steamed Carrots
Toast	Angel Food Cake	Coffee or Tea

Infection Prevention and Control (IPAC)

One of the policies implemented in LTC is Infection Prevention and Control (IPAC) to prevent and control the spread of infections between residents, staff and visitors. All homes will have their own IPAC policies. You should be sure to take the time to familiarize yoaurself with them.

Staff and visitors are asked to stay home if they are feeling unwell or experiencing the following symptoms: vomiting, diarrhea, fever, cough, sore throat. There will be specific IPAC policies and procedures to help inform hand hygiene, use of personal protective equipment (PPE), and immunizations.

Hand Hygiene

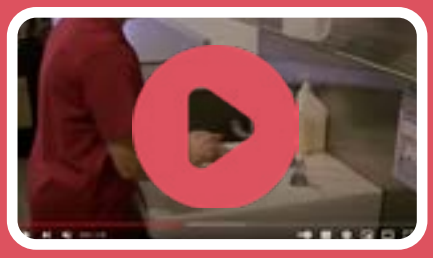
Hand Hygiene is one of the most effective strategies to prevent the spread of infections and outbreaks in LTC. You will find dispensers for alcohol-based hand sanitizers throughout the home, including the main entrance and dining rooms.

You should sanitize your hands when you arrive at the home, before you leave and if you have handled anything unclean (i.e. used tissue). You may also be asked to wear PPE to protect yourself and those around you. You may be asked to wear a mask, or in certain situations full PPE including mask, eye protection, gloves and gown. You will receive training on how to wear and remove PPE and there will be posters displayed to help remind you of the proper way to wear PPE.

To help support proper hand hygiene, LTC communities will have posters to help remind caregivers, visitors, staff and residents about proper hand washing techniques with soap and water or with hand sanitizer.

VIDEO:

You can also watch the following video from Public Health Ontario on Youtube to help teach you the proper technique for hand washing.



LINK: YOUTU.BE/5OETKTTVGOW

IMAGE: EXAMPLE OF A HAND WASHING POSTER USED IN TORONTO

Immunizations

In LTC, residents are part of an immunization program. Their medical records will be reviewed as a part of the move in process to help determine what vaccines are required to keep the resident safe and healthy. If any additional vaccines are needed, the registered staff will be in charge of administering the vaccines in accordance with schedules outlined by the Ministry of Health.

Unfortunately, in LTC there is a higher risk of getting the flu. Residents in LTC will be offered the influenza vaccine each year. It is strongly advised that residents, staff and family or friends get the flu shot each year. Additional vaccines may be offered to residents depending on new and emerging viruses (i.e. COVID-19).

Fall Prevention Program

One of the many assessments that is part of the move in process is to assess residents' risk of a fall. If they are deemed to be at risk of a fall, they will be referred for further assessment with members of the restorative care team to develop a plan to reduce the risk of future falls.

In LTC, the goal of a fall prevention program is to help residents stay safe, independent and walking for as long as possible. Through a falls prevention program, members of the care team work to prevent falls and reduce the risk of injuries.

To minimize the risk of falls, you will see handrails, adequate lighting, flooring that reduces the glace and minimal clutter in common areas as well as in resident rooms. If there is an increased risk of a fall for the resident, the care team will work in collaboration with the resident and their family to develop a plan.

If needed, they will introduce safe and appropriate interventions based on observation of the resident in their daily life, a review of the residents' medications and working with the physiotherapists and restorative care team to improve the residents' balance, strength and comfort in using a mobility aid (i.e. Cane, walker).

Pain Management Program

Many seniors experience some form of pain before transitioning into long-term care. The goal of the Pain Management program is to assess their pain management needs and help improve residents' quality of life. Members of the Care team will work with residents and their families to develop an individual, resident-centered plan to manage their pain needs.

When residents are non-verbal, alternate methods of x are used to assess their pain. Pain management is more than just exploring medication, it also includes exploring the use of supportive equipment and comfort care measures. There is on-going assessment of the pain management plan and changes are made as needed.

Continence Care & Management

This program is focused on supporting independence, comfort and dignity through treatments and interventions to promote bladder and bowel control. This program will also focus on preventing constipation. Depending on resident needs this will include the use of continence supplies and assistive devices.

Palliative Care

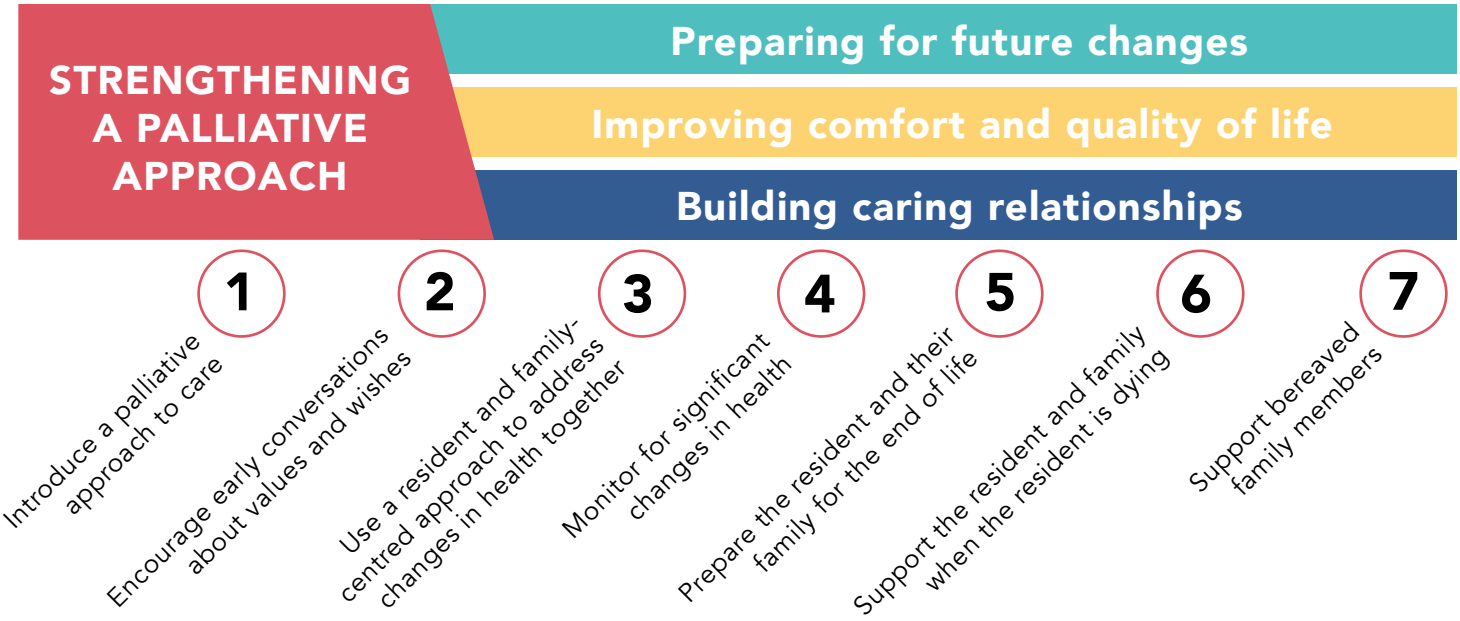
Palliative care is focused on providing residents services to promote comfort and support the best quality of life for residents. It is important to understand that it is not Medical Assistiance In Dying (MAID). It is focused on managing pain as well as providing social, emotional, spiritual and cultural support for residents and their families throughout the course of chronic illness of disease. This also extends to bereavement support.

Palliative care is available to residents and families at any time and can occur simultaneously with other treatments and interventions. Having conversations about their wishes for the end of their life early on, or even prior to moving into LTC is the first step in a Palliative Approach to Care (SPA-LTC, 2023).

In April 2022, the Fixing Long-term Care Act, 2021 (FLTCA) and Ontario Regulation 246/22 expanded the requirements for palliative care in LTC.

Under FLTCA, staff are required to adopt a broad, holistic approach to palliative care. The options for palliative care available to residents and family members will be discussed as part of the move in process. Programs offered in homes will:

- Shift focus to quality of life
- Pain management
- Prepare and manage end-of-life choices and the process of dying
- Cope with loss and grief
- Treat curable conditions and prevent new issues
- Promote opportunities for meaningful experiences, personal and spiritual growth



End of Life Care

Palliative care occurs in stages with the final stage being referred to as end-of-life care. Staff take a resident-centered approach to end-of-life care. The focus of end-of-life care is to ensure residents are comfortable and experience dignity at the end of their life. Actions are guided by their wishes, which were discussed as part of your move in day experience and updated with the Registered staff on an annual basis. For residents who are unable to make decisions about their health care treatments, the Substitute Decision Maker (SDM) will take the lead in these conversations.

Staff recognize that the end of life can be emotional for residents and their family members. Staff are committed to providing care with compassion, taking steps to prevent pain, relieve suffering and provide psychological and spiritual support. Residents often prefer to stay in their home rather than be moved to a hospital. The exact process to remember and honor a resident once they have died is unique to each home.

ALL ABOUT MEDICATIONS

Making sure a resident's medications are safe and effective involves a team approach that includes prescribers (doctors, nurse practitioners), nurses, pharmacists AND YOU!

Before moving into a LTC home, a team member will ask about all medications the resident is currently taking, including prescription medicines and those purchased without a prescription, such as natural health products, vitamins and supplements, or cannabis. Providing a complete list ahead of time is very helpful. Providing information like the reasons medications are used, when they started, or previous medications tried helps the team make decisions about medication safety. When a resident moves in, the LTC home will order the needed medications through the home's pharmacy and nursing staff will administer them to the resident as ordered by the prescriber.

The move into a LTC home and the first care conference offers chances to have conversations with the care team about goals of care for residents, including making decisions about continuing or changing medications. To prepare for those conversations, think about the residents' experiences and goals for each medication.

IMAGE: COURTESY OF DEPRESCRIBING.ORG

As we age, our bodies process medications differently, making us more sensitive to side effects. Medications that were once a good fit for someone, may not be the best choice now. Deprescribing is a process where you and the team work together to reduce or stop medications that may no longer be of benefit or that may be causing more harm than good. You can find more information about deprescribing at deprescribing.org. Tips on how to have a conversation about deprescribing and a short list of steps to follow that you can bring to a care conference are available.

Find out more at deprescribing.org

The Pharmacists' role in Long-Term Care

Pharmacists assess residents' medications to see how well they are working, whether a medication may be causing side effects and check that doses are a good fit for the resident. Pharmacists also dispense medications. Pharmacists can also provide a list of medications, and answer questions about why a medication is being used, side effects, and drug interactions.

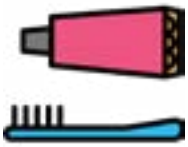
Additional Services available in LTC

Cable, Internet & Phone
All LTC communities will have televisions and cable available in common areas throughout the home. Some common areas of the home may also have wireless internet available and desktop computers.

If a resident wants to set up and have a television, phone and internet in their own room they will need to let the Business Office know. They will share details about the service providers. Residents and their family are responsible for arranging for these services and the related fees. The specific service provider will be unique to each LTC community so make sure to ask the Office Staff to get additional details to help you arrange cable, internet & phone service for residents before they move into the LTC community.

Hairdresser/Barber
Hairdressing and barber services are available on site. Specific details about the price and hours vary from home to home. You can book appointments via phone, submitting a request form or speaking directly with the salon staff.

Foot Care
Foot care is available to residents of LTC and offered through an external service. The Business office can share information about Foot Care with you upon request. You will need to call the organization and arrange for them to provide care to your person when they visit the home. You will be responsible for the fees related to this service.



Dental Care
Dental care is available and provided by an external organization. The Business office can share information about Dental Care with you. You will need to call and arrange for the dental care that you would like the person you support to receive in this LTC. You will be responsible for the additional fees for this service.

Eye and Ear Care
These services are not provided in LTC. You can continue to make appointments and bring the resident to appointments in the community to address issues or concerns with their eyes or ears.

Guest Meals
Family and friends are welcome to join a resident for a meal in the dining room. You can purchase meal tickets/vouchers for guests at the Administration office during business hours. The exact process and cost of a meal ticket varies from home to home. For Holiday Meals, special meals may be offered to family members at a set cost. Tickets would be purchased in advance to ensure adequate quantities of food are available for all who want to join.

How to let the Resident Know they are Living in LTC: Angela & Marie

Talking to your loved one when leaving them for the first time at a Long-Term Care (LTC) home is crucial for their emotional well-being and smooth transition. This conversation helps reassure them that they are not being abandoned, but rather, receiving the care they need. It allows them to express their fears or concerns, which can provide an opportunity for you to offer comfort and address any uncertainties.

Angela: Aunt Marie, how are you settling in? How are you feeling?

Marie: It's different... quieter than I expected. It feels strange, like I'm visiting someone else's home.

Angela: I know it must feel that way right now. It's your first day, and everything's still new. But remember, we brought all your favorite things.

Marie: But this doesn't feel like home yet.

Angela: That's normal, Aunt Marie. It's only your first day here. The staff are really kind, and they'll help you settle in. And remember, I'll be visiting all the time, just like I promised. This place, it's meant to help you, to make sure you're comfortable and safe.

Marie: I hope so. I just need time to get used to everything.

WHAT TO EXPECT AFTER MOVE-IN

After the move-in day, it is common for family members to experience a range of emotions. We encourage you to connect with your circle of support and to take the time and do things that feel right for you as you adjust to your new role as a partner in care. If there is an active Family Council in your home, ask how you can get involved and where you can find details about the next meeting. Examine the resources available for Caregivers through the Ontario Caregiver Organization. Use a notebook and write down questions and concerns as the come up. Take note of any changes you notice as your family member adjusts to their life in LTC. Bring these questions with you to the Care Conference.

About six weeks after the move in date, staff from the LTC community will connect with you to arrange a meeting with you. A Care Conference is a meeting held with staff from each department. The focus of this meeting will be to discuss the new residents' health and wellbeing. Information gained through this conversation between family, resident and staff is used to develop a residents' plan of care (aka Care Plan). During the initial Care Conference, you can invite anyone you want to participate in the discussion including your partner/ spouse, family members, friends or interpreter. This is a great opportunity for home staff to share updates on the resident as they adjust to their new home. This is also an opportunity for family and caregivers to share any questions or concerns about the resident as they continue to adjust to their new life in LTC. During the Care Conference, you can confirm the contact details for members of the Care team to help you maintain communication. Following the initial Care Conference within the first 6 weeks following a resident moving into a LTC community, Care Conferences are held on an annual basis.

The document created following a Care Conference to describe what is needed to meet a residents' needs is called a Care Plan (aka Plan of Care). Care plans will provide guidance to staff involved in providing direct care to residents including PSW's, Social Workers, Registered Nurses, Physiotherapists & Recreation Staff. The plan will also include details about the types of activities that you as a caregiver can do, may need support from staff to do including any specialized training. This document will also provide guidance on how to promote resident autonomy and opportunities for choice. This is a living document that evolves and changes as the residents' needs and health change.

Occasionally, there will be restrictions on visits due to medical Outbreaks in the home. Details about the policy and procedures for visits during an Outbreak are unique to each home and will be discussed with you on move in day. Details will also be shared in the resident and family handbook. Homes will post updates on their Outbreak status including the specific areas of the home impacted by an Outbreak on their website.

What Are the Components of a Care Plan?

The transition to Long-Term Care (LTC) can be a deeply emotional and challenging time for both residents and their families. Adjusting to the new environment involves more than just a change in physical surroundings; it requires emotional adaptation, a shift in routine, and redefined family roles. Understanding the emotional responses from both perspectives can help families and staff support a smoother adjustment process, fostering a sense of security and well-being for the resident.

Step 1: Assessment

The first step in developing a care plan in Long-Term Care (LTC) begins with a comprehensive assessment. This process requires gathering both subjective information (such as patient or family statements) and objective data (such as medical history, weight, or vital signs). Healthcare providers in LTC collect this data through interviews, observations, and reviewing digital health records. The goal is to understand the resident's physical health, cognitive abilities, and emotional needs, providing a complete picture to shape the care plan.

Step 2: Diagnosis

Once the assessment is complete, the next step is to identify the resident's needs. This is often referred to as a "diagnosis," which helps prioritize areas that require care and attention. This process uses a framework, such as Maslow's Hierarchy of Needs, to ensure that basic physiological needs (like nutrition and mobility) are addressed before emotional or social needs. This prioritization ensures that critical areas of care are addressed immWediately while allowing for more complex, long-term issues to be tackled over time.

Step 3: Outcomes and Planning

After identifying the needs, the care team works to set realistic goals for the resident's health and quality of life. Goals are based on evidence-based practices and should be Specific, Measurable, Achievable, Relevant, and Time-bound (SMART). These goals guide the resident's care plan, helping to create a path toward improved well-being.

Step 4: Implementation

Once the goals are established, the care team starts implementing specific nursing interventions to support the resident's needs. These interventions cover a wide range of areas, including physical support, emotional well-being, and safety precautions. Nurses follow either doctor's orders or create their own interventions based on best practices to ensure residents receive the appropriate care.

Step 5: Evaluation

The final step is evaluating the effectiveness of the care plan. Care providers regularly assess whether the resident is meeting the outlined goals, adjusting the plan as necessary. This ongoing evaluation ensures that the resident's care is continuously optimized, adapting to any changes in health status or needs over time.

This structured process helps ensure that residents in LTC receive personalized, comprehensive care that meets their physical, emotional, and social needs.

Family and Resident Responses to Moving Into Long-term Care

Adapted from Best-Martini (2011)

The transition to Long-Term Care (LTC) can be a deeply emotional and challenging time for both residents and their families. Adjusting to the new environment involves more than just a change in physical surroundings; it requires emotional adaptation, a shift in routine, and redefined family roles. Understanding the emotional responses from both perspectives can help families and staff support a smoother adjustment process, fostering a sense of security and well-being for the resident.

Stage Name:

Denial

Timing:

Between move-in date and up to 2 months after move-in

Common Resident Feelings and Thoughts:

- I'm not as sick as they think I am!
- If you let me go home I can take care of myself!
- My home has a better set up for me and my routine!
- Everyone is counting on me to get better so I have to!

Common Family Feelings and Thoughts:

- This is only a temporary situation, soon they will be back at home
- I wonder if this will be a permanent arrangement, I don't want them to get discouraged.

Communication Strategies:

- False hope is negative to the situation, don't feed into this
- Ask them to describe the specific skills and performance necessary for their loved one to return home.
- In doing this reflection, they may eventually pick up on the truth.

Stage Name:

Anger

Timing:

Between 2 weeks and up to 2 months after move-in

Common Resident Feelings and Thoughts:

- You put me here!
- You just dumped me and left me here to die!
- I hate it here!
- I hate the people here!
- I'm not like the others here, I don't belong here.
- I'm disappointed with your decisions
- You're treating me like a child!
- I can still take care of myself most of the time!
- Everything I eat tastes the same!
- Instead of helping me they turned off my light and left me in bed. That's no way to treat me!
- When will you take me home?
- You're glad to get rid of me?
- How can you leave me here?

Common Family Feelings and Thoughts:

- Everything in my life is upside down
- Not only have they been taken away from me, you don't know how to take care of them like I do!
- No one comes when they call.
- They hate the food and activities here!
- I know I'm here at 8 am everyday, but I like to know that my loved one has eaten breakfast, has their dentures in properly and they're dressed for the weather.
- That's how I cared for them when they were at home and I want to see it continue here

Communication Strategies:

- Most challenging emotion to address because it has the highest intensity
- Most of us ignore anger, deny it is a necessary process in adapting to the situation
- Family responses are often viewed as anger by staff
- Families need help in understanding policy and procedures in the LTC home, what has happened to their loved on and where you can go from there
- Consider Why a family member is angry, is it because of their limited control? Guilt? The inconvenience of home policies? Stress in dealing with diversity in the home?
- Consider their anger is justified
- Deal with anger through concrete and correctible complaints
- Realize that the child of a resident may also be dealing with role reversal
- Anger is a barrier to forming a collaborative relationship between family and staff in LTC
- Allow families time to heal and build trust with staff
- Anger of residents/family is not an attack on you as a staff member, rather an attack on the situation

Stage Name:

Bargaining

Timing:

Between 6 weeks to 3 months after move-in

Common Resident Feelings and Thoughts:

- I feel abandoned
- I feel isolated
- I don't think this is where I belong
- I would do so much better at home
- There must be a better place for me!
- I think I can walk as well as before you won't need to help me at home
- I will work hard at my rehabilitation so I can go home
- Please find me another home, I don't belong here

Common Family Feelings and Thoughts:

- I heard about a home that is good at rehabilitation, I want to check it out.
- There must be some way to take care of them at home
- There must be a better place
- We're looking for a better home
- It's hard to find a better place for them
- We're trying to bring them home, do you know of any organizations that can help us?

Communication Strategies:

- Resident may ask their family to 'get me out of here'
- Family may respond to their own emotions by searching for alternatives
- Most of the time this does not lead to the resident moving out
- It is still important that both residents and families feel they have explored every possibility
- Families may experience guild when they experience enjoyment without their loved one
- Families experience a sense of guilt for a sense of normalcy in life outside of the home
- Support Groups/Family Councils are key resources to help family and friends address their feelings and thoughts
- It is helpful to understand how others in similar situation have addressed their feelings and thoughts
- Participating in support group or Family Council are helpful for new family members to gain a sense of membership in the home community where they are accepted and understood.

Stage Name:

Sadness

Timing:

Between 6 months to 1 year after move-in

Common Resident Feelings and Thoughts:

- There is nothing that interests me here!
- I don't want to get out of bed!
- I don't want to go out of my room!
- I don't want to get my hair done!
- Sitting on their own
- Refusing to participate in activities
- Limited interaction with other staff/ residents
- I'm sorry I don't feel like doing that right now
- I suppose we can talk about this but I might cry There must be a better place for me!
- I think I can walk as well as before you won't need to help me at home
- I will work hard at my rehabilitation so I can go home
- Please find me another home, I don't belong here

Common Family Feelings and Thoughts:

- I miss them!
- It's not the same at home!
- I hate visiting, it makes me feel so guilty when I share good news.
- I cry a lot at home
- The only time my mind is at ease is when I visit them
- I just can't visit it makes me too sad.
- Talking with other families makes me feel better. There must be a better place
- We're looking for a better home
- It's hard to find a better place for them
- We're trying to bring them home, do you know of any organizations that can help us?

Communication Strategies:

- Highly individual response
- Duration and intensity are shaped by personal values, support systems and medical diagnosis
- Time, an increased sense of control, trust and security will shift emotions of residents/families away from sadness
- Essential to acknowledge their feelings and emotions
- Never negate their grief
- Encourage visits by creating positive experiences through activities like: (a) Sharing a meal together at a BBQ which has a natural start and end, (b) visiting as part of a night time routine before the resident goes to sleep, (c) bring in a special treat to share with them, (d) bring in a pet, (e) personalize their room with photos, their favorite things from home that will trigger positive memories, (f) take a walk outside to explore the community.

Stage Name:

Acceptance

Timing:

2 months or more after move-in

Common Resident Feelings and Thoughts:

- I enjoy the routine and activities here
- I especially enjoy euchre and Java club
- I requested to have my shower on Saturday so that I am feeling good for Church on Sunday
- I love how comfortable I am sitting in my armchair to watch TV in my room
- They will appear more relaxed
- I've made so many friends here
- The Residents and Staff are so nice
- I trust they care about me
- I trust that I can express how I feel without worrying about what will happen to me
- I appreciate your help in making me comfortable

Common Family Feelings and Thoughts:

- I enjoy coming to visit
- It's nice to see them smiling again
- It's fun to bring the roses from the garden to share in their room
- It's nice to have them living in a place where they feel like they belong
- It's nice not to worry about them all the time!
- Easygoing relationship with staff
- Friendly attitude
- Trust in staff
- Mutual respect between family/ staff
- Everyone here is so friendly and helpful
- You're always willing to listen and address my concerns

Communication Strategies:

- Sometimes families and residents start here
- Some may fool you into thinking they are here when they are really in another stage
- Arriving at this stage requires hard work for families, residents and staff
- Everyone is at a point in their relationship where they have established trust and mutual understanding
- Never forget that families and residents are new to the LTC community, the policies and procedures in your home.
- It is important that staff listen to their concerns with empathy and compassion
- Don't judge residents and families for raising their concerns
- Seek out the information or pursue actions that will address their needs
- Listen to them
- Write their concern down
- Make a list of concerns they have raised
- Address their concerns one at a time
- Avoid being defensive
- Concerns often stem from misunderstandings and miscommunication

SECTION FIVE:

HOW IS LONG-TERM CARE FUNDED?

LEARNING OBJECTIVES

- *Identify the costs associated with accommodations in Long-term Care.*
- *Understand the Comfort Allowance.*
- *Explain the financial supports available to help pay for accommodations.*
- *Understand the process and benefits of involuntary separation for couples.*
- *Explain the assistive devices program and how it supports residents.*

Long term care homes are funded and regulated by the provincial government and generally for those for whom there is no longer sufficient support for them to live independently in the community, or the hospital is ready to discharge a patient who may not be able to cope at home any longer. People living in a home pay a fee for accommodation, which is set by the government and is based on the type of accommodation chosen (e.g. basic/standard, semi-private or private). Long term care homes can operate either on a not-for-profit (municipal, charitable, non-profit nursing home) or for-profit basis (Advantage Ontario). All LTC homes, regardless of operator type (municipal, charitable, nonprofit, or for-profit) receive the same amount of funding.

All long-term care homes in Ontario are regulated by the Ministry of Long-Term Care, and are inspected at least once a year. In addition, not-for-profit homes are accountable to their governing body which is either anon-profit board or Municipal Council for the community to adhere to the specific mandates determined by the governing body.

FINANCIALS

Preparing financially for long-term care (LTC) is an essential step in ensuring that you or your loved one can access the necessary care and support. LTC involves various costs, including accommodation fees, care services, and personal expenses, all of which can add up over time. Understanding these costs and planning ahead can help alleviate the financial burden and ensure a smoother transition into LTC.

Cost of Accommodation in Long-Term Care

Anyone living in LTC is required to pay a fee each month. Just like rent, this fee goes towards the upkeep of the space where they live and the food they will eat that month. In LTC, this fee is referred to as a co-payment fee. This fee is determined by the type of accommodation they opt to live in —basic, semi-private or private. The type of room only shapes the extent of privacy and space that belongs to that resident, it does not influence the level of care the resident receives. All residents in LTC are entitled to the same level of care.

The Ministry of Long-Term Care establishes maximum co-payment fees each year, which are standardized across all long-term care homes in Ontario, regardless of whether they are municipal, for-profit, or not-for-profit.

Long-term care home maximum co-payment fees (effective July 1, 2024)

The morates typically go up every July with an estimated increase of approximately 40 to 50 dollars

Type of Accommodation	Daily rate	Monthly Rate
Long-stay Basic	$66.95	$2034,40
Long-stay Semi-Private	$80.72	$2455.24
Private	$95.65	$2909.36
Short-stay	$43.34	N/A

Services Offered for Additional Fees:

While the government pays for services like nursing, recreation, and physiotherapy there are some additional services that residents can purchase to help them maintain their quality of life. These are some examples of additional services offered in an LTC for an additional fee:

- Hairdresser or Barber Services
- Cable TV
- Phone
- Internet
- Transportation to hospital or community appointments

NOTE: Find a full list of these services on **page 87**

What is a Comfort Allowance?

During the move-in process as you are meeting with the LTC home staff, you may hear the term 'Comfort Allowance'. The comfort allowance is a portion of income set aside by the LTC home in an expense account to help with residents' personal needs, such as clothing, telephone, cable and the Ontario Drug Benefit Program's mandatory prescription co-payment. Currently, the monthly amount is $149 per subsidized resident, but this may fluctuate due to changes in income during the year.

Long-Term Care Home Per Diems (Effective April 1, 2022)
Average Rate Per Day

Nursing & Personal Care (based on a CMI* of 100)	$103.88* includes a $2.12 supplement
Programming & Support Services	$12.24
Raw Food	$11.00
Other Accommodation	$43.34
Sub-total	**$183.64**
2020/21 Global Increase (1.5%)	$43.34
Total	**$191.02**

Case Mix Index

The Case Mix Index (CMI) is a critical tool used to assess and compare the care needs of residents across different long-term care homes. It evaluates the complexity and intensity of care required by each home's resident population relative to others. This evaluation helps ensure that funding is allocated more equitably across the LTC system. By analyzing the CMI, authorities can identify homes with higher or lower care needs and adjust funding distributions accordingly. As a result, funds can be redistributed between LTC homes from one year to the next, ensuring that each facility receives financial support that aligns with the specific care needs of its residents. This system helps maintain a balanced and responsive funding structure that addresses the varying levels of care required in different LTC environments.

What supports are available to help pay for a bed in Long-Term Care?

There are several programs designed to help ease the financial burden of paying for a bed in long-term care. These programs offer various forms of financial support, making it more accessible for residents to afford the care they need. In this section, we'll explore the details of several key rate-reduction programs available to LTC residents, including:

Involuntary Separation: This program assists couples who are separated due to one partner needing LTC while the other remains in the community. It provides financial relief by adjusting the couple's combined income to reduce the cost of LTC for the resident.

Veterans Affairs: Veterans and their spouses may be eligible for financial assistance through Veterans Affairs Canada, which can help cover the costs associated with long-term care. This program is designed to honor their service by ensuring they receive the necessary care without undue financial strain.

Insurance: Various insurance policies, including long-term care insurance, may provide coverage for some of the costs associated with staying in an LTC home. This section will guide you through understanding how your policy might apply and what steps to take to access these benefits.

Assistive Devices Program (ADP): For residents requiring specific medical equipment or assistive devices, the ADP can help offset the costs. This program ensures that residents have access to the necessary tools to maintain their quality of life while residing in LTC.

REDUCED RATE FOR LOW-INCOME RESIDENTS

A resident is eligible for financial assistance through the Long-term Care Rate Reduction Program when they are unable to afford the co-payment fee for Basic Accommodation. The fee for basic accommodation is $65.32/day or $1986.82/month. This program will help cover the cost of the co-payment fee for those who live in basic accommodation or spouses and partners who live together in a 2-bed, semi-private room designated as basic accommodation. Residents in a regular semi-private or private room are not eligible for a rate reduction.

There is no specific income threshold for eligibility for a rate reduction because the program considers a variety of factors to calculate a resident's rate reduction. Examples of factors that shape eligibility for the program include the resident's income and if they support any dependents in the wider community like a spouse or child.

For residents over the age of 65, their Old Age Security (OAS) and Guaranteed Income Supplement (GIS) are some additional sources of income that will be considered when completing a rate reduction calculation. For residents under the age of 65, they may qualify for the Ontario Disability Support Program (ODSP) which will be considered with your application.

While the program recognizes that each resident's situation is unique, a resident can qualify if their annual income is $25,629.00 or less. Most residents awarded a rate reduction will still pay a portion of their co-payment fees.

To apply for a rate reduction, you will need to complete an application form and submit it to the LTC. Once approved, you will need to complete and re-submit an application for a rate reduction on an annual basis because a resident's income can change from year to year. The rate reduction program runs from July 1st to June 30th. For the reduced rate to begin on July 1, it is important for you to submit your application between July 1st and September 28th. If you do not re-submit the application, then the LTC home can charge the resident for the full cost of the basic accommodation.

How is a Rate-Reduction Calculated?

Across Ontario, the following formula is used to calculate reduced monthly rates in LTC:

When Should I Apply for a Rate-Reduction?

You can only apply for a rate reduction after a new resident has moved into LTC. The application should be completed and submitted within 90 days of the date of moving into a LTC community.

Why do I Need to Submit an Application Each Year?

Because a resident's income can fluctuate from year to year, it is important to reassess their financial situation regularly. Therefore, you will need to submit an application for a rate reduction on an annual basis. This ensures that the resident's financial contributions accurately reflect their current income, helping to maintain affordability and access to the necessary care and services.

What if the Resident I Support Turns 65 After They Move into Long-Term Care?

You will need to reapply for a rate reduction one month after the resident turns 65. Even if a rate reduction was granted before their 65th birthday, the application must be resubmitted. This is because their eligibility for government benefits changes at 65, which may affect their income and, consequently, their rate reduction eligibility.

How can I get help in completing the Rate Reduction Application?

Assistance is available at each LTC home to help you complete the Rate Reduction forms. To access this support, you will need to speak with the designated staff member at the LTC home.

If you have any additional questions beyond what is shared by the LTC home staff member you can email the Ministry of Long-term Care at

LTC.RateReduction@ontario.ca

or call the Long-Term Care Family Support and Action Line at

1-866-4324-0144

INVOLUNTARY SEPARATION

Involuntary separation is used to describe an LTC resident who is no longer able to live in the same home as their spouse. This type of separation is not by choice and occurs often because of factors like chronic illness or the need for specialized care. It is also a federal tax relief measure that allows the government to consider the resident's individual, rather than family income. Once the resident's spouse moves into the same LTC home and they share a room, they are no longer eligible to claim Involuntary Separation. Once approved by Service Canada, successful applicants are eligible for retroactive payments for the previous eleven months.

To apply for voluntary separation, you will start by contacting Service Canada via mail, in person, phone or online.

Mail:	Phone:	Online:
Service Canada, PO Box 1816, Terminus Station, Quebec City, G1K7L5	**1-800-277-9915**	**Use Service Canada: My Account**

What documents are required to apply for Involuntary Separation?

As part of the application process for Involuntary Separation, two essential forms must be completed and submitted to Service Canada. These forms are required to officially document the change in your circumstances and ensure that your benefits and services are adjusted accordingly.

The ISP3040 Form

cataloague.servicecanada.gc.ca/content/EForms/en/Detail.html?Form=ISP3040

The ISP3025 Form

catalogue.servicecanada.gc.ca/content/EForms/en/Detail.html?Form=ISP3025

Veterans Affairs

Current or former members of the Canadian Armed Forces (CAF) or the Royal Canadian Mounted Police (RCMP), or a family member of a current or former member may be eligible for services to support the cost of their care. As outlined earlier, the assessments and application for a bed in LTC are managed by the Provincial Government and regional health organizations.

Before applying for support through Veterans Affairs, the applicant must already have moved into an LTC. To complete and submit an application, you can download the VAC1503APe form and drop it off at a Veterans Affairs Canada office.

If you have any questions, you can contact VAC staff by calling:

1-866-522-2122

If you want to submit your application online, you will need to register and create a MY VAC Account by following this link:

hmva-mda.vac-acc.gc.ca/pub/MVA_7_24_1?request_locale=CA&register=

Learn more online

veterans.gc.ca/en/housing-and-home-life/long-term-care

ASSISTIVE DEVICE PROGRAM

For individuals moving into LTC who have long-term physical disabilities or require specialized medical equipment like a wheelchair or hearing aids, the Assistive Devices Program (ADP) is another program to help cover the costs. The program is open to any resident of Ontario with a valid OHIP card who will require the equipment or supplies for 6+ months. The ADP program does not cover the cost of repairs to any equipment. You will be responsible for the cost associated with the care and maintenance of assistive devices.

If there are significant changes in the health of the LTC resident using the assistive device and there is a need to replace the equipment the ADP may provide some contribution to the replacement. They may also cover the cost of a replacement if the equipment is no longer under warranty or can't be repaired at a reasonable price.

How can I apply for the Assistive Devices Program?

It is possible for vendors offering specific types of assistive devices to support direct applications for funds. The following list is associated with vendor applications:

- Mobility aids
- Hearing aids
- Communication aids
- Visual aids
- Diabetic equipment & supplies
- Respiratory equipment & supplies
- Home oxygen therapy
- Artificial eyes and facial prosthetics
- Custom orthotic braces, compression garments and lymphedema pumps
- Prosthetic breasts or limbs
- External feeding pumps & Ostomy supplies

ADP-registered vendors will submit an application on behalf of their clients. They will then receive payments related to invoices submitted for claims that are approved and eligible for payment through the ADP program.

How much is covered in the ADP program?

Once an application is submitted by a vendor and approved, the ADP program will cover 75% of the cost of most equipment and supplies. The supplier will bill the ADP program directly and you will pay the vendor the remaining 25% of the cost when you purchase the supplies or the assistive device. For some supplies, you may also receive a series of payments throughout the year to help cover the cost of the supplies.

What can I do if I can't Afford the 25% ADP payment?

If you are unable to pay the 25% cost for assistive devices or supplies, there are a number of volunteer charity organizations that may be able to provide some financial assistance. You will want to visit the following organizations to see if they have a program that can offer you support:

marchofdimes.ca

March of Dimes Canada is a leading national charity committed to championing equity, empowering ability, and creating real change that will help the more than eight million people with disabilities across the country unlock the richness of their lives.

waramps.ca

The War Amps provides financial assistance to Canadian amputees for artificial limbs, peer support and information on all aspects of living with amputation.

SECTION SIX:

VISITING THE LONG-TERM CARE HOME

LEARNING OBJECTIVES

- *Develop a plan for when visiting a resident in LTC.*
- *Make sense of items and features commonly found in LTC homes.*
- *Delete explore fresh activity ideas.*
- *Understand the benefits and impact of pet therapy in Long-term care.*

After move-in day, visiting is a great way to show your support and stay connected to the new resident. We know that visits may seem difficult, and you may not know what to do with your time together. That's why we're sharing some best practices and suggestions for activities you can do during your visit.

BEST PRACTICES FOR A VISIT

Make sure to plan the best time of day for your visit. Avoid conflicts with their favourite program or care activity (i.e. bath). Many residents in LTC have a cognitive impairment so ask staff to let you know the time of day they are most alert. If they do have challenges with their memory, you may need to introduce yourself each time you arrive for a visit. Let them know who you are and why you are there to visit with them. Speak to them slowly and make sure they can see your face as you speak.

Use plain language in your conversation and follow their lead by listening to what they want to share. You can also spend time reminiscing together and discussing stories about their past. This conversation can be supported by looking through a family photo album. Encourage them to be as actively engaged in the visit as possible and be patient with them. As you enjoy your time together create opportunities for them to make their own choices.

Make your visits part of a continued life-long routine. You can schedule your visit around an activity like sharing a coffee or tea time. You can make it a social experience for both of you by joining an activity together. Examine the care home's monthly activity calendar and arrange to join them for concerts or games that you both enjoy. If the resident shares their room, you can take your visit to a common area like the library, or during the warmer months to the gardens outside. This space will allow you to sit together and enjoy each other's company.

Important items you will find around the Long-Term Care home

Being in a new environment you will encounter new equipment and assistive devices to help staff and residents. This section will provide a description of some specialized equipment you will see in LTC.

Call Bell

Call bells are available in each resident room near the bed. There are also call bells located in washrooms. When the call bell cord is pulled, a member of the care team will respond as soon as possible. When saying goodbye to a resident after a visit, please make sure that their call bell is within reach before you leave. You should not loop the call bell around the bed rail as this creates a tripping hazard.

Exit Alarm Systems

When you visited the LTC home for a tour and when you arrived for move in day you most likely encountered the security system. Depending on the home and the time of day, the front doors may open automatically or you will need to enter a code into a key pad to enter and exit the home. Doors to the home are locked in the evenings and based on the season. Information for how to enter the home after hours will be posted near the key pad. All exterior doors of the home are connected to the security system with an alarm that is active at all times. For the secure neighbourhood, there is also a keypad needed to enter and exit the area of the home. When entering and leaving this area, pay attention and do not allow anyone you don't know to follow you as you leave the home.

Wanderguards

Some residents with cognitive impairments and dementia may be equipped with a special necklace or bracelet called a wanderguard. This bracelet will help keep them safe and prevent them from leaving the LTC community. If they approach the main exit of the home, an alarm will sound and the exterior door will lock preventing them from leaving the home. Please make sure you do not let a resident wearing a wanderguard out of the home.

ACTIVITY RESOURCES

Mindfulness in nature is a powerful way to connect with the environment and foster a sense of peace and well-being. Engaging in mindful activities outdoors allows you to slow down, breathe deeply, and fully experience the sights, sounds, and sensations of the natural world.

In the following list, you'll find a variety of mindfulness practices that can be done in nature, each designed to help you relax, focus, and find balance in the present moment.

Nature on Demand (wayfarerforest.com) An innovative service provided by Wayfarer Forest that offers a unique way to experience the beauty and tranquility of nature, regardless of your location. This service delivers high-quality, on-demand video content featuring serene natural environments, allowing users to immerse themselves in the sights and sounds of forests, streams, and other calming outdoor settings. Ideal for those seeking a moment of peace or a mental escape from the hustle and bustle of daily life, Nature on Demand provides an accessible way to reconnect with nature whenever you need it.

Java Music Club Programs (javagp.com) Programs designed to enhance the lives of seniors by combining the power of music with the benefits of peer support. These programs are tailored for long-term care and community settings, offering a structured, supportive environment where participants can connect through shared musical experiences. The Java Music Club uses a unique approach that blends music, storytelling, and discussion to promote social interaction, emotional expression, and a sense of belonging. By participating in these sessions, seniors can build meaningful connections, improve their well-being, and enjoy the therapeutic effects of music in a group setting.

Intergenerational Jamboree Program (the-ria.ca/resources/intergenerational-jamboree) Programs designed to enhance the lives of seniors by combining the power of music with the benefits of peer support. These programs are tailored for long-term care and community settings, offering a structured, supportive environment where participants can connect through shared musical experiences. The Java Music Club uses a unique approach that blends music, storytelling, and discussion to promote social interaction, emotional expression, and a sense of belonging. By participating in these sessions, seniors can build meaningful connections, improve their well-being, and enjoy the therapeutic effects of music in a group setting.

Boredom Busters Ontario Centres for Learning Research and Innovation (clri-ltc.ca/files/2020/04/BOREDOM-BUSTERS-FOR-LTC-1.pdf) - A creative resource developed by the Ontario Centres for Learning, Research, and Innovation in Long-Term Care (CLRI) to help staff and caregivers engage residents in meaningful and enjoyable activities. This guide offers a wide range of ideas designed to combat boredom and enhance the quality of life for seniors living in long-term care homes. The activities are varied, easy to implement, and tailored to different levels of ability, ensuring that everyone can participate in some way. Whether through games, crafts, or social interactions, Boredom Busters provides practical solutions to keep residents active, entertained, and connected.

Activities You Can Do During a Visit

Look at pictures or a photo album: Reminisce together by going through old photographs, sharing stories, and reconnecting with cherished memories from the past.

Go for a walk together to explore: Take a stroll around the facility or in a nearby park, enjoying the fresh air and the changing scenery while engaging in light conversation.

Listen to music: Play their favourite songs or soothing music, which can evoke memories and emotions, creating a relaxing and enjoyable atmosphere.

Look at magazines, books, or picture books: Flip through magazines or books that match their interests, discuss the content, and enjoy the visuals together.

Read the newspaper with them: Stay updated on current events by reading the newspaper aloud, sparking conversation about the news and sharing opinions.

Play an instrument for them: If you play an instrument, serenade them with a tune, which can bring joy and comfort, especially if it's a song they love.

Brush their hair: A gentle and nurturing activity, brushing their hair can be soothing and provide a moment of connection and care.

Massage their hands or feet: Offer a gentle hand or foot massage to help them relax, relieve tension, and improve circulation.

Paint their nails: Give them a mini manicure, adding a splash of colour to their nails, which can be a fun and uplifting experience.

Play a game of cards: Engage in a simple card or board game, which can be a great way to stimulate their mind and enjoy each other's company.

Watch a movie or TV together: Share the experience of watching a favourite movie or TV show, offering a comforting and familiar routine.

Look through memorabilia that is important to them based on their interests (i.e. sports items, fabrics): Bring along memorabilia that resonates with their hobbies or past experiences, sparking conversation and nostalgia.

Share a snack: Enjoy a favourite snack together, turning it into a moment of bonding and shared enjoyment.

Do a craft or paint together: Get creative by working on a craft or painting project, which can be both fun and therapeutic.

Work on a jigsaw puzzle: Spend time putting together a puzzle, which can be a calming and engaging activity that promotes focus and teamwork.

Watch the birds: If they enjoy nature, sit by a window or outside and watch the birds, appreciating the peacefulness and beauty of the natural world.

Sit in the garden: Take advantage of any garden or outdoor space, sitting together to enjoy the flowers, plants, and tranquility.

Fold laundry: Turn a simple task like folding laundry into a shared activity, providing a sense of purpose and accomplishment.

Meditate or practice mindfulness: Guide them through a meditation or mindfulness exercise, helping them relax, focus on the present moment, and reduce stress.

FAQ: VISITING A LOVED ONE IN LONG-TERM CARE

Can I Bring them Food?

You can bring in treats to share during a visit; however, food is monitored by the care team in LTC to prevent food poisoning or any food-borne illness. If you bring perishable food in to share with a resident during a visit, please do not leave it in their room. You can label the food in a container with the resident's name and the date the food arrived so it can be stored in the fridge. Do not share the food you bring with other residents as you may not be aware of their dietary restrictions, requirements, health issues, or if they are at risk of choking.

Do I Need to Stay in their Room for a Visit?

Unless there are specific restrictions on visits due to an active outbreak in the home or the resident's medical needs, you do not need to stay in their room during your visit together. You can spend time in communal areas of the home, like the library, or attend group programs together.

Can We Go Outside for Our Visit?

You are welcome to go outside with the resident during your visit. Make sure you dress the resident appropriately for the weather. If it is cold, they will need their winter coat, shoes, a winter hat, mittens or gloves, and a blanket. If it is hot out, make sure they are wearing sunscreen and a sun hat, and they stay well hydrated.

Can we Host Family Celebrations at the Long-Term Care Home?

Yes, LTC homes have private spaces available where families of residents can host celebrations. These spaces need to be booked in advance by speaking to the appropriate member of staff. You can also communicate details about how you would like the space to be set up with the environmental manager. You can share details about any food and beverage requirements with the business office and dietary department.

Can I Bring Pets?

Yes, domestic pets are often welcome to join you for a visit to the long-term care home, but it's essential to check the specific policies of the home beforehand. There are a few rules that must be met to keep everyone safe:

- Up-to-date vaccines.
- The animal is in good health.
- Always under their owner's control (i.e. on a leash or in a cage).
- Animals are not permitted in food handling or dining areas during mealtimes.
- Owners should be sensitive to staff and other residents who do not want to be close to animals.
- Place animal food and water bowls in a safe area.
- Any spilled water must be cleaned up.
- Animals that bark, bite, or jump will be asked to leave the home.
- When a resident is in isolation or the home is in an active outbreak, Public Health. may direct the home to suspend pet visits until after the outbreak.

PET THERAPY ORGANIZATIONS

If it is not possible to bring your family pet to the home for a visit, the recreation team often works with various organizations to arrange for pet therapy.

Therapeutic Paws of Canada (tpoc.ca)
A volunteer-based organization dedicated to enhancing the lives of people in various settings through pet therapy. Specially trained dogs and cats, along with their handlers, visit hospitals, long-term care homes, schools, and other community facilities to offer comfort, companionship, and emotional support. These visits help reduce stress, alleviate loneliness, and bring joy to individuals of all ages. Therapeutic Paws of Canada ensures that all pets involved are well-behaved, healthy, and suited to therapeutic work, making their visits safe and beneficial for everyone involved. By fostering positive human-animal interactions, TPOC contributes to the overall well-being of those they visit.

Sunshine Therapy Dogs (Durham/Toronto) (sunshinetherapydogs.ca)
A non-profit organization based in Durham and Toronto that focuses on bringing joy and comfort to people through the therapeutic benefits of pet visits. Trained dogs, along with their volunteer handlers, visit a variety of settings including long-term care homes, hospitals, schools, and community centres. These visits are designed to provide emotional support, reduce anxiety, and improve the overall well-being of individuals by offering them the opportunity to interact with friendly, affectionate dogs. Sunshine Therapy Dogs is committed to making a positive impact in the community by harnessing the power of the human-animal connection.

Companion Paws Canada (companionpaws.ca)
Companion Paws Canada is dedicated to enhancing the quality of life for individuals through the support of specially trained therapy dogs. They focus on creating meaningful connections between people and their canine companions, providing emotional support and comfort. By training dogs to assist with various needs, from mental health challenges to physical disabilities, Companion Paws Canada aims to foster a sense of well-being and companionship. Their programs are designed to bring joy, alleviate stress, and improve overall life satisfaction for those they serve.

St. John Ambulance (sja.ca/en/community-services/therapy-dog-program) - St. John Ambulance's Therapy Dog Program is committed to bringing comfort and joy through the compassionate presence of trained therapy dogs. This program focuses on enhancing the well-being of individuals across various settings, including hospitals, care facilities, and community events. By pairing skilled therapy dogs with dedicated volunteers, the program offers emotional support, reduces stress, and creates uplifting experiences for people in need. Through their service, St. John Ambulance aims to foster healing and positivity, demonstrating the profound impact that a loving canine companion can have on people's lives.

SECTION SEVEN:

WHO WORKS IN LONG-TERM CARE?

LEARNING OBJECTIVES

- *Recognize the roles and responsibilities of team members in Long-term care.*
- *Develop a plan to approach with your questions as a Caregiver in Long-term care.*

In this resource, we've covered various staff titles within Long-Term Care, each with its unique responsibilities. In this section, we clarify the specific duties associated with each role to help you identify the right staff member to approach with your questions. Our goal is to assist you in navigating LTC and finding the most suitable person to connect with as you continue to learn about your new role as a partner in care.

Administrator

A key leadership role for any LTC community. Administrators are tasked with overseeing the delivery of services and care for all departments within an LTC home. They ensure compliance with quality standards, infection control, occupational health and safety, professional practice, and emergency procedures. They set the tone supporting the creation of a person-centred community that celebrates diversity.

Director of Care (DOC)

Responsible for managing the nursing department and making sure that the care provided by staff follows best practice guidelines, regulations, home policies, and residents' wishes. Staff in this role work closely with the administrator. They are tasked with hiring, training, and performance reviews of clinical care staff.

Associate Director of Care (ADOC)

This role reports to the DOC and is tasked with managing the clinical staff for specific neighbourhoods of the home. An ADOC supports and guides the staff in these areas as they develop care plans to provide person-centred care.

Office Lead

Keeps the home running smoothly. They support new residents and their families in completing the documentation to move into the home. Office staff can also answer questions about the financial aspects of the LTC home, including the cost of accommodations, the process to apply for a rate reduction, how you will be billed for accommodations, and additional services provided to residents in the home.

Office Assistant

Their main responsibility is to support the operation of the business office. They perform a variety of clerical tasks like printing documents, mailing letters, answering the phone, and greeting visitors and answering their questions. They may also support people as they enter and exit the home for visits and prompt them to sign the appropriate log book.

Medical Director

Responsible for the leadership of the medical team and supporting the LTC home through their advice. Each community has a contract with a doctor and/or a nurse practitioner who will provide medical care to all residents living in the LTC home. Each resident's health needs will determine how often they see the doctor or nurse practitioner. Members of this team share the responsibility of being on-call to ensure medical support is available to residents 24 hours a day, 7 days a week.

Clinical Documentation Informatics Lead (CDI)

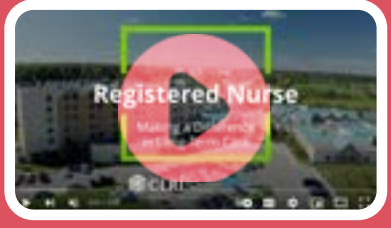
Responsible for maintaining the home's documentation system, which encompasses a variety of important tasks. This includes managing paperwork associated with move-in day and ensuring that all necessary forms and records are accurately completed and filed as new residents join the facility. Additionally, they handle documentation related to care conferences, where details about residents' care plans and progress are discussed and recorded. Their duties also involve managing paperwork for transfers to and from the hospital, ensuring that all medical information and relevant records are correctly updated and communicated to facilitate smooth transitions and continuity of care.

Registered Nurse (RN)

Responsible for providing both nursing care to residents with complex needs and guidance to Registered Practical Nurses (RPN) and Personal Support Workers (PSW) related to care issues. They can share updates about the care provided to a resident with their family members. They are in charge when the DOC and ADOC are not in the home.

VIDEO:
NURSING: A CAREER IN LONG-TERM CARE

VIDEO LINK: YOUTU.BE/TQ76A76JHJA
WATCH TIME: 2 MINUTES



This video from Ontario CLRI offers a brief glimpse into the role of a registered nurse working in long-term care, highlighting the unique responsibilities, and rewarding experiences involved in caring for older adults.

Registered Practical Nurse (RPN)

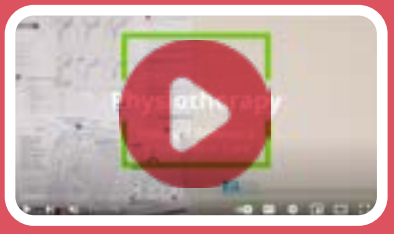
Responsibilities include conducting thorough assessments to evaluate each resident's health and needs, administering medication, and carrying out other prescribed treatments as directed by healthcare professionals. This hands-on care is essential for maintaining residents' health and managing their conditions effectively, requiring a deep understanding of medical protocols and a compassionate approach to address both physical and emotional needs.

Physiotherapist

Supports the physical health and well-being of residents by assessing and diagnosing symptoms of pain and limited mobility caused by illness, injury, or disability. Their activities focus on improving residents' strength, balance, and range of motion. In Ontario, physiotherapists complete a Masters degree from a rehabilitation program after they graduate from a four-year undergraduate program. Once they graduate, and pass the Physiotherapy Competence Examination (PCE), they are registered with the College of Physiotherapists in Ontario.

VIDEO:
PHYSIOTHERAPY: A CAREER IN LONG-TERM CARE

VIDEO LINK: YOUTU.BE/G2ZIY3NHH-0
WATCH TIME: 3 MINUTES, 42 SECONDS



This informative video from Ontario CLRI shows a dedicated physiotherapist working in long-term care. It provides valuable insights into their role in supporting residents' physical health and well-being.

Infection Prevention and Control Manager (IPAC)

Also referred to as the IPAC lead, they are responsible for the creation of an IPAC program for the home and oversee the implementation of the IPAC plan. They work with staff from various departments in the home to develop and update the IPAC plan as necessary.

Pharmacist

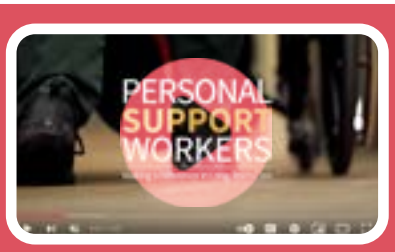
A healthcare professional who is highly trained in the use of medications and plays a key role in optimizing medication therapy for patients. Pharmacists are responsible for ensuring that medications are used safely and effectively, and they collaborate with other healthcare professionals to manage and adjust medication regimens.

Personal Support Worker (PSW)

Tasked with providing direct care to residents, which involves a range of essential activities aimed at supporting their daily needs and overall well-being. This includes assisting residents with their activities of daily living (ADLs), such as helping them get dressed, bathe, and eat. By offering support in these fundamental tasks, they ensure that residents maintain personal hygiene, comfort, and dignity. Their role is not only to aid with physical tasks but also to offer encouragement and companionship, fostering a caring and respectful environment.

VIDEO:
PERSONAL SUPPORT WORKERS: MAKING A DIFFERENCE IN LONG-TERM CARE

VIDEO LINK: YOUTU.BE/XGRZJNA5HSU
WATCH TIME: 2 MINUTES, 53 SECONDS



This video from the Schlegel-UW Research Institute for Aging offers insight into the vital role of a Personal Support Worker (PSW) and their meaningful career in long-term care, highlighting the compassionate care they provide to residents and the essential support they offer in day-to-day living.

Nutrition and Environment Manager

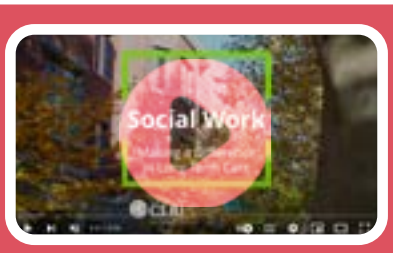
Responsible for managing the housekeeping, laundry, and dietary departments. Duties include overseeing department budgets, ordering supplies, and managing relevant staff. They make sure each department provides services that follow the regulations and legislation and meet each resident's needs.

Resident and Family Support Worker

This role is often filled by social workers who support families and residents throughout the process of joining the LTC home. They will meet with families and potential residents to provide a tour of the home and support communication between OHAH and the home. They play a big role on move-in day, as well as throughout the time when a resident and their family members adjust to LTC.

VIDEO:
SOCIAL WORK: A CAREER IN LONG-TERM CARE

VIDEO LINK: YOUTU.BE/BCGASBF4Z_I
WATCH TIME: 4 MINUTES, 26 SECONDS



This video from Ontario CLRI explores the role of a social worker in long-term care, highlighting how they support residents and their families with mental health and well-being while helping those with complex needs navigate the system.

Dietary Aide

Helps the cooks to prepare food and beverages for meals. Sets the tables in the dining room for meal services. Serves meals to residents in the dining room. Follows meal times and performs cleaning duties in the dining area and the serving area.

VIDEO:
FOOD SERVICE WORKER: A CAREER IN LONG-TERM CARE

VIDEO LINK: YOUTU.BE/7G-UPESNMNU
WATCH TIME: 2 MINUTES, 21 SECONDS

This video from Ontario CLRI showcases the crucial role food service workers play in supporting residents with their nutrition and dining experience in long-term care.

Registered Dietitian

Reviews meal menus to ensure resident feedback is addressed. Creates menus to offer residents a variety of nutritious food. Supports residents with complex nutritional needs. Ensures residents are well-fed and hydrated.

Food Service Supervisor

Responsible for overall food service operation in accordance with health and safety regulations, Ministry of Long-Term Care standards, and Public Health regulations. They supervise all dietary staff including cooks and dietary aides.

Cook

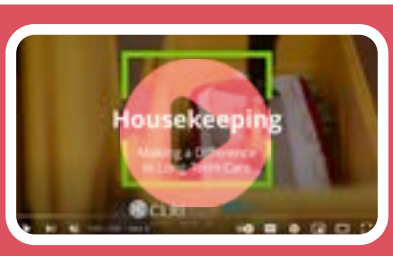
Tasked with properly preparing and cooking resident meals to ensure they are served on time. Ensures the use of proper food handling techniques. Follows recipes and daily menus. Dates, labels, and stores food properly. Supports the planning and preparation of food for special events and themed meals. Receives and stores incoming food and supplies.

Housekeeping Aides

Complete general housekeeping tasks, like cleaning the floors and handrails. Involved in setting up resident rooms and large programs and special events. Follows IPAC policy to help reduce the spread of infections within the home.

VIDEO:
HOUSEKEEPING: A CAREER IN LONG-TERM CARE

VIDEO LINK: YOUTU.BE/Y6G7-XDNQPQ
WATCH TIME: 3 MINUTES, 23 SECONDS



This video from Ontario CLRI highlights the essential role housekeepers play in long-term care homes, where they are responsible for cleaning, disinfecting, and performing tasks that ensure the building remains tidy and functions smoothly for both residents and staff.

Laundry Aides

Completes on-site laundry for towels, bedding, and residents' laundry. On move-in day, they work with family members to make sure resident clothing is properly labelled. They follow IPAC policy to reduce the spread of infection in the home.

Program Manager

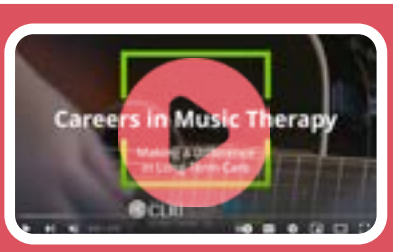
Oversees staff providing a range of programs and services to residents in the LTC home. This includes staff involved in delivering recreational programs, rehabilitation services, spiritual care, hair styling, and any volunteers within the home.

Music Therapist

Accredited Music Therapists (MTA) use music to address the cognitive, emotional, physical, social, sensory, and spiritual needs of residents, supporting overall health and well-being. They lead programs focused on music-based verbal and non-verbal communication. Music therapy is an effective program for individuals with dementia or speech and visual impairments. These programs can support pain management and create meaningful experiences shared with other residents and family members.

VIDEO:
MUSIC THERAPY: A CAREER IN LONG-TERM CARE

VIDEO LINK: YOUTU.BE/CDCNUVAZBHO
WATCH TIME: 2 MINUTES, 10 SECONDS



In this engaging video from Ontario CLRI, viewers are introduced to the rewarding career of music therapy within long-term care settings. The video explores how music therapists use the power of music to support residents' emotional, cognitive, and physical well-being.

SECTION EIGHT:

ORGANIZATIONS TO HELP YOU NAVIGATE LONG-TERM CARE

We know the process of applying and supporting the transition into LTC is challenging. It is important to know that you are not alone in this journey. In this section we will share information about two important organizations available to support Caregivers in Ontario. The first organization you will learn about is the Ontario Caregiver Organization, which supports Caregivers in all settings from community to hospital to LTC. Family Councils Ontario is another important organization that can support you as you adjust to your new role supporting a resident in LTC and as you seek opportunities to participate in the LTC community. We will also highlight the role of the Ontario Association of Residents' Councils who play a role in supporting residents as they join LTC communities.

THE ONTARIO caregiver ORGANIZATION

The Ontario Caregiver Organization (OCO) exists to improve the lives of caregivers across the province by connecting caregivers with the support they need: providing comprehensive resources, tools, and information tailored to the setting they're in, including long-term care (LTC). Recognizing the important role caregivers play in the healthcare system, OCO offers a range of accessible programs and services designed to address the diverse issues that impact caregivers and promote caregiving-inclusive practices in healthcare.

Caregivers can visit ontariocaregiver.ca for free programs and services:

The Ontario Caregiver Helpline

The Ontario Caregiver Helpline is a one-stop resource for information about the programs and resources that can support you in your caregiving role.

Free of charge phone support 24/7 at 1-833-416-2273 or live chat online Monday to Friday 7 am until 9pm ET.

1:1 Peer Support

Connect with another caregiver, share your experiences, and receive direct support online or by phone.

Online Support Groups

Connect with other caregivers in a supportive environment to share your, challenges, successes and concrens.

Monthly Webinars

(Live and Recorded) Webinars presented by subject matter experts — visit our library to view them anytime.

Online Learning Library

Free of charge, self-directed e-learning courses.

I am a Caregiver Toolkit

In addition to these resources, OCO has developed the ”I am a Caregiver Toolkit” specifically designed for LTC homes. A valuable resource for navigating the challenges of caregiving in a long-term care setting, this toolkit includes information to support new or long-time caregivers in long-term care, with input from mental health professionals. It includes:

- Practical advice,
- Emotional support strategies, and
- Resources created by caregivers, for caregivers.

A key resource available to service providers and caregivers alike is the OCO Helpline (1-833-416-2273), which connects caregivers to support wherever they might be across the province, regardless of their age or medical diagnosis. The helpline is available 24/7 in English and French and has interpretation services available in 150 languages.

The SCALE Program

Supporting Caregiver Awareness, Learning and Empowerment (SCALE) provides caregivers with the skills needed to find a balance between caregiving and their own needs. This 8-week virtual program is offered twice a year. Recognizing caregivers are busy, the webinar sessions are recorded and available on demand at ontariocaregiver.ca/counselling-coaching/scale-program

Caregiver Coaching Program

This program provides caregivers with a one-to-one interaction between a caregiver and an OCO coach. Coaches have a combination of work experience in health or social services along with their personal experiences as caregivers. Coaches can provide support to caregivers about the following topics:

- Caregiver Burn-out/fatigue
- Balancing work & caregiving
- Self-Care
- Setting boundaries
- Effective communication with the healthcare team
- Grief & Loss, end-of-life care
- Financial concerns
- Planning for future care needs

To participate in one-to-one coaching, you will need to meet the following criteria:

- Access to a phone (cell or landline) or the internet
- Feel stuck in your role as a caregiver
- Experience challenges in managing your stress
- Feel burnt out
- Readiness to participate in the program
- Acknowledge the program is not a substitute for therapy or counselling

The coaching program consists of up to six coaching sessions available to those who are accepted following their application surveymonkey.com/r/L87KT57

Family Councils Ontario also known as FCO is a registered, charitable non-profit organization funded by the Ontario Ministry of Long-Term Care. From 1998 to 2015, The Family Councils' Program was a program of The Self-Help Resources Centre. The program was initially funded by a Trillium Foundation grant in 1998. In 2004, the program secured permanent funding from the Ontario Ministry of Health and Long-term Care. The Ontario Family Councils' Program emerged in response to a need identified by Concerned Friends of Ontario Citizens' in Care Facilities. Family members as primary caregivers were asking for support and information on a variety of topics after their loved ones moved into a long-term care home in Ontario. In the late 1990s, it was obvious that an increasing number of residents in Ontario's long-term care homes were living with dementia and in need of support to speak for themselves.

When a resident was unable to voice their own needs, they relied on their family/friends to be their voice and advocate for their needs in partnership with the staff in their long-term care home. Changes in the resident population as well as to the role of Caregivers in long-term care led to the need for Family Councils where family, friends or individuals deemed important in their lives (i.e. neighbour, life-long friend) could come together, discuss their challenges and engage in peer support. In 2015, the program became Family Councils Ontario, an independent, charitable non-profit that continues to receive funding from the Ontario Ministry of Long-term Care.

The team at FCO work with long-term care home residents' families, Family Councils and staff working in long-term care across Ontario supporting them as they develop positive relationships, build effective Family Councils and improve the long-term care experience.

FCO's mission is to lead and support families in improving the quality of life in long-term care. This is possible through their work with families, staff and sector partners.

FCO's vision is that people in long-term care have a vibrant experience and the best care.

The FCO team strive to create a safe, vibrant, inclusive, and respected long-term care system. Examples of services and supports offered by FCO include:

Consultations

Members of the FCO team, including our Client Services Manager, Bi-lingual Outreach Coordinator, Education Manager or Policy and Research Manager are happy to respond to questions or inquiries via phone or e-mail.

Family Council Education

Family Council education sessions are offered by FCO throughout the year. Presentations are available on a variety of topics including How to Start a Family Council, the Fixing Long-Term Care Act, Conflict Resolution, Group Development, Succession Planning, and Recruiting new members. For more information on educational topics and resources available to Family Councils please visit the FCO website at fco.ngo.

What is a Family Council?

A Family Council is a group of family members and friends of the residents of a long-term care home (LTC) who gather together for peer support, education, and to improve the experiences of all people in long-term care.

Each Council across Ontario will be different, but they all seek to create safe, vibrant, and supportive LTC homes for residents, families, and staff. They share common goals. Read more about each of the four main Family Council goals below:

Support: A Family Council can be a great source of mutual support to family members and offer guidance to new families during their transition to long-term care. No one knows what a family member is going through like another family member! By being involved in a Family Council, you can give and receive emotional, informational, and practical support.

Education: Family Councils provide a mechanism for family members to learn and gain an understanding of the home and how it operates. Many Councils also invite guest speakers from the community and from within the long-term care home to present information/resources on various topics (for example, how to have meaningful visits with residents who have dementia, Power of Attorney, End of Life Care).

Problem-solving: Also called advocacy, Family Councils advocate regarding collective concerns to improve residents' quality of life. Councils can bring concerns to the administration of the home and make suggestions for improvements. These could be improvements to the physical layout of the home (for example: creating a safe walkway around the property); suggestions for new programs and activities for residents (for example: new weekend programs or activity boxes available for families to use with their resident); collective concerns about menus, laundry service, or staffing levels); and ways to connect the home to the broader community (for example, working with the local transit authority to have the community bus service the long-term care home).

Communication: Family Councils provide an opportunity for families to be informed about what is happening in the home. Councils can use their meetings and other communication tools (website, emails) to share information from the home with family members. Councils can also solicit ideas, feedback, and suggestions from members and share them with the home.

The Ontario Association of Residents' Councils (OARC) is a non-profit organization focused on strengthening the voice of residents living in Long-term Care through participation in the Residents' Council in their home. Funded by the Ministry of Long-term Care, it is mandatory for ALL LTC Homes in Ontario to have a Residents' Council. Staff at the OARC work with residents to understand their rights, create a space for peer support between residents and advocate for positive culture change at the government and systems levels and in each individual LTC community.

OARC encourages, supports and assists residents to:

- Start, lead and maintain effective Residents Councils
- Engage as active participants in the operations of their LTC home
- Engage as active participants in the community in which their LTC home is located
- Share and present ideas and promote policies to improvethe quality of life for residents
- Educate about life in LTC including the issues facing residents

What is Residents' Council?

A Residents' Council isa formal advisory body that is mandated by the Fixing Long-Term Care Act (FLTCA, 2021) to exist in every long-term care home in Ontario. All residents who live in a LTC home are members of the Residents' Council. The Council belongs to the residents, who decide on the structure, how meetings will work and what will be discussed during meetings. In Ontario, the Residents' Council holds specific powers, rights, roles and responsibilities outlined in FLTCA, 2021..

The Residents' Council, perhaps with an elected Executive or Leadership Team, meets regularly to provide advice and recommendations to the licensee regarding what the residents would like to see done to improve care or the quality of life in the home, and to provide peer to peer support.

Residents' Councils also meet to exercise several powers including, but not limited to sponsoring and planning activities, collaborating with community groups, reviewing the financial documents and operations of the LTC home, and attempting to resolve disputes.

Every home must also appoint a Residents' Council Assistant who is a designated staff member of the LTC who takes direction from the Residents' Council.

Tips for Moving into Long-Term Care from Ontario Association of Residents' Councils:

Involvement Before the Move: Encourage the prospective resident to participate in discussions, tours, and pre-admission processes. This way, the move won't be a complete surprise, and they can give input on room setup and packing.

Trust in Family's Decisions: Some residents may not be able to tour the home themselves but can find comfort in knowing that their family or caregivers have done thorough research and chosen a reputable LTC home. They understand the move is necessary for their safety and well-being.

Ask About Move-In Day: Contact the home in advance to understand what the move-in process looks like. Can guest meals be arranged? Share this information with the prospective resident to manage expectations and answer any concerns honestly.

Support for Cognitive Changes: For residents with cognitive challenges, it's important to offer repeated reminders and visual cues to provide comfort and ease the transition.

Honesty About Family Routines: Be transparent with the resident about needing to return home for sleep, work, or errands, but reassure them by highlighting ways you'll continue familiar routines, like watching favorite TV shows or attending regular activities together.

Reassure Frequent Visits: Let the resident know that family and friends will visit often, share meals, or go on outings. Highlight the proximity to loved ones as a benefit of the new home, and ensure they have access to a phone or internet to stay connected.

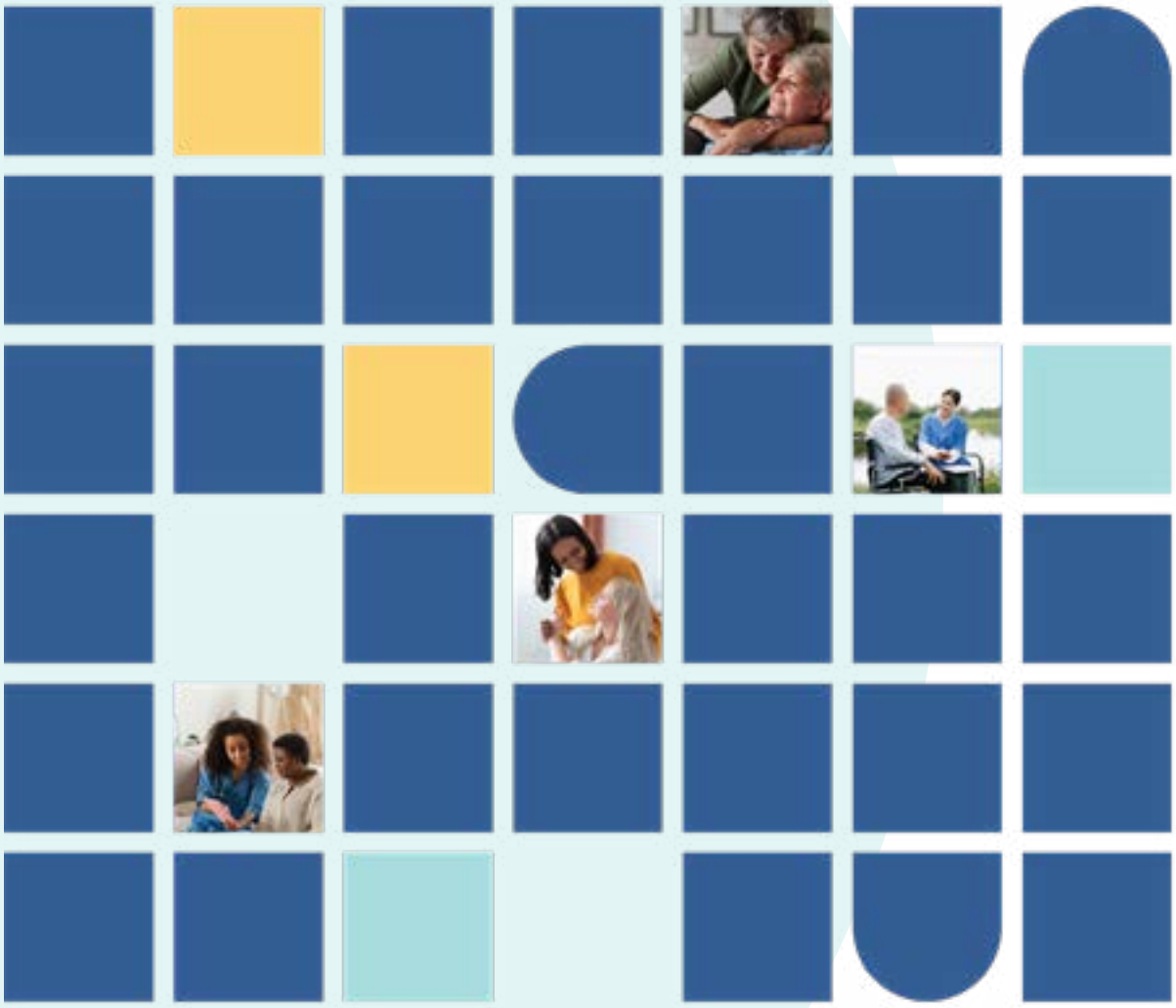
Facilitate Social Connections: Work with the home to introduce the resident to a co-resident or an activity on day one, helping them feel welcome and easing the feeling of isolation.

Contact OARC

Ontario Association of Residents' Councils
4261 Highway 7 East
Suite # A14-360
Markham, ON L3R 9W6

Telephone: 905-731-3710 | 1-800-532-0201
Email: info@ontarc.com
Web: ontarc.com

YouTube: youtube.com/@ontarioassociationofreside1832
LinkedIn: linkedin.com/company/ontario-association-of-residents-councils



SECTION TEN:

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MAKING THE MOVE TO LONG-TERM CARE

A Practical Navigation Guide
for Ontario Families

The LTC Navigation Guide is designed to help families, caregivers, and future residents smoothly transition into long-term care. It covers essential steps, including applying for a bed, understanding financial support, preparing for move-in day, and engaging with the care community. This guide is a practical resource to empower individuals with the knowledge and confidence needed to navigate the complexities of long-term care, ensuring a positive and informed experience.

Family Councils Ontario