



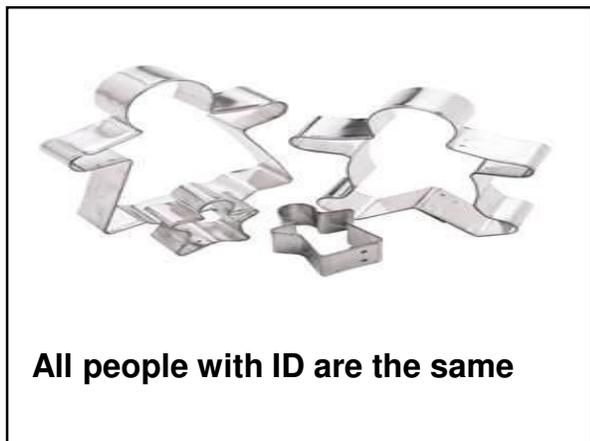
Participants will understand the transition process from a 'needs' perspective.

Participants will be able to identify interventions and support strategies to assist with the transition process.





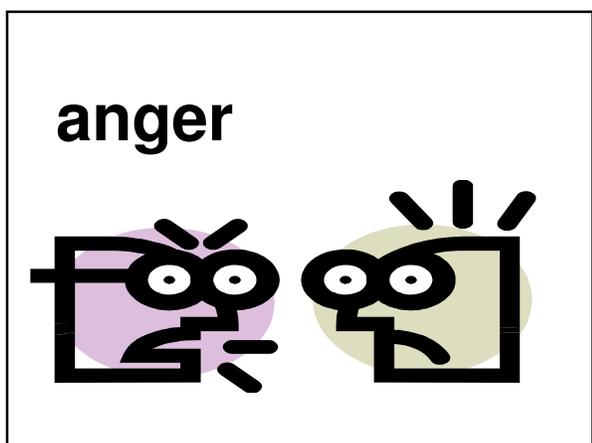












loss



sadness



powerless



How has the person reacted/adapted to previous losses and changes in their lives?



Does the person have well developed coping skills?



Is the person able to express their feelings in an appropriate way? How have they expressed themselves emotionally in the past?







Discuss the potential for health related issues during a transition from one setting to another.

“I try to do therapy (physiotherapy) every day. If I don’t I won’t be able to get around. I need help with this”.

**we could address
the need for health
and well being by:**

The need to feel safe and secure

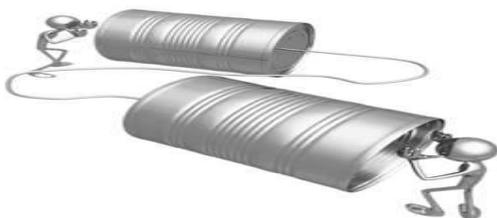


**Discuss the potential for fear
associated with a transition and
possible consequences of a lack
of safety and security**

*"I kept quiet.
I didn't stick my neck out."*

We could address the **need** for **safety** and **security** by:

The need to understand and be understood



Discuss the potential for communication problems associated with the transition and problems with the need for understanding

"I need to have things written down on paper... don't expect me to remember everything you tell me."

We could address the need for **communication** and **understanding** by:



The need for choice and control over my own life

Discuss the potential for problems with the transition associated with lack of choice and control

“I have lots of things. I had my own apartment. I needed to make a decision about what I brought with me. They have been telling me to get rid of some of my things because my room is too messy.”

We could address the need for **choice and control** by:

The need for access to meaningful, familiar activities and pursuits



Discuss transitional issues associated with meaningful activities and pursuits.

*“I can't get out much.
It's difficult for my family to visit me here.
Everyone is really busy with their own lives”.*

We could address the **need** for **meaningful activities and pursuits** by:

The need to be independent and have responsibility



Discuss the potential for problems related to independence and responsibility

"I can't move very fast. Sometimes I don't make it to the washroom on time ... that's embarrassing. If I go too fast I might fall over backwards".

**We could
address the need for
independence
and responsibility by:**

The need for **recognition** and **self-esteem**



**Discuss the potential for
problems
meeting the need for self esteem
during a transition to LTC**

“I try to stay out of trouble”.

We could address the need for self-esteem by:

The need for social contact, networks and a connected community



Discuss the potential for problems associated with the need for social supports, networks and a connected community.

“My church minister doesn’t come very often. It is farther now for him to travel. He said he would see about someone else coming to visit me who was closer... but no one has”.

We could address the need for **social supports and networks** by:

Case Study # 1

Joanne is a 65 year old woman with mild to moderate ID. She was transferred to a LTC facility close to her mother and has since been moved to a hospital because she could not tolerate the environment. Multiple factors are involved.

Key medical history

- Recurrent UTI
- Dyslipidemia
- Obesity
- HTN
- Sleep apnea



Medications

- Celexa
- Valium
- Lithium
- Risperidone
- Metoprolol
- Multivite and Vit. D
- Lipitor
- Ducosate



Social History

Joanne lived in a group home setting and was sexually assaulted in this setting and was subsequently moved to an all female boarding home. She attended a TPA day program while living in this home. Her mother was aging and was due to be transferred to a LTC facility and wanted Joanne to be closer in proximity – thus Joanne was transferred to an available facility.

Supports in Place

- Client was provided a tour of facility prior to moving
- 1 FTE DS staff at facility daily
- Client integrated into activities provided Paratranspo to day program

Lessons Learned

Client had significant ongoing co-morbid mental health needs that were not able to be met in this facility.

Reviewing background and history may have emphasized the need to remain in an all women environment.

Case Study # 2

Joe is a 78 year old man living in a LTE with mild to moderate ID. He resided in RRC since the age of 7 yrs. At the time of closure of the institution is was felt that he would be best supported in a LTC facility.



Key Medical History

- HTN
- NIDDM
- Dyslipidemia
- Enlarged Prostate



Medications

- Metformin
- Lipitor
- Ramipril
- Trazadone
- Metamucil



Social History

Joe was brought to RRC as a child and lived there until the time of the transition. He had limited involvement with his family and considered the staff at RRC his family.

He enjoyed reading swimming and participating in other activities.

Supports for Transition

- Joe was actively involved in the process
- He had three visits prior to the transition
- He set up his own room and selected his own furniture (custom desk for his books and magazines).
- Familiar staff from RRC came for 2 weeks
- Full time staff associated



Lessons Learned

- Good planning goes a long way
- Ask and LISTEN to client
- Determine likes and dislikes PRIOR to transition
- Consistent staffing during transition
- Meaningful activities
- Use available resources (ie. Paratranspo)

Case Study # 3

Maria is a 57 year old woman who has transferred from a psychiatric facility. She has moderate to severe DD



Key Medical History

- Epilepsy (partial complex)
- Hypothyroid
- Cerebral palsy



Medications

- Citalopram
- Clonazepam
- Divalproex Sodium
- Eltroxin
- Dilantin
- Seroquel XR
- Haldol
- Benadryl
- Lorazepam
- Lactulose



Social History

Maria lived with her mother in the community and was independent of ADL's and was active in the community. Her mother passed away and Maria was transferred to a psychiatric facility. She was then transferred to a LTC facility as it was felt that she would be closer to her family.

Supports in place



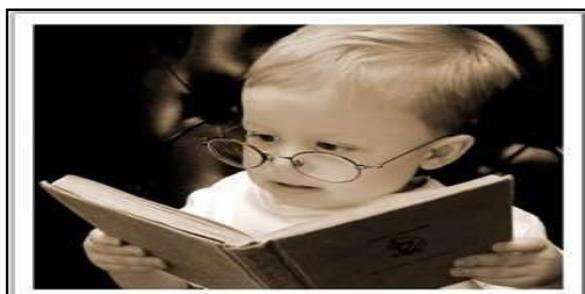
Family lived in local community visited infrequently

Lessons learned

- Important to understand and address behaviour before medicating
- People with DD grieve and this needs to be acknowledged and addressed
- Putting supports in place BEFORE transitioning can be extremely beneficial







Easing Transitions in Long-Term Care
Sherry L. Dupuis, Ph.D.
Murray Alzheimer Research and
Education Program
