



CONNECTING MINDS

DEMENTIA CARE NEWSLETTER

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Helping with the Transition to Long-Term Care

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When family members move a loved one to a long term care setting, they face stressful decisions and consequences. Unfortunately, we have yet to fully appreciate or understand the nature of this experience for family members and for the new resident, as well as for the staff at the long term care setting who are trying to ensure that the move is as comfortable as possible.

The *Enhanced Long-Term Care Transitions Framework* developed by Reuss, Dupuis and Whitfield (2005) identifies the key components that, if implemented, would go some way to ensuring that the transition is less traumatic. For example, the *Framework* emphasizes:

- ◇ Family and resident involvement in decision-making
- ◇ Support from others throughout the process
- ◇ The need to better prepare families for the move
- ◇ Open communication between all parties involved

However, we remain uncertain about the extent to which each of these components is effectively in place. So, using the *Framework* as a guide and in collaboration with the *Partnership in Traditional Care* project team, the experiences of family members and staff recently involved in the process of moving a loved one were examined. Staff and family members in 34 long term care homes in the Champlain region of Ontario responded to questionnaires to indicate which aspects of the transition best described their experience: preparations for admission, time allocated to make arrangements, clarity and relevancy of information provided, and nature and quality of support provided. In addition, both family members and staff were asked to describe what they remembered most about the experience and what, if anything could be done differently to smooth the transition.

Responses were received from over 300 family members, 63% of whom were the adult children of the person moving to a long-term care setting, and from over 400 staff, representing mainly nurses (40%) and personal support workers (22%) but also dietary workers, maintenance staff, recreation professionals and management personnel. Many provided rich details about the nature of their experiences. Overall, the perceptions of both family members and staff fell into four categories:

1. The nature of the experience for the new resident
2. The nature of the experience for the family
3. The role played by the staff
4. The process of administration

Both groups frequently identified the confusion and anxiety that resulted from the transition as well as the trauma that it generated for the new resident. They also recognized that for family members, the consequences of the move included feelings of guilt, helplessness, uncertainty and being overwhelmed.

Both family members and staff felt that creating a welcoming environment was clearly an important role played by the long-term care home. Staff also recognized that the extent to which they acted as a key resource for family members was critical, as was the need to facilitate communication among staff members at the home. Insofar as the administration process was concerned, family members and staff felt there were larger problems with the entire system; in particular, the shock of a “lengthy wait, sudden admission” contributed significantly to the traumatic experience for both family members and the new resident.

Interestingly, just as family members and staff tended to hold similar perceptions of the transition process, they also offered similar solutions for easing the experience. In contrast, when reflecting on the role of staff and the admission process, family members and staff offered quite different solutions to reduce the emotional impact of the experience and to help ease the transition process.

Solutions to Ease the Transition Experience as Suggested by...

Perceptions of..	Family Members	Staff
Experience of Family	Better preparation prior to admission Better preparation at time of admission Staff members must support families	Better preparation prior to admission Better preparation at time of admission
Experience of Resident	Get to know new resident Support resident through adjustment period More staff training on dementia care	Get to know new resident Support resident through adjustment period
Role of Staff	Initial contact with family represents first impression for family Staff need to further appreciate family input	Get to know new resident Facility staff need to appreciate the emotions and act as a resource
Process of Admission	More time to accept new “home Allow greater flexibility in process Make process more transparent to family	Start process prior to admission Resolve systemic issues with CCAC

Primary Dementia Care Agencies In the Algoma District

The following is a list of Primary Dementia Care Agencies and their services that may be helpful for someone affected by dementia. The list is not all inclusive nor is it meant to endorse any particular service.

North East Community Care Access Centre

Services: Assessment for in-home services, referral to community agencies, long-term care placement, occupational/physio/speech therapy, social work and dietary services. ***Physician referral not required.***
Sault Ste Marie.....949-1650 Toll free.....1-800-668-7705

Alzheimer Society of Sault Ste. Marie and Algoma District

Services: Individual and group support, Safely Home (Wandering Registry), in-home recreation therapy, education/information, lending library, companion visitor program, information on community services.
Physician referral not required.
Sault Ste. Marie.....942-2195 Toll free.....1-877-396-7888

Geriatric Assessment Program—Group Health Centre

Services: Diagnostic assessment, initiation of a treatment plan, information on community services.
Physician referral required.
Sault Ste Marie.....759-7484 Toll free.....1-800-461-2407

Geriatric Clinic—Blind River District Health Centre

Services: Diagnostic assessment, initiation of a treatment plan. ***Physician referral required.***
Blind River.....356-2265

Seniors Mental Health Services—Sault Area Hospital

Services: Diagnostic assessment, referral to geriatric psychiatry, referral to North Network resources, information on community services, care-planning, education, advocacy, driving risk assessment and referral.
Physician referral not required.
Sault Ste. Marie.....759-9396

Seniors Mental Health Services—North Shore Community Support Services

Services: Diagnostic assessment, referral to geriatric psychiatry, information on community services, care-planning, education, advocacy. ***Physician referral required.***
Elliot Lake.....848-2800

For a listing of other community support services, please visit our website www.dementiaalgoma.org.

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