3-157 Admission of congenital MH residents

TIPS Question:

Who decides, and at what stage of the disease, and when does it become OK for individuals with congenital mental health issues to be placed among LTC residents where the resident population is mixed on all the floors and staff are not adequately trained to deal with complex behaviours?

What are the significant factors you have learned as a result of working through the six-question template?

- Only after we understand the behaviour can we meaningfully manage the problem.
- Take holistic approach to problem-solving and planning the best care strategies.

Response:

Your question regarding the care of individuals with congenital mental health issues in a long-term care setting is not uncommon but unfortunately one to which there is no simple response. While persons with developmental disabilities and associated mental health issues reflect the same aging patterns and demographics as the general population, we know that they do not necessarily share the same level of public or community services. We also recognize that in the future as our population ages the care issues for these persons will have a significant impact across both the community and long-term care sectors. Unfortunately, at present within many communities there is a lack of clarity in terms of what services are available and who are the service providers who can partner together to meet the needs of these individuals.

The Community Care Access Centres (CCAC) in Ontario play a key role in coordinating the placement of any individual moving from the community into a long-term care facility. I also know from my partnering with CCAC that they too struggle to meet the unique and sometimes complex needs of persons with developmental disabilities who can no longer be cared for in the community. They recognize only too well the challenges that exist for the individual, his/her caregivers and the staff and residents of the LTCF into which the person is moved. Ultimately the planning for services for this population needs to be addressed at an organizational, local and regional level.

So, what can you do? If you think back to the video The Art of Possibility, and in particular the message reminding us that we all have the power to lead from wherever we stand, there are a number of things that you and your team can meaningfully do now.

Beginning to identify who are the partners who need to collaborate to discuss this issue, at an organizational (within your own facility), and at a local and regional level might allow you to plan in a broader and more proactive manner. Who within your facility can come together as a team to identify the questions that need to be asked in order to enhance your ability to provide the best care possible, for example:

- How do you assess the needs of each individual at the time of admission and what does your admission process include now in terms of gathering information? What questions do you presently ask about the individual and who do you currently involve in gathering that information? What other information do you need to know about the person and what other partners (both internal and external) do you need to include? Use the U-First! wheel to help you to organize your review of the admission process and determine where the gaps are.

- The more you know about the “whole person” (using P.I.E.C.E.S. on the wheel) the better able you will be to develop a meaningful care plan from the beginning. Whenever someone is admitted you also want to ask the question, who was involved in this person’s care prior to admission and is there any way you can continue to partner with them following admission to help you get to know the person better and his/her unique care needs?

- Involving the family as early as possible will be important and using the U-First! wheel will greatly facilitate your ability to focus and enhance the discussions and care planning with them.

- As well, there may be other community health professionals who were involved prior to admission and while they may not be able to continue to provide follow-up care you can contact them to gather as much information as possible to help you get to know the person (as mentioned, identifying the questions you need to always ask at admission will be important in preparation for your partnering with other community health care providers). In a number of cases where I have had involvement, the care providers from community agencies have attended the initial care conference to provide information and facilitate the adjustment to LTC.

- Involve your Psychogeriatric Resource Consultant (PRC) in this process and think abut other external partners who can meet with your team to discuss how you can begin to more meaningfully share information within your community e.g. try to include someone from your local CCAC who has familiarity with your facility. There may also be a Dementia Network in your area that could begin to discuss these issues – ask your PRC about this. As well, if you have a P.I.E.C.E.S. Support Network in your community brainstorm about these issues within your meetings and what you can do as PRPs (leading from you stand) to enhance communication between and among partners in care, and the assessment and care planning process.

- Remember, the 6-Question template will help you to organize and structure your clinical assessment, particularly if there are concerns about a co-existing dementia; i.e. clear identification of issues, gathering of assessment data and sharing of valuable information and observations among the team using such tools as the DOS. The U-First! wheel will certainly help you to engage the team in the assessment process and in the care planning; what do people understand about the resident's abilities, needs, etc, (think P.I.E.C.E.S.) and how will you continue to communicate and be proactive in your care?

I know these are challenging issues but remember you are not alone – seek the help of your partners in care. You do have the tools that will help you to get to know the needs of these individuals better.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*