PATIENT NAVIGATOR TOOLBOX

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Healthy Seniors Pilot Project
Projet pilote sur les aînés en santé

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

SOAR
Support Opportunities & Assistance for Research

content

INDEPENDENCE MATTERS

HOME SUPPORT SERVICES

Explores resources and programs to help seniors maintain independence at home. Includes safety tips, agency lists, and practical guides for daily living.

STAYING INDEPENDENT

Home Safety Checklist

NB Trauma Program
Programme de traumatologie du NB

Finding Balance

Using your Home Safety Checklist

Falls in older adults are often due to hazards that are easy to overlook but simple to fix. In order to reduce your risk of fall, this checklist will help you identify some of the most common hazards in and around your home. It will also provide you with helpful suggestions for reducing and removing those hazards.

The **Home Safety Checklist** asks about hazards found in the different room of your home. As you go through each room and answer the questions, make note of any changes and/or repairs that need to be completed in your copy of the accompanying **Personal Action Plan** one-pager. If possible, consider having a family member or friend help you.

When you are finished, go through your notes and make a plan to eliminate the hazards you discovered. However, it is important to determine which tasks you can complete yourself, which ones require two or more people to complete, and which ones require professional assistance. If you are uncertain, you are encouraged to consult a licensed professional before getting started. Keep in mind that you may be creating a new hazard if you try to repair something in an unsafe manner.

Thank you for taking the time to make your home a safer place for yourself, your family and your friends!

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Outside Your Home

	Yes	No	N/A
1. Are the paths around your home in good repair? **Suggested action:** Have your walkways repaired before the winter season to avoid hidden trip hazards. Make sure to address common hazards such as cracks, holes or uneven surfaces.			
2. Are walkways clear of clutter? **Suggested action:** Keep all yard tools in a proper storage area away from any walkways. Use a hose reel to store your garden hose. Trim shrubs and bushes so that they do not infringe on walkways. Keep paths free of leaves which may hide potential tripping hazards.			
3. Are walkways clear of ice and snow? **Suggested action:** Remove snow immediately after it falls. Keep a bag of rock salt (or other type of ice melter) at each door to sprinkle on icy patches when needed.			
4. Are the paths and entrances well-lit? **Suggested action:** Install extra lights outside your house to keep paths and entrances well lit. Sensor lights that turn on automatically are recommended			
5. Are the stairs leading to your home in good repair? **Suggested action:** Fix any loose, cracked or uneven steps as soon as possible. Make sure all outside stairs and/or ramps have sturdy, easy-to-grip handrails on both sides of the entrance.			
6. Are the edges of your outside steps slip-resistant and clearly marked? **Suggested action:** Make sure outside steps are easy to see by painting the front edge of the step a contrasting colour or by installing non-skid treads.			

Garage

	Yes	No	N/A
7. When your car is in the garage, can you get in and out of it easily? **Suggested action:** Walkways around the car should be free of any objects. Use storage racks to help organize your garage. Store your heavy objects on lower shelves.			
8. Is your garage free of debris and other hazards? **Suggested action:** Garage floors should be kept free of clutter. Watch for liquid leaks from your vehicle and clean any wet spots immediately.			
9. Is your garage well lit? **Suggested action:** Many garages only have one light in the middle of the room which is not enough to cover the whole area. Install extra lighting as needed to help keep the garage well lit.			

Stairs

	Yes	No	N/A
10. Are the stairs safe and in good repair? **Suggested action:** Remove loose or torn carpet from the stairs and scatter mats from the top of the staircase. Fix any loose or uneven steps as soon as possible.			
11. Do all stairs have a sturdy handrail? **Suggested action:** Make sure that the handrails go beyond the top and bottom step. Fix any loose handrails or put in new ones. Handrails should be installed on both sides of the stairs for maximum safety.			
12. Are you able to see the edges of the steps clearly? **Suggested action:** Stairs can be made safer by painting the front edge of the steps with a contrasting color, or putting an adhesive non-slip strip on the steps. It is also important to make sure that you do not leave any objects on the stairs since this is a common tripping hazard.			
13. Are all stairs well lit? **Suggested action:** Make sure that both the light switch at the top and bottom of each stairway function properly so you are never using the stairs in the dark. Install a night light in the stair area for extra lighting.			

Did you know?

If needed, it is important to know how to safely use stairs with a cane. To climb stairs, place your cane in the hand opposite your weaker leg. With your free hand, grasp the handrail. Step up on your good leg first, then step up on the weaker leg and proceed carefully.

To come down stairs, put your cane on the step first, then your weaker leg. and then, finally, your good leg, which carries your body weight.

Floors and Hallways

	Yes	No	N/A
14. Are all floors and hallways well lit? **Suggested action:** Make sure that all light switches function properly. Install rechargeable, motion-sensing lights that turn on automatically to help guide you at night or during a power failure.			
15. Do your carpets and mats lie flat without wrinkles or curled edges? **Suggested action:** Remove all loose mats and rugs or ensure they are firmly secured with double-sided carpet tape or a non-slip backing so they won't slip.			
16. Are floors free of clutter? **Suggested action:** Keep items off the floor (especially in main traffic areas), as clutter is a trip hazard. Consider using tape or cable clips to secure cords, wires and cables next to the wall, so you will not trip over them.			
17. Are floor surfaces slip-resistant? **Suggested action:** You are less likely to slip on surfaces such as carpet or unglazed tiles. These surfaces are preferable to polished floors that can be slippery. Wear proper fitting shoes with non-slip soles or anti-slip slippers when walking around your home.			

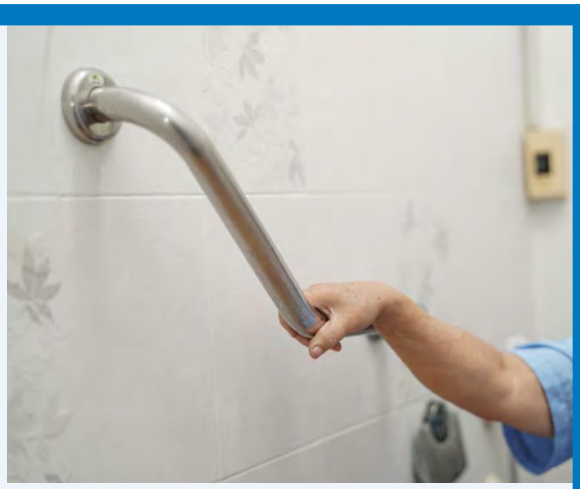
Basement & Laundry

	Yes	No	N/A
18. Are your laundry room and basement well lit? **Suggested action:** Many rooms in the basement, including the laundry room, have small windows. There should always be enough lighting where you can see all areas of the room.			
19. Can you quickly and easily access your breaker box, furnace, and other basement appliances? **Suggested action:** Quickly accessing your furnace or breaker box is critical to preventing/controlling certain incidents. Contact a professional to find out what the laws and regulations are for the areas around these and other appliances.			
20. Is there a clear path to the washer and dryer? **Suggested action:** Many laundry rooms are in storage areas or furnace rooms with open piping and wires. Make sure you can safely navigate the room while carrying your laundry items.			
21. Does your laundry room drain water properly? **Suggested action:** Keep a non-slip mat in the main laundry area as the floor can get wet. Water spills should flow naturally towards the floor drain. If you notice stagnant pools of water, contact a professional as soon as possible. Wipe up any spills immediately.			

Bathroom

	Yes	No	N/A
22. Do you use slip-resistant mats in the bathroom? **Suggested action:** Use slip-resistant mats around the shower and bath. A bath mat, paint-on or self-adhesive slip-resistant strips are advisable in the shower and bath.			
23. Are common bathroom items within easy reach? **Suggested action:** Items such as soap, shampoo and towels should be within easy reach so that you don't have to bend or reach too far for them. Remember to place soap dishes and install towel bars strategically.			
24. Is it difficult to stand during a shower? **Suggested action:** A tub or shower seat allows you to shower without getting tired or losing balance when eyes are closed. It can also reduce the need to bend to wash feet or shave legs. Consult a qualified professional to determine which model is the most appropriate for you.			
25. Are you able to use the toilet easily? **Suggested action:** Consider installing a high toilet or a raised toilet seat to help you get on and off the toilet. You may also need to install the toilet paper caddy within better reach of the seat or keep a free-standing toilet paper holder close to the toilet.			
26. Do you have grab bars near the bathtub, shower and toilet? **Suggested action:** Grab bars are recommended near the toilet. They are also useful in and around the bathtub and shower. For more information, consult the "Did you know" section below.			

Did you know?



Bathrooms can be a tricky place to maneuver. They are often small with limited space and slippery surfaces. Ensure that there is a clear path into the bathroom and keep in mind that towel bars, toilet paper holders or shower doors should not be used to hold onto or support a person's weight. These bathroom fixtures could loosen or break resulting in a serious fall.

To make the bathroom safer, install grab bars near the bathtub, shower and toilet. However, you may need to consult a qualified professional (occupational therapist or physiotherapist) to have an assessment completed to determine the most functional location and position for the safety grab bars for the person at risk for falls.

Living Room

	Yes	No	N/A
27. Can you get out of your lounge chair safely?			
Suggested action: Make sure the chair is sturdy and the proper height with arm rests that provides adequate support. If the chair is too low, add a cushion or pillow on the seat to help raise the height. You may also consider placing sturdy furniture risers underneath each leg so that the chair remains at a more convenient height.			
28. Is there adequate lighting?			
Suggested action: Increase bulb wattage to allowable limits in lamps and lights. Use additional lamps with 'clap-on' adapters to help make it easier to turn them on or off. Consider installing window coverings that allows more natural light in the room.			
29. Is your telephone within easy reach?			
Suggested action: Cordless telephones allow you to keep your telephone close to you in case of an emergency. Remember to keep the phone charged by regularly placing it in its base which should be within easy reach.			
30. Do you have a doorbell you can hear easily?			
Suggested action: Add a wireless door chime and place the chime box where you can hear it best.			

Bedroom

	Yes	No	N/A
31. Can you turn on a light before you get out of bed?			
Suggested action: Make sure that you have a light within reach of your bed and consider using a 'clap-on' adaptor for your lamp. Keep a flashlight and extra batteries in the nightstand near the bed in case of a power outage.			
32. Can you get in and out of your bed easily?			
Suggested action: Beds should be at a good height for easy movement on or off. A firm mattress will make getting into and out of bed easier. If you are having difficulty getting into or out of your bed, talk with an occupational therapist.			
33. Is the path to the nearest bathroom safe?			
Suggested action: Make sure that there is enough lighting to the nearest bathroom by installing nightlights along the way. If you wear eyeglasses, make sure they are on the nightstand within reach.			
34. Is your closet safe ?			
Suggested action: Make sure to remove all clutter. Use baskets to keep small and loose items together. Only store lighter items on the top shelves.			

Kitchen

	Yes	No	N/A
35. Do your cabinet doors and drawers close all of the way? **Suggested action:** Doors and cabinets should close all of the way so you don't unexpectedly walk into one. If possible, renovate the doors/drawers with a "soft-close" feature which will close them the last few inches for you.			
36. Can you easily reach kitchen items you use regularly? **Suggested action:** Arrange your kitchen so the most frequently used items are easy to reach without climbing, bending or losing your balance. Store these items at or near chest level with your large or heavier items in lower cupboards and lighter items up high.			
37. Do you keep a step stool in your kitchen? **Suggested action:** A sturdy step stool is a must for any kitchen. This prevents the urge to stand on a chair or counter top to reach high items, which is dangerous. It is recommended to use a step stool that has been approved by the Canadian Standards Association (CSA).			
38. Do you have a non-slip mat in front of your kitchen sink? **Suggested action:** A non-slip mat will help prevent a fall if you spill water while doing dishes or if there is an unexpected leak in your sink causing the floor to be wet.			
39. Is there good ventilation to reduce the risk of eyeglasses fogging? **Suggested action:** Range hoods, vents or exhaust fans can be installed to provide better ventilation when cooking.			

Did you know?

As we age, our vision can weaken. Adding proper lighting will help you find your way around the kitchen and make it easier for you to avoid injury. Install extra lighting at the range, sink, over countertops and other work areas to ensure these areas are well-lit. Light switches should be located at all entrances to the kitchen. You can also use nightlights to help you see more clearly in low light situations.

Fire Safety Concerns

	Yes	No	N/A
40. Do you smoke in your home?			
Suggested action: Smoking inside your house can be hazardous. We recommend and encourage ALL seniors and adults to quit smoking in order to help reduce the risk of fire at home in addition to decreasing the risk of serious health problems. However, if you are a senior smoker, make sure you never smoke in bed or anywhere home oxygen is used.			
41. Are smoke detectors and carbon monoxide alarms installed and working?			
Suggested action: Make sure that you have a smoke detector and a carbon monoxide alarm on every floor of your home, especially near sleeping areas. Test the alarms once a month to make sure the battery is working and that you can hear the alarm from your bedroom. Change the batteries at least once a year or whenever the alarm "chirps" to tell you that the battery power is low. Any alarm that is 10 years old should be replaced.			
42. Is there a fire extinguisher in the house?			
Suggested action: Have at least one easily accessible fire extinguisher in your home. Make sure that you use the right type of fire extinguisher and that you know how to operate it properly. However, if a fire becomes large, get out of the house immediately since fire extinguishers are designed to put out small fires, not large ones. Keep in mind that you should know the easiest way to leave your home and be familiar with at least 2 exit ways.			
43. Is your fireplace or wood-stove safe?			
Suggested action: It is important to keep an area of at least one metre around the stove or fireplace clear of anything that might catch fire or overheat. You may need to install a heat shield behind or beside the stove to prevent heat damage to any nearby walls. Remember to always use a screen in front of your fireplace. Never leave your house or go to bed when a fire is still burning.			

Did you know?

To prevent creosote from building up in your chimney flue, do not burn cardboard, trash or green wood. Burning too much wood at once can also cause tar and creosote to build up, which creates a fire hazard. If you use a fireplace or a wood-stove at home, make sure to regularly have the chimney cleaned and serviced by a professional.

Other Safety Concerns

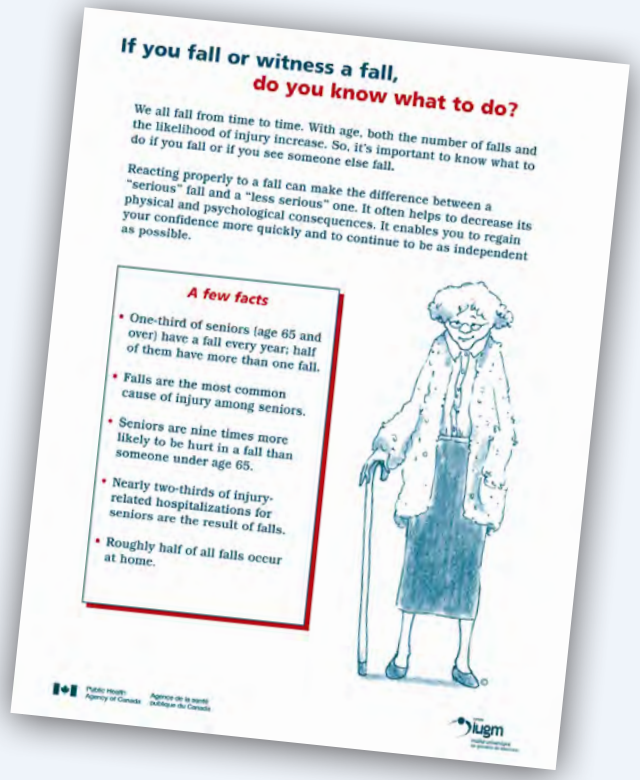
	Yes	No	N/A
44. Is your furniture placed so that you can use your walking aid easily in your home?			
Suggested action: Remove or reorganize furniture in order to provide enough space so that a walking aid can be used easily. Consider removing certain items from the floor that are purely decorative, such as large potted plants.			
45. Do you have any pets in your home?			
Suggested action: Having a pet around the home can help to ease stress and loneliness. However, it can also lead to more messes and unintentional injury when interacting with them. Make sure to clean up spills from water bowls and food crumbs which can cause slips. Clear floor areas, hallways and stairs of any toys. Always watch that your pets are not underfoot.			
46. Do you know what to do in case of an emergency?			
Suggested action: Prepare in advance for an emergency. We recommend that you have a list of emergency numbers near all phones. In addition, consider purchasing a one button medical alert system to help you with emergency response if you are unable to use your phone.			

Do you know what to do?

If you fall or if you witness a fall, you should know the best and safest way to get up without risking further injury. It is important to remember that reacting properly to a fall can help to limit any physical and psychological consequences.

Although you may feel shocked, remaining calm will help you to assess the situation. What you do next will depend on if you're hurt and whether you're able to get up without help.

For more information, we recommend that you consult this useful step by step guide that was developed by the Public Health Agency of Canada.


If you fall or witness a fall,
do you know what to do?

We all fall from time to time. With age, both the number of falls and the likelihood of injury increase. So, it's important to know what to do if you fall or if you see someone else fall.

Reacting properly to a fall can make the difference between a "serious" fall and a "less serious" one. It often helps to decrease its physical and psychological consequences. It enables you to regain your confidence more quickly and to continue to be as independent as possible.

A few facts

- One-third of seniors (age 65 and over) have a fall every year; half of them have more than one fall.
- Falls are the most common cause of injury among seniors.
- Seniors are nine times more likely to be hurt in a fall than someone under age 65.
- Nearly two-thirds of injury-related hospitalizations for seniors are the result of falls.
- Roughly half of all falls occur at home.

http://www.publications.gc.ca/site/eng/340342/publication.html

The NB Trauma Program, and our provincial stakeholders, would like to remind you that most injuries can be prevented!

We encourage everyone to learn more about how to stay safe.

For more information on this and other injury prevention topics, for people of all ages, please visit www.NBTrauma.ca.

NB Trauma Program
Programme de traumatologie du NB

Horizon Health Network / Réseau de santé Horizon | Vitalité Health Network / Réseau de santé Vitalité | Ambulance NB | New Brunswick Department of Health / Ministère de la santé du Nouveau-Brunswick

Finding Balance

www.NBTrauma.ca

www.findingbalancenb.ca

Home Support Agencies / Des agences de soutien à domicile

List of agencies contracted by Social Development /Liste des agences retenus par contrat par le ministère du Développement Social

Zone du Sud-Est / South East Zone

Richibucto, Bouctouche, Rexton, Shediac, Moncton, Sackville, River Glade, Shemogue, Norton, Memramcook, Saint-Antoine, Saint-Louis-de-Kent

Access Home Care Inc.

272 Rue Weldon Street
Moncton, NB
E1C 5X1

☎ (506) 874-0757
✉ info@acceshomecare.ca
accesshomecare.ca

Bayshore Home Health

1600 Rue Main Street
Moncton, NB
E1E 1G5

☎ (506) 857-9992
✉ Moncton@bayshore.ca
bayshore.ca

Boulier Home Care Services Inc.

48 Rue Church Street
Norton, NB
E5T 1A3

☎ (506) 434-1099
✉ cws4626@gmail.com

C.J All Care Home Health

120 Rue High Street, Suite 105
Moncton, NB
E1C 6B5

☎ (506) 388-3433
✉ allcarehome@nb.aibn.com

Kent Senior Homecare Inc.

334 Rue Main Street, Unit 1
Shediac, NB
E4P 2E5

☎ (506) 532-3222
✉ kshc@nb.aibn.com

Kevin LeMoine

112 Chemin Collins Lake Road
Shemogue, NB
E4N 0A6

☎ (506) 577-4424
✉ kevinlemoine506@yahoo.ca
kevinlemoine.jimdofree.com

Kindred Home Care (Charlotte Country Human Resources) Inc.

66 Rue Queens Way (Central Office)
St. Stephen, NB
E3L 1L4

☎ (506) 466-5081
✉ willbernard@kindredhomecare.com
kindredhomecare.com

Le Havre Communautaire Inc.

17 Rue Commerciale Street
Richibucto, NB
E4W 3X5

☎ (506) 523-6790
✉ havre@nbnet.nb.ca
lehavrecom.ca

Co-Aide Home Care & Support Services Ltd 11 Rue Leslie Street Moncton, NB E1C 6M3 ☎ (506) 389-2433 ✉ coaide@nb.sympatico.ca 🖱 coaide.ca	**Le phare des services communautaires inc.** 68 Ave de la rivière Ave Bouctouche, NB E4S 3A7 ☎ (506) 743-7377 ✉ lephare@nb.aibn.com
Dow Quality Health Care Inc. 95 Boul. Millenium Blvd. Moncton, NB E1E 2G7 ☎ (506) 878-0350 ✉ amanda.dowquality@outlook.com 🖱 dowqualityhealthcare.com	**Manoir Pascal Poirier Manor, 057033 NB Inc.** Rue 366 Pascal Poirier Street Shediac, NB E4P 2K9 ☎ (506) 533-9808 ✉ manoirp@nb.aibn.com
Integrity Home Health Services 102 Rue Weldon Street Moncton, NB E1C 5W2 ☎ (506) 383-1273 ✉ info@integretyhhs.com 🖱 integrityhhs.com	**Peoples Park Tower** 960 Boul. St. George Blvd. Moncton, NB E1E 3Y3 ☎ (506) 857-8872 ✉ ppt@pptseniorliving.ca 🖱 pptseniorliving.ca/peoples-park-tower
Jordan Lifecare Centre, The Glades Outreach Program 747 Chemin Sanitorium Road River Glade, NB E4J 1W6 ☎ (506) 756-3355 ✉ gary.buchanan@rogers.com 🖱 thejordanlifecare.com	

Zone du Sud-Ouest / South West Zone

Sussex, Saint John, Quispamsis, Grand Bay-Westfield,
St. Stephen, Saint Andrews, Kingston, Titusville, Norton

A.B.L.E Home Care Inc.

159 Rue Water Street, Unit 3
Saint Andrews, NB
E3B 1A7

☎ (506) 321-2500
✉ linoddin@gmail.com

Age Friendly Innovation Group (Home Care by Design)

85 Chemin Rogers Road
Kingston, NB
E5N 1L3

☎ (506) 343-2659
✉ home@homecarebydesign.ca
🖱 homecarebydesign.ca

Assessment Plus

6 Cour David Court
Quispamsis, NB
E2E 1H8

☎ (506) 847-7577
✉ assessmentsplus@rogers.com

Bayshore Home Health

600 Rue Main Street, Suite C 150
Saint John, NB
E2K 1J5

☎ (506) 633-9588
✉ mestey@bayshore.ca
🖱 bayshore.ca

Home Support Services Inc.

252 Rue King Street
St. Stephen, NB
E3L 2E5

☎ (506) 466-1759
✉ hss@nb.aibn.com
🖱 homesupportservicesinc.com

Integrity Home Health Services

65 Ave University Ave
Saint John, NB
E2K 5M1

☎ (506) 657-1273
✉ krisprice@integirtyhhs.com
🖱 integrityhhs.com

Joan's Home Support Care

1815 Rte 860
Titusville, NB
E5N 3V6

☎ (506) 640-2494
✉ joanmitchell57@hotmail.com

Kindred Home Care (Charlotte Country Human Resources) Inc.

66 Rue Queens Way (Central Office)
St. Stephen, NB
E3L 1L4

☎ (506) 466-5081
✉ willbernard@kindredhomecare.com
🖱 kindredhomecare.com

Boulier Home Care Services Inc.

48 Rue Church Street
Norton, NB
E5T 1A3

☎ (506) 434-1099
✉ cws4626@gmail.com

Moving Forward for Better Inc.

89 Rue Prince William Street, Unit 6
St. Stephen, NB
E3L 1S8

☎ (#506) 466-6200
✉ movingforward4better@gmail.com

Darlene's Home Support Services Inc.

275 Promenade River Valley Drive, Unit 2
Grand Bay-Westfield, NB
E5K 4V4

☎ (506) 763-3256
✉ rayman1@nb.sympatico.ca

Senior Watch Inc. (Care-Ed Learning Centre)

111-100 Rue Prince Edward Street, Prince Edward Square Mall
Saint John, NB
E2L 4M5

☎ (506) 634-8906
✉ services@seniorwatch.com
seniorwatch.com

Dow Qualify Health Care Inc.

5 Ave Moffat Ave
Sussex, NB
E4E 1E9

☎ (506) 432-9481
✉ angelia.dowquality@outlook.com
dowqualityhealthcare.com

Zone Centrale / Central Zone

Perth-Andover, Woodstock, Fredericton, Miramichi, Neguac, McAdam, Minto, Oromocto
Harvey Station, Stanley, Chipman, Boisetown, Fredericton Junction, Jemseg, Bath, Blackville

Bayshore Home Health

850 Rue Prospect Street, Suite 404
Fredericton, NB
E3B 9M5

☎ 1 (866) 227-3890
✉ mestey@bayshore.ca
bayshore.ca

McAdam Outreach for Seniors, Wauklehegan Manor Inc.

11 Chemin Saunders Road
McAdam, NB
E6J 1K9

☎ (506) 784-6308
✉ admin@wauklehegan.com
wauklehegan manor.weebly.com

Bayshore Home Health

389 Rue Connell Street, Suite 105
Woodstock, NB
E7M 5G5

☎ 1 (866) 227-3890
✉ mestey@bayshore.ca
🖱 bayshore.ca

Carleton Victoria Community Vocational Board Inc.

344 Promenade East Riverside Drive
Perth-Andover, NB
E7H 1Y5

☎ (506) 273-6866
✉ abunker@nb.aibn.com

Chipman Outreach Inc.

12 Cour Civic Court
Chipman, NB
E4A 2H9

☎ (506) 339-5939
✉ chipmanoutreach@nb.aibn.com

Harvey Outreach for Seniors Inc.

2019 Rte 3
Harvey Station, NB
E6K 3E9

☎ (506) 366-3017
✉ hofs@nb.aibn.com

Home Care Plus Ltd.

652 Rte 715
Jemseg, NB
E4C 3P2

☎ (506) 488-6196
✉ homecareplus@nb.aibn.com

Minto Services to Seniors Inc.

1100 Promenade Pleasant Drive
Minto, NB
E4B 2V7

☎ (506) 210-2159
✉ ms2s@nb.aibn.com

Miramichi Community Care

8 Croi O'Toole Cres
Miramichi, NB
E1N 6C1

☎ (506) 773-7971

Unicare Home Health Care Inc.

540 Rte King George Hwy
Miramichi, NB
E1V 1N3

☎ (506) 622-0808
✉ unicarehealthcare@nb.aibn.com
🖱 unicarehealthcare.ca

Unicare Home Health Care Inc.

117 Rue Principale Street
Neguac, NB
E9G 1P1

☎ (506) 622-0808
✉ unicarehealthcare@nb.aibn.com
🖱 unicarehealthcare.ca

Upper Nashwaak Community Outreach Inc.

69 Chemin Limekiln Road
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E6B 1E9

☎ (506) 367-7735
✉ uncoutreach@nb.aibn.ca

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Integrity Home Health Services 606 Rue Main St, Unit #3 Woodstock, NB E7M 2C4 ☎ (506) 243-1040 ✉ krisprice@integirtyhhs.com 🖱 integrityhhs.com	**White Rapids Manor Outreach** 235 Promenade Sunbury Drive Fredericton Junction, NB E5L 1S1 ☎ (506) 368-6504 ✉ office@whiterapidsmanor.nb.ca
Integrity Home Health Services 334 Allée Veterans Lane Miramichi, NB E1V 1X1 ☎ (506) 836-1273 ✉ krisprice@integirtyhhs.com 🖱 integrityhhs.com	**Windsor Court Retirement Residence Limited Partnership** 10 Croissant Barton Crescent Fredericton, NB E3A 5S3 ☎ (506) 450-7088 ✉ contact@windsorcourt.nb.ca 🖱 windsorcourt.nb.ca
Kindred Home Care (Charlotte Country Human Resources) Inc. 66 Rue Queens Way (Central Office) St. Stephen, NB E3L 1L4 ☎ (506) 466-5081 ✉ willbernard@kindredhomecare.com 🖱 kindredhomecare.com	**York Developments Inc.** 100 Promenade Sunset Drive Fredericton, NB E3A 1 A3 ☎ (506) 444-3880 ✉ info@yorkcarecentre.ca 🖱 yorkcarecentre.ca

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60 Rue Pleasant Street
Miramichi, NB
E1V 3V1

☎ (506) 622-5400
✉ krt.associates@nb.aibn.com
krthomehealthcare.com

Zone du Nord / Northern Zone

Edmundston, Kedgwick, Campbellton, Bathurst, Tracadie-Sheila, Caraquet, Shippagan, Lamèque, Restigouche, Péninsule acadienne/Acadian Peninsula, Gravelhill, Dalhousie, Balmoral, Saint-Quentin, Grand Falls/Grand-Sault, Sainte-Anne-de-Madawaska

Amy's Quality Care/Home Care

199 Chemin Gravelhill Road
Gravelhill, NB
E8G 1N5

☎ (506) 237-5837
✉ amy.lapointe.academy@gmail.com

KRT & Associates

3505 Rue Principale Street
Tracadie-Sheila, NB
E1X 1C9

☎ (506) 395-5467
✉ admin@krtandassociates.com
krthomehealthcare.com

Atelier Tournesol Inc.

19 Rue Ferry Street
Edmundston, NB
E3V 3S1

☎ (506) 739-6820
✉ soinsdomicile@nb.aibn.com

Restigouche Home Care Services Inc (Sainte-Anne Home Care)

110 Plaza Blvd, Suite 7
Dalhousie, NB
E8C 2E2

☎ (506) 684-2091
✉ curriemill@bellaliant.net

Centre de Bénévolat de la Péninsule Acadienne (CBPA) Inc.

220 Boul. St Pierre Ouest Blvd. Suite 100
Caraquet, NB
E1W 1A5

☎ (506) 727-1860
✉ centbene@nbnet.nb.ca
cbpa.ca

Service d'aide à la famille d'Edmundston

13 Rue Dugal Street
Edmundston, NB
E3V 3S1

☎ (506) 737-8000
✉ safe@nbnet.nb.ca
aidealafamille.ca

D.S. Forma-Soins 276 Rue Victoria Street Edmundston, NB E3B 2H9 ☎ (506) 737-9419 ✉ formasoins@outlook.com	**Soins à Domicile Mallais Home Care** 1716 Av. Des Pionniers Ave Balmoral, NB E8E 1G1 ☎ (506) 753-9394 ✉ jlsoinsadomicile@rogers.com
Integrity Home Health Services 10 Rue Emmerson Street Edmundston, NB E3V 1R7 ☎ (506) 253-1273 ✉ krisprice@integirtyhhs.com integrityhhs.com	**Soins de Qualité Atlantik Quality Care Inc.** 100 Rue Water Street, Suite 301 Campbellton, NB E3N 1B1 ☎ (506) 789-1519 ✉ sqa@bellaliant.com
Integrity Home Health Services 100 Rue Main Street, Suite 2 Bathurst, NB E2A 1A4 ☎ (506) 350-1273 ✉ krisprice@integirtyhhs.com integrityhhs.com	**Unicare Home Health Care Inc.** 600 Rue Saint Anne Street Bathurst, NB E2A 2N6 ☎ (506) 622-0808 ✉ unicarehealthcare@nb.aibn.com unicarehealthcare.ca
Kindred Home Care (Charlotte Country Human Resources) Inc. 66 Rue Queens Way (Central Office) St. Stephen, NB E3L 1L4 ☎ (506) 466-5081 ✉ willbernard@kindredhomecare.com kindredhomecare.com	

Call (506) 643-7175 EXT. 6913 for more information!

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1973 2023
CELEBRATING 50 YEARS OF PROVIDING QUALITY CARE IN OUR COMMUNITY
LOCH LOMOND Villa
Enriching Life's Journey

NURSING HOMES WITHOUT WALLS

Helping Seniors Stay at Home
Greater Saint John Directory of Services for Seniors

Table of Contents

Personal Information

EMERGENCY CONTACTS	Phone
Primary Emergency Contact	
Next of Kin	
Power of Attorney	

MEDICAL & CARE	Phone
Physician	
SERVICES	Phone
Emergency	911
Tele-Care and Patient Connect NB	811
Social Development Seniors' Information Line	1-833-733-7835

MEDICATIONS (Prescription and Non-Prescription)

Name of Medication:	Dosage (mg/ml/mcg):	Frequency:

Emergency Response Information Kit- Health Information Form
Please Print and keep information updated as needed.

Personal Information

First Name:	**Middle Name(s):**	**Last Name:**
Address (Street, Apt. #, Box #, Civic #):		☐ **Male** ☐ **Female** ☐ **Other**
Village, Town, or City:	**Province:**	**Postal Code:**
Telephone #	**Date of Birth (Month, Day, Year):**	
Medicare #		
Other Medical Plans Held:		
Family Physician:	**Telephone #**	
Pharmacy Used:	**Telephone #**	

Contacts

Emergency Contact Person (Name in Full):		
Address:		
1st Telephone #:	**2nd Telephone #:**	**Relationship:**
Second Emergency Contact Person (Name in Full):		
Address:		
1st Telephone #	**2nd Telephone #**	**Relationship:**

Welcome Message

Welcome to the first edition of the Greater Saint John NB Directory of Services for Seniors. This guide has been prepared by Nursing Homes Without Walls team at Loch Lomond Villa in order to better inform you of the services and programs available to seniors.

You will also find tips and suggestions such as:

- Advance healthcare directives
- Fraud and scam prevention information
- Healthy eating for seniors
- Prevention of falls in and around your home
- Plus, many more

Your telephone book, local newspaper and local service organizations are good sources of information.

Disclaimer:
This is an information guide and is limited by the information available at the time of its latest update in September 2023. The team does not promote or guarantee any of the services or resources listed.

You must check directly with the organizations for up-to-date information about the services they offer.

If you notice any errors or omissions to this guide, please provide the correct information by contacting Loch Lomond Villa's Nursing Homes Without Walls at 506-643-7175 EXT 6913 or by emailing NHWWAdmin@lochlomondvilla.com.

A Message from Dr. Suzanne Dupuis-Blanchard

For the first time in its history, Canada currently has more adults over the age of 65 than youth under the age of 15. Known as population aging, the next 30 years will see a shift where there are continually more older adults than younger adults. In New Brunswick, we currently have close to 22% of the population over the age of 65, the highest proportion of older adults in Canada.

The Nursing Home Without Walls project is the result of an outstanding collaboration between the Loch Lomond Villa Nursing Home and myself at the Université de Moncton. Together, we received funding from an anonymous donor as well as the Healthy Seniors Pilot Project funded through the Provincial Government in partnership with the Public Health Agency of Canada.

With the goal of keeping older adults aging in place, providing information on services available to you is an important first step to keeping you informed in your health decisions. Along with the Seniors' Navigator and the Seniors' Navigator Assistant, the project has flourished beyond our expectations, and I hope you have benefited from these services.

I hope that you will find this guide useful and informative and that it will help you stay well!

Dr. Suzanne Dupuis-Blanchard
Professor – Université de Moncton

Nursing Homes Without Walls
Helping Seniors Stay at Home

Assisting Seniors 60 and Over and Their Caregivers in Greater Saint John to Access Support Services to Age in Place

Caregivers
We are here to support you, let us know how we can help!

Independence
It is hard to ask for "Help", but by doing so…we can help you remain in your home more safely.

Helping Seniors to Access These Home Support Services:
- List of homemakers
- List of local handymen
- Foot care providers
- Transportation
- Home repairs
- Weekly check-in calls

Some of the Social Activities We Provide
- Exercise classes
- Seniors' fun bingo
- Weekly coffee group
- Educational talks

LOCH LOMOND Villa
Enriching Life's Journey

Provincial/Federal Programs:
- NB seniors' drug plan
- Low-income seniors' benefit
- CPP survivor benefit
- Disability benefits
- Home repair and energy assistance programs

Aging Well
We provide lots of tips on aging well:
- Staying active
- Health conditions
- Social activities
- Safety at home
- Fall prevention

Home Visits
Call us today to book a visit. There is no fee for our services.
506-643-7175 EXT 6913

Legal
- Power of attorney
- Wills
- Advance health care directives
- Legal concerns

We Can Assist with Social Development Applications:
- Health services – seniors drug plan, dental program, orthopedic program, vision program, ostomy/incontinence program, health equipment loan program, home oxygen program, hearing aids
- Emergency housing repairs
- Home adaptations for medical reasons
- At home long term care for housekeeping and much more

Plan for the Future - To Age in Your Home

About Nursing Homes Without Walls

Who We Are:
The office for Nursing Homes Without Walls is located inside Loch Lomond Villa in Saint John, NB. The Nursing Homes Without Walls team at Loch Lomond Villa are helping seniors 60 and over in the Greater Saint John Region. Our role is to guide seniors to access services that are available to help you remain in your own home. There is no fee for any of the services we provide.

What We Do for Seniors:

- Help with applications for Social Development programs including Health Services and Long-Term Care
- Provide information on health services such as diabetes, Parkinson's, and vision loss
- Provide information regarding Power of Attorney, Wills, and Health Care Directives
- Provide information on aging well and staying active
- Weekly calls are made to seniors who live alone
- Provide information to caregivers
- Maintain updated lists of local providers, such as:
    - Handymen
    - Foot care
    - Homecare workers
    - Personal support workers

Help with Senior Isolation and Social Outings:
We have created programs and events to help seniors living alone to reduce the effects of isolation. Some of the programs include:

- Education series
- Seniors' fun bingo
- Weekly exercise class

Are You a Younger Senior? We Can Help Plan for the Future:
Seniors in their early 60's may not need any of our services right now, but we can help you plan to age in place. Health changes happen quickly we can help you to prepare. We can show you all the programs and services that are available now and in the future.

Are You a Caregiver?
Nursing Homes Without Walls is also looking to meet with younger seniors 60 and over who are caring for a partner, loved one, or older senior. We would like to meet to discuss how we can help you manage the day-to-day challenges that you face being a primary caregiver.

Call Nursing Homes Without Walls today to register with us. It is never too early to start planning for your future to age in place.
506-643-7175 EXT 6913 – 185 Loch Lomond Rd Saint John NB E2J 3S3

Social Development

The New Brunswick Government wants to support seniors staying in their home and provides several services that allow seniors to do this. One number is all you need to apply for all Social Development Programs and services: **1-833-733-7835**

Adult Protection

Provides services to seniors and adults with disabilities who are victims of abuse or neglect. Abuse can be physical, sexual, or mental cruelty. Neglect can be self-neglect or caused by others.

Day Activity Services for Seniors

Day Activity Services provide caregiver relief, social support, and meaningful social recreational programs in a group setting. Services provided in Day Activity Centers for seniors include:

- General supervision and physical assistance ensuring the safety and security of all participants
- Planned recreational and social activities
- Information and education regarding the aging process and healthy living
- Healthy meals for full-day programs; nutritious snacks for both the half-day & full-day program
- Opportunities for rest periods during morning and afternoon quiet times

Emergency Fuel Benefit

The emergency fuel benefit is designed to provide assistance to eligible households to assist with the costs of winter heating. Any household in New Brunswick that is in an emergency and unable to afford the cost of heating its home may be eligible to receive this benefit. The department will assess eligibility on a case-by-case basis. An emergency fuel benefit of up to $550 per calendar year may be provided to eligible New Brunswick households whether they are receiving social assistance or not. This benefit is provided to eligible applicants regardless of what type of heating they use.

Fuel Supplement

The fuel supplement is designed to provide assistance to eligible households to assist with the costs of winter heating. The Regular Fuel Supplement is available from November to April of each year to social assistance recipients who meet the criteria.

Heating Allowance

The Heating Allowance provides assistance for the heating costs of subsidized households in Social Development's rental programs and in Non-Profit and Cooperative Housing projects whose rental payments are subsidized by the Department. The Heating Allowance is part of the rental payment calculation for clients subsidized under these programs and is utilized to reduce their monthly rental payment.

Home First

Home First program offers assistance for minor home improvements to support seniors to live in their own homes safely. To support you and your family, the Government of New Brunswick would like to help identify available services in your community and discuss ways for you to maintain a healthy, active, and independent lifestyle.
If you or someone you care about is 65 years of age or older, you can call and request a home visit to learn about these services and programs.

Homeowner Repair Program

Provides financial assistance for:

- Low-income homeowners occupying existing substandard housing to repair, rehabilitate or improve their dwellings
- Modifications to low-income homeowner and rental units to improve the accessibility of the dwelling for occupants with disabilities
- Adaptations for low-income seniors who have difficulty with daily living activities in the home
- Limited modifications to eligible households to accommodate adaptive needs

Long Term Care – Home Support Services

Long-Term Care Services refer to a range of personal support, physical, social, and mental health services required by individuals who, because of long term functional limitations, need assistance to function as independently as possible. Home support services can help with the senior's daily activities such as personal care (ex: bathing, grooming, feeding), light housekeeping, and meal preparation. These services can also include relief for caregivers. Clients can choose to receive home support services from approved Home Support Agencies or from private individuals.

Low-Income Seniors' Benefit

To assist low-income seniors in New Brunswick, the government offers an annual benefit to qualifying applicants.
To be eligible for the $400 benefit, a person must have been a resident of New Brunswick during the current calendar year, and have received one of the following federal benefits under the Old Age Security Act:

- Guaranteed Income Supplement (65 years or older)
- Allowance for Survivor Program (between 60 and 64 years old)
- Allowance Program (between 60 and 64 years old)

Minor Home Repairs Grant – Part of the Home First Program

Eligible participants of the Seniors Health, Well-being and Home Safety Review who are:

- 65 years of age or older, and
- A resident of New Brunswick
- Total household income is at or below the low-income seniors' benefit limits

You can receive a one-time, non-repayable grant of up to $1500, one per household for:

- Ramps or repairs to assist in entering and exiting your home
- Handrails or grab bars in hallways and stairways
- Bathroom grab bars
- Improved lighting
- Non-slip or non-skid bath, shower, and floor surfaces
- Repairs to flooring including carpets, rugs, and mats
- As well as other home repairs

Property Tax Deferral Program for Seniors

This program provides property tax relief to eligible seniors in New Brunswick, who want to apply for a deferral of the annual increase in property taxes on their principal residence. Deferred property tax and interest amounts constitute a lien against the property and become due and payable to the Province when the property is sold or transferred.

Eligibility:

- One of the property owners listed on the deed must be age 65 or older
- The property must be their principal residence
- The property must be currently receiving the Provincial Residential Tax Credit
- The property tax account must be in good standing, as of December 31, prior to the year of application

Rent Supplement Assistance Program

Provides assistance to households in need so that they may obtain affordable, adequate and suitable rental accommodation by subsidizing rents in eligible rental dwellings.

For eligibility requirements, please contact NB Housing – Social Development.

Seniors Information Line

The toll-free Seniors Information Line provides basic information about provincial programs and services and assists older adults to navigate their way through the various government departments and agencies. Calls will be answered Monday to Friday, from 8:30 am to 4:30 pm. Messages can be left after hours and calls will be returned the following business day.

1-855-550-0552

Health Services - Social Development

Adaptive Equipment Loan Program

The Mobility and Adaptive Equipment Loan Program loans specific mobility and adaptive equipment to eligible clients of the Department to support them in the performance of their activities of daily living such as, enable them to live and be cared for safely.

Dental Program

This program assists clients of Social Development who are over the age of 19 with coverage for specific dental benefits that are not covered by other agencies or private health insurance plans. Clients must have one of the following:

- A valid white Health Services Card indicating “DENTAL” coverage in the BASIC HEALTH ELIGIBILITY section

OR

- A valid yellow Health Services Card with a “Y” or an “X” under DENT in the VALID ONLY FOR box

Benefits covered under this program are:

- Exams, x-rays
- Dentures and repairs
- Specific types of fillings

Clients are eligible for a maximum of $1000 per year, excluding emergency and prosthetic services. Clients will be charged up to a 10% participation fee for dentures and denture repairs. Once a treatment plan has been determined the dental professional will advise of the amount payable.

Health Card

Social Development health cards are required by many financial institutions as identification. Health card ambulance coverage is administered by Ambulance Services, Department of Health. Coverage for certain Health Card benefits is administered by the Health Services Program. These programs include:

- Convalescent / Rehabilitation Program
- Dental Program
- Enhanced Dental Program
- Hearing Aid Program
- Medical Supplies / Services Program
- Therapeutic Nutrients Program
- Orthopedic Program
- Respiratory Program
- Ostomy / Incontinence Program
- Prosthetic Program Vision Program
- Wheelchair / Seating Program

Programs are subject to benefit guidelines and limitations and have specific eligibility criteria.

Hearing Aid Program

This program assists clients of this department with coverage for the purchase and maintenance of hearing aids services which are not covered by other agencies or private health insurance plans.

This program is available to:

- Clients of Social Development and their dependents
- Individuals who have special health needs and who qualify for assisted healthcare

Clients must have one of the following:

- A valid white Health Services Card showing "SUPPLEMENTARY" in the BASIC HEALTH ELIGIBILITY section, or "HA" (Hearing Aid) in the ADDITIONAL HEALTH ELIGIBILITY section

OR

- A valid yellow Health Services card with a "Y" under the OTH in the VALID ONLY FOR box, or an "X" under SUPP in the VALID ONLY FOR box

This program covers:

- Behind the Ear (BTE), In the Ear (ITE) and In the Canal (ITC) hearing aids
- Repairs & ear molds

Medical Supplies / Services Program

The Health Services Medical Supplies/Services Program assists clients with coverage for specific medical supplies not covered through other Health Services Programs.

This program covers the following medical supplies:

- Blood Pressure Monitors for long term use
- Burn Supplies (Burn garments, Burn dressings)
- Central venous access device supplies (example Port-o-cath)
- Canes, crutches, and two-wheeled walkers
- Foot Nail Care for services (clients of income assistance only)
- Infusion Pump monthly rental and the purchase of necessary supplies
- Personal emergency response system rental (example Lifeline)
- Pressure garments (Medical grade compression stockings – knee or thigh length, compression sleeves)
- Special Authorization benefits (compression pantyhose, compression wraps, custom made compression garments)

There may be co-pays or specific limits for each benefit.

Orthopedic Program

This program assists clients of this department with the coverage of orthopedic items which are not covered by other agencies or private health insurance plans.

This program is available to:

- Clients of this department and their dependents
- Individuals who have special health needs and who qualify for assisted health care under Section 4.4 of the Family Income Security Act and Regulations

Clients must have one of the following:

- A valid white Health Services Card showing "SUPPLEMENTARY" in the BASIC HEALTH ELIGIBILITY section, or "OR" (Orthopedic) in the ADDITIONAL HEALTH ELIGIBILITY section

OR

- A valid yellow Health Services card with a "Y" under the OTH in the VALID ONLY FOR box, or an "X" under SUPP in the VALID ONLY FOR box

This program covers:

- Specific custom fitted braces and supports
- Custom made braces
- Therapeutic and Orthopedic design footwear
- Custom made shoes and insoles
- Modifications & Repairs

Ostomy/Incontinence Program

This program assists clients of this department with coverage for ostomy, catheterization and incontinence supplies which are not covered by other agencies or private health insurance plans.

Eligibility:

- Department of Social Development clients and their dependents who hold a valid white Health Card indicating- "Supplementary" in the BASIC HEALTH ELIGIBILITY section OR - "OS" (Ostomy Supplies) in the ADDITIONAL HEALTH ELIGIBILITY section
- Department of Social Development clients who hold a valid yellow Health Card that indicates - a "Y" under the OTH in the VALID ONLY FOR box

OR

- Clients must not have any other medical coverage to be eligible for full benefits.

This program covers supplies directly related to the management of:

- A colostomy, ileostomy or urostomy
- Internal, external, or intermittent catheterization
- Incontinence

Prosthetic Program

This program assists clients of this department with coverage for specific prosthetic services that are not covered by other agencies or private health insurance plans.
This program is available to:

- Clients of this department and their dependents
- Individuals who have special health needs and who qualify for assisted health care under Section 4.4 of the Family Income Security Act and Regulations

Clients must have one of the following:

- A valid white Health Services Card showing “SUPPLEMENTARY” in the BASIC HEALTH ELIGIBILITY section, or “PR” in the ADDITIONAL HEALTH ELIGIBILITY section
- A valid yellow Health Services Card with a “Y” under the OTH in the VALID ONLY FOR box a “X” under SUPP in the VALID ONLY FOR box

This program covers:

- Limb prostheses (arm, leg, foot)
- Artificial larynx (Servox device, voice prostheses)
- Ocular prostheses (artificial eye)
- Breast prostheses and one bra
- Modifications and repairs

Respiratory Program

This program assists clients of this department with coverage of respiratory equipment and supplies which are not covered by other agencies or private health insurance.
This program is available to:

- Clients of Social Development and their dependents
- Individuals who have special health needs and who qualify for assisted health care under Section 4.4 of the Family Income Security Act and Regulations
- Oxygen Services available to clients aged 64 and under

Services MUST be provided through an eligible Respiratory Services Vendor Clients must have one of the following:

- A valid white Health Services Card showing “SUPPLEMENTARY’ in the BASIC HEALTH ELIGIBILITY section, or “Respiratory Services” in the ADDITIONAL HEALTH ELIGIBILITY section
- A valid yellow Health Services card with a “Y” under the OTH in the VALID ONLY FOR box, or an “X” under SUPP in the VALID ONLY FOR box

This program covers:

- Aerosol machines, Portable Nebulizers
- Aerochambers
- Chest vibrators
- Spirometer
- Lung volume recruitment
- Humidifiers and dehumidifiers
- Suction machines
- CPAP machines (up to $1400.00) / BPAP machines (up to $3000.00)
- Oxygen conserving devices
- Cough assist machines

Therapeutic Nutrients Program

This program assists clients of Social Development with coverage for feeding supplies and formulas which are not covered by NB Medicare or private health insurance plans. To be eligible you must be Department of Social Development clients and their dependents who hold a valid white Health Card indicating:

- "Supplementary" in the BASIC HEALTH ELIGIBILITY section

OR

- "TN." (Therapeutic Nutrients) in the ADDITIONAL HEALTH ELIGIBILITY section Department of Social Development clients who hold a valid yellow Health Card that indicates
- a "Y" under the OTH in the VALID ONLY FOR box.

Clients must not have any other medical coverage to be eligible for full benefits. Social Development clients residing in Nursing Homes are not eligible for benefits in this program.
This program covers:

- Total Parenteral Nutrition (TPN) pump and supplies
- Enteral feeding formula, pump rental, and supplies
- Dietary Supplement

Vision Program

This program assists clients of Social Development who are over the age of 19 with coverage for specific vision benefits which are not covered by other agencies or private health insurance plans. Vision services are negotiated with the New Brunswick Association of Optometrists and the Opticians Association of New Brunswick.
This program is available to:

- Clients of this department and their dependents 19 years of age and older
- Individuals who have special health needs and who qualify for assisted health care under Section 4.4 of the Family Income Security Act and Regulations

Clients must have one of the following:

- A valid white Health Services card showing "OPTICAL' in the BASIC HEALTH ELIGIBILITY section

OR

- A valid yellow Health Services card with a "Y: or an "X" under the OPT in the VALID ONLY FOR box

This plan covers:

- Major exams
- Emergency exams
- Minor exams (subject to prior approval)
- Visual fields test
- Selected frames
- Corrective lenses
- Cases

Provincial Government

Department of Finance and Treasury

Chancery Place
PO Box 6000
Fredericton, NB E3B 5H1
506-453-2264
Email: TB-CT@gnb.ca
www.gnb.ca/finance

Department of Transportation and Infrastructure

Saint John
110 Charlotte St
Saint John, NB E2L 2J3
506-658-2416
Email: transportnb@gnb.ca
www.gnb.ca/Transportation

Grand Bay-Westfield
50 Crown St
Saint John, NB 32L 2X6
506-643-7463
Email: transportnb@gnb.ca
www.gnb.ca/Transportation

Emergency Measures Organization

Saint John
45 Leinster St
Saint John, NB E2L 1H9
506-658-2910
Email: emo@gnb.ca
www.gnb.ca/emo

Grand Bay-Westfield
609 River Valley Dr
Grand Bay-Westfield, NB E2K 1B3
506-738-6400
Email: administration@towngbw.ca
www.grandbaywestfield.ca/emo/

Home Energy Assistance Program – New Brunswick

The Home Energy Assistance Program provides a $100 benefit designed to help low-income families cope with high energy prices. The program will provide a payment of $100 to families with incomes up to and including $30,000.

Chancery Place
PO Box 6000
Fredericton, NB E3B 5H1
1-800-669-7070
Email: TB-CT@gnb.ca
www.gnb.ca/finance

Legislative Assembly of New Brunswick

706 Queen St
PO Box 6000
Fredericton, NB E3B 5H1
506-453-2506
www.gnb.ca/legis/index-e.asp

Local Service Districts (LSDs) - Environment and Local Government

The Minister provides residents of the Province's unincorporated areas or Local Service Districts (LSDs) with a variety of services such as fire protection, solid waste collection and disposal, and street lighting. The minister also provides for dog control services in unincorporated areas and has designated the NBSPCA to handle complaints concerning dogs and to carry out the functions of the Provincial Dog Regulation, New Brunswick Regulation 84-85.

Saint John
110 Charlotte St
Saint John, NB E2L 2J3
506-658-3046
Email: elg.egl-region4@gnb.ca
www.gnb.ca/environment

Grand Bay-Westfield
609 River Valley Dr
Grand Bay-Westfield, NB E2K 1B3
506-738-6400
Email: administration@towngbw.ca
www.grandbaywestfield.ca/emo/

Medavie Blue Cross Seniors Health Program

If you're age 65 or older, you may qualify for the Medavie Blue Cross Seniors' Prescription Drug Program and Seniors' Health Program for a monthly fee, which provides prescription drug coverage and optional hospital, health, and dental benefits.
644 Main St
PO Box 220
Moncton, NB E1C 8L3
1-888-227-3400

Medicare – Eligibility and Claims

New Brunswick Medicare Department of Health
PO Box 5100
Fredericton, NB, E3B 5G8
1-888-762-8600 Ext 2
Email: Medicare@gnb.ca
Website: www.gnb.ca (keyword Medicare)

New Brunswick Human Rights Commission

The New Brunswick Human Rights Commission is the government agency responsible for the administration of the Human Rights Act. The mandate of the Commission is:

- To forward the principle that every person is free and equal with dignity and respect
- To promote an understanding of, acceptance of, and compliance with the Act
- To develop and conduct educational programs designed to eliminate discriminatory

Barry House
PO Box 6000
Fredericton, NB E3B 5H1
506-453-2301
www2.gnb.ca/content/gnb/en/departments/nbhrc.html

New Brunswick Prescription Drug Program - Seniors

There are various plans that offer prescription drug coverage to seniors in the province. Seniors who receive the Federal Guaranteed Income Supplement (GIS) from Employment and Social Development Canada are covered by the New Brunswick Prescription Drug Program (NBPDP). Seniors who do not receive the Federal Guaranteed Income Supplement (GIS) from Employment and Social Development Canada but whose income falls below a certain amount may be eligible for coverage under the New Brunswick Prescription Drug Program (NBPDP). Alternatively, seniors can enroll in the New Brunswick Drug Plan, an income-based plan that covers uninsured New Brunswickers, including seniors.

PO Box 690
Moncton, NB E1C 8M7
506-867-4515 / 1-800-332-3692
Email: info@nbdrugs-medicamentsnb.ca
www.gnb.ca/health

New Brunswick Seniors' Home Renovation Tax Credit

The New Brunswick Seniors' Home Renovation Tax Credit is a refundable personal income tax credit for seniors and family members who live with them. If you qualify, you can claim up to $10,000 worth of eligible home improvements on your tax return. The amount of money you get back for these expenses is calculated as 10 per cent of the eligible expenses you claim. For example, if you spend and then claim $10,000 worth of eligible expenses, you could get $1,000 back.

Chancery Place
PO Box 6000
Fredericton, NB E3B 5H1
506-453-2264
Email: TB-CT@gnb.ca
www.gnb.ca/finance

Department of Finance
Revenue Administration Division
PO Box 3000
Fredericton, NB E3B 5G5
1-800-669-7070

New Brunswick Veterans Information Line

The toll-free NB Veterans Information Line provides basic information about provincial programs and services and assists veterans to navigate their way through the various government departments and agencies.

189 Prince William St
Saint John, NB E2L 2B9
1-866-522-2122
Email: mieux-etre.wellness@gnb.ca

Order of New Brunswick

The object of the Order of New Brunswick is to recognize individuals who have demonstrated excellence and achievement and who have made outstanding contributions to the social, cultural, or economic well-being of New Brunswick and its residents.
Office of Protocol
PO Box 6000
Fredericton, NB E3B 5H1
Email: onb.brunswick@gnb.ca
www2.gnb.ca/content/gnb/en/corporate/promo/order_of_new_brunswick.html

Patient Connect New Brunswick

Patient Connect NB is a provincially managed, bilingual patient registry for New Brunswickers without access to a primary health care provider (family doctor or nurse practitioner). New Brunswickers without a provider can register with Patient Connect NB and will be assigned to a provider on a first-come, first-serve basis.
520 King St
Fredericton, NB E3B 5G8
1-877-795-3773
Email: www.gnb.ca/0051/mail-e.asp
www2.gnb.ca/content/gnb/en/departments/health/Hospital-Services/content/Patient_Connect_NB.html

Premier's Council on the Status of Disabled Persons

The Premier's Council on Disabilities is a body for consultation, study, and information sharing, which was created to advise the Provincial Government on matters relating to the status of persons with disabilities. The Council reports directly to the Premier of the Province.
140-250 King St
PO Box 6000
Fredericton, NB E3B 9M9
1-800-442-4412
Email: pcd-cpmph@gnb.ca
www.pcd-cpmph.ca/

Property Tax Deferral Program for Seniors – Account Management Branch

The program provides property tax relief to eligible seniors in NB, who want to apply for a deferral of the annual increase in property taxes on their principal residence. Deferred property tax and interest amounts constitute a lien against the property and become due and payable when the property is sold or transferred.
20 McGloin St
Fredericton, NB E3A 5T8
Email: wwwfin@gnb.ca
www2.gnb.ca/content/gnb/en/services/services_renderer.201264.Property_Tax_Deferral_Program_for_Seniors.html

Public Health – Saint John Office

The PHAC empowers Canadians to improve their health. In partnership with others, its activities focus on preventing disease and injuries, promoting good physical and mental health, and providing information to support informed decision making. It values scientific excellence and provides national leadership in response to public health threats.

55 Union St
Suite 500
Saint John, NB E2L 5B7
506-643-2305

Service New Brunswick

Some of the services available through Service NB are vehicle registration and renewals, water and sewer payments as well as Municipal services, application and declaration for low-income seniors' benefit, fishing and hunting license, and many more.

85 Charlotte St
Suite 300
Saint John, NB E2L 2J2
1-888-762-8600
Email: snb@snb.ca
www.snb.ca/

Tele-Care 811

Tele-Care is a free, confidential, health advice and information line. Dial **811** for access to bilingual, registered nurses, 24 hours a day, seven days a week. In an emergency, call 911 or visit the local emergency department. When you or someone you know requires non-urgent health advice or information, call Tele-Care. A registered nurse will assess your needs and provide information, education, advice about self-care or advise you to make an appointment with your doctor, go to a clinic, contact a community service, or go to a hospital emergency room.

Federal Government

Canada Pension Plan (CPP)

www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-benefit

To qualify for your Canada Pension Plan (CPP) retirement pension, you must:

- Be at least 60 years old
- Have made at least one valid contribution to the CPP

Valid contributions can be either from work you did in Canada, or as the result of receiving credits from a former spouse or former common-law partner at the end of the relationship.

Canada Pension Plan (CPP) Survivors Benefit

1-800-277-9914

www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-survivor-pension.html

The CPP provides survivor benefits to eligible survivors or to the estate of a deceased contributor who has made enough contributions to the CPP. There are three types of CPP Survivor Benefits:

- The death benefit is a one-time payment to, or on behalf of, the estate of a deceased CPP contributor
- The survivor's pension is a monthly benefit paid to a deceased contributor's surviving spouse or common-law partner if the survivor meets the eligibility requirements
- The children's benefit is a monthly benefit for dependent children of a deceased contributor

EI Caregiving Benefits and Leave

www.canada.ca/en/services/benefits/ei/caregiving.html

Through Employment Insurance, you could receive financial assistance of up to 55% of your earnings, to a maximum of $573 a week. These benefits will help you take time away from work to provide care or support to a critically ill or injured person or someone needing end-of-life care. As a caregiver, you do not have to be related to or live with the person you care for or support, but they must consider you to be like family.

Guaranteed Income Supplement (GIS)

www.canada.ca/en/services/benefits/publicpensions/cpp/old-age-security/guaranteed-income-supplement.html

The Guaranteed Income Supplement (GIS) provides a monthly non-taxable benefit to Old Age Security (OAS) pension recipients who have a low income and are living in Canada. Service Canada will send you a notification letter the month after you turn 64. If you did not receive a letter from Service Canada informing you that you were selected for automatic enrolment, and you wish to start receiving your OAS pension and the GIS at age 65, you should apply for them right away.

National Seniors Council (NSC)

www.canada.ca/en/national-seniors-council.html

The role of the National Seniors Council (NSC) is to advise the Government of Canada on issues related to the health, well-being, and quality of life of seniors. As an advisory body, their role is to take into consideration the views of stakeholders and seniors and to provide solid, evidence-based advice to the government that takes into consideration these views.

New Horizons for Seniors Program

www.canada.ca/en/employment-social-development/programs/new-horizons- seniors.html

The Program provides grants and contributions funding for projects that make a difference in the lives of seniors and in their communities. Some of the goals are:

- Empowering seniors
- Encouraging them to share their knowledge, skills, and experience with others in the
- Community, and enhancing seniors' social well-being and community vitality

Service Canada

Service Canada is a federal institution that is part of Employment and Social Development Canada. Service Canada provides Canadians with a single point of access to a wide range of government services and benefits. They are committed to improving services for Canadians by working with partners to provide access to the full range of government services and benefits that Canadians want and need through the Internet, by telephone, in person, or by mail.

Saint John
1 Agar Place
Saint John, NB E2L 5G4
1-800-622-6232
www.Canada.ca/service-canada-home

Veterans Affairs Canada

Veterans Affairs Canada's mandate is to support the well-being of Veterans and their families, and to promote recognition and remembrance of the achievements and sacrifices of those who served Canada in times of war, military conflict, and peace. To achieve this mandate, the Department focuses on its four main roles: providing, helping, listening, and engaging veterans.

Saint John Office
126 Prince William St
1st Floor, Suite 14A
Saint John, NB E2L 2B6
1-866-522-2122
www.veterans.gc.ca/eng

Legal / Civic Government

Canadian Anti-Fraud Centre (CAFC)

The Canadian Anti-Fraud Centre collects information on fraud and identity theft. They provide information on past and current scams affecting Canadians. If you think you're a victim of fraud, report it!

1-888-495-8501

www.antifraudcentre-centreantifraude.ca/index-eng.htm

Canadian Association of Retired Persons (CARP)

Federal and provincial governments need to hear from Canadians on policies and legislation that sooner or later affect us all. CARP ensures that older Canadians' voices are heard in Parliament and that vital political promises are made and kept.

70 Jefferson Ave
Toronto, ON M6K 1Y4

1-833-211-2277

Email: support@carp.ca
www.carp.ca/

City of Saint John

City Hall
15 Market Square
Saint John, NB E2L 4L1

506-658-4455

www.saintjohn.ca/en

Crime Stoppers

Crime Stoppers is a registered charitable organization funded and managed by people like you. N.B. Crime Stoppers is focused on preventing and solving crimes in New Brunswick, working in partnership with law enforcement agencies, the media, and the public.

1445 Regent St
PO Box 3900
Fredericton, NB E3B 4Z8

1-800-222-TIPS (8477)

Email: info@crimenb.ca
www.crimenb.ca/

Elections New Brunswick

Provides information on several elections' topics, including voter eligibility, marking a ballot, search my voter information, voters away from home, voter ID requirements, accessibility and accommodation, voter's list, voting in nursing homes, and when, where, and how to vote.
PO Box 6000
Fredericton, NB E3B 5H1
506-453-2218
Email: info@electionsnb.ca
www.electionsnb.ca/content/enb/en.html

Financial and Consumer Services Commission (FCNB)

Protects consumers and enhances public confidence in the financial and consumer marketplaces through the provision of regulatory and educational services. They recognize the importance of setting an example in the areas of transparency and effective governance.
85 Charlotte St
Suite 300
Saint John, NB E2L 2J2
1-866-933-2222
www.fcnb.ca/en

Grand Bay-Westfield Fire-Rescue Department

PO Box 3001
Grand Bay-Westfield, NB E5K 4V3
506-738-6421
Email: fire@towngbw.ca
www.grandbaywestfield.ca/fire/

Members of the Legislative Assembly

Saint John East (District 30)
Glen Savoie, MLA
8 Stonehammer Crt
Saint John, NB E2J 0L3
506-658-6333
Email: Glen.Savoie@gnb.ca

Saint John Harbor (District 32)
Arlene Dunn, MLA
55 Union St
Saint John, NB E2L 5B7
506-643-6138
Email: Arlene.Dunn@gnb.ca

Saint John Lancaster (District 33)
Dorothy Sheppard, MLA
640 Manawagonish Rd
Saint John, NB E2M 3W5
506-643-2900
Email: Dorothy.Sheppard@gnb.ca

Kings Centre (District 34)
Bill Oliver, MLA
227 River Valley Dr
Grand Bay-Westfield, NB E5K 1A5
506-839-3048
Email: Bill.Oliver@gnb.ca

Members of Parliament for New Brunswick Southwest

John Williamson, MP
69 Milltown Blvd
St. Stephen, NB E3L 1G5
1-888-350-4734
Email: John.Williamson@parl.gc.ca
Fax: 506-466-2813

Parliamentary Office
House of Commons
Ottawa, ON K1A 0A6
1-613-995-5550
Email: John.Williamson@parl.gc.ca
Fax: 1-613-995-5226

Member of Parliament for Saint John-Rothesay

Wayne Long, MP
N306-1 Market Square
Saint John, NB E2L 4Z6
506-657-2500
Email: Wayne.Long@parl.gc.ca
Fax: 506-657-2504

Parliamentary Office
House of Commons
Ottawa, ON K1A 0A6
1-613-947-2700
Email: Wayne.Long@parl.gc.ca
Fax: 1-613-947-4574

New Brunswick Community Land Trust Inc.

The NBCLT is a conservation organization in NB that is holding and stewarding easements on working lands, the NBCLT offers a valuable service to the province's rural economy.
180 St. John Street
Fredericton, NB E3B 4A9
506-461-5521
Email: geofull@nbnet.nb.ca
https://www.mltn.org/trust/new-brunswick-community-land-trust/

New Brunswick Legal Aid Services Commission

NBLASC gives legal assistance to low-income individuals for certain family and criminal matters.
15 Market Square
Suite 1509
Saint John, NB E2L 1E3
506-633-6030
Email: info@legalaid.nb.ca
www.legalaid-aidejuridique-nb.ca/home/

Office of the Fire Marshall

The Office of the Fire Marshal carries out the provisions of the Fire Prevention Act, delivers fire prevention and protection programs, and works with fire departments, municipalities, and partner organizations to promote fire safety.
506-453-2004
Email: Fire-Feu@gnb.ca
www2.gnb.ca/content/gnb/en/departments/public-safety/law-enforcement-and-inspections/content/fire_marshal.html

Office of the Ombudsman

Investigates complaints against administrative decisions and acts of officials of the NB government, agencies, or organizations, and any of the municipalities of the province to determine if the decisions or actions were unreasonable, unjust, oppressive, or discriminatory, or made under a mistake of law or fact, or contrary to law or by an abuse of discretion.
548 York St
Fredericton, NB E3B 5H1
506-453-2789
Email: nbombud@gnb.ca
www.ombudnb.ca/

Office of the Rentalsman

The Residential Tenancies Act details the rights and obligations of residential landlords and tenants. The Residential Tenancies Tribunal's role is to provide residential landlords and tenants with accurate information, and fair and expedient resolution to residential tenancy conflicts through mediation and/or adjudication.
PO Box 3
Saint John, NB E2L 3X1
506-633-0981
www.sjaoa.ca/

Official Opposition Office

Old Education Building, East Block
PO Box 6000
Fredericton, NB E3B 5H1
506-453-2548

Public Legal Education and Information Service New Brunswick

PLEIS-NB's mandate is to develop bilingual educational products and services about the law for the public to promote access to the legal system. Their goal is to assist the public in identifying and understanding their legal rights and responsibilities and attaining self-help skills.
P.O. Box 6000,
Fredericton, NB E3B 5H1
506-453-5369
E-mail: pleisnb@web.ca
www.legal-info-legale.nb.ca/en/

Public Trustee Services

The organization is a new provincial government agency set up to protect the interests of the most vulnerable persons in NB.
412 Queen Street, Suite 210
Fredericton, NB E3B 1B6
506-444-3688
www.legalaid.nb.ca/

Royal Canadian Mounted Police

Available services through the RCMP include criminal record and vulnerable sector checks, general information, non-emergency complaints, outside detachment emergency phone, police certificate, and to report a crime.

Saint John
189 Prince William St
Suite 200
Saint John, NB E2L 2B9
506-636-4914

Grand Bay-Westfield
21 Chestnut Dr
Grand Bay-Westfield, NB E5K 3M1
506-757-1020

Saint John Fire Department

45 Leinster St
Saint John, NB E2L 1H9
506-658-2910

Senators for New Brunswick

Represents this area in the Senate of Canada, which is the Upper House of Parliament.

Senator René Cormier
613-996-2247
Email: Rene.Cormier@sen.parl.gc.ca

Senator Rose-May Poirier
613-943-4027
Email: rosemay.poirier@sen.parl.gc.ca
www.rosemaypoirier.sencanada.ca/

Senator Nancy J. Hartling
613-995-9191
Email: Nancy.Hartling@sen.parl.gc.ca
www.senatorhartling.sencanada.ca/en/

Senator Jim Quinn
613-944-1050
Email: jim.quinn@sen.parl.gc.ca

Senator Percy Mockler
613-947-4225
Email: percy.mockler@sen.parl.gc.ca
www.percymockler.sencanada.ca/

Senator David Richards
613-943-6263
Email: David.Richards@sen.parl.gc.ca

Senator Pierrette Ringuette
613-943-2248
Email: pierrette.ringuette@sen.parl.gc.ca
www.pringuette.sencanada.ca/

Seniors and Healthy Aging Secretariat
PO Box 6000
Fredericton, NB E3B 5H1
506-453-2001
Email: seniors@gnb.ca
Email: sd-ds@gnb.ca
www.gnb.ca/socialdevelopment

Town of Grand Bay-Westfield
PO Box 3001
Grand Bay-Westfield, NB E5K 4V3
506-738-6400
www.grandbaywestfield.ca

Health Centres & Hospitals

Crown Street Medical Clinic
110 Crown St
Saint John, NB E2L 2X7
506-635-2273

Guardian - Grand Bay pharmacy
114 River Valley Dr
Grand Bay-Westfield, NB E5K 1A2
506-738-8406

Horizon's St. Joseph's Community Health Centre
116 Coburg St
Saint John, NB E2L 3K1
506-632-5537

Hospice Greater Saint John (Bobby's Hospice)
385 Dufferin Row
Saint John, NB E2M 2J9
506-632-5593

Lakewood Guardian Pharmacy
2075 Loch Lomond Rd
Saint John, NB E2N 1A1
506-693-7979

Lawtons Drugs

Brunswick Square
39 King St
Saint John, NB E2L 4W3
506-634-1422

Catherwood
107 Catherwood St
Saint John, NB E2M 5J7
506-635-1126

McAllister Place
519 Westmorland Rd
Saint John, NB E2J 3W9
506-633-8984

New Brunswick Association of Nursing Homes

1133 Regent St
Suite 206
Fredericton, NB E3B 3Z2
506-460-6262
Email: info@nbanh.com
www.nbanh.com/

PJC Jean Coutu

35 University Ave
Saint John, NB E2K 1Z2
506-696-0000

Saint John Regional Hospital

400 University Ave
Saint John, NB E2L 4L2
506-648-6000

Shoppers Drug Mart

Crown
110 Crown St
Saint John, NB E2L 2X7
506-636-9610

Fairville Boulevard
667 Fairville Blvd
Saint John, NB E2M 3W2
506-636-7740

Lansdowne
57 Lansdowne Ave
Saint John, NB E2K 2Z9
506-636-7700

Westmorland
407 Westmorland Rd
Saint John, NB E2J 3S9
506-636-7777

St. Joseph's Hospital

130 Bayard Dr
Saint John, NB E2L 3L6
506-632-5555

The Medicine Shoppe Pharmacy
317 River Valley Dr
Grand Bay-Westfield, NB E5K 1A8
506-738-3355

University Avenue After Hours Medical Clinic
35 University Ave
Saint John, NB E2K 1Z2
506-657-9355

Community Health Organizations

Ability New Brunswick
Their mission is to empower the independence and full community participation of persons throughout New Brunswick who have a mobility disability.
440 Wilsey Rd
Suite 102
Fredericton, NB E3B 7G5
506-462-9555
Email: info@abilitynb.ca
www.abilitynb.ca/

Active Aging - New Brunswick Physical Literacy
This document contains information on the role physical activity plays in our well-being and quality of life and provides tips and ideas to make physical activity a bigger part of your life.
70 Melissa St
Richibucto Road, NB E3A 6W1
506-459-1929
Email: physicalliteracy@recreationnb.ca
www.nbphysicalliteracy.ca/2018/11/active-aging-a-new-brunswick-physical-activity-resource/

ALS Canada
ALS Canada is providing support and services for people and families living with ALS.
ALS Clinic
Stan Cassidy Centre for Rehabilitation
800 Priestman St
Fredericton, NB E3B 0C7
506-452-5225
www.als.ca/

Alzheimer Society of New Brunswick

The Alzheimer Society is the leading not-for-profit health organization working nationwide to improve the quality of life for Canadians affected by Alzheimer's disease and other dementias and advance the search for the cause and cure.

221 Ellerdale St
Saint John, NB E2J 3S4
506-634-8722
E-mail: info@alzheimernb.ca
www.alzheimer.ca/en/nb

Arthritis Society

Arthritis is a chronic condition which means once diagnosed, a person with arthritis has many challenges and factors to consider in treating, managing, and coping with the disease. The Arthritis Society has a long tradition of providing educational programs to professionals and those with arthritis, as well as innovative solutions aimed at helping people affected by arthritis have the best possible quality of life.

133 Prince William St
Suite 101
Saint John, NB E2L 4Z4
506-452-7191
Email: NB.info@arthritis.ca
www.arthritis.ca/about-us/contact-us

Avenue B (AIDS Saint John Inc.)

62 Waterloo St
Saint John, NB E2L 3P3
506-652-2437
Email: avenueb@avenueb.ca
www.avenueb.ca/

Canadian Cancer Society – New Brunswick

At the Canadian Cancer Society (CCS), their vision is a world where no one fears cancer. With the support of their volunteers and donors, they improve and save lives by taking a comprehensive approach to their work against more than 100 types of cancer. CCS funds research, provides services to those living with cancer, advocates on important cancer-related issues and educates and empowers people to make healthy choices.

133 Prince William St
Saint John, NB E2L 3T5
506-634-6274
www.cancer.ca/en

Canadian Celiac Association – Saint John Chapter

PO Box 1576
Moncton, NB E1C 9X4
506-532-0106
Email: chapter.nb.saintjohn@celiac.ca
www.celiac.ca/

Canadian Liver Foundation – Saint John Chapter

CLF brings liver research to life by sharing important research to help Canadians protect their liver health and prevent liver disease in themselves and their loved ones.
422 Young St
Saint John, NB E2M 2V2
506-635-2996
Email: clf@liver.ca
www.liver.ca/how-you-help/new-brunswick/

Canadian Mental Health Association of New Brunswick – Saint John

CMHA facilitates access to the resources people require to maintain and improve mental health and community integration, build resilience, and support recovery from mental illness.
560 Main St. Suite A315
Saint John, NB E2K 1J5
506-633-1705
E-mail: saintjohn@cmhanb.ca
www.cmhanb.ca/

Canadian National Institute of the Blind – Saint John Office

CNIB delivers innovative programs and powerful advocacy that empowers people impacted by blindness to live their dreams and tear down barriers to inclusion.
65 Canterbury St. Unit 209
Saint John, NB E2L 2C7
1-800-563-2642
Email address: info@cnib.ca
www.cnib.ca/en?region=nb

Canadian Public Health Association

CPHA is the independent national voice and trusted advocate for public health, speaking up for people and populations to all levels of government.
404-1525 Carling Ave
Ottawa, ON K1Z 8R9
613-725-3769
Email: info@cpha.ca
www.cpha.ca/

Canadian Red Cross – Saint John Branch

The Canadian Red Cross mission is to improve the lives of vulnerable people by mobilizing the power of humanity in Canada and around the world. Some services that are available are:

- Community support services
- Emergency and disaster services
- First aid and CPR training
- Health equipment loans
- Migrant and refugee services
- Nutrition and transportation
- Senior support services
- Swimming and water safety
- Violence, bullying, and abuse prevention

120 McDonald St
Saint John, NB E2J 1M5
506-674-6200
www.redcross.ca/

Community Addiction and Mental Health Services

Addiction & Mental Health Services provide a range of services for individuals, youth, and family members affected by substance abuse, problem gambling, and mental health issues.
55 Union St
Saint John, NB E2L 5B7
506-658-3737
www.horizonnb.ca/services/addictions-mental-health/

Crohn's & Colitis Foundation of Canada - Maritimes Chapter

They are transforming the lives of people affected by Crohn's and colitis (the two main forms of inflammatory bowel disease) through research, patient programs, advocacy, and awareness.
PO Box 59
Waterville, NS B0P 1V0
1-800-265-1101
Email: saintjohn@crohnsandcolitis.ca
www.crohnsandcolitis.ca/Location/Maritimes/Saint-John

Diabetes Canada

Regional Office
C/O Diabetes Canada Atlantic
PO Box 25199
Halifax, NS B3M 4H4
506-451-1639
Email: info@diabetes.ca

Donation Centre
637 Rothesay Ave
Saint John, NB E2H 2G9
506-693-4232

Extra Mural Program

The NB EMP, known as the "hospital without walls' is the provincial home healthcare program that provides healthcare services to New Brunswickers' of all ages, in their homes (personal residence, special care home, nursing home). All New Brunswick residents with a valid NB Medicare card (or in the process of receiving a card) are eligible to receive EMP services, as long as health care needs can be met safely in the home.

1490 Manawagonish Rd
Saint John, NB E2M 3Y4
506-649-2626
Email: extramuralnb.ca
www.extramuralnb.ca/

Go Ahead Seniors – Health Active Living for the 50Plus

Directed by "Go Ahead Seniors Inc.", a group of senior volunteers, the Healthy Living Program for 50-Plus is an innovative bilingual program aimed at helping New Brunswick older adults make more informed choices about their health and well-being through health education, personal empowerment, and prevention.

c/o Jean-Claude Cormier
428 Collishaw St
Moncton, NB E1C 3C7
506-860-6548
Email: halvsa2@nb.aibn.com
www.ainesnbseniors.com

Harding Medical Supplies

Harding Medical has been helping clients discover and enjoy the benefits of an independent lifestyle since 1987. They take pride in helping customers select the right assisted living products and home medical equipment for their health care needs.

175 Caledonia Rd. Unit 2
Moncton, NB E1H 2S5
506-855-5200 / 1-800-479-4700
www.hardingmedical.com/index.aspx

Heart and Stroke Foundation of New Brunswick

The Heart and Stroke Foundation leads in eliminating heart disease and stroke through the advancement of research and its application, the promotion of healthy living, and advocacy. The Foundation offers programs for heart disease and stroke survivors - Heart to Heart and Partners in Stroke Recovery, and many other programs.

580 Main Street
Saint John, NB E2K 1J5
506-634-1620 / 1-800-663-3600
Email: info@hsf.nb.ca
www.heartandstrokenb.ca/

Huntington Society of Canada

Their mission is to improve the quality of life for those affected by Huntington disease. They will address their mission through the oversight and facilitation of excellent support services, providing access to the best and most up to date educational resources, increasing national and global awareness, and advocacy and investing in promising research.
20 Erb St W. Suite 801
Waterloo, ON N2L 1T2
1-800-998-7398
Email: info@huntingtonsociety.ca
www.huntingtonsociety.ca/

Kidney Foundation of Canada

The KFC is the national volunteer organization committed to eliminating the burden of kidney disease through research, education, advocating for improved access to high quality health care, and increasing public awareness to advancing kidney health and organ donation.
Atlantic Branch Office
PO Box 13381
St. John's, NL A1B 4B7
709-753-8999 / 1-800-563-0626
Email: rosanna.mitchell@kidney.ca
www.kidney.ca/

Lupus Canada

Lupus Canada promotes education and public awareness of lupus and brings together lupus patients, friends, family, and other interested persons to achieve these common goals.
Mailing Address
PO Box 8 LCD 1
Newmarket, ON L3Y 4W3
1-800-661-1468
Email: info@lupuscanada.org
www.lupuscanada.org/

Rheumatology Clinic
Saint John Regional Hospital
400 University Ave
Saint John, NB E2L 4L2
506-648-6000

Multiple Sclerosis Canada

MS Canada provides services to people with multiple sclerosis and their families and funds research to find the cause and cure for this disease. MS Navigators provide trusted information on all aspects of life with MS. Contact an MS Navigator to learn more about their services.
MS Canada
250 Dundas St W
Suite 500
Toronto, ON M5T 2Z5
1-800-268-7582
Email: info@mscanada.ca
www.mscanada.ca/

Muscular Dystrophy Canada

MDC's mission is to enhance the lives of those impacted with neuromuscular disorders by continually working to provide ongoing support, resources, and research.
40 Eglinton Ave E. Unit 500
Toronto, ON M4P 3A2
1-800-567-2873
Email: info@muscle.ca
www.muscle.ca/

New Brunswick Hospice Palliative Care Association

Dr. Everett Chalmers Hospital
700 Priestman St.
Fredericton, NB E3B 5N5
Email: secretary@nbhpca-aspnb.ca
www.nbhpca-aspnb.ca/

New Brunswick Lung Association

Their mission is to lead lung health initiatives, prevent lung disease, help people manage lung disease and promote lung health.
65 Brunswick St.
Fredericton, NB E3B 1G5
506-455-8961 / 1-800-565-5864
Email: Info@nb.lung.ca
www.nb.lung.ca/

Osteoporosis Canada

Osteoporosis Canada works to educate, empower, and support individuals and communities in the risk-reduction and treatment of osteoporosis.
National Office
201-250 Ferrand Dr
Toronto, ON M3C 3G8
416-696-2663 / 1-800-463-6842
www.osteoporosis.ca/

Schizophrenia Society of Canada

Mission is to improve the quality of life for those affected by schizophrenia and psychosis through education, support programs, public policy, and research.
103 Harvest Drive
Steinbach, MB R5G 2C6
1-204-223-9158
Email: Chris@schizophrenia.ca
www.schizophrenia.ca/

Seniors' Resource Centre

This Centre is an essential service where +50 adults, their families and caregivers can find resources for planning and living a healthy and continued independent lifestyle.
Brunswick Square Level 3
39 King St
Saint John, NB E2L 4W3
506-633-8781
Email: seniorsresourcecenter@nb.aibn.com

St. John Ambulance – New Brunswick Council

Enables Canadians to improve their health, safety, and quality of life by providing training and community service.

Provincial Office
200 Miles St
PO Box 3599 Station B
Fredericton, NB E3A 5J8
1-800-563-9998
Email: nb.info@sja.ca

Saint John Location
Parkway Mall
212 McAllister Dr
Saint John, NB E2J 2S7
1-888-840-5646 / **506-458-9129**
www.sja.ca

Vision Loss Rehabilitation Services

Vision Loss Rehabilitation NB provides training to people who are blind or partially sighted to develop or restore key daily living skills, independence, safety, mobility, & emotional well-being.

Moncton Office
525 Main St
Moncton, NB E1C 1C4
506-857-4240
Email: info@vlrehab.ca

Fredericton Office
130-77 Westmorland St
Fredericton, NB E3B 6Z3
506-458-0060
www.visionlossrehab.ca

Support Groups

Alcoholics Anonymous

For information regarding meetings close to you contact:
506-650-3114
Email: info@saintjohnaa.ca
www.saintjohnaa.ca/

Alzheimer Society New Brunswick - Caregiver Support Network

The Caregiver Support Network provides an opportunity to meet and connect with family members, friends, and caregivers of someone living with Alzheimer's or another dementia. An understanding place where people touched by the effects of caregiving can learn from others who are on a similar journey.
1-800-664-8411
Email: info@alzheimernb.ca
www.alzheimer.ca/nb/en/help-support/programs-services/caregiver-support-network

CHIMO Helpline Inc.

CHIMO is a provincial crisis phone line to provide access to someone to talk to about mental health issues, accessible 24 hours a day, 365 days a year to all residents of New Brunswick.
PO Box 1033
Fredericton, NB E3B 5C2
506-450-2750 / 1-800-667-5005
Email: office@chimohelpline.ca
www.johnhowardfredericton.ca/chimo/

Compassionate Grief Centre

They offer private counselling for adults, seniors, children, and teens. They also offer community funded programs such as grief groups, a weekly Grief Café and non-medical cancer support services to help people cope with grief, loss, and life's challenges.
55 Drury Cove Rd
Saint John, NB E2H 2Z8
506-696-0202
Email: hello@compassionategriefcentre.ca

Coverdale Centre for Women Inc.

148 Waterloo St
Saint John, NB E2L 3P9
506-634-1445

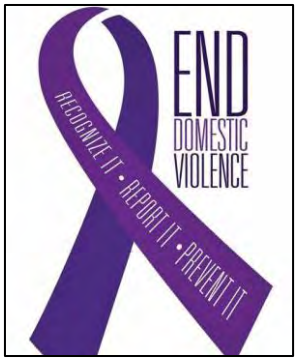
Crisis Services Canada

1-833-4564566 | Text 45645
www.crisisservicescanada.ca/en/

Daybreak Senior Centre
661 Dever Rd
Saint John, NB E2M 4J2
506-214-3800

Domestic Violence Outreach
Saint John: **506-632-5616 / 506-566-5960**
KV: **506-847-6277**

GNB Support Services for Victims of Abuse
Women's Equality Branch
20 McGloin St
PO Box 6000
Fredericton, NB E3A 5T8
506-453-8126 / 1-877-253-0266
Email: WEB-EDF@gnb.ca



Hestia House
Business Line: **506-634-7571**
24-hour Distress Line: **506-634-7570**
Text Only Option: **506-566-6667**
Email: info@hestiahouse.ca

Housing Alternatives Inc.
Their main purpose is to provide housing support services to non-profit and housing co-operative groups working to provide housing to low- and moderate-income households.
171 Adelaide St
Saint John, NB E2K 1W9
506-632-9393
E-mail: office@housingalternatives.ca
www.housingalternatives.ca/

Second Stage Housing
Second Stage Housing is safe and affordable housing to enable women and their children who have experienced domestic/intimate partner violence to work towards personal and economic independence and a future free of violence.
Safe Haven Inc.
506-632-9289

Smokers Helpline
1-866-366-3667
www.smokershelpline.ca/

The Compassionate Friends of Canada

The Compassionate Friends is an international, non-profit, self-help organization, offering friendship, understanding, grief education and HOPE for the future to all families who have experienced the death of a child at any age, from any cause.

1-866-823-0141

Email: nationaloffice@tcfcanada.net

www.tcfcanada.net

Wellness Together Canada

Wellness Together Canada is a mental health and substance use website to support people across Canada and Canadians living abroad in both official languages. They provide the following resources for you at no cost: Immediate text support, information and videos on common mental health issues, mental wellness programs you can do on your own and with coaching, monitored communities of support, and individual phone, video, and text counselling. This online service was launched in response to growing mental health concerns related to the COVID-19 pandemic.

1-866-585-0445

For immediate support Text WELLNESS to 741741

www.wellnesstogether.ca/

Information on Local Breast Cancer Supports

Compiled by Horizon Health

Look Good – Feel Better

Free programs that can help bolster self-esteem of recovering women in active cancer treatment. The 2- hour monthly clinics are conducted by volunteer cosmeticians who receive certification in the special beauty techniques used in the program. Participants learn simple techniques and receive a complimentary kit of cosmetic products. They also offer videos, magazines and information on workshops designed to help women with cancer redefine their self-image during and after chemo and radiation.

Date & Time: 3rd Monday of each month, 1:30-3:30pm. (Please call to register prior to attendance).

Location: Sessions are run at the Saint John Regional Hospital.

Contact: Oncology Dept. 648-6885

New Brunswick Breast and Women's Cancer Partnership (NBBWCP)

At the time of diagnosis, patients are provided with the Purple Violet kit. This is an information packet intended to provide patients and their families with current information about breast cancer. It also provides information about diagnosis and treatment options.

Phone: 506 858 8252

Email: NBwomenscancer@gmail.com

New Brunswick Breast Cancer Network – Retreats
The mandate for this group is to support people affected by breast cancer and to provide hope through education, public awareness and partnering with others.
President: Linda Saulnier
Email: lindacsaulnier@gmail.com
Phone: 696-7604
www.breastcancernetwork.nb.ca

Breast Ahoy: Saint John Breast Cancer Survivor Dragon Boat Team
Breast Ahoy is a group of breast cancer survivors. These survivors help us to see that you can lead a full and active life, despite your diagnosis or physical limitations imposed by the disease – to grow stronger as individuals and as a team and have fun in the process – to celebrate being alive. To find out more about becoming a member:
Email: contact@breastsahoy.com

Breast and Women's Cancer Support Groups
Support groups for women who are currently experiencing or have survived breast or gynecological (ovarian, cervical, and uterine) cancers. These meetings create an atmosphere where breast and gynecological cancer patients and survivors can share feelings and provide support and information about living with a cancer diagnosis.
Saint John
Date & Time: 2nd Wednesday of each month 6:30 – 8:00pm
Location: 9th floor St. Joseph's Hospital, Resource Room
Contacts: Janet Kyle 654 1075
Sussex
Time & Date: 4th Tuesday of each month
6:00-8:30pm
Location: Fairview Banquet Room
Contacts: Brenda Brown 433-5028 or Joyce Bean 433-5652

CBCF toll free helpline
Phone: 1-888-778-3100
Email: support@cbcf.org
Website: support.cbcf.org.

The Breast Health Program Trust Fund
This program was established to provide patients with funding for items that they could not otherwise afford during breast cancer treatment and recovery. Items included are: wigs, support garments (lymphedema sleeves and gloves, compression bras), breast prosthesis, and transportation costs to and from treatments. For further information:
Contact: Kathy Woodhouse 632-5620.

The Breast Health Program, St Joseph's Hospital
Nurse Case Manager: Kathy Woodhouse 632-5620

Menopause Clinic, Community Health Centre
Physician referral needed
Phone: 632-5454

Oncology Social Worker (SJRH)
Isabelle Chiasson 648-6636

Oncology Medical Reimbursement Officer (SJRH)
Mildred Heans 649-2599

Online Support:
www.breastcancersupport.org
www.cbcf.org
www.cbcn.ca/en/
www.rethinkbreastcancer.com
www.breastcancer.org/community
www.pink-link.org
www.bccancer.bc.ca

Head Scarves:
www.hairandbeautycanada.ca
www.headcovers.com

Lymphedema Program
Saint John: 632-5606 (physiotherapy) Andrea Tilley
Sussex: 432-3103

Massage Therapy
Saint John: Darlene Mapp 693-1118
St. Stephen: Nicole Dufour 466-1405

Diana Leitch
Intimacy and Sexuality Relationship Therapist
506-647-2463 call for appointment

Second Sight Coaching & Counseling
Margaret Totten
Email: margaret@secondsightcoaching.com
Phone 639-7972

Prosthetic Supplies:
Most health plans cover prosthetics but generally require a prescription stating Hair Prosthetic or Breast Prosthetic

Canadian Cancer Society have free wigs and turbans at 133 Prince William Street, SJ, NB

Complete Sense Salon & Day Spa, Sussex - Wigs & head scarfs, breast prosthesis
Shelley Doyle 506-432-3602

Mobile Medical – Breast Prosthesis, Bathing Suits and Bras
Carmel Sullivan: 657-7325
Cell phone: 636- 1450
Email: thesullivans@rogers.com
Fax: 214-0154

Shoppers Drug Mart, Crown St, Saint John
Heather Savoy: 636-9610

Guardian Drugs, St. Stephen
Laurie Rideout: 506-466-4447

Drugs, Sussex
Cindy Creighton: 506-432-6789

Lawton's Drugs 107 Catherwood Street, Saint John
506-635-1126

Sensitive Directions for Creative Inspiration
Mastectomy products and bras
Call Karen Jennings 506-645-0213

The Bra Room
Mastectomy styles in everyday sport and swim wear, as well as breast forms for everyday and swim. We have trained fitters ready to help you find a comfortable fit.
Location: 47 Clark Rd. Unit 2, Rothesay, NB
Phone: 849-0600
Contacts Katherine Crilley and Teresa Goldsmith

Community Groups / Organizations /Churches

Canada Games Aquatic Centre

A community centre for wellness and active living, featuring a fully equipped Fitness Centre and the only 50-metre pool in NB.
50 Union St
Saint John, NB E2L 1A1
506-658-4715
Email: info@aquatics.nb.ca
www.aquatics.nb.ca/

Canadian Association of Gerontology

The Canadian Association on Gerontology (CAG) is a national, multidisciplinary scientific and educational association established to provide leadership in matters related to the aging population. Their mission is to improve the lives of older Canadians through the creation and dissemination of knowledge in gerontological policy, practice, research, and education.
c/o Department of Occupational Science & Occupational Therapy
University of Toronto
160 – 500 University Avenue Toronto, ON M5G 1V7
1-855-224-2240
www.cagacg.ca/

Canadian Snowbird Association

The Canadian Snowbird Association (CSA) is a 100,000-member national not-for-profit advocacy organization. It is dedicated to actively defending and improving the rights and privileges of Canadian travelers.
180 Lesmill Road
Toronto, ON M3B 2T5
1-800-265-3200
Email: csastaff@snowbirds.org
www.snowbirds.org/

Carleton Community Centre

The Carleton Community Centre is a public amenity located on the Lower West Side of Saint John that aims to promote wellness and quality of life in community members through the provision of various social, recreational, and basic-needs programs/services. They offer an assortment of recreational activities to keep all members of the community busy.
120 Market Pl
Saint John, NB E2M 1B5
506-658-2920
Email: info@carletoncommunitycentre.ca
www.carletoncommunitycentre.ca/

Catholic Diocese of Saint John

115 Villa Madonna Rd
Rothesay, NB E2H 2X4
506-653-6800
Email: reception@dioceseofsaintjohn.org
www.dioceseofsaintjohn.org/

Churches of Greater Saint John

Online directory compiled by the Telegraph Journal
Link: marketplace-sj.tj.news/categories/religion/churches

College of Physicians and Surgeons New Brunswick

The College of Physicians and Surgeons of New Brunswick has responsibility within the province of New Brunswick, Canada for:

- The licensing of physicians
- Monitoring standards of medical practice
- Investigating complaints against physicians

In addition to these three primary areas of responsibility, the College is often approached for advice in ethical, medical-legal, and general quality of care matters. The College operates under the authority of the Medical Act and applicable regulations.
1 Hampton Rd. Suite 300
Rothesay, NB E2E 5K8
506- 849-5050 / 1-800-667-4641
www.cpsnb.org

Easter Seals New Brunswick

Easter Seals New Brunswick is a bilingual, not-for-profit organization, working in partnership with persons with disabilities, enabling them to attain independence and equality of opportunity available in their communities.
65 Brunswick St
Fredericton, NB E3B 1G5
506-458-8739 / 1-888-280-8155
Email: info@easterseals.nb.ca
www.easterseals.nb.ca/index.php/en/home

Family Resource Centre Inc.

211 Wentworth St
Saint John, NB E2L 2T4
506-633-2182
www.frc-crfsaintjohn.com/

Finding Balance NB

Finding Balance is a program which was developed over 10 years ago by the Injury Prevention Centre at the University of Alberta and designed to raise awareness about the prevention of slips, trips, and falls among older adults.

Online Resources

www.findingbalancenb.ca/

GoodLife Fitness

519 Westmorland Rd
Saint John, NB E2J 3W9
506-652-2348
Email: saintjohnmcallister@goodlifefitness.com
www.goodlifefitness.com/clubs/club.318.html?utm_source=G&utm_medium=LPM&utm_campaign=GoodlifeFitness

Greater Saint John Volunteer Connector

PO Box 20061
Brunswick Square
Saint John, NB E2L 5B2
Email: info@sjfoundation.ca

Habitat for Humanity - Saint John Region

727 Rothesay Ave
Saint John, NB E2H 2H6
506-635-5977
Email: info@habitatsaintjohn.ca

Irving Oil Field House

129 McAllister Dr
Saint John, NB E2J 2S7
506-717-4080
www.irvingoilfieldhouse.com/

Key Industries

Providing employment-first programs and personalized services to empower persons with a disability to achieve personal, community and economic independence.
239 Charlotte St
Saint John, NB E2L 2K1
506-634-6888
Email: info@keyindustries.ca
www.keyindustries.ca/

Le Cormoran Library
67 Ragged Point Rd
Saint John, NB E2K 5C3
506-658-4610
www1.gnb.ca/0003/Pages/fr/biblio-f.asp?CODE=FB

Meals on Wheels Saint John
Private Client Pricing: For hot or frozen is $8.00 each. We deliver nutritious and affordable meals for Greater Saint John. Monday to Friday our volunteers deliver professionally prepared hot or frozen meals to those who are unable to prepare meals for themselves.
33 Beaverbrook Ave
Saint John, NB E2K 2W2
506-658-1888
Email: mealsonwheels@nb.aibn.com
www.mealsonwheelssj.ca/

National Association of Federal Retirees – Fundy Shores Branch
This organization is the largest national advocacy organization representing active and retired members of the federal public service, Canadian Armed Forces, Royal Canadian Mounted Police and retired federally appointed judges, their partners, and survivors.
PO Box 935 STN Main
Saint John, NB E2L 4E3
506-529-3164
Email: fsna65@gmail.com
www.federalretirees.ca/

New Brunswick Community College – Saint John Campus
950 Grandview Ave
Saint John, NB E2J 4C5
506-460-6222 / 1-888-796-6222
Email: nbcc@nbcc.ca
www.nbcc.ca/home

New Brunswick Home Support Association
The New Brunswick Home Support Association works towards advancing the home and community care industry by promoting quality care in the home environment through education, collaboration, and advocacy.
PO Box 30057,
Fredericton, NB E3B 0H8
1-888-562-8333
Email: admin@nbhsa.ca
www.nbhsa.ca/

New Brunswick Senior Citizens Federation

The New Brunswick Senior Citizens' Federation is a mutual, bilingual, non-for-profit organization devoted to the advancement of issues related to the well-being of all seniors aged 50 years and over in New Brunswick.
451 Paul St
Suite 209G, Box 23
Dieppe, NB E1A 6W8
506-857-8242 / 1-800-453-4333
Email: NBSCF-FCANB@outlook.com
www.nbscf.ca/

New Brunswick Seniors Advocate

PO Box 6000
Fredericton, NB E3B 5H1
506-453-2789 / 1-888-465-1100
Email: advocate-defenseur@gnb.ca
www.nbseniorsadvocate.ca/welcome

New Brunswick Society of Retired Teachers

The mission of the NBSRT shall be to protect, advance, and advocate for the well-being of retired teachers.
President: Robert (Bob) Fitzpatrick
Email: president@nbsrt.org

Royal Canadian Legions

Bayview Branch 22
27 Woolastook Dr
Grand Bay-Westfield, NB E5K 1R4
506-738-8020

New Brunswick Command
490 Douglas Ave
Saint John, NB E2K 1E7
506-634-8850 / 1-866-320-8387
Email: legion@bellaliant.com
www.nb.legion.ca/

Jervis Bay Branch 53
1016 Bayside Dr
Saint John, NB E2J 4Y1
506-633-0092

Lancaster Branch 69
PO Box 27052 RPO Manawagonish
Saint John, NB E2M 5S8
506-635-8096

Saint John Free Public Libraries

East Branch
55 McDonald St
Saint John, NB E2J 0C7
506-643-7250

Central Branch
1 Market Square
Saint John, NB E2L 4Z6
506-643-7220

West Branch
621 Fairville Blvd
Saint John, NB E2M 4X5
506-643-7260

The Saint John Newcomers Centre

A go-to place for all newcomers to Saint John. Helping you to settle down and integrate into the local community.
75 Prince William St. Suite 100
Saint John, NB E2L 2B2
506-642-4242
Email: welcome@sjnewcomers.ca
www.sjnewcomers.ca/

Saint John Rotary Club

30 Wedgewood Sr
Rothesay, NB E2E 3P7
Email: rotarysaintjohn@gmail.com
www.portal.clubrunner.ca/1226/

Saint John SPCA Animal Rescue

295 Bayside Dr
Saint John, NB E2J 1B1
506-642-0920

The Anglican Diocese of Fredericton

168 Church St
Fredericton, NB E3B 4C9
506-459-1801
office@anglican.nb.ca
www.nb.anglican.ca/saint-john

The University of New Brunswick – Mature Students

100 Tucker Park Rd
Saint John, NB E2K 5E2
506-648-5900
Email: tellmemore@unb.ca

YMCA of Greater Saint John

191 Churchill Blvd
Saint John, NB E2K 3E2
506-693-9622
Email: hello@saintjohny.ca
www.saintjohny.ymca.ca/

Homecare Providers

Bayshore Home Care Solutions
600 Main St (Hilyard Place)
Suite C150, Building C
Saint John, NB E2K 1J5
506-633-9588 / 1-866-227-3092
Email: tlearmonth@bayshore.ca
www.bayshore.ca/

Home Care by Design
510 Boars Head Rd
Saint John, NB E2K 5A1
506-343-2659
Email: home@homecarebydesign.ca
www.homecarebydesign.ca/

Integrity Home Health Services
65 University Ave
Saint John, NB E2K 5M1
506-657-1273 / 1-833-383-1273
www.integrityhhs.com/

Kindred Home Care
337 Rothesay Ave
Suite 354
Saint John, NB E2J 2C3
1-877-999-6602
www.kindredhomecare.com/

Riley Home Health Services
1216 Sand Cove Rd
Saint John, NB E2M 5V8
506-672-1943

Senior Watch Inc.
100 Prince Edward St
Saint John, NB E2L 3G1
506-634-8906

Other Providers

Bell Aliant
General Line
1-888-214-7896

Calvary Temple Church Food Pantry
83 Sydney St
Saint John, NB E2L 2L7
506-634-1688
Email: ctsjmainoffice@gmail.com
www.calvarytemplesj.com/

Canada Post
Saint John Area
125 Rothesay Ave
Saint John, NB E2L 3B0

Lawtons Drugs
39 King St
Saint John, NB E2L 4W0

Shoppers Drug Mart
110 Crown Street
Saint John, NB E2L 2X0

Grand Bay-Westfield
1 Woolastook Dr
Grand Bay-Westfield, NB E5K 1W0

Shoppers Drug Mart
407 Westmorland Rd
Saint John, NB E2J 2S0

Shoppers Drug Mart
57 Lansdowne Ave
Saint John, NB E2K 3A0

Shoppers Drug Mart
667 Fairville Blvd
Saint John, NB E2M 3W0

Handi-Bus Service
211 Main St
Saint John, NB E2K1H7
506-648-0609
Hours of Operation:

- Monday, Wednesday, Friday: 7 am – 7 pm
- Tuesday & Thursday: 7 am – 9 pm
- Saturday: 10:30 am – 7 pm
- Sunday: No service

Lakewood Headstart Association – Food and Clothing Bank

The program is eligible to residents in East Saint John, Barnsville, and St. Martins, and people need to call in advance. Proof of address and identification for all family members is required. The program is available the second and third Thursday of the month from 10am to 2pm.
234 St Martins Rd
Saint John, NB E2S 2H9
506-696-6164
Email: lakewood.headstart@hotmail.com

Lifeline Program

Personal in-home emergency response service.
Saint John Regional Hospital Auxiliary
506-648-6292 / 1-800-387-8120

NB Power

Energy Efficiency Services
35 Charlotte Street
Suite 101
Saint John, NB E2L 2H3
1-800-663-6272
www.nbpower.com/Welcome.aspx?lang=en

North End Food Bank

Please call in advance for more information regarding the registration process and hours of operation.
211 Main St
Saint John, NB E2K 4T7
506-634-7403
Email: northendfoodbanksj@gmail.com
www.northendfoodbanksj.com/

River Valley Food Bank

Please call in advance for more information regarding the registration process and hours of operation.
3540 Westfield Rd
Saint John, NB E2M 7C7
506-738-2088
Email: rvfb@outlook.com

Romero House Soup Kitchen

Please call in advance for more information regarding the registration process and hours of operation.
647-649 Brunswick Dr
Saint John, NB E2L 3S9
506-642-7447
Email: romerohouse@rogers.com

Saint John City Transit

55 McDonald St
Saint John, NB E2J 0C7
506-658-4700
www.saintjohn.ca/en/transit

Fares (effective until January 1, 2024)

- Adult Cash Fare (age 15 and over) $2.75
- Senior Citizen Cash Fare (65 and over) $2.50
- Monthly Adult Pass $77.00 (approx. $1.54 per ride)
- Monthly Senior/Child Pass $55.00 (approx. $1.10 per ride)

See the website for more information and bus routes.

Saint John Community Food Basket

Please call in advance for more information regarding the registration process and hours of operation.
245 Union St
Saint John, NB E2L 1B2
506-652-2707
executive.director@sjcfb.ca

Saint John East Food Bank

Please call in advance for more information regarding the registration process and hours of operation.
648 Westmorland Rd
Saint John, NB E2J 2H4
506-633-8298
Email: sjefb.648@gmail.com

Saint John Energy

325 Simms St
Saint John, NB E2M 3L6
506-658-5252
www.sjenergy.com/

Salvation Army Saint John

Hours vary per program, call for details.
27 Prince Edward St
Saint John, NB E2L 3S1
506-634-1633
Email: robert.england@salvationarmy.ca
www.salvationarmy.ca/

West Side Food Bank

Please call in advance for more information regarding the registration process and hours of operation.
120 Market Place
Saint John, NB E2M 1B3
506-635-1060
Email: westsidefoodbanksj@gmail.com

211 New Brunswick

This website is the public online version of the database used by information and referral specialists for the 211 telephone/email service. This up-to-date, accessible, searchable database provides comprehensive access to information about social, community, health, and government services in New Brunswick. This website complements our 211-telephone service, which was launched in 2020. By dialing 211, residents of New Brunswick can obtain information on a wide range of community programs and services. Key features of 211:

- Easy to remember, non-emergency phone number that provides quick access to information and referral to community, social, health and government services
- Always answered by a person
- Available 24 hours a day, seven days a week by phone or online
- Offers multilingual phone services
- Available to people who are deaf, deafened, or hard of hearing via TTY

211 / 1-855-258-4126
Text: 1-855-405-7446
Email: 211nb@findhelp.ca
www.nb.211.ca/search/

Aging Well – Helpful Hints

Advanced Health Care Directives

An advance health care directive is a document in which a person sets out his or her wishes regarding future health care decisions. These might include consent, refusal to consent, or withdrawal of consent for any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for an individual's physical or mental health.
For more information, please visit Public Legal Education and Information Service of New Brunswick (PLEIS-NB) or contact Nursing Homes Without Walls.
Website: www.legal-info-legale.nb.ca/en/index.php?page=advance-health-care-directives

Canadian Physical Activity Guidelines

To achieve health benefits, and improve functional abilities, adults aged 65 years and older should accumulate at least 150 minutes of moderate - to vigorous intensity aerobic physical activity per week, in bouts of 10 minutes or more." For more information, please use the link.
Website: www.csep.ca/CMFiles/Guidelines/CSEP_PAGuidelines_0-65plus_en.pdf

Caregivers' Guide

The Caregivers' Guide contains practical information for caregivers of older adults. More than eight million Canadians are family caregivers. They are individuals (family members, neighbors, friends, and other significant people) who take on the caring role to support someone as he or she ages. With an aging population, it is no longer a question about whether someone will assume the role of caregiving, rather it is when. Today, New Brunswickers are living longer and with fewer health issues than in the past; however, most seniors continue to be challenged by at least one chronic disease or condition. This guide provides information to individuals who are now or anticipate becoming family caregivers. It provides advice about various aspects of caregiving as well as practical ways caregivers can adapt their lifestyles and living environments to ensure a better quality of life for themselves and the seniors for whom they are caring.
Website: https://www2.gnb.ca/content/gnb/en/departments/social_development/seniors/content/caregivers_guide.html

Congratulatory Messages

- The Prime Minister sends congratulatory messages for 65th Birthdays and 25th Wedding Anniversaries in 5-year increments ONLY.

After 100 messages are sent for the individual year. Requests for messages will only be accepted if sent within 6 months of the event.

- The Lieutenant-Governor sends congratulatory messages for 80th Birthdays and 50th Wedding Anniversaries.
- The Governor General sends congratulatory messages for 90th Birthdays and 50th Wedding Anniversaries.
- The Federal Leader of the Opposition sends congratulatory messages for 65th Birthdays and 50th Wedding Anniversaries.
- Her Majesty the Queen sends congratulatory messages for 100th Birthdays and 60th

- Wedding Anniversaries (needs to be accompanied by a copy of a birth or marriage certificate or a declaration from clergy).

To download a copy of the application form, please use the link.
Website: https://www.gnb.ca/Scripts/CNB/Greeting/index-e.asp

Food Safety for Adults Ages 60 and Over

WHAT IS FOOD POISONING? Food poisoning (also known as foodborne illness or food-related illness) is caused by eating food that has been contaminated by bacteria, viruses, or parasites. Food can become contaminated by these microorganisms at any time before you eat it, including at home during handling, storing, and cooking. Health Canada has published a great booklet called "Safe Food Handling for adults ages 60 and over". You can visit their website and download a PDF version or order a paper copy.
Website: www.canada.ca/en/health-canada/services/food-safety-vulnerable-populations/food-safety-adults-ages-60-over.html

Fraud and Scam Prevention

Scammers are sneaky and sly. They can target anyone, from youngsters to retirees. They can also target businesses. No one is immune to fraud. The Government of Canada has a group of superheroes that have found a way to see through the scams. Their secret is simple: knowledge is power! Please take a few minutes to become a real-life superhero by arming yourself with the information you need to fight fraud and keep yourself, your family, and your money safe. Everything you need to know can be found in The Little Black Book of Scams.
Website: www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/04333.html

Healthy Eating for Seniors - Health Canada

Healthy eating is a key part of aging well, and is a way to stay healthy and strong, which is important to maintain your independence and quality of life. Healthy eating can help:

- Maintain a healthy weight and promote and protect health and well-being
- Prevent, lower the risk or slow the progression of chronic diseases like heart disease, type 2 diabetes
- Prevent muscle and bone loss to reduce your risk of falling or breaking your bones. For more information on healthy eating for seniors, please visit the link

Website: www.food-guide.canada.ca/en/tips-for-healthy-eating/seniors/

Plan Your Future Today - Live the Life You Want Tomorrow

If you are like many Canadians, you want to Age in Place in your own home and community. Aging in place means having the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able. The earlier you start planning, the more prepared you will be to respond to changes that may occur as you age such as changes in your health, mobility, or social connections. To successfully plan, you need to start thinking about how you want to live as you age and what steps you need to take to achieve that lifestyle. When planning, you should also consider the unexpected. This

includes planning for what you would do if you had a sudden onset of a chronic illness, developed a disability, or had a change in resources. For more information on Aging in Place, please visit the link.
Website: https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/aging.html

Powers of Attorney

Creating a power of attorney is one way that individuals can plan for the future. To help the public explore their options, the Public Legal Education, and Information Service of New Brunswick (PLEIS-NB) has published the "Powers of Attorney" booklet. The booklet describes the different kinds of powers of attorney, explains how to set them up and explores some advantages of creating powers of attorney to deal with property and financial matters and/or personal care.
For more information on Powers of Attorney, please contact Nursing Homes Without Walls or The Public Legal Education and Information Service (PLEIS-NB).
Website: www.legal-info-legale.nb.ca/

Preventing Falls in and Around Your Home

The first step to avoiding falls is to understand what causes them. For example, poor balance, decreased muscle, and bone strength, reduced vision or hearing, and unsafe conditions in and around your home can increase your chance of falling.
For more information on fall prevention, please visit the link.
Website: www.canada.ca/en/public-health/services/health-promotion/aging-seniors/publications/publications-general-public/you-prevent-falls.html

Seniors and Aging - Bladder Control Problems (Incontinence)

Incontinence can have devastating effects on the lives of seniors. It can limit social contacts due to embarrassment, can negatively affect feelings of well-being, and can also cause stress, leading to other health problems. Fortunately, there are a number of treatment options that can help restore quality of life for people with bladder control problems.
For more information, please visit the link.
Website: www.canada.ca/en/health-canada/services/healthy-living/your-health/medical-information/seniors-aging-bladder-control-problems-incontinence.html

Seniors and Aging – Osteoarthritis

Osteoarthritis is caused by the wearing down of cartilage in the joints of the body, causing varying degrees of pain, stiffness and swelling. A majority of Canadians will be affected by it by age 70. However, there are prevention and coping strategies that can help seniors with the disease remain active and enjoy a good quality of life. For more information, please visit the link.
Website: www.canada.ca/en/health-canada/services/healthy-living/your-health/diseases/seniors-aging-osteoarthritis.html

Seniors and Aging - Vision Care

As people get older, it is normal for their vision to change. However, there are steps you can take to preserve your eyesight and improve your vision - an important part of staying safe and independent. Because vision is so vital to daily living, it is important to recognize the changes. Having your eyes examined regularly can help to detect problems early on and help maintain good vision. For more information, please visit the link.
Website: www.canada.ca/en/health-canada/services/healthy-living/your-health/lifestyles/seniors-aging-vision-care.html

Seniors Guidebook to Safety and Security- RCMP

This guide is for seniors, their family members, caregivers, friends, and anyone else who may find it useful. It is not meant to include everything but tries to answer some common concerns when it comes to seniors' safety and security. To download a PDF copy of this guidebook please use the link.
Website: www.rcmp-grc.gc.ca/en/seniors-guidebook-safety-and-security?re=#wb-cont

The Safe Living Guide

A guide to home safety for seniors. This guide provides advice on how to prevent injuries by keeping your home, yourself, and your environment as safe as you can. Checklists allow you to verify and increase the safety of your surroundings and lifestyle, and real-life stories offer testimony to the value of adapting. For more information, please visit the link.
Website: www.canada.ca/en/public-health/services/health-promotion/aging-seniors/publications/publications-general-public/safe-living-guide-a-guide-home-safety-seniors.html

Wills

There are several reasons why you should consider making a will. They are, for example:

- To distribute your property as you wish
- To allow you to choose your own executor
- To give you flexibility in carrying out your wishes
- To provide guardianship for your children under the age of 19
- To avoid delays and costs

For More information on Wills, please visit The Public Legal Education and Information Service (PLEIS-NB) or contact Nursing Homes Without Walls.
Website: www.legal-info-legale.nb.ca/en/making_a_will

Notes:

Notes:

NURSING HOMES WITHOUT WALLS

185 Loch Lomond Road
Saint John, NB E2J 3S3
506-643-7175 EXT 6913
NHWWAdmin@lochlomondvilla.com

Fall Prevention SAFETY TIPS FOR HOME

Why worry about home safety? (Public Health Agency of Canada, 2005)

- Falls cause injuries and death. Falls account for more than half of all injuries among Canadians 65 years and over.
- Falls account for 27% of all injury-related hospital admissions and 79% of seniors' injury-related hospitalizations.
- Falls cause loss of independence and lower quality of life.
- Nearly half of injuries among seniors occur at home. Falls in the bathroom and stairs are responsible for more injuries than any other household area or product.

Lighting

☐ Provide adequate lighting throughout house, so no one trips over unseen objects.
☐ Use night lights in bedrooms, bathroom, halls and stairways.
☐ Light switch at the top and bottom of your stairs.
☐ Keep a flashlight by the bed.

Floors

☐ Remove throw rugs unless taped down; tack carpet edges down.
☐ Only use rugs with non-skid backing.
☐ Eliminate any clutter, including loose wires and cords.
☐ Ensure pathways to major rooms are clear.
☐ Use non-slip floor wax.
☐ Watch out for pets underfoot.

Furniture

☐ Place piece of furniture in front of hot radiators.
☐ Raise sofas or armchairs to make it easier to sit down on and get up from.
☐ Consider a bedrail for helping to get out of bed or for safety.

Bathrooms

☐ Use rubber mats in the bathtub and shower.
☐ Install grab bars in the bathtub or shower, and by the toilet. (DO NOT rely on towel rack or soap dish for support.)
☐ Install raised toilet seats.
☐ If needed, use bath seats/chairs/lifts or tub transfer benches. Consider a hand-held, flexible shower.
☐ Adjust the hot-water heater or install a device that will prevent water from reaching too high a temperature.

Kitchen

☐ Food and equipment in easy-to-reach locations.
☐ Heavy items in lower cupboards.
☐ “ON” and “OFF” clearly marked on stove dials.
☐ Stove safety knobs can be used.
☐ Use an automatic shut-off kettle.
If needed

Outside the Home

☐ Keep sidewalks, walkways and driveways repaired so they are smooth and even.
☐ Keep pathways clear of shrubbery.
☐ Keep steps and walkways free of ice, snow, newspapers, and wet leaves.
☐ Outdoor light at entrances.
☐ Easy-to-reach mailbox.
☐ Consider ramps.

Stairs

- ☐ Install handrails on both sides of stairways.
- ☐ Even surfaces; no cracks or bunched up stair coverings or protruding nails.
- ☐ Steps of the same size and height.
- ☐ Good contrast on edges of steps. Avoid visually distracting patterns.
- ☐ Non-slip surface on steps.

Storage

- ☐ Store frequently used items on shelves within easy reach (e.g., kitchen).
- ☐ If necessary, use a stable stepping stool or a reacher.
- ☐ Flammable and hazardous materials clearly labeled and properly stored.

Wandering/Confusion

- ☐ If possible, add a fence with a gate around the yard.
- ☐ Keep medications, dangerous, and fragile items out of reach (including poisonous house plants).
- ☐ Consider child-proofing devices to secure potentially hazardous items.
- ☐ Remove stove switch knobs or take out fuses out of stove. Turn off gas underneath stove, etc.
- ☐ Install accordion gate (e.g., baby gates) at tops of stairs.
- ☐ Put plastic plugs in electrical outlets.
- ☐ Remove sharp-cornered furniture and sharp objects.
- ☐ Keep outside lights off at night to discourage a person from going out of the house.
- ☐ Camouflage windows or doors with decorations.
- ☐ Mark sliding glass doors with decals to prevent walking into them.
- ☐ Use a sounding device to signal when a door is open (e.g., wind chimes, bells, electronic alarm system).
- ☐ Close up the fireplace.
- ☐ Remove locks from all inside doors. Evaluate locks.

Communication

- ☐ Wear your glasses and hearing aid!
- ☐ Ensure that the telephone and/or emergency call buttons can be reached from the floor should a fall occur.
- ☐ Place important and emergency numbers (in large print) by every telephone.
- ☐ Fire detector on every floor.
- ☐ Recommend a carbon monoxide alarm in the home.
- ☐ Test smoke alarm every six months.

Other Considerations

- ☐ Check vision every year. Check hearing at least every two years (more often if hearing problems are suspected).
- ☐ Follow-up with doctor with any concerns (e.g., foot pain, dizziness, weakness, unsteadiness, disturbances of vision or hearing, confusion, weight loss, joint stiffness, etc.).
- ☐ Have regular check-ups (e.g., review medications, blood pressure, walking ability and balance, overall physical fitness, nutrition, etc.).
- ☐ Encourage good health habits
    - o Limit alcohol intake
    - o Regular physical activity (e.g., walking)
    - o Regular good nutrition
    - o No smoking
- ☐ Safe behaviours:
    - o Use your mobility aid (e.g., cane, walker).
    - o ASK FOR HELP when you need it!
    - o Take your time. Don’t rush! Get up slowly.
    - o Take care while carrying objects, especially on the stairs.
    - o Wear suitable footwear (with non-skid soles).
    - o Take care in unfamiliar environments
    - o Lack of attention.
    - o Turn on the lights. Hold the handrail.
    - o Don’t leave objects on stairs.
    - o Wipe any spills right away.

Public Health Agency of Canada
Agence de la santé publique du Canada

The Safe Living Guide

A guide to home safety for seniors

Canada

The Safe Living Guide

A guide to home safety for seniors

To promote and protect the health of Canadians through leadership, partnership, innovation and action in public health.

—Public Health Agency of Canada

The Safe Living Guide—A guide to home safety for seniors
is available on the Internet at the following address:
http://www.publichealth.gc.ca/seniors

Également disponible en français sous le titre :
Chez soi en toute sécurité — Guide de sécurité des aînés

To obtain more information on this publication, please contact:

Division of Children, Seniors and Healthy Development
Public Health Agency of Canada

Telephone: 1 800 O-Canada (1-800-622-6232)
TDD/TTY: 1-800-926-9105
Web site: www.publichealth.gc.ca/seniors

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There's no place like home... but...

There's no place like home—and sometimes it seems like there's no place safer. For seniors, however, the home is where many injuries occur, and most of these are due to falls. Changes that are part of the normal aging process, such as declining vision, hearing, sense of touch or smell and bone density can increase the risk of injury. Injuries can also be more of a problem for seniors because, as the body ages, it takes longer to heal and recover from injury.

You might think that "accidents just happen" and that nothing can really be done to prevent them. Not so. By taking some simple measures, you can considerably reduce your chances of being injured at home. It's a matter of knowing what the potential hazards are, taking precautions and making adjustments. These changes can make a big difference!

This guide provides advice on how to prevent injuries by keeping your home, yourself and your environment as safe as you can. Checklists allow you to verify and increase the safety of your surroundings and lifestyle, and real-life stories offer testimony to the value of adapting.

As the old saying goes: "An ounce of prevention is worth a pound of cure." Inspecting your home and taking action to prevent home injuries can help you to live comfortably and safely for many years to come. We hope you will find this guide to be a practical tool to help you along the way.

The facts:
Seniors and injury in Canada

Falls cause injuries and death

Falls are the leading cause of injuries among Canadians 65 years and over. Between 20% and 30% of community-dwelling Canadian seniors experience one fall each year. Research suggests that falls are the direct cause of 95% of all hip fractures, leading to death in 20% of cases.

Hospitalization

Falls account for 85% of seniors' injury-related hospitalizations, making this the leading cause of injury-related admissions for seniors. The average Canadian senior had to stay in hospital 10 days longer for falls than for any other cause. Falls are associated with over 1/3 of admissions to long-term care facilities after being released from the hospital.

Cost of injuries

Apart from personal suffering, loss of independence and lower quality of life, the costs of seniors' injuries to the health system are enormous—approximately $2 billion annually is spent on direct health care costs.

Where injuries occur

Approximately half of all falls that lead to hospitalization among seniors occur at home. The bathroom and stairs are particularly hazardous due to the risk of slipping, tripping and stumbling.

Fear of falling

Seniors who fall may limit their activities for fear of falling again. Yet by limiting activities, they are likely to lose strength and flexibility and *increase* their risk of falling again. Maintaining physical activity is essential if you wish to prevent falls and injury.

Source: Seniors' Falls in Canada: Second Report available at http://www.phac-aspc.gc.ca/seniors-aines/publications/public/injury-blessure/seniors_falls-chutes_aines/index-eng.php

The facts:
Aging brings changes

Aging affects each individual differently. Some seniors experience physical limitations that seriously affect their level of activity while others are able to remain quite active. The natural process of growing older, however, generally includes changes in abilities. If you're experiencing some of the problems associated with the changes described below, consult your health professional and make sure you undertake whatever changes or adaptations will help you cope and compensate.

Vision

Eyes take longer to adjust from dark to light and vice versa, and become more sensitive to glare from sunlight or unshielded light bulbs. There is a decline in depth perception that can make it hard to judge distances. Perceiving contrasts and colours can also be more difficult.

Touch, smell and hearing

Sensitivity to heat, pain and pressure decreases; this may make it more difficult to detect a liquid's temperature or changes in ground or floor surfaces. Sense of smell diminishes, making it harder to smell spoiled food, leaking gas and smoke. Hearing loss can result in difficulty hearing telephones, doorbells, smoke alarms, etc.; it can also result in a decrease in balance, which can make falling more likely.

Bone density

Bones naturally become less dense and weaker with age. Bone loss (osteoporosis) among seniors can be worsened by lack of exercise and nutritional deficiencies. Bone loss can lead to painful fractures, disfigurement, lowered self-esteem and a reduction or loss of mobility.

Balance and gait

Balance is a complex function involving eyes, inner ear, muscular strength and joint flexibility. Any one of these can change as a result of aging. A general decline in equilibrium can make it more difficult to maintain or recover balance, meaning that a slip or trip can become a fall. The speed of walking, the height to which the heels are lifted, and the length of a person's stride can change with age. These changes can make it more likely for someone to experience a fall.

Memory

In general, sharp brains tend to stay sharp. Cognitive processing and memory may take a bit longer, but this is a normal effect of aging. This is why it's important to make lists and keep phone numbers handy.

Most seniors develop effective coping mechanisms as they age. Being aware of the normal changes of aging allows you to plan for home and lifestyle adaptations that will help you retain your health, quality of life and independence.

Keeping your home safe

Injuries can result from seemingly innocent things around your home—many of which are easily fixed or adapted after you do some detective work to track them down. The following checklists will help you inspect your home for evidence of trouble that may be waiting to happen. Every NO answer is a clue that your home may not be as safe as it could be and that you should be making the needed changes as soon as you can. Your safety depends on it!

Checklists:

Outside

	Yes	No
• Do all your entrances have an outdoor light?	☐	☐
• Do your outdoor stairs, pathways or decks have railings and provide good traction (i.e. textured surfaces)?	☐	☐
• Are the front steps and walkways around your house in good repair and free of clutter, snow or leaves?	☐	☐
• Do the doorways to your balcony or deck have a low sill or threshold?	☐	☐
• Can you reach your mailbox safely and easily?	☐	☐
• Is the number of your house clearly visible from the street and well lit at night?	☐	☐

If you live in a rural area and don't have a visible house number, make sure your name is on your mailbox and keep a clear description of directions to your home (main roads, landmarks, etc.) by each phone in your house.

Inside

	Yes	No
• Are all rooms and hallways in your home well lit?	☐	☐
• Are all throw rugs and scatter mats secured in place to keep them from slipping?	☐	☐
• Have you removed scatter mats from the top of the stairs and high traffic areas?	☐	☐
• Are your high traffic areas clear of obstacles?	☐	☐
• Do you always watch that your pets are not underfoot?	☐	☐
• If you use floor wax, do you use the non-skid kind?	☐	☐
• Do you have a first aid kit and know where it is?	☐	☐
• Do you have a list of emergency numbers near all phones?	☐	☐

TIP

Install a seat at the entrance of your home to remove or put on your shoes and boots.

Avoid throw rugs and scatter mats. They're dangerous!

Stairs

	Yes	No
• Are your stairways well lit and do you have light switches at the top and bottom of the stairs?	☐	☐
• Are your stairs in good repair and free of clutter?	☐	☐
• Do the steps of your stairs have a non-skid surface?	☐	☐
• Are there solid handrails on both sides of the stairway?	☐	☐
• Do you remove your reading glasses when using the stairs?	☐	☐

TIPS

To help avoid taking a misstep, you can paint wooden or concrete steps with a strip of contrasting colour on the edge of each step or on the top and bottom steps.

Don’t rush going up or down stairs. Rushing is a major cause of falls.

Are your stairs in good repair?

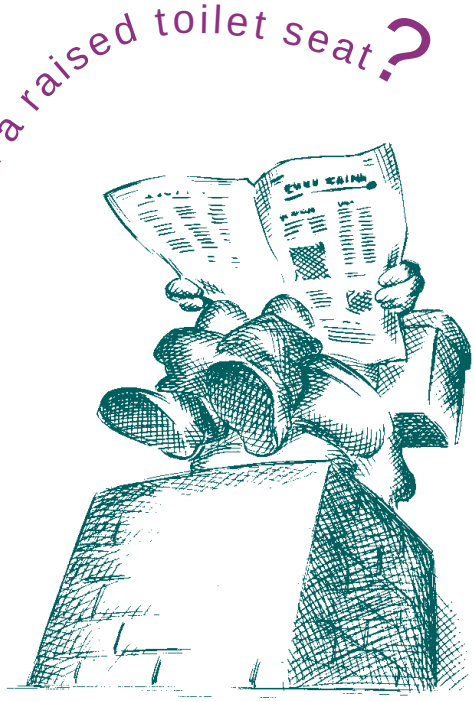
Fire and hazardous materials

	Yes	No
• Do you have a smoke detector on every floor of your home?	☐	☐
• Do you test your smoke detector every six months?	☐	☐
• Have you developed an escape route in case of fire and a fire safety plan?	☐	☐
• Are you registered on your apartment building's fire safety plan?	☐	☐
• Do you have a carbon monoxide detector in your home?	☐	☐
• Are flammable and hazardous materials clearly labelled and properly stored?	☐	☐
• If you use a space heater, is it placed well away from flammable substances and materials?	☐	☐
• Do you use appropriate power bars to prevent overloading electrical outlets?	☐	☐
• If you live in an older home, have you or an electrician inspected your wiring, fuse box, electrical cords and appliances for safety?	☐	☐
• Do you have a fire extinguisher and know how to use it?	☐	☐

To remember to test your smoke detector twice a year, make a habit of testing it when you turn your clocks forward in the spring and back in the fall.

Bathroom

	Yes	No
• Do you test the water temperature before you get into the bathtub or shower?	☐	☐
• Is your hot water temperature set to the recommended 49°C (120°F)?	☐	☐
• Do you have non-slip surfaces in the tub or shower?	☐	☐
• Do bath mats next to the tub or shower have rubberized backing or are they secured in place to keep them from slipping?	☐	☐
• Do you have a night light in the bathroom?	☐	☐
• Does your bathroom door lock have an emergency release?	☐	☐
• Do you have grab bars that have been properly placed and well anchored to the wall in the bathtub or shower?	☐	☐
• If you have any trouble getting on and off the toilet, do you have a raised toilet seat and a grab bar that is well anchored?	☐	☐
• If it's difficult for you to take a shower standing up, have you considered a bath seat?	☐	☐



Some tile and bath cleaning products actually increase slipperiness. Be careful when using such products.

Kitchen

	Yes	No
• Are your pots and pans, canned goods and staple foods stored in an easy-to-reach location—between knee and shoulder heights?	☐	☐
• Are heavy items stored in the lower cupboards and light items in the higher cupboards?	☐	☐
• Do you have a stable step stool (with a safety rail) for reaching high places?	☐	☐
• Are the “off” and “on” positions on the stove dials clearly marked?	☐	☐
• Are your oven mitts within easy reach when you are cooking?	☐	☐
• Do you make sure never to cook while wearing loose-fitting clothing or sleepwear?	☐	☐
• Do you have a fire extinguisher in the kitchen, mounted on the wall away from the stove?	☐	☐
• Do you regularly check that your fire extinguisher is in good operating order?	☐	☐

Use heat-resistant oven mitts rather than potholders; they provide a better grip on hot containers and give you better protection against splatters and steam. If you do experience a burn, immerse in cool water (not ice or butter!).

Are your oven *mitts* in a handy location?

Bedroom

	Yes	No
• Is there a light switch near the entrance to your bedroom?	☐	☐
• Do you have a lamp or a light switch near your bed?	☐	☐
• Do you keep night lights or other sources of light on in case you get up in the middle of the night?	☐	☐
• Is there a clear path from your bed to the bathroom?	☐	☐
• Do you have a phone and a list of emergency phone numbers near your bed?	☐	☐

TIPS

Make sure your bed is not too high or low, so that it is easy to get in and out of it.

You can purchase short bed rails to steady yourself when getting out of bed.

Is there a clear path from your bed to the bathroom ?

Garage/Basement/Workroom

	Yes	No
• Are your workroom and laundry room well lit?	☐	☐
• Do you have a telephone in the basement and a list of emergency phone numbers?	☐	☐
• Do you keep floors and benches clean to reduce fire and tripping hazards?	☐	☐
• Are all your tools and service equipment in good condition? Are the safety locks on?	☐	☐
• Is your work area well ventilated, summer and winter?	☐	☐
• Are heavy items on lower shelves or in bottom cupboards?	☐	☐
• Do you use a ladder or a stable step stool (with a safety rail) for reaching high places?	☐	☐
• Are all chemicals, such as bleach, cleaners and paint thinners, clearly identified?	☐	☐
• Are flammable materials stored as indicated by the directions on the label and away from sources of heat and flame?	☐	☐
• If you have a gas barbecue, is your propane tank stored outside of the house?	☐	☐

When you use a ladder, never stand or sit on the top three rungs. Maintain your balance by keeping your body centred between the rails, not reaching to the sides and not pushing or pulling on anything.

Childproofing

(a must, for doting grandparents)

	Yes	No
• Have you removed items from your lower surfaces to prevent breakage, injury and spills?	☐	☐
• Child-resistant caps are not childproof. Are all medications and pill boxes stored out of the reach of children?	☐	☐
• Are household products and chemicals, such as cleaning products, paint, paint thinners and alcohol, stored and locked in a cupboard that is out of the reach of children?	☐	☐
• Are cosmetic products, such as nail polish remover, creams, mouthwash and perfumes, out of the reach of children?	☐	☐
• Have you stored small objects out of the sight and reach of younger children to prevent choking?	☐	☐
• Have you stored lighters, matches and candles out of the sight and reach of children?	☐	☐
• Have you installed safety catches on your cupboards and medicine cabinet doors?	☐	☐
• Have you purchased safety gates for stairs or unsafe rooms?	☐	☐
• Is there a safety latch on your stove and dishwasher?	☐	☐
• Are extension, telephone and venetian blind cords out of children's way?	☐	☐
• Are your garage and workshop locked with deadbolts installed high on the doors?	☐	☐

If you have a pool, or if there's one in the building where you live, exercise extreme vigilance. Make sure the pool is absolutely off-limits to children by installing safety devices on house doors leading to the pool and a very high latch on the pool fence gates. Never leave any child without supervision.

Eileen's story

When Eileen Shannon was taking care of her ailing mother-in-law, she decided to get grab bars installed in the bathroom. She also got a bath seat. She was pretty familiar with safety devices and she knew her mother-in-law needed the support in the bathroom. Now, several years later, Eileen is surprised to find herself using those same grab bars. Although Eileen is fairly healthy, she did have two unexpected bouts of illness. "I thought, I'm 69, I won't need those things. But when you get ill, and you come back from the hospital and you're weak, you're mighty glad to have that bar on the bathtub wall."

Eileen's house has other safety features that she installed and finds handy, such as improved lighting, night lights, and lever taps that are easy to turn. As she lives in a large house and her home is the place where everyone gathers for family get-togethers, she has also childproofed the rooms. When she looks ahead to the future, she sees herself remaining in this house safely for a long time to come.

Keeping yourself healthy and active

What does home safety have to do with fitness and food? Plenty! Spending time and energy on your health can provide a big pay-off. You'll not only feel better, you'll be considerably reducing your chances of having a fall or other injury.

Benefits of healthy eating

The foods you eat build and maintain your body. With age, your body continues to need essential nutrients to function correctly. Food deficiencies in seniors can cause or increase the risk of bone loss, heart disease, diabetes, arthritis, etc.—all of which increase your risk of falling. *Eating Well with Canada's Food Guide* provides general guidelines on the foods you need to maintain or improve your health. This *Guide* is available on Health Canada's Web site (www.hc-sc.gc.ca) or through 1 800 O-Canada (see page 36).

Healthy eating promotes a healthy heart, strong bones and good resistance to infection and injury. Eating poorly, skipping meals or not eating enough can cause weakness and dizziness, and increase your risk of a fall. That's also why it's so important to eat regular, well-balanced meals every day.

Checklist:

Nutrition

	Yes	No
• Have you checked out *Eating Well with Canada's Food Guide* to understand your basic nutritional needs?	☐	☐
• Do you eat a variety of foods from each food group every day?	☐	☐
• Do you eat a variety of fruits and vegetables?	☐	☐
• Do you often choose whole grain and enriched products?	☐	☐
• Do you select leaner meats, poultry and fish, as well as dried peas, beans and lentils?	☐	☐
• Skipping meals can cause weakness and dizziness. Do you eat at regular times?	☐	☐

Benefits of active living

Remaining physically active also reduces your risk of falling by giving you more flexible joints, stronger bones and muscles, better heart and lung function, more energy, less fatigue, better sleep and less anxiety and depression. Being active includes everyday activities, such as walking, climbing stairs, gardening and shopping, as well as exercise classes and recreational activities like swimming, golfing and Tai Chi. Whatever your current physical condition, you can engage in some form of physical activity with the help of your doctor.

The Public Health Agency of Canada's *Physical Activity Tips for Older Adults* explain why physical activity is important for seniors and offer easy ways to increase your level of activity. These *Tips* are available online.

Checklist:

Physical activity

	Yes	No
• Have you checked out the *Physical Activity Tips for Older Adults*?	☐	☐
• Have you had a check-up recently and talked to your doctor about increasing your physical activity?	☐	☐
• Do you make sure you have regular and appropriate physical activity that stimulates your muscles and heart?	☐	☐
• Do you choose physical activity whenever you can (walk instead of taking the car, use the stairs instead of the elevator)?	☐	☐

There's no time like the present. Even when physical activity starts in later life, it can lead to significant improvements in your health and quality of life. Choose activities that will build your endurance, increase your flexibility and improve your strength and balance. Remember to check with your doctor first and to start slowly.

Eleanor's story

In Eleanor Mills' opinion, "it's absolutely never too late" to start exercising. When she was 68 years old, Eleanor was almost bedridden and "barely able to teeter across a room." When she was 81 years old, however, she was leading five-kilometre walks in cities across the country.

Eleanor had advanced osteoporosis, a disease in which the bones become so thin and brittle that they break easily. In time, several of her vertebrae collapsed, and three years later she suffered further fractures. "With the pain and agony and the lack of activity—because I could hardly do anything at all—I went down to 46% bone density. I really began to feel like a china cup walking around because it really is about half the strength you should have."

Eleanor knew that one of the best ways to improve her condition was to be active. She started challenging herself to walk a little bit each day. "I was in terribly bad shape," she says. "I only kept going because I knew that if you keep still, you lose more bone than ever. It goes much faster." Through exercise, good nutrition and medical treatment, Eleanor eventually increased her bone density by 20%.

A turning point came when Eleanor first tried a walker. "I simply flew along, and I said to myself, 'Gee, I could walk to Vancouver with this.'" It was Eleanor's idea to form what was called the "Boney Express," a series of walks to raise money for, and awareness of, osteoporosis.

Eleanor admits that when she first used the walker, she felt a little strange and wondered what people would think. “There are many people who have resisted getting a walker because it sort of labelled them as unable. And I did feel a little odd pushing around what seemed like an empty chair because my walker has a seat. But that is so much offset by the value of the walker that I very soon got over it. I think we should welcome all the aids we can find, and we must be proud that we can do so much more when we use them.”

One of Eleanor’s goals is to try walking for the whole day. As she puts it, “I just want to see how far I can go.”

Keeping track of your medicine

Seniors may be more prone to illness due to the weakening of the body's natural defences. It's not surprising, therefore, that many require a greater number of drugs to treat their health problems. Because seniors also tend to have more than one health problem, they may receive multiple prescriptions or they may combine prescription drugs with over-the-counter products or with natural remedies. Given that the aging body is more sensitive to the effects of many medications, the combinations can cancel the benefits of any or all medications and produce adverse reactions, such as memory loss, sleepiness, agitation and confusion. These effects have been associated with falls and other injuries.

Checklist:

Medication safety

	Yes	No
• Have you talked to your health care professional about alternatives to medication? (Medication may not always be the best solution.)	☐	☐
• Have you told all your doctors and your pharmacist about all of the medicine you're taking (prescription, over-the-counter or herbal) as well as your use of alcohol and/or tobacco?	☐	☐
• Do you read the instructions on each of your medication containers to check for side effects or possible ill effects of combining one medication with another?	☐	☐
• Do you take your medication exactly as prescribed or know of any alternative instructions should you forget to take it?	☐	☐
• Do you have a list of what medications you are currently taking, and is your family aware of it?	☐	☐

	Yes	No
• If you have medication allergies, do you wear a bracelet or necklace to show this?	☐	☐
• If you react to a medicine or experience side effects, do you report it to your doctor or pharmacist?	☐	☐
• Do you use only one pharmacy for all your prescription needs?	☐	☐
• Have you gone through your medicine cabinet and discarded any medicines that are past the “Best before” date?	☐	☐
• Whenever you get a new medicine, do you ask for and obtain all the information on its use and side effects?	☐	☐

Don’t mix drugs and alcohol. Alcohol can react with many common medications, including tranquillizers, sleeping pills, cold or allergy medicines, high blood pressure pills and pain medication.

To inform your doctor or pharmacist about all the medications you take, put all your medications, including herbal remedies, over-the-counter and non-prescription medicines in a bag and take it to your next doctor’s appointment or pharmacy visit.

If your medication causes dizziness or sleepiness, adjust your activities so you aren’t at risk of falling.

Margaret's story

Margaret Deschamps believes in being on top of the medications she's taking. One of her friends suffered from an accidental overdose of medication because she'd gone to two different doctors and was prescribed two different drugs with similar ingredients. Margaret has always been careful about her medicine, and this made her even more so.

"I make sure I know everything there is to know about my medication's side effects and bad combinations. I've found out that there's one pill I take that can't be combined with grapefruit! It's really important to ask the questions. There's no reason to be afraid: you ask, and you get an answer. When you go to the drugstore, they can write everything down for you [about your medication], the side effects and all. They'll even check if you're taking medication from another doctor."

As Margaret explains, "You can often have several doctors: a general practitioner, a heart specialist, a rheumatologist, etc. And one doesn't always know what the other ones are giving you. But if you go to the same drugstore and you're prescribed something that, along with your other medication, could cause an adverse reaction or an overdose, they can let you know. They can contact the doctors, if necessary. This is a marvelous service that many drugstores offer now."

Keeping safe with safety aids

Many of the products on the market today can make your life easier, more enjoyable and safer. Many are not very expensive, and some would make nice gifts. These products can be found in hardware stores, pharmacies, medical supply stores, mail-order catalogues and other specialty stores. Also look in the Yellow Pages under "Senior Citizens' Services and Centres," "Hospital Equipment and Supplies," "Medical Equipment and Supplies" and "Orthopedic Appliances."

Useful aids

For walking

Canes can be a handy aid for walking, and these days they come in some fashionable styles too. It's very important to make sure your cane is the right height and the rubber tips are checked every once in a while to ensure they are still in good shape. Wrist straps can be attached to your cane to prevent dropping. A clip can be put on the cane so that it will hang on the edge of a table or walker.

Cane spikes fit over the end of your cane for extra grip on an icy day. Spikes with four or five prongs are best. Many spike attachments flip up or down as needed. The spikes should be flipped up or taken off your cane when you enter a store or shopping mall, as the spike can slip on floor surfaces.

Safety soles are anti-skid detachable soles with studded treads that make walking safer in the wintertime. The safest design is a full sole that runs the entire length of the shoe. These have to be removed when you are walking indoors, such as in a shopping mall, since they will slip on floor surfaces.

Walkers—If walking for 20 minutes without help is a problem for you, an inside or an outside walker could be worth having. With a walker, you can go further, longer and, with some models, you can even have a seat when you want to take a rest. Many models also come with a basket for carrying packages. Special tote bags, trays, and cane and oxygen holders that attach to the walker can also be purchased.

Appropriate footwear—Comfortable shoes that provide good support can help to prevent falls. Lower heels are easier on your feet and back and are more stable for walking. Elastic laces are available to make laced shoes easier to get on and off. Beware: easy-on shoes or slippers without fitting around the heel (i.e. backless) can be dangerous; shoes with smooth, slippery soles can cause you to fall; and composition soles, such as crepe soles, can stick to carpets and cause you to trip.

Bathroom aids

Ensure that you have **non-slip surfaces** in the tub or shower. There are products available, i.e. anti-slip liquids, that can be applied directly to the tub itself to create a non-slip surface.

Bath mats on the floor beside the tub should have rubberized or non-skid backing.

Bath seats allow you to take a shower sitting down. If you have trouble standing, or if you find it difficult to lower yourself into the tub, a bath seat will help you. Some models are specially designed to make it easier to get in and out of the tub.

Grab bars and poles can be installed by the bathtub or shower and beside the toilet to provide more stability and help prevent slips and falls. Grab bars must be anchored firmly into the studs in the wall. Towel racks or soap dishes should never be used for support! Floor-to-ceiling poles, securely installed, can also help to steady you while getting out of bed or while dressing.

Hand-held shower heads can make showering easier, especially if you're using a bath seat. The shower head can also be installed with two or three mounting positions, allowing it to be used by standing or seated bathers. This type of shower head is inexpensive, widely available and relatively easy to install.

Raised toilet seats can make getting on and off the toilet easier. There are many designs available—some adjustable, some portable and some with safety/hand rails.

Kitchen aids

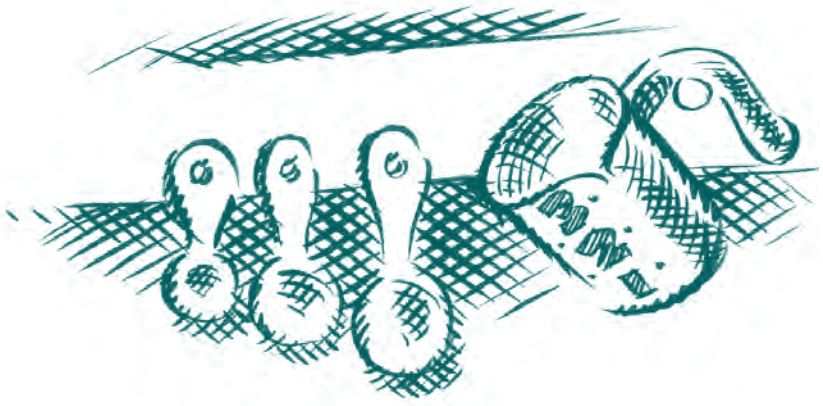
An **automatic shut-off** is featured on many appliances, such as kettles, irons, electric frying pans, toaster ovens. The switch turns the appliance off once it has been idle for a few minutes' time, eliminating the potential risk of fire.

Large-handle utensils give you a better grip. So do L-shaped knives and heavy cutlery. Find out what's available for cooking and eating safely.

Pot stabilizers consist of a wire frame that keeps pots from spinning while you're stirring the contents. Since this item holds the pot handle in place, it can also prevent the cook or any children from accidentally knocking the pot off the stove. **Pot watchers** are small ceramic disks that are inserted in the pot to prevent boiling over. These can be purchased in most kitchen gadget stores.

Stepladders can keep you from harm. Don't risk your safety reaching for an item on your top shelves. Get someone to reach for you or use a short stepladder with a grab bar.

Reachers are very useful for those who have trouble bending or reaching high places. Many have suction cups, grips or magnets on the ends to ensure a firm grip on the object to be reached.



Vision aids

There are a number of technologies available to help you with vision loss, from sunglasses to large playing cards, and from large pad touch-tone phones to magnifying glasses. Vision rehabilitation clinics and a wide range of assistive devices are available across the country in eye care centres and through the Canadian National Institute for the Blind (CNIB).

Hearing aids

Most people report significant benefits from hearing aids—in family relationships, mental health and other areas that affect the quality of their lives. Devices, such as a hearing aid, a telephone handset with built-in volume control, and a flashing light to signal when your doorbell or telephone rings, can help to compensate for loss of hearing. Keep in mind that choosing a hearing aid is a very individual process and the right device for you depends on your preferences and the nature of your hearing problem. Ask your family doctor about regular hearing testing, and if required, consult a qualified hearing health professional for the trial and purchase of a hearing aid.

Memory aids

There are a number of ways to compensate for memory loss, such as writing down information, using pictures on containers and cupboards to label contents and putting your medications in pill organizers. Some technologies are also available, such as talking clocks and vibrating watches. Important factors in stabilizing memory with age are physical activity, a healthy diet and social activities.

Other aids

Cordless and cellular telephones can be safer because the receiver can be separated from the telephone's base, eliminating the need to run telephone cords across a room or across frequently travelled areas. You can keep the phone close at hand and don't have to run to answer it; you can sit in your favourite chair while you talk.

Medication organizers (dosettes) are compartment boxes designed to help you keep track of medications. They're available in drugstores.

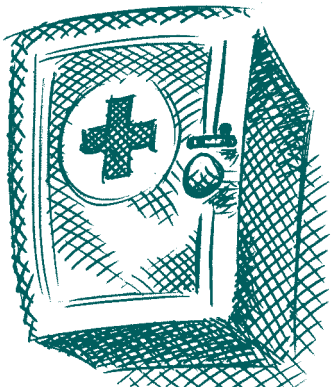
Wire/cord clips enable you to tack down electrical and telephone cords along the walls so they don't run across the floors, where they're more likely to cause you to trip. You can find these clips at most hardware stores.

Emergency response systems are communication devices that will get help for you in case of an emergency. A variety of businesses and some non-profit organizations are involved in this kind of service. The company will install the device in your home for a minimal price and then charge a monthly fee to monitor the unit. You wear a wristwatch or pendant-type of device with a call button, which you press in case of an emergency. To find out more about these devices, look in the Yellow Pages under "Medical Alarms."

First aid kits can be a godsend when there's an emergency. Make up your own first aid kit or purchase one from a reputable provider. Take note of where you keep it.

Asking for help

One of your best aids is your own voice. Don't hesitate to ask for help when you need it. Most people are delighted to be of assistance, and asking for help may well respond to your neighbours' and friends' need to be useful and to enjoy your company! All kinds of community and health services are available, for example, Meals on Wheels. Asking for help is also a way to keep safe by making your environment aware of your presence and your needs.



Peter's story

Peter is a 75-year-old veteran who was severely paralyzed in a car accident. A keen volunteer, he had enjoyed working with students at his local library. After his accident, he underwent therapy but worried that he would not regain his autonomy or remain a useful member of society. His health and spirits sagged.

The therapy paid off and he was eventually able to sit and use an electric chair. From then on, Peter began to reclaim his life. "My objective was to become useful again. At first, I was very wary of trying new gadgets and aids. I felt it made me look vulnerable."

With time, Peter learned to navigate his wheelchair with art. He also learned to use the computer to write because of his weak right hand and acquired many of the bathroom and kitchen aids that facilitate his daily activities. He started to use Meals on Wheels and has become great friends with the senior who makes the deliveries.

He returned to his volunteer work when at his request, the library gladly had the three-step entrance made level and provided facilities for him to use the washroom. He now enjoys his students again and feels very much part of the community.

"I don't care who sees me using aids anymore, I just want to stay safe. And I try to get all the help I can. It feels good knowing that my neighbours know me!"

Keeping safe through adapting your home

If you're thinking of renovating, why not consider adding a few additional safety features to your home to help make it a comfortable and safer place for years to come? Should you decide to move, the increased safety and accessibility could also be selling features. Word of mouth is often the best way to find reliable tradespeople to do renovations. Ask friends and acquaintances for information, and be sure to get price quotes from at least two potential contractors. The following suggestions will give you some ideas for your renovation planning.

Useful changes

Lighting and switches

It's important to have plenty of well-positioned and well-diffused lighting. If you're having electrical work done, consider adding lighting in high traffic areas, in stairways, in closets and over the bathroom sink and kitchen work areas. Install switches at the top and bottom of your stairs. Consider installing all switches lower on the walls if someone in your household uses a wheelchair. Rocker switches are easier to use. Dimmer switches allow you to leave certain lights on low, for example, between the bedroom and bathroom.

Electrical outlets

Adding more electrical outlets will help prevent overloading or having to run electrical cords across areas where they may be in the way. Extension cords should never be used on a permanent basis since this presents a fire hazard. Power bars can help prevent short circuits and fires.

Doors

If you plan to work on or replace a door, check the height of the door sill or threshold. It should be no more than 1/2" (13 mm) high. It may be a good idea to reduce or remove the door sill because uneven surfaces can lead to a trip or a fall. You may also want to widen doorways to accommodate wheelchairs or replace doorknobs with lever handles, which are easier to use. Also, consider the advantages of sliding or swinging doors, and doors that open outward.

Stairs

The backs of stairs should be closed in. There should be firmly anchored handrails on both sides of the stairway, which extend beyond the top and bottom steps and are mounted far enough out from the wall to allow for a solid grip. In addition, the stairway should be well lit and the steps should have a non-skid surface.

Flooring

If you're replacing flooring, use non-glare, slip-resistant flooring material. A hard floor surface or tight pile carpeting is best. Consider using the same floor surface over different areas in order to eliminate uneven surfaces.

Shelving

For efficiency and convenience in your kitchen, consider adding lower level shelves, for example, between the counter top and cupboard level. Lower cupboards, sliding shelves and lazy susans in cupboard corners put kitchen items within easier reach. You may also wish to install lower shelves in your pantry and closets.

Taps, shower heads, grab bars

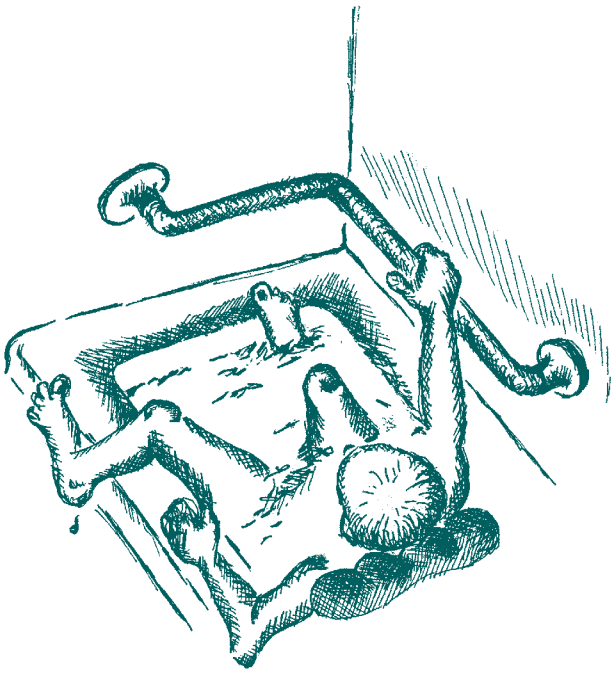
If you plan to replace your kitchen or bathroom taps, lever-type or control-arm-type faucet handles are easier to use. When you add grab bars, make sure to install them solidly on the wall studs. A hand-held shower head is easier to use when using a bath seat.

Locks and latches

Door locks in bathrooms must have an emergency release. Locks and latches should have large, easily manipulated knobs or levers. The market now has models that offer both safety and security, such as push-button or card-access locks.

Workroom

Windows and overhead lights are a must. Additional lighting should also be available over benches and stationary tools. Adequate ventilation systems are needed to vent smoke, fumes and exhaust gases. Open windows and doors may provide enough ventilation in the summer but not in the winter. The wiring must be of adequate capacity to handle lighting, heating and power tool requirements.



Stan's story

Seven years ago, when the Krzaniaks decided to have some renovations done to their home, they were thinking ahead to the future: they had a small laundry room built on the back of their three-bedroom bungalow. "When everything is on one floor, it's like living in a condominium, really," says Stan.

The Krzaniaks also added other safety features to the house. "We installed rails on both sides of the stairs to the basement. We have a total of six telephones in the house—if a telephone rings, you never have to run! We have smoke detectors and lots of lights. One thing we might add later on is rails along the hall, or wherever we've got an open wall. That's a small thing to do."

Stan recently suffered a heart attack. He now participates in mall walking to help recuperate. He has also started hiring people to do many of the outdoor chores he used to do himself—like shoveling snow and digging the garden. The Krzaniaks are fortunate to have the savings to spend this way. In Stan's opinion, it's money well spent. "I think you have to balance the benefits against the expense. If you look at the number of people who've fallen down with heart attacks while shoveling snow—why, it probably pays to get someone to do it."

The Krzaniaks feel that the precautions they're taking around the house are their way of promoting their independence for a long time to come.

You CAN prevent falls!

Falls are by far the leading cause of seniors' injuries and injury-related hospitalization in Canada. They cause pain and, for many, lead to a move from home to a care establishment. They often cost seniors their independence and quality of life. They also represent huge costs to our health system. Yet most falls incurred by seniors are preventable.

Whether you live in a house, a condo or an apartment, living safely at home requires adapting your environment, your behaviour and your lifestyle to the normal changes that age brings.

You need to make sure **your home** is safe. This may involve installing brighter lighting, moving your furniture around, uncluttering your floors, rethinking the arrangement of your storage shelves, putting in night lights or getting a good fire extinguisher.

You need to keep **yourself healthy** and active. Whatever your physical condition, it's never too late to eat well and to be more active. Consult your health professional if you're in doubt about a new diet or a new exercise program. Not only will this benefit your overall health and increase your resistance to disease, it will also help you maintain the balance and strength you need to ward off falls and serious injury at home and elsewhere.

You need to recognize that **assistive devices** and gadgets are a smart way to make your everyday life easier, independent and safe. Find out which are available and use them!

Every change you make to adapt your home and to stay healthy will help keep you from falls and injury. We hope that this guide has provided you with many suggestions that will allow you to remain safely in your own home for many years to come.

Public Health Agency of Canada
Division of Children, Seniors and Healthy Development

For more information...

Division of Children, Seniors and Healthy Development
Public Health Agency of Canada

Telephone: 1 800 O-Canada (1-800-622-6232)
TDD/TTY: 1-800-926-9105
Web site: www.publichealth.gc.ca/seniors

Other publications

- *Seniors' Falls in Canada: Second Report*
- *Bruno and Alice—A love story in twelve parts about seniors and safety*
- *12 steps to stair safety at home*
- *Stay safe! (poster)*
- *You CAN prevent falls!*
- *If you fall or witness a fall, do you know what to do?*
- *What to do after a fall… (poster)*

Home Care Services (Veterans Independence Program)

Effective Date: January 1, 2013

Purpose

This policy outlines the provision of home care services under the *Veterans Health Care Regulations*.

Policy

General

1. The Veterans Independence Program (VIP) assists eligible clients (see Eligibility for Health Care Programs – Eligible Client Groups) to remain healthy and independent in their principal residence by offering a variety of services. Home care services that may be provided to, or on behalf of, a client at the client's principal residence include:

    a. health and support services;

    b. personal care;

    c. housekeeping;

    d. access to nutrition, and

    e. grounds maintenance.

2. VIP home care services may be approved if:

    a. the services are not available to the client either as an insured service under a provincial health care system, or, if applicable, as a former member or reserve force member of the Canadian Forces;

    b. the client is resident in Canada; and

    c. the client has an identified need that impairs their ability to remain self-sufficient at their principal residence.

3. VIP home care services may be required for an indefinite period of time or intermittently based upon the client's need. In some cases, the underlying health issue may be resolved, while in other cases it is not and the need for support exists until the client enters long-term care. (See Benefit Arrangement [VIP] policy.)

Health and Support Services

4. Health and support services are diagnostic or health care interventions which are provided by a regulated health professional. (See Health Professionals policy.)

5. The list below illustrates some of the types of health and support services which may be approved, if appropriate for a client's assessed health need. The list is NOT all inclusive, but rather a guide to indicate the types of services that may be considered:

    a. nursing visits (e.g. basic wound care, health teaching, catheter and ostomy care and pain management);

    b. nursing foot care, and

    c. occupational therapy.

6. Prior to approving health and support services, a comprehensive assessment must have been completed within the last three months by a qualified individual to determine the client's need for the health and support services. Refer to Requirements for Decision Making and Determination of Need for guidance on the necessary documentation and action required.

7. When a client has eligibility for both Treatment Benefits and the VIP, the provision of health and support services should first be considered under Treatment Benefit policies and procedures. The Treatment Benefits Nursing Services policy sets out the criteria for the provision of nursing services, regardless if the service is provided as a Treatment Benefit or a VIP Health and Support service.

Personal Care Services

8. Personal care services are services provided by someone other than a health professional. Such services may include:

    a. those services required to aid or assist in the performance of the activities of daily living; or

    b. supervision required by a client who cannot be left unattended.

9. Prior to approving personal care services, a comprehensive assessment must have been completed within the last three months by a qualified individual to determine the client's need for the personal care services. Refer to Requirements for Decision Making and Determination of Need for guidance on the necessary documentation and action required.

10. When selecting a personal care provider, a client should be advised that registered service providers are highly recommended and preferred because they must meet certain qualifying criteria to register with the third party contractor, and they can be paid directly instead of the client being out-of-pocket for the expenses. Registration assures a certain degree of competency.

11. A client who uses a non-registered service provider (e.g. a friend, neighbour, etc.) should be advised that there may be risk involved. For example, non-registered service providers may not be properly trained, or the client may be required to pay for the services in advance and then wait to be reimbursed. Where existing clients are using non-registered service providers, every effort should be made to transition them to a registered service provider.

Attendance Allowance Recipients

12. Personal care services provided by non professionals/unregulated workers are available to eligible clients under two programs: the VIP and/or Attendance Allowance under the *Pension Act*.

    a. If a client is receiving Attendance Allowance, the maximum amount available for personal care services under VIP cannot exceed 59 days per calendar year. A "day" is defined as the actual personal care service needs of a client within a 24 hour period. For example, one client may require two hours of personal care service per day, and another client may require eight hours of personal care service per day. Both of these cases would be considered a "day".

    b. A client who has applied for Attendance Allowance may continue to receive up to the maximum yearly amount for personal care VIP services until a decision is made on the Attendance Allowance application.

    c. Once a client receiving personal care services under VIP is approved for Attendance Allowance, the client may continue to receive VIP personal care services for a maximum of 59 days, from the date of approval of Attendance Allowance to the end of the calendar year.

Housekeeping Services

13. Housekeeping services are:

a. routine tasks or domestic chores to assist with daily living; and

b. certain other non-routine tasks or domestic chores required as a result of a client's health and safety being at risk.

Routine Housekeeping Services

14. Under housekeeping services, financial contributions (as calculated by the Annual Grant Determination Tool) toward the cost of routine tasks or domestic chores may be approved. Following is a list of some examples of routine tasks or domestic chores:

    a. laundry, ironing and mending;

    b. making and changing beds;

    c. general cleaning, vacuuming, scrubbing, dusting, appliance cleaning;

    d. meal preparation;

    e. washing and changing windows;

    f. errand services to purchase food, do banking and pay bills when the client is unable to do so; and

    g. routine tasks such as changing fuses, changing batteries in smoke detectors, etc.

    While the above list is not all inclusive, it establishes the scope of those types of services that may be provided. Other routine tasks or domestic chores may be approved, at the discretion of the decision-maker, on a case-by-case basis.

Non-routine Housekeeping Services

15. Under housekeeping services, financial contributions (as calculated by the Annual Grant Determination Tool) toward the cost of non-routine tasks or domestic chores may be approved if the health and safety of the client is at risk. Following is a list of examples of non-routine tasks or domestic chores:

    a. washing walls and ceilings when environmental pollution is a factor (i.e. wood is the primary fuel source, and the client requires a relatively dust-free environment);

    b. shampoo/steam cleaning carpets and furniture, or professional drapery cleaning may be necessary for clients suffering from respiratory conditions, skin allergies, incontinence, etc.;

    c. chimney cleaning if a fire hazard exists;

    d. furnace and duct cleaning for a client requiring a relatively dust-free environment;

    e. cleaning attics, basements, and garages, if a fire hazard exists;

    f. extermination/fumigation for the presence of rodents, infestation of fleas or ticks, etc.; or

    g. industrial cleaning where the lack of cleanliness is to the point that service providers cannot, or refuse to, enter the home until it is professionally cleaned.

    While the above list is not all inclusive, it establishes the scope of those types of services that may be provided. Other non-routine tasks or domestic chores may be approved, at the discretion of the decision-maker, on a case-by-case basis.

16. If necessary, the decision maker may seek medical advice to determine if the health and safety of the client is at risk.

Access to Nutrition Service

17. Access to nutrition service is ensuring clients have access to nutritional prepared food, whether it is delivered to the client's principal residence, offered in the community or served at a local restaurant. Access to nutrition services covers the cost, up to the maximum per meal rate, for the:

    a. delivery of prepared meals to the client if the reimbursement is for the delivery charge which, ideally, should be clearly indicated on the invoice; or

    b. transportation of the client to access prepared meals, such as transportation to a local restaurant or community facility.

18. Financial contributions toward the cost of access to nutrition services do not cover the cost of the prepared meal. The only exception is where the cost of the food and the transportation cost may be considered as one cost (as an example, meals-on-wheels type programs). In these cases:

    a. the invoice may be paid as billed up to the maximum per meal rate; or

    b. if multiple meals are included in a single delivery and the delivery charges cannot be separated, the client may claim reimbursement for each meal, up to the maximum per meal rate.

19. If Access to Nutrition service is unavailable to a client (e.g. a client lives in a remote location) meal preparation support under the housekeeping service could be considered (see paragraphs 13-14).

Grounds Maintenance

20. Grounds maintenance provides the necessary services required in support of the client's independent living at their principal residence when:

    a. the maintenance is the client's responsibility and would normally be performed by the client were it not for the client's limiting health condition; and

    b. there are no relatives living at the client's principal residence capable (i.e. willing and able) of performing the grounds maintenance. (See Client Relatives (VIP) policy.)

21. Grounds maintenance services are those regularly required to maintain the grounds immediately surrounding the client's principal residence. Subject to the requirements set out in paragraph 20, a financial contribution (as calculated by the Annual Grant Determination Tool) toward the cost of the following grounds maintenance services may be approved:

    a. Tilling ground to enable the client to plant a small flower or vegetable garden;

    b. Removing snow and ice from steps, walkways and driveways to allow safe access to the principal residence;

    c. Removing snow and ice from roofs and eaves troughs, when such conditions pose a threat to the client’s safety and access;

    d. Cleaning leaves and debris from eaves troughs;

    e. Mowing and raking lawn, sweeping leaves from pathways, trimming hedges and shrubs;

    f. Pruning or removing trees which pose a threat to the client’s safety and access; and

    g. Blocking, splitting and stacking firewood, when wood is, and continues to be, the main source of heat and the work was previously performed by the client.

While the above list is not all inclusive, it establishes the scope of those types of services that may be provided. Other reasonable grounds maintenance services normally performed by the client may be

approved, at the discretion of the decision-maker, on a case-by-case basis.

When a Facility Considered the Client's Principal Residence Provides Home Care Services

Note: When a person is receiving VIP intermediate care or long-term care as an eligible client, their accommodation does not constitute a principal residence.

22. Some clients live in facilities, considered their principal residence, where home care services are provided as part of the monthly fee agreement. Although the services are provided by the facility, the Department may compensate the client for the cost of certain services if the services are performed as a direct, individual service to the client.

23. Financial contributions toward the cost of the health and support, personal care, or cleaning the client's personal living quarters, including making and changing the bed, may be considered if:

    a. a current client assessment identifies a need for the service provided;

    b. the duration and cost of the service can be identified on an individual client basis, and

    c. the cost of the service is equal to or less than the standard rate for similar services in the area.

24. If the service provider is unable to break down the cost of the VIP services indicated in paragraph 23, the Department may determine the amount of the financial contribution by taking the amount of hours that is deemed necessary to provide the services according to the current assessment and multiplying those hours by the standard rate for a similar service in the area.

25. Financial contributions toward access to nutrition service may only be considered if a client is billed separately and specifically for meal delivery or transportation to a meal.

26. Financial contributions toward the cost of services that do not provide a direct, individual benefit to the client will not be considered. For example:

    a. Grounds maintenance service is not the responsibility of the client and would not normally be performed by the client in these situations. In addition, this service is not performed as a direct, individual benefit for the client, but rather the entire facility.

    b. Meal service reflects the cost of the food and its preparation rather than the cost of accessing it. In addition, this service is not performed as a direct, individual benefit for the client, but rather the entire facility.

When a Facility Considered the Client's Principal Residence Does Not Provide Home Care Services

27. If a client lives in a facility considered their principal residence and the facility does not provide home care services, the client is eligible to receive a financial contribution for home care services in the same manner as if they were living in a traditional principal residence.

Temporary Absences

28. Housekeeping and grounds maintenance services may continue to be required when a client is temporarily absent from their principal residence. Financial contributions toward these services:

    a. may continue for periods of absence for treatment or respite.

        i. This arrangement may continue uninterrupted for up to 30 days.

        ii. If after 30 days the client has not returned to the principal residence, the case must be reviewed to determine the likelihood of the client returning.

        iii. If the client's return to the principal residence continues to be a potential outcome, the

Benefit Arrangement may be extended; however, if it is determined that the client requires permanent long-term care, the home care services of the Benefit Arrangement must be terminated immediately. If a client's Benefit Arrangement requires termination and the primary caregiver's eligibility for an extension of services is being considered, care should be taken to avoid a break in service, if possible. (See Termination of Benefits, Services and Care policy and Primary Caregivers (VIP) policy, if applicable.)

b. may not continue for periods of absence for extended periods of time (e.g. snowbirds). In these cases, Benefit Arrangements for these services are suspended during the client's absence.

29. Health and support, personal care, and access to nutrition services are not required when the clients are temporarily absent from their principal residence. In these cases, Benefit Arrangements for these services are to be suspended during the absence.

Client Relatives

30. Relatives of a client who reside in the client's principal residence are not usually paid to provide home care services; however, they may be paid in exceptional circumstances. (See Client Relatives (VIP) policy)

31. Relatives of a client living outside the client's principal residence may be paid to provide home care services and are to be treated like any other service provider in the community.

Primary Caregivers and Survivors (see Primary Caregivers (VIP) and Survivors (VIP) policies.)

32. Primary caregivers and survivors are eligible for the home care services of housekeeping and/or ground maintenance if they meet the necessary eligibility requirements.

33. Eligible primary caregivers and survivors may receive the housekeeping services described in paragraph 14 and in paragraph 15 if the specific criteria are satisfied.

34. Primary caregivers and survivors are not eligible for health and support, personal care, or access to nutrition services.

Rates Payable for Home Care Services

35. Subject to exceeding rates, the maximum rates payable for VIP Home Care services are outlined in Maximum Rates Payable for Veterans Independence Program and Long-term Care Program Services. These rates are adjusted annually, effective January 1.

References

Pension Act

Veterans Health Care Regulations

Health Professionals policy

Nursing Services (POC 8) policy

Foot Care Services (POC 8) policy

Nurse Visits (POC 8) policy

Benefits Arrangement (VIP) policy

Principal Residence (VIP) policy

Client Relatives (VIP) policy

Primary Caregivers (VIP) policy

Survivor (VIP) policy

Termination of Benefits, Services or Care policy

Exceeding Rates (VIP and LTC) policy

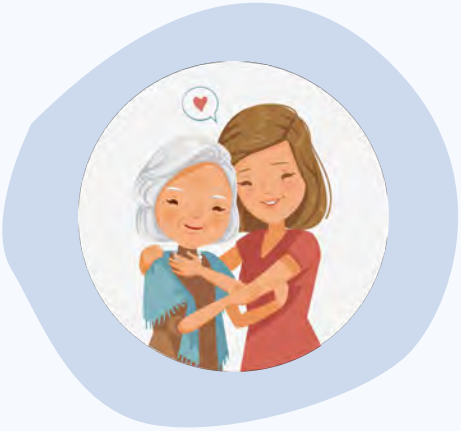
Eligibility for Health Care Programs – Eligible Client Groups

HOW DO I... ACCESS HOME CARE SERVICES?

DEMENTIA PATIENT NAVIGATOR PROGRAM

HELPING YOU TO AGE IN PLACE

ASSISTANCE WITH HOUSEHOLD TASKS



RELIEF FOR CARE PARTNERS

ASSISTANCE WITH PERSONAL CARE

IS THERE FINANCIAL ASSISTANCE TO HELP ME PAY FOR HOMECARE?

YOU MAY APPLY TO DEPT. OF SOCIAL DEVELOPMENT TO SEE IF YOU QUALIFY FOR A SUBSIDY.

UNB UNIVERSITY OF NEW BRUNSWICK

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

www.socialsupportsnb.ca

1-833-733-7835

HOW DO I...

TAKE CARE OF MYSELF?

DEMENTIA PATIENT NAVIGATOR PROGRAM

CARE PARTNER SUPPORT

- Learn as much as you can about the disease
- Share diagnosis with family and friends
- Ask for help

- Regular checkups with your doctor
- Eat properly
- Exercise and rest
- Respite care
- Support groups

CONTACT YOUR LOCAL ALZHEIMER SOCIETY!

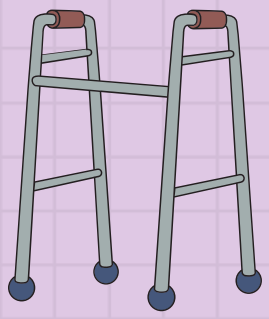
www.alzheimer.ca

1-800-664-8411

UNB UNIVERSITY OF NEW BRUNSWICK

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

EQUIPMENT RENTALS & INFORMATION



To best find out what equipment you may need, reach out to an occupational therapist or physiotherapist. Can be seen either privately, through your local hospital or by ExtraMural.
Equipment can be rented from certain drug stores, your local Red Cross or purchased from retailers. For rentals, you may need a note from your Dr., physiotherapist or member of your care team. Some equipment may be covered under private insurance, check before buying.

1

ABILITY NB

1-866-462-9555
Non-Profit that can assist people who are dealing with mobility disabilities.

2

VETERANS DISABILITY BENEFITS

1-866-522-2122(english)
1-866-522-2022(french)
If you have served or are currently serving and need more information, contact regarding what/how you qualify.

3

EASTER SEALS

1-888-280-8155
The Easter Seals Equipment Rental Program can help with long-term rentals. Can be reached through their website:
https://www.easterseals.nb.ca/index.php/en/inner-page/personal-services-program-psp

4

FIRST NATIONS

1-800-567-9604
The First Nations and Inuit Health Branch can help community members who are struggling with their mobility.
Can also be reached at:
https://www.sac-isc.gc.ca-eng/1569861171996/1569861324236

5

HEALTH SERVICES PROGRAM

1-833-733-7835
Program is for low income New Brunswickers, to assist them with getting medical supplies and equipment (such as wheelchairs, compression socks, hearing aids, vision care, ostomy supplies, etc.)
Can also be reached at:
https://socialsupportsnb.ca/en/complex_page/health-services

6

PARKING PERMITS

1-888-762-8600
Complete the form and part of the form is completed by your Dr, physiotherapist or Nurse Practitioner to receive a parking permit/placard.

Amplifying Device on Amazon.ca

- 

Williams Sound Pocket Talker Ultra with Single Minibud and Headset, 0.42 Kg

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$155.00

- Housed in an abs plastic impact resistant plastic silver case with a removable battery door. Tone control: external rotary control knob to allow user to optimize hearing
- Microphone: omnidirectional, electret microphone assembled in housing with foam wind
- Weight: 2.5-ounce (70.9 Grams) (with batteries and microphone). Low battery indicator: red light on top panel flashes
- Color/Material: silver gray, abs/polycarbonate molded plastic case. Battery type: two 1.5v (Aaa size) alkaline. Battery life: 100 hours (typical usage)

Answer the statements in this pamphlet and bring it to your primary care provider to discuss your concern about falling.

To help you stay independent and prevent falls:

Your provider may ask you about:

- previous falls
- if you feel unsteady when standing or walking
- how you manage your daily activities
- if you are worried about falling

Your provider may ask about your:

- vision and hearing
- medications
- calcium and vitamin D
- blood pressure, heart rate and rhythm
- muscle strength
- feet and footwear
- bladder control
- ability to move around and balance

Did you know?

- Half of older adults who have fallen before are afraid of falling again.
- Falls usually happen due to a factor or combination of factors that can be prevented.
- The more risk factors a person has, the greater their chances of falling.

For more information, consult with your primary care provider and/or visit:

NB Trauma Program
Programme de traumatologie du NB

www.NBTrauma.ca

Finding Balance

www.FindingBalanceNB.ca

New Brunswick Medical Society
Société Médicale du Nouveau-Brunswick

www.nbms.nb.ca

202007v2

STAYING CONFIDENT

Fear of falling can lead to an increased risk of having a fall.

ARE YOU CONCERNED ABOUT FALLING?

NB Trauma Program
Programme de traumatologie du NB

We would like to ask some questions about how concerned you are about the possibility of falling.

Please reply thinking about how you usually do the activity. If you currently don't do the activity (e.g. if someone does your shopping for you), please answer to show whether you think you would be concerned about falling IF you did the activity. For each of the following activities, please tick the box which is closest to your own opinion to show how concerned you are that you might fall if you did this activity.

		NOT AT ALL CONCERNED 1	SOMEWHAT CONCERNED 2	FAIRLY CONCERNED 3	VERY CONCERNED 4
1	Cleaning the house *(e.g. sweep, vacuum or dust)*	1 ☐	2 ☐	3 ☐	4 ☐
2	Getting dressed or undressed	1 ☐	2 ☐	3 ☐	4 ☐
3	Preparing simple meals	1 ☐	2 ☐	3 ☐	4 ☐
4	Taking a bath or shower	1 ☐	2 ☐	3 ☐	4 ☐
5	Going to the shop	1 ☐	2 ☐	3 ☐	4 ☐
6	Getting in or out of a chair	1 ☐	2 ☐	3 ☐	4 ☐
7	Going up or down stairs	1 ☐	2 ☐	3 ☐	4 ☐
8	Walking around in the neighbourhood	1 ☐	2 ☐	3 ☐	4 ☐
9	Reaching for something above your head or on the ground	1 ☐	2 ☐	3 ☐	4 ☐
10	Going to answer the telephone before it stops ringing	1 ☐	2 ☐	3 ☐	4 ☐
11	Walking on a slippery surface *(e.g. wet or icy)*	1 ☐	2 ☐	3 ☐	4 ☐
12	Visiting a friend or relative	1 ☐	2 ☐	3 ☐	4 ☐
13	Walking in a place with crowds	1 ☐	2 ☐	3 ☐	4 ☐
14	Walking on an uneven surface *(e.g. rocky ground, poorly maintained pavement)*	1 ☐	2 ☐	3 ☐	4 ☐
15	Walking up or down a slope	1 ☐	2 ☐	3 ☐	4 ☐
16	Going out to a social event *(e.g. religious service, family gathering or club meeting)*	1 ☐	2 ☐	3 ☐	4 ☐
	Subtotal				

Add up the number of points for each column in the corresponding subtotal. Then, add up each of the 4 subtotals to obtain your total score. If you scored 28 points or more, you may have a high level of concern about falling. Answer the statements above and bring this pamphlet to your primary care provider to discuss your concern about falling.

Total _____

This checklist was developed in a collaborative effort with members of the Prevention of Falls Network Europe (ProFaNE) and is a validated self-assessment tool (Yardley L, Todd C, et al. Development and initial validation of the Falls Efficacy Scale-International (FES-I) *Age and Aging* 2005; 34(6): 614-619).

Answer the statements in this pamphlet and bring it to your primary healthcare provider to discuss your risk factors.

To help you stay independent and prevent falls:

Your provider may ask you about:

- previous falls
- if you feel unsteady when standing or walking
- how you manage your daily activities
- if you are worried about falling

Your provider may ask about your:

- vision and hearing
- medications
- calcium and vitamin D
- blood pressure, heart rate and rhythm
- muscle strength
- feet and footwear
- bladder control
- ability to move around and balance

Did you know?

- Staying fall-free can help you to stay independent and help delay the need to enter a long-term care facility.
- Falls usually happen due to a factor or combination of factors that can be prevented.
- The more risk factors a person has, the greater their chances of falling.

For more information, consult with your primary care provider and/or visit:

NB Trauma Program
Programme de traumatologie du NB

www.NBTrauma.ca

Finding Balance

www.FindingBalanceNB.ca

New Brunswick Medical Society
Société Médicale du Nouveau-Brunswick

www.nbms.nb.ca

202007v2

STAYING INDEPENDENT

Falls are a main reason many older adults lose their independence.

ARE YOU AT RISK?

NB Trauma Program
Programme de traumatologie du NB

Check Your Risk for Falling

Circle "Yes" or "No" for each statement below			Why it matters
Yes (2)	No (0)	I have fallen in the past 6 months.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	Strengthening your leg muscles can reduce your risk of falling and being injured.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.

Total _____

Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Answer the statements above and bring this pamphlet to your primary healthcare provider to discuss your risk factors.

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fa ll risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499). Adapted with permission of the authors.

Learning

New Brunswick Community College (Saint John).....506-460-6222
READ Saint John.....506-633-2011
Saint John Learning Exchange.....506-648-0202
Senior Watch Inc./CARE-ED Learning.....506-634-8906
University of New Brunswick, Saint John.....506-648-5500

Legal Supports

Elizabeth Fry Society.....506-635-8851
Family Law Information Line.....1-888-236-2444
John Howard Society.....506-657-5547
Legal Aid Saint John.....506-633-6030
New Brunswick Human Rights Commission.....1-888-471-2233
Public Legal Education and Information Service of New Brunswick
.....1-888-236-2444

Medical Alert

Canadian MedicAlert Foundation.....1-800-668-1507
Saint John Regional Hosp. Auxiliary, Lifeline Program 506-648-6692
Security Pro.....1-866-266-1072
Vial for Life (Saint John Fire Department).....506-658-2962

Recreation/Leisure

Canada Games Aquatic Centre.....506-658-4715
Carleton Community Centre.....506-658-2920
City of Saint John, Growth and Community Services, Seniors Programming/Events.....506-658-4455
Libraries:
- East Branch.....506-643-7250
- Main Branch (Market Square).....506-643-7220
- West Branch.....506-643-7260
- Kennebecasis Valley.....506-849-5314
- Samuel de Champlain.....506-658-4610

Market Place Wellness Centre 506-674-4335
Nick Nicolle Community Centre.....506-658-2980
Recreation/Leisure, Municipal Departments
- Hampton.....506-832-1565
- Quispamsis 506-848-5900
- Rothesay.....506-848-6600
- Saint John.....506-658-2908

Royal Canadian Legion, NB Command.....506-634-8850
Saint John Arts Centre.....506-633-4870
Seaside Lawn Bowling Club.....seasidelawnbowling@gmail.com
Seniors Shuffleboard League.....506-672-8666
Seniors' Resource Centre.....506-633-8781
Walks n' Talks 506-672-8601
YMCA.....506-693-9622

Social Supports

Centenary Queen Square Centre.....506-693-8080
Loch Lomond Villa, Seniors Outreach Program....643-7175 ext 6949
Saint John and Fundy Region Seniors Inc.....506-647-8872/652-2180
Salvation Army Family and Community Services.....506-634-1633
Seniors' Resource Centre.....506-633-8781
The HIVE Seniors Resource Centre (KV).....506-799-9240

Transportation

A2B Transportation.....506-631-0968
Handi-Bus.....506-648-0609
Saint John Transit Commission.....506-658-4700

Thank you to our sponsors:

2024-2025 Seniors' Directory

Produced By:

HUMAN DEVELOPMENT COUNCIL

Abuse/Assault

Domestic Violence Outreach.....506-566-5960 / 506-632-5616
Emergency.....911
Hestia House.....506-634-7570
Police (Non-Emergency):
Kennebecasis Regional Police.....506-847-6300
Saint John Police Force.....506-648-3333
Sexual Assault Response Team.....506-634-8295 ext. 214

Advocacy and Counselling:

Alzheimer Society, New Brunswick Info Line.....1-800-664-8411
Saint John Branch.....506-634-8722
Arthritis Society, Info line.....1-800-321-1433 ext. 3307
Canadian Cancer Society.....506-634-6272
Canadian Mental Health Association, Saint John.....506-633-1705
CHIMO Suicide Crisis Line Inc.....1-800-667-5005
CNIB (Vision Loss Rehabilitation).....506-634-7277
Community Mental Health Services, Saint John.....506-658-3737
Compassionate Grief Centre.....506-696-0202
Diabetes Canada (New Brunswick Branch).....1-800-505-5525
Family Plus/Life Solutions.....506-634-8295
Gentle Path Counselling.....506-652-7284
Heart and Stroke Foundation.....506-634-1620
Horizon Health Mobile Crisis Services.....1-888-811-3664
Multiple Sclerosis Society of Canada.....1-800-268-7582
NB Deaf and Hard of Hearing Services.....506-633-0599 ext. 4
NB Office of the Ombud.....1-888-465-1100
NB Office of the Seniors' Advocate.....1-888-465-1100
Osteoporosis Canada.....1-800-463-6842
Parkinsons Canada.....1-800-565-3000
Ridgewood Addiction Services (Saint John).....506-674-4300
Seniors Information Line.....1-855-550-0552
Seniors' Resource Centre.....506-633-8781
St. Joseph's Community Health Centre.....506-632-5537

Financial Assistance

Income Tax Assistance (Year-Round):
Nick Nicolle Community Centre.....506-658-2980
PULSE.....506-632-6807
Salvation Army.....506-634-1633
Seniors' Resource Centre.....506-633-8781
Canada Revenue Agency:
Canada Pension Plan-Old Age Security.....1-800-277-9914
.....TTY-1-800-926-9105
GST/HST.....1-800-387-1193
.....TTY..1-800-665-0354
Income Tax Enquiries.....1-800-959-8281
TTY 1-800-255-4786
Credit Counselling Services of Atlantic Canada.....506-652-1613
Financial and Consumer Services Commission.....1-866-933-2222
Saint John Police Fraud Unit.....506-648-3333
New Brunswick Justice and Consumer Affairs.....1-866-933-2222
New Brunswick Prescription Drug & Seniors' Health Benefit Programs.....1-800-332-3692
Office of the Public Trustee.....1-888-336-8383
Veterans Emergency Transition Services (VETS).....1-888-228-3871

Food

Food Banks:
Community Food Basket.....506-652-2707
Kennebecasis Valley Food Basket.....506-847-5854
Lakewood Headstart Association.....506-696-6164
North End Food Bank.....506-634-7403
Saint John East Food Bank.....506-633-8298
West Side Food Bank.....506-635-1060
Food Purchase Clubs/Produce Packs:
Carleton Community Centre.....506-658-2920
Crescent Valley Resource Centre.....506-693-8513
Nick Nicolle Community Centre.....506-658-2980
PULSE.....506-632-6807
St. Joseph's Community Health Centre.....506-632-5537
St. Mary's St Bartholomew's Church.....506-696-1347
Meals on Wheels:
Community Meals on Wheels Saint John Inc.....506-658-1888
Sobeys Home Delivery.....506-652-4470
Romero House.....506-642-7447
Other Food/Clothing:.....Contact Local Churches

Government Departments

Department of Social Development 1-833-733-7835
Residential Tenancies Tribunal.....1-888-762-8600
Service Canada.....1-800-622-6232
Service New Brunswick.....1-888-762-8600
Veterans Affairs Canada.....1-866-522-2122

Health/Home Care

Assessments Plus.....506-847-7577
Bayshore Home Care Solutions.....506-633-9588
Canadian Red Cross, Saint John.....506-674-6200
Extra Mural Programs.....1-888-862-2111
Integrity Home Health Services.....506-657-1273
Kindred Home Care.....506-651-4726
NB Drugs and Prescription.....1-833-733-7835
Quality Respiratory Care Inc.....506-638-8401
Senior Watch Inc/CARE-ED Learning.....506-634-8906
Tele-Care.....811
Prescription Delivery:
Jean Coutu (University Ave).....506-696-0000
KV Guardian Drugs/Pharmacy.....506-847-7581
Lawtons Home Health Care.....1-866-990-1599
Rexall Pharmacy, Saint John.....506-674-4444
Shoppers Drug Mart (Crown Street).....506-636-9610
Clinics/Hospitals:
After Hours/Walk-In Clinics:
KV Medical Clinic.....506-849-2273
University Avenue After Hours Medical Clinic.....506-657-9355
West Side Medical Clinic.....506-693-2273
Loch Lomond Villa, Seniors Wellness Centre.....506-643-7139
Market Place Wellness Centre 506-674-4335
New Brunswick Heart Centre.....506-648-7782
North End Wellness Centre (NEW-C).....506-649-2704
Ridgewood Veteran's Health Wing.....506-635-2420
Saint John Regional Hospital.....506-648-6000
St. Joseph's Community Health Centre.....506-632-5537
St. Joseph's Hospital.....506-632-5555
Willow Grove Health Care.....506-721-1962
Health Equipment:
Metro Health Services.....506-648-6150
Red Cross Seniors Specialized Equipment Program.....506-674-6200
Tango Medical.....1-877-854-8842
Foot Care:
Integrity Home Health Service.....506-657-1273
Jackie's Foot Care.....506-696-7672
Orthopaedics Plus.....506-633-1312
Senior Watch Inc.....506-634-8906
Thera-Ped Foot and Ankle Clinic.....506-632-9397

Housing

Home First Program.....1-855-550-0552
Home Insulation Energy Saving Program, NB Power 1-800-663-6272
Independent Living:
Carleton Kirk Lodge Inc.....506-643-7040
Chateau de Champlain.....506-633-1195
Hillcrest Village.....506-858-7870
Parkland Saint John.....506-633-7275
Kings Way Care Centre.....506-847-1131
Loch Lomond Villa.....506-643-7100
Nursing Homes:
Dept. of Social Development for application...1-833-733-7835
Subsidized Housing:
NB Housing.....1-833-733-7835
Emergency Shelters and Community Housing Supports:
Coverdale Centre for Women.....506-634-1649
Fresh Start Services for Women.....506-638-1409
Housing Alternatives.....506-632-9393
Outflow Men's Shelter.....506-658-8050
Saint John Non-Profit Housing.....506-658-1925
Residential Tenancies Tribunal.....1-888-762-8600

Other

AVENIR Hearing (KV).....506-847-3030
Avenue B Harm Reduction (substance use).....506-652-2437
Bobby's Hospice.....506-632-5593
Breast Screening (St. Joseph's Hospital).....506-632-5555
Centenary Queen Sq. Care Centre, Adult Outreach Centre.....
.....506-657-6681
St. Luke's Anglican Outreach Programs.....506-693-4152
Lifemark Total Ability Inc. (Occupational Therapy and Speech Language Pathology Services).....506-847-0677 / 1-877-784-5353
Medicare NB.....1-888-762-8600
New Beginnings Relocation Services.....506-333-1554
Public Health, Saint John Office.....506-658-2454
RECAP (Hepatitis C prevention and treatment).....506-657-5699
Sexually Transmitted Infections Info Line.....811

Websites and Telephone Numbers for Seniors' Services:

Sites web et numéro téléphone pour services aux ainées:

NB Home Support Association : (1-833-733-7835)
Liens et ressources | Association de Soutien a Domicile | Nouveau-Brunswick (nbhsa.ca)

ASNB (1-800-664-8411):
First Link® | Alzheimer Society of New Brunswick

Calculatrice en ligne évaluation financière ou contacter DS (1-833-733-7835):
Home (force.com)

Programme de soins de longue durée de Soutiens sociaux NB (1-833-733-7835):
Soutiens sociaux NB | Gouvernement Nouveau Brunswick

Formulaire en ligne ou contacter DS (1-833-773-7835):
Home (force.com)

Crédit d'impôt pour personne handicapée ARC (1-800-959-8281):
Crédit d'impôt pour personnes handicapées (CIPH) - Canada.ca

Dépenses médicales ARC (1-800-959-8281):
Détails des frais médicaux - Canada.ca

La préservation de l'autonomie et la prévention des chutes (Trauma NB):
Home - Fall Talk

Plan de médicaments sur ordonnance pour les aînés croix bleu medavie (1-800-332-3692):
Programme de soins de santé pour les aînés | Croix Bleue Medavie (medaviebc.ca)

Extra-mural NB ((1-888-862-2111):
New Brunswick Extra-Mural Program (extramuralnb.ca)

Ability NB/Capacité NB (506-462-9555):
Ability New Brunswick (abilitynb.ca)

Prestations d'invalidité pour anciens combattants Canada (1-866-522-2122-A 1866-522-2022-F):
Prestations d'invalidité - Anciens Combattants Canada (veterans.gc.ca)

Programme de prêt d'équipement medical (HELP) Richibucto 506-523-4479, Moncton 506-863-2650):
Programme de prêt d'équipement médical (HELP) - Croix-Rouge canadienne (croixrouge.ca)

Programme de véhicules adaptés (1-866-462-9555) :
APPLICATION FOR CAPITAL ASSISTANCE (snb.ca)

Programme de véhicules adaptés :
Programme de véhicules adaptés (pour personnes handicapées) (gnb.ca)
Programme de réadaptation en déficience visuelle (Bathurst : 505-546-9922, Moncton : 506-857-4240)
Accueil | Réadaptation en déficience visuelle Canada (visionlossrehab.ca)

Soutiens sociaux NB programme de soins de longue durée (1-833-733-7835) :
Soutiens sociaux NB | Gouvernement Nouveau Brunswick

Aide médicale à mourir Horizon (1-844-225-0220) :
Aide médicale à mourir - Réseau de santé Horizon (horizonnb.ca)

Canada Death Benefit (1-800-277-9914):
Canada death benefit - Search (bing.com)

Support groups in NB:
Provincial-Resources_NB_FWD_EN_PDF.pdf (forwardwithdementia.ca)

Older Drivers:
Older Drivers | NHTSA

Clinical Assessment of Driving Related Skills:
older.pdf (virginia.gov)

Alzheimer Products:
Alzheimer's Products | Activities | Wandering | Safety (alzstore.com)

Assist devices for wandering patient:
Assistive Devices, Mobility Aids, Disability Aids, Senior Aids - Seniors Store -

Fall prevention:
Assistive Devices, Mobility Aids, Disability Aids, Senior Aids - Seniors Store -

End-of-Life video:
iGeriCare | Palliative Care and End-of-Life Planning (healthhq.ca)

Medications with dementia:
iGeriCare | Medications & Dementia (healthhq.ca)

Dementia talk App:
Dementia Talk App - Dementia Carers

Geriatric consent:
iGeriCare | Consent, Capacity, and Care Planning (healthhq.ca)

Stigma and dementia:
iGeriCare | Stigma & Dementia (healthhq.ca)

Risk of fall dementia:
iGeriCare | Risk of Falls in Dementia (healthhq.ca)

Indigenous and dementia:
I-CAARE | Factsheets

How to diagnose dementia:
iGeriCare | How Dementia is Diagnosed (healthhq.ca)

Delirium and confusion:
iGeriCare | Delirium and Confusion in the Hospital (healthhq.ca)

The stages of dementia:
iGeriCare | The Stages of Dementia (healthhq.ca)

Coping with care giving:
iGeriCare | Coping with Caregiving - Providing Effective Care for a Person with Dementia (healthhq.ca)

Responsive behaviours with a person with dementia:
iGeriCare | Understanding & Managing Responsive Behaviours in Persons with Dementia (healthhq.ca)

Dementia App:
Dementia Advisor App - Dementia Carers

Understanding the challenges with a person with dementia:
iGeriCare | Understanding the Challenges of Communication with Persons with Dementia (healthhq.ca)

How to respond to a person asking to go home:
Shifting focus: "I want to go home" - YouTube

Caregiver's Guide to Understanding dementia behaviours:
Caregiver's Guide to Understanding Dementia Behaviors - Family Caregiver Alliance

Healthy eating:
Healthy eating - Specific diets | Heart and Stroke Foundation

Young onset of dementia:
Young onset dementia | Alzheimer Society of Canada

Rare types of dementia:
Rare types of dementia | Alzheimer Society of Canada

Conditions related to dementia:
Conditions related to dementia | Alzheimer Society of Canada

Mindfulness and brain health:
Mindfulness and Brain Health | (kateswaffer.com)

Dementia and dairies:
John Quinn from Australia - This is me - Dementia Diaries

Alzheimer Society of NB:
Alzheimer Society of New Brunswick

Positive self talk:
What is Positive Self-Talk? (Incl. Examples) (positivepsychology.com)

You don't look like you have dementia video:
DAI Master Class: "But you don't look like you have dementia" - YouTube

My conversation with my doctor video:
Master Class 2: My Conversation with My Doctor - YouTube

Taking action against stigma:
Dementia | Flipping Stigma Tool Kit

My Carer video:
My Carer - Alzheimer's Society - YouTube

Stop fall risks at home:
Risks Archive » Home FAST (stopfallsathome.com.au)

Red Cross stay connect:
Connection New Brunswick - A Red Cross Project

7 reasons to make a will:

7 important reasons to make a will right now (and what happens if you die without one) | Alzheimer Society of Canada

24 Hour Movement Guidelines:
Downloads – 24-Hour Movement Guidelines (csepguidelines.ca)

Health & Aging (Seniors Health):
Health and Aging (Seniors Health) - Horizon Health Network (horizonnb.ca)

Dementia your companion guide:
https://767b071f.flowpaper.com/DementiaPt1excerpt13MAY2021/#page=1

Appui proches aidants:
Dossier Alzheimer et maladies neurodégénératives - L'Appui (lappui.org)

Aging Care:
Understanding Anosognosia in Dementia Patients - AgingCare.com

Medications side effects:
Types of Medications Used to Treat Dementia (webmd.com)

Fitness for brain:
NeuroNation

Elevate App:
Elevate - Brain Training and Brain Games (elevateapp.com)

CAA Senior Drivers:
Assess and Maintain Your Driving Skills - CAA National

Driving and dementia:
Driving & Dementia - YouTube

Dementia in public:
How Can We Include People With Dementia in Our Community? on Vimeo

Aphasia:
Aphasia: The disorder that makes you lose your words - Susan Wortman-Jutt - YouTube

24 Hour Movement Guidelines 18-64:
Adults 18-64 – 24-Hour Movement Guidelines (csepguidelines.ca)

The many voices of dementia video:

The Many Voices of Dementia - YouTube

Advance Care Planning – Conversations:
Advance Care Planning - Conversations - YouTube

Advance Health Care:
Advance health care directives (gnb.ca)

Delivering an Alzheimer's Disease Diagnosis video:
Delivering an Alzheimer's Disease Diagnosis - YouTube

Approaching Driving Cessation in Older Adults video:
Approaching Driving Cessation in Older Adults with Dementia on Vimeo

St. Thomas University: Aging in NB: A User's Guide:
Aging in New Brunswick - St Thomas University (stu.ca)

IMPORTANT NUMBERS

The following are some important phone numbers to know as you recover. This not a complete list, so please add ones that you feel are important to your recovery.

Social Development

To understand programs and services: 1-833-733-7835

Extra-Mural

1-888-862-2111. Seeking information about services available.

Saint John Regional X-Ray Depart.

1-506-648-6923. To check on booking x-rays, cancelling appointments.

Telecare

Have questions or concerns once you are home, after hours. 811

NB Prescription Drug Program

1-800-332-3692. See if you qualify for the provinces drug program.

Horizon (Saint John Area) Physiotherapy Booking

1-506-648-7888. If you don't have private insurance and need physiotherapy.

Red Cross Equipment Rental

1-506-647-6200. Short and long-term equipment rentals in the saint john area.

Ambulance NB Billing Depart.

1-888-657-3222. Questions regarding your ambulance bill. If you are on social assistance, have that information on hand.

Orthopedics Clinic (Clinic 1)

1-506-648-6784. For all post-op appointments, will be seen at the clinic. Need to contact your surgeon, reach out.

YOUR IMPORTANT NUMBERS

This section is for you to keep track of any important numbers for your recovery. This can be your physiotherapy, your surgeon, transportation, etc. Can be helpful to keep all of it in one place.

COMFORT & CARE

LONG-TERM CARE HOMES

Focuses on residential care options, planning for long-term care, and resources for transitioning to nursing homes.

LONG TERM CARE

for persons 65 and over

New Nouveau Brunswick

www.gnb.ca/socialdevelopment

What are long term care (LTC) services for persons 65 and over?

Seniors who need help with daily activities (e.g., mobility, bathing, preparing meals) on a long term basis may be eligible for subsidized LTC. These services may be provided in your own home, in a special care home or nursing home.

What services are available under LTC?

- **Home support services** can help you with your daily activities such as personal care (e.g., feeding, grooming, bathing), housekeeping and meal preparation in the comfort of your own home. This service can also be used to offer relief to caregivers.
- **Adult Day Centres** provide caregiver relief, social support, and meaningful social/recreational activities in a group setting. Seniors normally pay a small fee to cover the costs of snacks and meals.
- **Special care homes** provide supervision and assistance with daily living for people with limitations who can no longer remain in their own home. Some special care homes also offer enhanced services to individuals with dementia or a physical frailty and who require help with all aspects of daily life.
- **Nursing homes** are for people who are medically stable but who need full-time nursing care. To order the *Going to a Nursing Home* booklet, contact the Public Legal Education and Information Service of New Brunswick at (506) 453-5369 or email at **pleisnb@web.ca**
- **Relief care** can be provided to give support to families or caregivers in order to keep seniors in their own homes and delay or prevent placement in residential facilities or hospitals. Temporary relief can be provided in a person's own home, a special care home or a nursing home.

How do I access LTC services?

Receiving LTC services is voluntary. It is your choice. For an assessment of your needs, please contact the Department of Social Development. Someone you trust can be with you during the assessment.

Who will pay for my long term care services?

LTC Services are not covered by Medicare. Your income will be considered in determining what you will pay. The government may provide financial assistance to those who are unable to pay the full cost of their services.

For more information about Long Term Care, please contact the Department of Social Development

1-833-733-7835

https://socialsupportsnb.ca/en/

13020

Going to a Nursing Home

Planning AHEAD

Public Legal Education
and Information Service
of New Brunswick

Public Legal Education and Information Service of New Brunswick (PLEIS-NB) is a non-profit organization and a registered charity. Its goal is to provide the public with information about the law. PLEIS-NB receives funding and in-kind support from the federal Department of Justice, the New Brunswick Law Foundation and the New Brunswick Department of Justice and Public Safety.

We gratefully acknowledge the contribution of members of the Law Society of New Brunswick and staff of the Department of Social Development. We also thank the Third Age Centre and the seniors who helped us to better understand the information needs of seniors in this area. The booklet does not contain a complete statement of the law or the policies in this area. Both may change from time to time and anyone needing specific legal advice should contact a lawyer.

Purpose of the Booklet

This booklet answers some questions commonly asked about entering a nursing home and applying for financial assistance. It touches on the services offered and explains how the Department of Social Development processes admissions into nursing homes. Information is based on what is available at time of print. It does not deal with other residential facilities such as community residences or special care homes.

Public Legal Education and Information Service of New Brunswick

P.O. Box 6000
Fredericton, NB E3B 5H1
Tel.: 506-453-5369
Email: pleisnb@web.ca
www.legal-info-legale.nb.ca
www.familylawnb.ca

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Table of contents

Nursing Home Admission

How do I enter a nursing home?

The Department of Social Development must approve all requests for services in nursing homes – even if you pay your own way. Staff from the Department will decide your eligibility by looking at your long term health care and social needs. If these are greater than what you, your family and the community can provide, you may be eligible for nursing home care.

Going to a nursing home is just one option. The Department provides a range of long term care services for seniors and adults with disabilities who need help. Services include personal support, physical, and social services. These are not covered by Medicare. However, people who can't pay the full cost can ask the Department to assess them for financial assistance.

To ask for an assessment for long term care services or for more information, contact the New Brunswick Department of Social Development in your region.

Can someone make me go into a nursing home?

Going into a nursing home is voluntary. To get in, you must agree to an assessment. Nobody can force a competent person to have this assessment or to go to a nursing home.

What happens if I do need nursing home care?

After the Department of Social Development finds you eligible and approves your application for placement in a nursing home, they will send your name to all of the nursing homes within 100 kilometers of the municipality from where your home is located. When these homes have a vacancy, they must select residents from the approved list. If your spouse is also eligible for long term care services and you both wish to be together, you can ask the Department to consider the admission request of your spouse on compassionate grounds.

Will I have a say which nursing home I go to?

Yes. When you are eligible for admission, you can show your preference by applying directly to the nursing home you prefer. Choose more than one to increase your chances of getting in early. If you can, visit the homes in your area before you decide. Ask about their policies.

What if I'm not offered the nursing home I want?

If there's no vacancy in the nursing home you prefer, you may have to go wherever there is one within 100 kilometers of the municipality from where your home is located. You would not have to go where you do not understand the official language spoken.

What if I don't want to go to the nursing home offered to me?

You are allowed one refusal to a nursing home not listed as your first choice. If you refuse an offer from the Nursing Home listed as your first choice, the Department will take your name off the waiting list and reassess your situation.

If you can't get into the nursing home you prefer, you can always apply to transfer there later. If you are in the hospital waiting for a placement, be sure to ask about hospital policies. The hospital may start to charge you for your room if you refuse a vacancy.

Is it hard to transfer from one home to another?

No, it is not hard to transfer. You can transfer anywhere in the province where there is a vacancy. All you or your family must do is send an application to the nursing home of your choice. How long you wait to get in depends on the vacancy rate at that nursing home. However, before you apply, consider taking a month to get used to the nursing home you are in. After that time, if you still want to transfer, then go ahead and make the application.

Your Rights in a Nursing Home

What rights do I have in a nursing home?

Your rights are much the same as your rights in the community. You may have to get used to living with other people who have their own likes and dislikes. However, you should expect certain basic rights such as privacy, dignity, and individuality.

For example, the staff should knock before entering your room and you should be able to have private visits with your family. You should be allowed to come and go, if you can do so safely.

You have the right to be as independent as possible.

Can I expect the nursing home to be safe and clean?

Yes. The provincial government has set standards for nursing homes. By law, the operator must keep the buildings, equipment and surroundings of the home clean, neat and safe. There are also standards regulating the services that homes must give the residents.

What can I bring with me to a nursing home?

Before going to the nursing home, ask the administration what you can take along. For various reasons, they may restrict what you can bring. For the safety of all residents and staff, the nursing home must check any equipment, furniture and electrical appliances that you wish to bring. They need to be in good condition. Be sure to bring personal items such as clothes and toiletries.

Must a nursing home give me notice that they plan to discharge me?

According to the *Nursing Homes Act* of New Brunswick, nursing homes may discharge any resident for any reason so long as they give **advance notice** to the resident and to their next of kin or legal representative. If the resident does not have a next of kin or legal representative, the nursing home may give notice to the resident and to the Director of Nursing Home Services.

Nursing homes do **not** have to give advance notice prior to discharge if they reasonably believe that immediate discharge of the resident is necessary to ensure the safety of the resident, other residents, or staff.

Nursing Home Costs

How much does it cost to live in a nursing home?

The amount a nursing home resident may have to pay to cover the costs of the nursing home, including room and board services, can vary depending on your income. Currently, the maximum amount is $113 per day. On a monthly basis, this would amount to about $3,437. This amount may be adjusted from time to time. The Department of Social Development will cover the costs of nursing and rehabilitation services for residents in nursing homes.

Can I get financial assistance to help pay the costs?

If you can afford to pay your nursing home room and board costs from income, you must do so. If you feel you cannot afford the costs, you can apply to the Department for a financial subsidy. The first step in getting a subsidy is to ask for a financial assessment. You can do this any time before or after the Department has evaluated your situation.

What if I need help right away?

Until the Department completes your financial assessment, you must pay your nursing home room and board costs.

The Financial Assessment

How do I get a financial assessment?

To get a financial assessment, you have two options. You can complete the Financial Application Form for CRA Process, or you can fill out the Request for Financial Subsidy Form. The **Financial Application for CRA Process** allows Social Development to access Canada Revenue Agency (CRA) information to verify your income while protecting your personal information.

The **Request for Financial Subsidy Form** asks for information about your family income and asks you to include photocopies of the last two years' tax information and financial information to verify your income.

After you fill out the **Request for Financial Subsidy Form** or the **Financial Application for CRA Process**, you will have 30 days to send it to the financial needs assessor whose name and address are at the bottom of the form or bring them in person to your local Social Development Office. Include all the documents and information requested on that form. (See the list of documents needed for the **Request for Financial Subsidy Form** in the Appendix.)

The financial needs assessor will review your application and let you know if you are eligible for a subsidy.

How is my ability to pay assessed?

The financial assessor looks at net income to calculate the financial contribution toward your nursing home room and board costs. (see *Terms to Know*). What is considered depends on whether you:

1. Live alone
2. Live with a spouse or a dependent(s)
3. Have a spouse who also needs long term care services

1 Applicants Living Alone

Your contribution is calculated by:

1. Calculating your **monthly net income**
2. **Subtracting this amount** from the monthly room and board costs for nursing home services.

OUTCOME

If the amount you are able to pay each month is **less than** the monthly cost of the room and board services, the government can give you a subsidy to offset the full cost of the services.

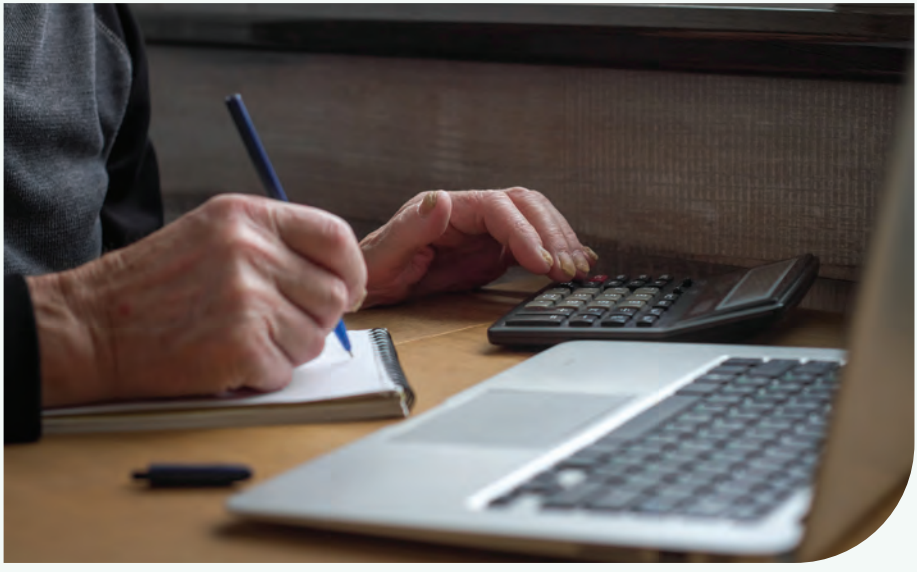
If the amount you are able to pay each month is **more than** the monthly cost of room and board at the nursing home, you will have to pay these costs.

2 Applicants with a Spouse or Dependents at Home

The Department decides how much you must pay by looking at your **net family income**. Your contribution to the nursing home is based on a graduated income scale reflecting your spouse and the number of dependents.

OUTCOME

If your contribution from net family income is **not enough** to cover nursing home room and board costs, you **may be eligible for a subsidy**. This method protects a portion of the net family income to support your spouse and dependents at home.



3 Applicants with Spouse also Needing Long Term Care

If your spouse or dependent is already getting, or later qualifies for approved **long term care services**, the cost of their services will be added to your nursing home costs.

OUTCOME

The Department would calculate only **one** family contribution on the total cost of all services. Generally, you would pay the amount of your contribution directly to the nursing home.

What if my financial situation changes after the financial assessment?

A change in your financial situation could affect your eligibility for a government subsidy. For example, if you enter the nursing home as a private payer, you could become eligible for financial assistance if your income decreases. If you are already subsidized, the Department would have to reassess you if your income increases or decreases.

It is your responsibility to let the Department know if your financial situation changes. If it does, please contact the Department of Social Development and ask to speak to the financial needs assessor.

Terms to Know

Net Income/Net Family Income

This is your total income from all eligible sources, whether taxable or non-taxable. Net income is calculated by subtracting all allowable deductions from your total income. This includes statutory and other employer deductions such as CPP, EI, Income Tax, and health insurance premiums.

If you are single, the Department considers 100% of your net income after deductions. If you have a spouse (married or common-law) or dependents, the Department considers the net income of the family unit on a graduated scale. In either case, you are allowed a monthly comfort and clothing allowance.

Income includes: wages, allowances, income from investments, pensions (ex. Old Age Security and Canada Pension), etc. **Fixed or liquid assets are not included in the financial assessment.**

Dependent

A dependent is a financially dependent child of, or a person under the guardianship of, the client entering the nursing home or that person's spouse. The dependent must be under 19 years of age, or under 25 years of age and enrolled full-time in an educational institution, or over 18 years and disabled.

Deciding what to do with your house

Must I sell my house when I enter the nursing home?

What you do with your house is your decision. The value of your house is not included when the financial needs assessor calculates your contribution to your nursing home costs. **Fixed or liquid assets are not included in the financial assessment.**

What if I rent my house?

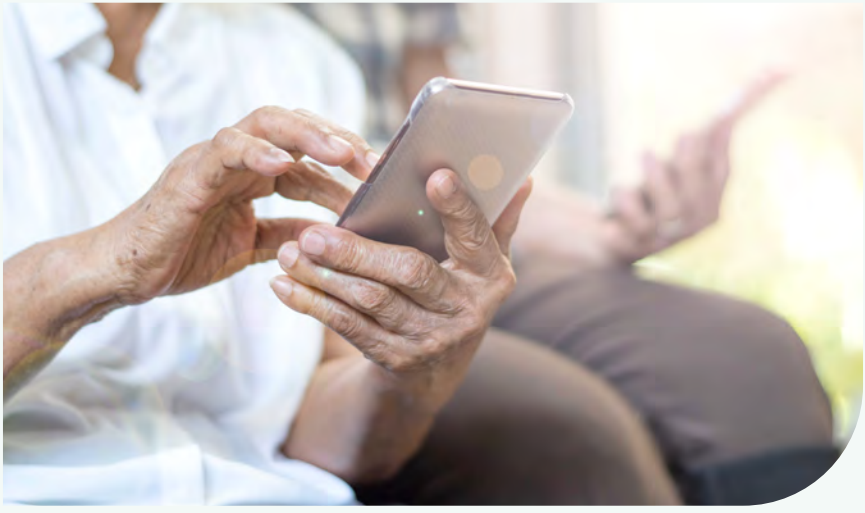
If the government is subsidizing your nursing home room and board costs and you decide to rent your house, even to a family member, you must contribute 75% of the rental income toward your room and board at the nursing home. You can use the remainder for the upkeep of the house.

OAS and GIS Payments

What happens to our OAS and GIS payments if only one spouse enters a nursing home?

When you enter a nursing home and your spouse does not, Service Canada may find that you and your spouse are each eligible for the same monthly financial benefits as single pensioners. You will have to fill out a form **"Spouses or Common-law Partners Living Apart for Reasons Beyond their Control"**. This allows both of you to possibly receive an increase in your Guaranteed Income Supplement (GIS) monthly pension amounts.

Contact the Service Canada office. The toll free number is 1-800-277-9914. Explain your situation and ask about getting an increase in your OAS/GIS benefit. Do not press any buttons after you dial, just wait and the operator will eventually come on line and talk to you.



Personal Expenses

Can I keep some money for personal expenses if I get assistance?

Yes. You can keep your GST rebate and your Low-Income Seniors Benefit. You can also keep your comfort and clothing allowance each month from your OAS and GIS. These amounts may change. If you have no income, the Department will give you a comfort and clothing allowance.

If I get a subsidy, will all my expenses be covered?

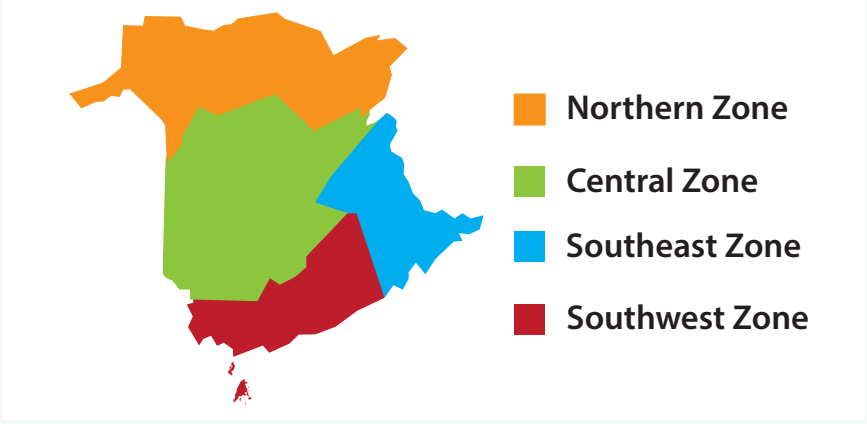
You will still be responsible for some personal expenses. For example, everyone must arrange their own transportation when they enter the nursing home. Residents in a nursing home, even those on financial assistance, are responsible for:

- clothing and personal items, such as dry cleaning, barber/hairdresser
- telephone and cable TV expenses
- participation fees for eye glasses/examinations and dentures/dentist
- cost of certain personal care items if the brand is not provided by the nursing home
- cost of any medication not covered by the Prescription Drug Program or by your private drug plan
- cost of transportation, other than to the hospital
- making funeral and burial arrangements

More Information

Where can I get more information?

To get more information about nursing homes and their policies in your area, call them and arrange to visit. Ask about their policies. To find out more about programs, nursing home admissions and government subsidies, contact the Department of Social Development at 1-833-733-7835 in your region.



You can also find the full details about nursing home legislation, regulations and policies free online at:

- Standard Family Contribution policy
- *Nursing Homes Act*
- *Nursing Homes Act* Regulations
  - General Regulations
  - Contribution Regulation
- Licensed Nursing Homes - Inspection, Standards and Management Directives

Appendix

Documents needed for a Financial Assessment for a Nursing Home subsidy:

Completed **Request for Financial Subsidy** application form. Make sure you (and your spouse, if applicable) sign, witness and date at the bottom of the form as it is required.

Copies of your **Notice of Assessment** for the previous 2 years (including spouse, if applicable). If you cannot find your Notice of Assessment, there are two easy ways to get a replacement copy:

Contact the Canada Revenue Agency (CRA)

1-800-959-8281

PDF

You can request an online copy through CRA's My Account website.

Copies of your **T4**s and **T5**s for the previous two years (including spouse, if applicable).

If any of the following applies to your situation, you will need to provide copies of these as well.

Please check the boxes that apply to you:

- ☐ Proof of cost of health insurance premiums
- ☐ Power of Attorney document
- ☐ Notification confirming private pension amount for the current year
- ☐ Proof of income from Veterans Affairs Canada
- ☐ Proof of any pensions from any other country
- ☐ Proof of rental income, if not declared on your income tax
- ☐ Last month's pay stubs (if employed)
- ☐ Proof of Long Term Disability payments
- ☐ Proof of Private Coverage for Long Term Care Services
- ☐ Proof of current income if you (or your spouse) have turned 65 in last year
- ☐ Proof of current income if you have become widowed in the last year
- ☐ Employment pay stubs

LONG TERM CARE: HOME SUPPORT

General Information

What does home support do?

Home support workers can assist a person with their Activities of Daily Living (ADL's); Such as light house cleaning, laundry, cooking, personal care (grooming, help with eating, taking medication).

The Department of social Development has a list of approved agencies on their website or you can call 211 for more information.
To find out more about home care organizations in your area, reach out to family and friends.

Cost

There is a cost to home support services.
First check with any private insurance, such as Blue Cross or Manulife, to see if you have any coverage.
The Department of Social Development can offer subsidies for those eligible; call or visit their website for more information. When you reach out, besure to have your date of birth, address, level of support needs (what you are looking for help with).

Contact Info

To find out more about home support and your options, contact the Department of Social development
https://sociialsupportsnb.ca/en/program/home-support-services
1-833-733-7835

Questions

When talking to a home support agency or the Department of Social Development, remember, there are no dumb questions.

Prior to calling, make a list of questions you would like answered.

Examples: what types of services does your company provide; what are the costs; what times are workers available?; what is the cancellation policy if a worker is not available?; are references provided?; what types of training are required for staff?

LONG-TERM CARE: RESIDENTIAL PLACEMENT

General Information

All information regarding long-term care (nursing homes and special care homes can be found on the Department of Social Developments (DSD) websites: https://socialsupportsnb.ca/en/program/special-care-homes https://socialsupportsnb.ca/en/program/nursing-homes or by calling 1-833-733-7835. In order to access a residential placement, you must apply to the DSD long term care program.

COSTS

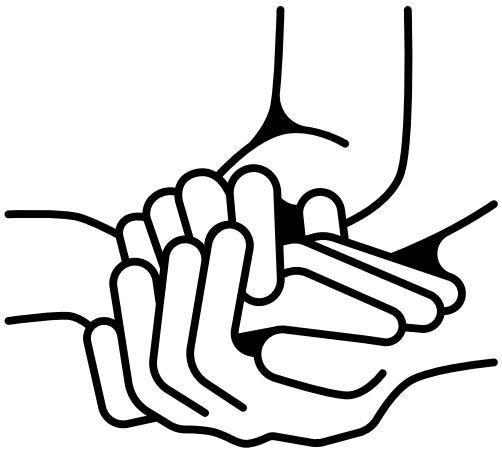
All long-term care are not covered under the health care system. Cost is determined through a financial assessment with the DSD. In order to access these services, you need to contact the Department of Social Development to discuss placement, payments and financial assistance.

ASSESSMENTS

A financial assessment (see if you qualify for assistance) and a functional assessment (determine level of care) will be completed. These help in determining an appropriate placement.

PROCESS

Prior to calling to discuss long-term care, ensure you have an idea of your or your loved ones care needs, as well as a date of birth, address. Once this has been done, an application needs to be completed, online or on the phone. This application can be found on their website or mailed (by request by calling their 1-800 number).



INFORMATION

For your application, it is important to gather as much information before you fill it out; you have 1 month to fill it out and send it back.
Information such as: social insurance number, Medicare number, name and number of family doctor, regular bills and how they are paid, medications and pharmacy. Also need your last 2 years tax returns, which can be acquired from the CRA at 1-800-959-8281 or at https://www.canada.ca/en/revenue-agency/services/e-services/e-services-individuals/account-individuals.html

HEALTH FIRST

HEALTH & MEDICAL CARE

Offers a range of health services and programs, from medical alert systems to drug plans and rehabilitation resources, empowering seniors to manage their health effectively.

HEALTH AND MEDICAL CARE INFORMATION

List of numbers and services in province of NB

911/811/211

Emergency/Telecare/Information

These are numbers to call if you are having an emergency (911), if you are dealing with a medical issue and are not sure where to go and what to do (811) or are looking for more information regarding programs in your area (211).

1-888-862-2111

ExtraMural Services

Assist people in returning home earlier from hospitals and help prevent readmission, assist with rehabilitation, palliative care, chronic health care and more.

Health Services

Department of Social Development

Health Services can help determine, based on your income, if you qualify for any of their programs. Call 211 for a full list of theri services.

1-506-634-7277

Vision Loss Rehab Program

This free service can be accessed by your doctor, optometrist or by self-referral. The number posted is for the Saint John office, but there are offices in other cities in NB.

1-800-332-3692

NB prescription Drug Program

Contact to see if you qualify for this drug program. For those who do not qualify, there is also the **NB Drug Plan** (1-855-540-7325)

1-800-332-3692

Medavie Blue Cross Seniors Prescription Drug Program

There is also the **Medavie Seniors Health Program** (1-844-209-7599)

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

FOR OFFICE USE ONLY
UNIQUE NUMBER

1. PATIENT IDENTIFICATION INFORMATION: Please complete this section with information relating to the person whose health information is being disclosed. (Please print clearly and provide as much information possible to ensure your request will be completed.)

Name: _____ _____ _____
(Last) (First) (Middle)

Current Address: _____ Date of Birth: _____
(Street/Unit/Apartment) (Day/Month/Year)

_____ Health Card #: _____
(City, Province, Postal Code)

Telephone: (____) _____ ☐ Please check box if patient is deceased

2. AUTHORIZATION TO RELEASE THE FOLLOWING PERSONAL HEALTH INFORMATION:

Please indicate the health care facility you are requesting health information from:

_____
(Name of Health Care Facility)

Specific Health Information: _____

_____

From: _____ To: _____
(Day/Month/Year) (Day/Month/Year)

☐ Is the requested health information for insurance purposes?

3. RELEASE PERSONAL HEALTH INFORMATION TO:

☐ I am requesting copies of my own record ***OR***

☐ I am authorizing release of information to the following person(s):

Name: _____

Address: _____
(Street/Unit/Apartment)

_____
(City, Province, Postal Code)

Telephone: (____) _____ Fax: (____) _____

4. HOW TO RECEIVE HEALTH INFORMATION:

☐ Pick up / Call when ready (ID required) ☐ Mail ☐ Fax: (____) _____

I HEREBY AUTHORIZE HORIZON HEALTH NETWORK TO RELEASE THE REQUESTED PERSONAL HEALTH INFORMATION AS DIRECTED ON THIS FORM. I UNDERSTAND I MAY REVOKE MY AUTHORIZATION AT ANY TIME, IN WRITING. I HEREBY RELEASE HORIZON HEALTH NETWORK AND ITS EMPLOYEES FROM ANY AND ALL CLAIMS WHATSOEVER WHICH MAY ARISE FROM THE RELEASE OF THE REQUESTED PERSONAL HEALTH INFORMATION.

_____ _____
Print Name Relationship to Patient

_____ _____
Signature Date

français au verso

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

AUTORISATION DE DIVULGUER DES RENSEIGNEMENTS PERSONNELS SUR LA SANTÉ

RÉSERVÉ À L'USAGE DU BUREAU
N° D'IDENTIFICATION UNIQUE

1. RENSEIGNEMENTS PERMETTANT D'IDENTIFIER LES PATIENTS : Veuillez remplir la section ci-dessous des renseignements sur la personne au sujet de laquelle des renseignements personnels sur la santé seront divulgués (veuillez écrire clairement en lettres détachées et fournir le plus de renseignements possible pour que votre demande puisse traitée).

Nom : _____ _____ _____
(Nom) (Prénom) (Deuxième prénom)

Adresse actuelle : _____ Date de naissance : _____
(rue/bureau/appartement) (jour/mois/année)

_____ No de carte d'assurance-maladie : _____
(ville, province, code postal)

No de téléphone : (____) _____ ❒ Veuillez cocher la case si le patient est décédé

2. AUTORISATION DE DIVULGUER LES RENSEIGNEMENTS PERSONNELS SUR LA SANTÉ SUIVANTS :

Veuillez indiquer l'établissement de soins de santé duquel vous souhaitez obtenir des renseignements sur la santé :

_____
(Nom de l'établissement de soins de santé)

Renseignements précis sur la santé : _____

_____

De : _____ à : _____
(jour/mois/année) (jour/mois/année)

❒ Les renseignements sur la santé sont-ils demandés à des fins d'assurances?

3. DIVULGATION DE RENSEIGNEMENTS PERSONNELS SUR LA SANTÉ À :

❒ Je souhaite obtenir une copie de mes propres dossiers ***OU***

❒ J'autorise la divulgation de renseignements à la personne suivante ou aux personnes suivantes :

Nom : _____

Adresse : _____
(rue/bureau/appartement)

_____
(ville, province, code postal)

No de téléphone : (____) _____ No de télécopieur : (____) _____

4. FAÇON D'OBTENIR DES RENSEIGNEMENTS SUR LA SANTÉ :

❒ En mains propres sur place / appel lorsque prêt (carte d'identification obligatoire) ❒ Poste

❒ Télécopieur : (____) _____

PAR LA PRÉSENTE, J'AUTORISE LE RÉSEAU DE SANTÉ HORIZON À DIVULGUER LES RENSEIGNEMENTS PERSONNELS SUR LA SANTÉ DEMANDÉS SELON LES INSTRUCTIONS DONNÉES DANS LE PRÉSENT FORMULAIRE. IL EST ENTENDU QUE JE PEUX ANNULER LA PRÉSENTE AUTORISATION EN TOUT TEMPS, À L'ÉCRIT. JE SOUSSIGNÉ LIBÈRE LE RÉSEAU DE SANTÉ HORIZON ET SES EMPLOYÉS DE TOUTE RÉCLAMATION QUI POURRAIT DÉCOULER DE LA DIVULGATION DES RENSEIGNEMENTS PERSONNELS SUR LA SANTÉ DEMANDÉS.

_____ _____
Nom en lettres détachées Lien avec le patient

_____ _____
Signature Date

New Nouveau Brunswick

Turning 65?

YOU CAN RECEIVE
DRUG AND HEALTH COVERAGE

NB Drug Plans

&

Medavie Blue Cross Seniors' Health Program

MEDAVIE BLUE CROSS™
SENIORS' HEALTH PROGRAM

MISC-425E 05/22

July 2022

Getting Started

You are receiving this package because you are turning 65 and you now have more options available for health and drug coverage.

This package details **different ways** you can receive prescription drug coverage. You can also add hospital coverage and choose between two health benefit plans. Read through the different plans to determine the coverage that is best for you.

In the centre of this package you will find application forms and return envelopes to sign up for the coverage you want.

Who is eligible?

New Brunswick seniors are eligible to apply for drug coverage if they:

- are 65 years of age or older;
- are a permanent resident of New Brunswick;
- have a valid NB Medicare Card, and
- do not have prescription drug coverage from another plan.

Privacy

The Government of New Brunswick is committed to safeguarding your privacy. Visit our privacy web page (www.gnb.ca/healthprivacy) for more information on our privacy practices and your rights regarding this issue.

Medavie Blue Cross is committed to safeguarding your privacy. Visit our privacy web page (medaviebc.ca/legal/privacy) for more information on our privacy practices and your rights regarding this issue.

Available Coverage

Prescription Drug Coverage

Additional Coverage

Questions & Answers

Forms

New Brunswick Prescription Drug Program

You qualify for the New Brunswick Prescription Drug Program if you receive the federal Guaranteed Income Supplement (GIS) from Employment and Social Development Canada. Each senior (65 years of age or older) in a family applies for the Prescription Drug Program individually.

Annual Premium	Co-pay per Prescription
None	**$9.05 up to an annual co-pay ceiling of $500 per person**

To enrol in this program:

- Complete the Guaranteed Income Supplement Confirmation Form
- Mail or fax us your form

For more information, visit our website: **www.gnb.ca/NBPDP**

CONFIRMATION FORM:

Guaranteed Income Supplement Confirmation Form

Telephone: **1-800-332-3692**

Fax: **1-888-455-8322**

Email: **info@nbdrugs-medicamentsnb.ca**
(email is not intended to send confidential information)

If you do not receive the Guaranteed Income Supplement, please contact us if you are:

- a single person (65 years of age or older) with an annual income of $17,198 or less
- a couple (with both persons 65 years of age or older) with an annual income of $26,955 or less
- a couple (with one person 65 years of age or older, and the other person under 65 years of age) with an annual income of $32,390 or less

New Brunswick Drug Plan

Uninsured New Brunswickers, including seniors, may enrol in the New Brunswick Drug Plan. Members in this plan pay a premium and a 30 % copayment, up to a maximum amount per prescription. Premiums and copayments are based on income.

Gross Income Levels		Premiums	Co-pay
Individual	Individual with children / Couple with or without children	Monthly Premium (per adult)	30% Co-pay to a Maximum per Prescription
$17,884 or less	$26,826 or less	$16.67	$5
$17,885 to $22,346	$26,827 to $33,519	$33.33	$10
$22,347 to $26,360	$33,520 to $49,389	$66.67	$15
$26,361 to $50,000	$49,390 to $75,000	$116.67	$20
$50,001 to $75,000	$75,001 to $100,000	$133.33	$25
Over $75,000	Over $100,000	$166.67	$30

To enrol in this plan:

- Complete the New Brunswick Drug Plan Application Form
- Mail or fax us your form

For more information, visit our website: **www.gnb.ca/drugplan**

APPLICATION FORM:

New Brunswick Drug Plan Application for Coverage

Telephone: **1-855-540-7325**
Fax: **1-888-455-8322**
Email: **info@nbdrugs-medicamentsnb.ca**
(email is not intended to send confidential information)

New Nouveau Brunswick

Medavie Blue Cross Seniors' Prescription Drug Program

Uninsured New Brunswickers (65 years of age or older) may enrol in the Medavie Blue Cross Seniors' Prescription Drug Program.

Monthly Premium	Co-Pay per Prescription
$140	$15

When should I apply for the Medavie Blue Cross Seniors' Prescription Drug Program?

Knowing when you should apply is very important. You will be accepted into the Medavie Blue Cross Seniors' Prescription Drug Program if:

- you apply within 60 days following your 65th birthday, or
- you are older than age 65 and you apply within 60 days following the cancellation of a previous prescription drug plan, or
- you are older than age 65 and you apply within 60 days following gaining eligibility for NB Medicare as a new resident.

Missed the dates or forgot to apply within the 60-day limit?

If you did not apply within the 60-day limit, you may apply as a late applicant but are required to complete a medical questionnaire. You may or may NOT be accepted, based on your medical history. To begin this process, call toll free 1-800-332-3692.

To enrol in this program:

- Complete the Medavie Blue Cross Seniors' Prescription Drug Program Application Form
- Mail, email or fax us your form

APPLICATION FORM:

Medavie Blue Cross Seniors' Prescription Drug Program Application Form

Telephone: **1-800-332-3692**

Fax: **1-888-455-8322**

Email: **info@nbdrugs-medicamentsnb.ca**

(email is not intended to send confidential information)

Hospital and Health Benefits

All the previous plans cover prescription drugs only. To complement your drug coverage, consider adding hospital coverage and health benefits to design a plan to best suit your needs.

Hospital Benefits	$31.50 per month

Hospital benefits cover 80% up to $50 per day up to a maximum of 90 days per year towards a semi-private or private hospital room. This plan does not provide hospitalization coverage for the first three months following enrolment.

Basic Health Benefits	$16 per month
Enhanced Health Benefits	$26 per month

View the Comparison Chart on page 6, to see which benefits are right for you.

***Late Applicant Provision**: There is a one year waiting period for certain benefits under Health Benefits (Basic and Enhanced) if you do not apply within 60 days following your 65th birthday, or within 60 days following the termination date of other health benefits, or within 60 days of obtaining NB Medicare as a new resident.

What if I want more coverage?

Medavie Blue Cross offers a wide range of benefits that may meet your needs including health, dental, travel and life insurance.

Individual Dental Benefits	$43.70 per month (billed separately)

Dental benefits are covered at 70% and include: recall exam, polishing, scaling, fillings, root canal treatment, extractions, minor denture repair, denture reline and rebase. Frequency limits may apply. This plan does not provide dental coverage for the first six months following enrolment.

To discuss further, call toll free 1-844-209-7599.

To add hospital, health or dental benefits:

- Complete the Medavie Blue Cross Seniors' Health Program Application Form
- Mail, email or fax us your form

APPLICATION FORM:

Medavie Blue Cross Seniors' Health Program Application Form

Telephone: **1-844-209-7599**
Fax: **1-855-551-9984**
Email: **individual.sales@medavie.bluecross.ca**

Health Benefits Comparison Chart

Health Benefits	Basic Health Benefits 80%	Enhanced Health Benefits 80%
Diabetic Test Strips and Lancets*	$320 per year	$320 per year
Diabetic Needles and Syringes*	$180 per year	$180 per year
Gradient Pressure Supports	2 per year	2 per year
Hearing Aids*	$320 every 5 years	$320 every 5 years
Braces, Splints, Orthotics	$200 per year	$400 per year
Custom-made Ankle Foot Brace	$300 per year	$400 per year
Ostomy Supplies*	Covered	Covered
Prosthetic Limb*	Maximums and frequency limits apply	Maximums and frequency limits apply
Breast Prosthesis*	$160 every 2 years	$160 every 2 years
Hair Prosthesis*	$240 per lifetime	$240 per lifetime
Tracheotomy Supplies	Covered	Covered
Vision Care*	$64 every 2 years	$100 every 2 years
X-ray	$20 per year combined with Chiropractor maximum	$20 per year combined with health practitioners maximum
Health Practitioners		
Chiropractor	$12 per visit up to $100 per year combined with X-ray	$200 per year per health practitioner up to a combined maximum of $400 per year
Podiatrist	$16 per visit up to 5 visits per year	
Psychologist	▲	
Massage Therapist	▲	
Osteopath	▲	
Physiotherapist	▲	
Speech Therapist	▲	
Respiratory Devices	▲	$400 every 3 years
Catheter Products	▲	Covered
Accidental Dental	▲	$7,000 per lifetime
Ambulance	▲	$400 per year
Emergency Drugs out of Province but within Canada	▲	Covered
Equipment Rental*	▲	Covered
Nursing	▲	$250 per year
Oxygen Equipment*	▲	$1,600 every 3 years
Oxygen*	▲	$1,200 per year
Blood Glucose Monitor*	▲	$80 every 5 years
Orthopedic Shoes and Supplies	▲	$100 per year
Eye Prosthesis*	▲	$300 every 3 years
Contact lenses due to disease*	▲	$200 every 2 years

▲ Benefit not covered. * Late applicant provision *(see page 5)*

Frequently Asked Questions

Which drugs are covered?

- To view the list of drugs eligible under the New Brunswick Drug Plan, visit **www.gnb.ca/drugplan** and follow the link entitled "New Brunswick Drug Plan Formulary".
- To view the list of drugs eligible under the New Brunswick Prescription Drug Program and the Medavie Blue Cross Seniors' Prescription Drug Program, visit **www.gnb.ca/nbpdp** and follow the link entitled "Formulary".
- Most drugs listed are regular benefits that are reimbursed with no criteria or prior approval requirements. Some drugs require special authorization and have specific criteria that must be met in order to be reimbursed.

Do the drug plans cover more than prescription drugs?

No, the drug plans cover prescription drugs only. If you desire coverage for additional benefits including vision care, hearing aids, nursing, oxygen, diabetic supplies and medical equipment, you can purchase health benefits through the Medavie Blue Cross Seniors' Health Program. Call toll free at 1-844-209-7599.

Can my spouse also be covered if he/she is under 65 years of age?

Yes, if your spouse is uninsured, he/she can apply for drug coverage under the New Brunswick Drug Plan or with Medavie Blue Cross.

Can my spouse and I be covered under different plans?

Yes, you and your spouse may be covered under different plans presented in this document, depending on your situation.

Frequently Asked Questions

How do I qualify for drug coverage if I am moving to New Brunswick?

- The first step is to apply for New Brunswick Medicare coverage. When you receive your Medicare card, check the date that your Medicare coverage becomes effective.
- Then call the telephone number corresponding to the coverage you wish to apply for.
- To guarantee your acceptance for the Medavie Blue Cross Seniors' Prescription Drug Program, you must apply within 60 days of your Medicare effective date. If you do NOT apply within 60 days following your Medicare effective date, you will be considered a late applicant and may or may NOT be accepted, based on your medical history.

If I'm moving outside New Brunswick, can I still get my drugs covered?

- All the drug plans are for New Brunswick residents only. If you are planning to move outside New Brunswick, you must advise Medicare and your drug plan of your moving date and your coverage will be cancelled accordingly.
- Although you can't take your drug plan with you, for most drugs you can obtain a 90-day supply of your medication before leaving New Brunswick, to cover the period until you can obtain coverage in your new province of residence.
- You should find out as soon as possible what your coverage options are in your new home province.

New Brunswick
Prescription Drug Program

Guaranteed Income Supplement Confirmation Form

Prescription Drug Program
P.O. Box 690
Moncton NB
E1C 8M7

Telephone: 506-867-4515
Toll Free: 1-800-332-3692
Fax: 506-867-4872
Toll Free Fax: 1-888-455-8322

How to complete this form

1. If you are receiving the Guaranteed Income Supplement (GIS), please complete all sections. Please print clearly. **Incomplete information may delay processing.** If you have any questions, please call us at the number above.
2. Mail or fax your completed and signed form along with the required documentation that confirms you are receiving the GIS (see below for details) to the address/fax number above.
3. Once this form is processed, you will receive a letter confirming if you qualify. The copayment for this plan is $9.05 per prescription, to a maximum of $500.00 annually.

Who is eligible to apply

- New Brunswick residents with a valid Medicare card, who are 65 years old or older, and who receive the federal Guaranteed Income Supplement are eligible for the New Brunswick Prescription Drug Program (NBPDP).

Section 1 - Personal information *(required)*

Name of Applicant: _____ Date of Birth: DD / MM / YYYY

Social Insurance Number: _____ Medicare Number: _____

Address: _____

_____ Postal Code: _____

Telephone Number: _____

Gender: ❑ M ❑ F ❑ X Language of Preference: ❑ English ❑ French

Have you had drug coverage through another health insurance plan within the last 12 months?
❑ Yes ❑ No

If "Yes", when did this coverage end or will be ending? DD / MM / YYYY

Section 2 - Documentation *(required)*

Please enclose the following document with this form.

❑ A letter from Service Canada that indicates the month the GIS was added to your Old Age Pension. You can obtain this letter by calling toll-free 1-800-277-9914.

CONTINUED ON REVERSE

Section 3 - Consent to release Guaranteed Income Supplement information *(required)*

I hereby consent to the release, by Employment and Social Development Canada to an official of the New Brunswick Department of Health and/or its Delivery Agent, of information about my eligibility and entitlement for the Guaranteed Income Supplement, and, if applicable, other required administrative information about me, whether supplied by me or by a third party. The information will be relevant to, and used solely for the purpose of, determining and verifying my eligibility for benefits under the New Brunswick Prescription Drug Program, and will not be disclosed to any other person or organization without my approval. I understand that, if I wish to withdraw this authorization, I may do so at any time by writing to the New Brunswick Prescription Drug Program. This authorization is valid for the current year and each subsequent consecutive year for which benefits under the New Brunswick Prescription Drug Program may be requested and determined.

Name of Applicant: _____

Signature: _____ Date Signed: DD / MM / YYYY

Section 4 - Personal declaration and authorization *(required)*

By signing this confirmation form, I confirm that:

I am applying to become a member of the New Brunswick Prescription Drug Program and I am providing information on this form for this purpose.

I understand that I can withdraw my application and cancel my membership at any time.

The information provided on this form is true to the best of my knowledge. I understand that knowingly providing false or incomplete information is an offence.

I authorize the New Brunswick Prescription Drug Program to collect my Social Insurance Number, as well as information from Medicare and other sources to verify the information on this form and to verify eligibility for the New Brunswick Prescription Drug Program.

I agree to notify the New Brunswick Prescription Drug Program immediately of any changes that may affect my coverage.

I understand that the personal information I provide, as well as any other personal information currently held or collected in the future, may be collected, used or disclosed to administer the New Brunswick Prescription Drug Program.

I authorize the New Brunswick Prescription Drug Program to collect, use and disclose my personal information as described above for as long as I remain a member of the New Brunswick Prescription Drug Program.

I understand that I can revoke my consent at any time. In some instances, revoking my consent may prevent the New Brunswick Prescription Drug Program from providing me with the requested coverage or benefits.

Name of Applicant: _____

Signature: _____ Date Signed: DD / MM / YYYY

This information is collected under the authority of the Prescription Drug Payment Act, SNB 1975, c P-15.01, s 2. This information will be used and disclosed to administer the New Brunswick Prescription Drug Program. It may be used and disclosed in accordance with the Personal Health Information Privacy and Access Act, SNB 2009, c P-7.05. For more information regarding collection and use of personal information, visit www.gnb.ca/healthprivacy, or contact the New Brunswick Prescription Drug Program at the address or telephone number shown on page 1 of this application.

NB Drug Plan

The New Brunswick drug plan

Application for Coverage

New Brunswick Drug Plan
PO Box 690
Moncton, NB E1C 8M7

Toll-Free Number: 1-855-540-7325
Fax: **1-888-455-8322**
Website: **gnb.ca/drugplan**

Prior to applying, please contact the New Brunswick Drug Plan Inquiry Line at 1-855-540-7325 to confirm that the drug you would like covered is included in the New Brunswick Drug Plan Formulary.

How to complete this form

1. **All sections must be completed.** Please print clearly. Ensure you (and your spouse if applicable) sign sections 3, 4 and 5. Any dependant (if applicable) over the age of 16 must sign section 5.
2. **Only one application form per family is necessary.** If you have a spouse and/or dependant(s), they do not need to complete a separate application.
3. If you are applying for coverage and have an existing drug plan, you must complete the **Existing Drug Coverage form** and send it along with your completed application form. The Existing Drug Coverage form is available on the New Brunswick Drug Plan website.
4. Mail or fax your completed and signed application to the address/fax number above.
5. Once your application is processed, you will receive notification of your acceptance in the New Brunswick Drug Plan with your premium and copayment details and the effective date of your coverage.

SECTION 1 - Personal information *(required)*

APPLICANT:

First name: _____ Last name: _____

Medicare number: _____ Date of birth: _____ DD/MM/YYYY

Gender: ❑ M ❑ F ❑ X

Marital status: ❑ single ❑ married ❑ common-law ❑ separated ❑ divorced ❑ widowed

Mailing address: _____

City/town: _____ Province: _____ Postal code: ⌊⌊⌊⌊⌊⌊

Telephone: _____ Alternate *(e.g. mobile)*: _____

Are you currently covered under a drug plan? ❑ yes ❑ no When is your coverage ending? _____ DD/MM/YYYY

If you have coverage from another drug plan that is not ending, please complete the Existing Drug Coverage form and send it with your completed application form.

SPOUSE: *(Your spouse's information is required even if your spouse is not applying for coverage. The premiums and copayments are based on your family income.)*

First name: _____ Last name: _____

Medicare number: _____ Date of birth: _____ DD/MM/YYYY

Gender: ❑ M ❑ F ❑ X

Is your spouse applying for coverage as well? ❑ yes ❑ no

Is your spouse currently covered under a drug plan? ❑ yes ❑ no When is the coverage ending? _____ DD/MM/YYYY

If your spouse has coverage from another drug plan that is not ending, you must send a completed Existing Drug Coverage form for your spouse along with your completed application form.

SECTION 2 - Dependant information *(if applicable)*

Please list all eligible dependants. If more space is required, please attach a separate sheet.

Eligible dependants are defined as:

- all dependent children under the age of 19
- all dependants age 19 or older who are eligible for a Disability Tax Credit under the federal *Income Tax Act*, **AND** were eligible for the tax credit as a minor, **AND** reside with the applicant

First name	Last name	Date of birth (DD/MM/YYYY)	Medicare number	Gender	Disabled (as per the definition above)	*Is your dependant applying for coverage?	*Is your dependant currently covered under a drug plan?
				❑ M ❑ F ❑ X	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ M ❑ F ❑ X	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ M ❑ F ❑ X	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ M ❑ F ❑ X	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no

* *If your dependant has coverage from another drug plan that is not ending, you must send a completed Existing Drug Coverage form for your dependant along with your completed application form.*

SECTION 3 - Consent to release income tax information *(required)*

Your annual premium and maximum copayment will be calculated based on your annual family income, as indicated on your Canada Revenue Agency (CRA) tax return for the most recent tax year.

Please choose one of the following options:

❑ I consent to the release of our family income, as indicated on our CRA tax returns for the most recent tax year. I/we hereby consent to the release, by the Canada Revenue Agency to an official of the **New Brunswick Department of Health** and/or its **Delivery Agent**, of information from my/our income tax returns, and, if applicable, other required taxpayer information about me/us, whether supplied by me/us or by a third party. The information will be relevant to, and used solely for the purpose of, determining and verifying my/our eligibility for benefits, required premiums and entitlement for subsidy under the **New Brunswick Drug Plan**, and will not be disclosed to any other person or organization without my/our approval. I/we understand that, if I/we wish to withdraw this authorization, I/we may do so at any time by writing to the **New Brunswick Drug Plan**. This authorization is valid for the current taxation year and each subsequent consecutive taxation year for which benefits under the **New Brunswick Drug Plan** may be requested and determined.

Applicant Social Insurance Number: ⌊⌊⌊ ⌊⌊⌊ ⌊⌊⌊ Spouse Social Insurance Number: ⌊⌊⌊ ⌊⌊⌊ ⌊⌊⌊

❑ I do <u>not</u> consent to the release of our family income, as indicated on our CRA tax returns for the most recent tax year. We will be charged the maximum annual premium and the maximum copayment per prescription.

Name of Applicant: _____

X Sign here - Applicant: _____ Date signed: _____ 20 _____ (DD/MM) (YY)

Name of Spouse: _____

X Sign here - Spouse: _____ Date signed: _____ 20 _____ (DD/MM) (YY)

Your spouse's consent is required even if your spouse is not applying for coverage. The premiums and copayments are based on your family income.

SECTION 4 - Payment information *(required)*

Your monthly premiums will be automatically deducted from your bank account each month. Please complete the Pre-authorized Debit (PAD) plan agreement below.

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I authorize the New Brunswick Drug Plan, and the financial institution designated (or any other financial institution I may authorize at any time) to begin deductions as per my instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my specified account on the first business day of every month. The New Brunswick Drug Plan will not provide pre-notification but will provide a premium statement indicating the amount of each regular debit. The New Brunswick Drug Plan will obtain my authorization for any other one-time or sporadic debits. The New Brunswick Drug Plan requires written notification of any changes to banking information.

This authority is to remain in effect until the New Brunswick Drug Plan has received written notification from me of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled. This notification must be sent to the New Brunswick Drug Plan. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting **www.payments.ca**.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim or for more information on my recourse rights, I may contact my financial institution or visit **www.payments.ca**.

BANKING INFORMATION: Tick the box that applies.

1. ❑ Applicant or spouse will be paying the premiums.

   Please **attach a void cheque or a direct deposit/pre-authorization payment form from your financial institution** and sign below.

   X Sign here -
   Bank account holder: _____ Date signed: _____ 20 _____
   DD/MM YY

2. ❑ Someone other than the applicant or their spouse will be paying the premiums. Please have them **attach a void cheque or a direct deposit/pre-authorization payment form from their financial institution** and complete the information below:

   First name: _____ Last name: _____

   Mailing address: _____

   City/town: _____ Province: _____ Postal code: ⌊⌊⌊ ⌊⌊⌊

   Telephone: _____ Alternate *(e.g. mobile)*: _____

   X Sign here -
   Bank account holder: _____ Date signed: _____ 20 _____
   DD/MM YY

SECTION 5 - Personal declaration, authorization and obligations *(required)*

By signing this application form, I confirm that:

I am applying to become a member of the New Brunswick Drug Plan, and I am providing information on this form for this purpose.

I understand that I can withdraw my application and cancel my membership at any time.

The information provided on this form is true to the best of my knowledge. I understand that knowingly providing false or incomplete information is an offence.

I authorize the New Brunswick Drug Plan to collect my information from Medicare and other sources to verify the information on this form and to verify eligibility for the New Brunswick Drug Plan.

I agree to notify the New Brunswick Drug Plan immediately of any changes that may affect my coverage.

I understand that the personal information I provide, as well as any other personal information currently held or collected in the future, may be collected, used or disclosed to administer the New Brunswick Drug Plan.

I authorize the New Brunswick Drug Plan to collect, use and disclose my personal information as described above for as long as I remain a member of the New Brunswick Drug Plan.

I understand that I can revoke my consent at any time. In some instances, revoking my consent may prevent the New Brunswick Drug Plan from providing me with the requested coverage or benefits.

I understand that I must pay my premiums each month in order to receive benefits, and that if I do not pay my premiums in full, benefits will not be provided and my coverage will be suspended or cancelled.

I understand that failure to pay premiums does not mean that I have cancelled my New Brunswick Drug Plan coverage and that I must contact the administrator in order to do so. I understand that action will be taken to collect any outstanding premiums owed.

The signatures of your spouse and all listed dependants over the age of 16 are required even if they are not applying for coverage.

Name of Applicant: _____

X Sign here - Applicant: _____ Date signed: _____ (DD/MM) 20 _____ (YY)

Name of Spouse: _____

X Sign here - Spouse: _____ Date signed: _____ (DD/MM) 20 _____ (YY)

*Name of Dependant (16 or older): _____

X Sign here - Dependant: _____ Date signed: _____ (DD/MM) 20 _____ (YY)

*Name of Dependant (16 or older): _____

X Sign here - Dependant: _____ Date signed: _____ (DD/MM) 20 _____ (YY)

***A parent/guardian can sign on behalf of the dependant if:**

- The dependant is between the ages of 16 and 18 (inclusive) and does not have the capacity to sign the personal declaration and authorization; or
- The dependant is 19 years of age or older and does not have the capacity to sign the personal declaration and authorization, or has given legal authority for another person to act on their behalf. Please attach a copy of the Power of Attorney for personal care.

This information is collected under the authority of the *Prescription and Catastrophic Drug Insurance Act*, SNB 2014, c 4, s 12 and s 13. This information will be used and disclosed to administer the New Brunswick Drug Plan. It may be used and disclosed in accordance with the *Personal Health Information Privacy and Access Act*, SNB 2009, c P-7.05. For more information regarding collection and use of personal information, visit www.gnb.ca/healthprivacy, or contact the New Brunswick Drug Plan at the address or telephone number shown on page 1 of this application.

Medavie Blue Cross
Seniors' Prescription Drug Program

MEDAVIE BLUE CROSS™
SENIORS' HEALTH PROGRAM

644 MAIN ST
PO BOX 220
MONCTON NB
E1C 8L3

APPLICATION FORM

Toll-Free Number: **1-800-332-3692**
Fax: **1-888-455-8322**

PLEASE COMPLETE THE FOLLOWING TO APPLY FOR BENEFITS

Name: _____

Address: _____

_____ Postal Code: _____

Telephone: _____ Date of Birth: _____
DD/MM/YYYY

Medicare No.: _____ Social Insurance No.: _____

Language preference for correspondence: ❑ English ❑ French

Are you currently or have you recently been covered by a Prescription Drug Plan? ❑ Yes ❑ No

If Yes, when will/did this benefit terminate? _____
DD/MM/YYYY

Please select when you would like your coverage to start:

- ❑ The month of your 65th birthday
- ❑ The month following your 65th birthday
- ❑ The month following the termination of your current/previous coverage
- ❑ *Other. Specify: _____

* A completed medical questionnaire is required.

DRUG COVERAGE RATES
$140.00 per month Medavie Blue Cross Seniors' Prescription Drug Program
$15 co-pay per prescription

AGREEMENT AND CONSENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-888-919-7378.

Signature _____ Date of signature _____
DD/MM/YYYY

CONTINUED ON REVERSE

FORM-4079KIT-E 05/22

BILLING SELECTION

❑ **Monthly Pre-authorized Debit (PAD)** (Please complete the Pre-authorized Debit (PAD) plan agreement below, sign, date and attach void cheque).

I authorize Medavie Blue Cross, and the financial institution designated (or any other financial institution I may authorize at any time), to begin deductions as per my instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited from my specified account on the first business day of every month. *Medavie Blue Cross will not provide monthly pre-notification but will provide 30-days notice if the deduction is subject to change.* Medavie Blue Cross will obtain my authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me of its change or termination. This notification must be received at least 30 business days before the next debit is scheduled. This notification must be sent to the Seniors' Health Program at Medavie Blue Cross. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting www.payments.ca.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my recourse rights, I may contact my financial institution or visit www.payments.ca.

BANKING INFORMATION: please **attach a void cheque or a direct deposit/pre-authorization payment form from your financial institution** and sign below. Please attach the void cheque to a separate sheet.

Signature of bank account holder: _____ Date of signature: _____
DD/MM/YYYY

If someone other than the applicant or their spouse will be paying the premiums, please have them **attach a void cheque or a direct deposit/pre-authorization payment form from their financial institution** and complete the information below:

Last name: _____ First name: _____ Initial: _____

Address: _____ Apt.: _____

City/town: _____ Province: _____ Postal code: _____

Telephone number: _____ Alternate (e.g. mobile): _____

Signature of bank account holder: _____ Date of signature: _____
DD/MM/YYYY

Medavie Blue Cross Seniors' Health Program

MEDAVIE BLUE CROSS™ SENIORS' HEALTH PROGRAM

644 MAIN ST
PO BOX 220
MONCTON NB
E1C 9N7

APPLICATION FORM

Toll-Free Number: **1-844-209-7599**
Fax: **1-855-551-9984**
Sales e-mail: **individual.sales@medavie.bluecross.ca**

PLEASE COMPLETE THE FOLLOWING TO APPLY FOR BENEFITS

Name: _____

Address: _____

_____ Postal Code: _____

E-Mail: _____

Telephone: _____ Date of Birth: _____ DD/MM/YY

Medicare Number: _____

Language preference for correspondence: ❑ English ❑ French

Sex: ❑ Male ❑ Female ❑ Intersex ❑ Undisclosed

Why do we ask? Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

BENEFIT SELECTION - Please refer to the Medavie Blue Cross Seniors' Health Program booklet for a complete description of the benefits. The amounts shown below are monthly rates.

Waiting periods apply for Hospital and Dental benefits. There may also be a one year waiting period on some health benefits if you do not apply within 60 days of your 65th birthday.

Please check all benefits you wish to include in your plan.

HEALTH COVERAGE

The following options do not include coverage for prescription drugs.

- ❑ $16.00 Basic Health Benefits
- ❑ $26.00 Enhanced Health Benefits (includes the benefits under Basic)
- ❑ $31.50 Hospital Reimbursement Plan
- ❑ $43.70 Individual Dental Benefits (billed separately)

Have you recently been covered for other health benefits, such as Vision or Physiotherapy? ❑ Yes ❑ No

Have you been covered for dental benefits in the last three months? ❑ Yes ❑ No

If Yes, when will these benefits terminate? _____ DD/MM/YY

Your coverage becomes effective on the first day of the month of your 65th birthday unless you are a late applicant or request a different effective date.

Requested Effective Date of Policy: Please begin my coverage on the 1st day of _____ Month/Year

AGREEMENT AND CONSENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-888-919-7378.

Signature _____ Date _____ DD/MM/YY

CONTINUED ON REVERSE

FORM-070KIT-E 05/22

BILLING SELECTION

❑ **Monthly Pre-authorized Debit (PAD)** (Please complete the Pre-authorized Debit (PAD) plan agreement below, sign, date and attach void cheque).

I authorize Medavie Blue Cross, and the financial institution designated (or any other financial institution I may authorize at any time), to begin deductions as per my instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited from my specified account on the first business day of every month. *Medavie Blue Cross will not provide monthly pre-notification but will provide 30-days notice if the deduction is subject to change.* Medavie Blue Cross will obtain my authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me of its change or termination. This notification must be received at least 30 business days before the next debit is scheduled. This notification must be sent to the Seniors' Health Program at Medavie Blue Cross. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting www.payments.ca.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my recourse rights, I may contact my financial institution or visit www.payments.ca.

Authorized Signature: _____

DATE: _____ DD/MM/YY Type of Service: ❑ Personal ❑ Business

Please attach a void cheque. (Credit card payments are not accepted.)
(PLEASE PRINT)

Financial Institution (FI): _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: ☐☐☐☐☐ ☐☐☐ FI Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐
(transit-5 digits; FI-3 digits)

Would you like your claim reimbursements automatically deposited in the same account? ❑ Yes ❑ No

If someone other than the policy owner will be paying the premiums, please have them sign, date and complete their financial information above and complete their personal information below:

Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (Bus.) ____ - ____ - _____ (Res.) ____ - ____ - _____

FOR OFFICE USE ONLY

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Name: _____ Agent's Number: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Agent's Signature: _____

Life Assure™
Medical Alert Systems

TOLL FREE
1-800-354-5706

- 30 Days Risk Free Guarantee
- NO Contracts
- FREE Activation
- No Hidden Fees

PROUDLY CANADIAN - PROUDLY CANADIAN -

EMERGENCY DEVICE FOR SENIORS

TOLL FREE
1-800-354-5706

WWW.LIFEASSURE.COM

Protect Yourself and Remain INDEPENDENT tm with **Life Assure Medical Alert.**

Life Assure Classic Home

Life Assure Total Home

Life Assure Premium Mobile

What is Life Assure Medical Alert?

Life Assure medical alert devices are an important life saving tool for seniors who are still living at home. The risk of falling in or around the home without the security of having anybody around to help is a problem that many seniors face each and every day.

With Life Assure Medical Alert Units, you can have peace of mind knowing that at any time, 24 hours a day 7 days a week, help is available at the push of a button. Whether you need to contact a family member, friend, or the local paramedics, our team of highly trained and dedicated staff is available whenever you need.

The device is simple, just wear one of our pendants either around your neck or on your wrist. If you fall and cannot get up, or have an emergency that requires assistance, simply press the button on the pendant and it will signal the base station to call for help. One of our trained customer care specialists will then be on the line to ask if you're ok. If you need help, simply tell them and they will notify the appropriate party and help will be on the way.

PROUDLY CANADIAN - PROUDLY CANADIAN -

Life Assure™
Medical Alert Systems

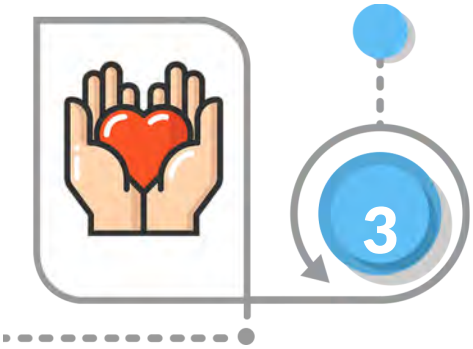
How Does It Work?

Push the button on your Life Assure Medical Alert necklace or wrist pendant.

All of our units come with a Resistance pendant that can be worn as either a necklace or on the wrist. Once the button has been pressed, a wireless signal is sent to your Life Assure Medical Alert station. The base then contacts one of our many monitoring stations and a voice will come on the line to make sure that you're ok.

Speak with a trained Life Assure Medical Alert customer care professional.

Within a few seconds after the button has been pressed, one of our trained professionals will be on the line to assist you. The representative will come on the line via the Life Assure Medical Alert unit to determine if you're ok. If you cannot speak to the representative or they can't hear you, don't worry, help will still be on the way.



Help is on the way!

It really is that easy. Your Life Assure Medical Alert unit has a microphone that is sensitive enough to hear you around corners and in other rooms within your home, so you don't have to be in the same room to communicate with our representatives.

Your Life Assure Medical Alert unit can also come with you on vacations or for a long term move or change of residence, just notify our customer service, this way you're covered no matter what.

Don't allow yourself to be caught in an emergency without the help you deserve. Remember, this button could save your life!

Life Assure™
Medical Alert Systems

Life Assure **Classic Home**

The Life Assure Classic Home is our flagship product. This unit is completely VoIP (Voice Over Internet Protocol) and Cable Compatible and will work on virtually any home telephone line. The Classic Home has a microphone with increased sensitivity, an excellent quality speaker, and two-way voice communication between your home and the response center to ensure that you're heard during an emergency. The water resistance pendant can be worn in the shower and can be worn as both a wristband or a necklace and has a detection range of 600 feet from the base and can be connected to multiple pendants at once.

- Two-way voice communication
- Microphone with increased sensitivity
- Excellent quality speaker
- Works on virtually any home telephone line
- Water Resistance Pendant (Wristband or Necklace)
- Has a detection range of up to 600 feet from base in any direction
- UP To 80 Hour Backup
- VoIP and Cable Compatible
- Fall Detection Capability (with pendant)
- No long term contract
- No activation fee
- Dependable 24 Hours a day 7 Days a week
- 30 day, zero hassle return policy

Two-way voice communication

Microphone with increased sensitivity

Excellent Quality Speaker

Works on Home Phone Line

VOIP (Voice over Internet Protocol)

Fall Detection (with pendant)

Life Assure™
Medical Alert Systems

Life Assure **Total Home**

The Life Assure Total Home is a perfect system for those without a landline. This unit provides all the benefits of our Classic Home model, including a microphone with increased sensitivity, two-way voice communication, a waterproof pendant that can be worn as either a WristBand or Bracelet, as well as a state of the art 3G cellular network connection. It also has a detection range of 600 feet from the base and can be connected with multiple pendants at once. If you're without a home telephone or landline, this is a great choice

- Two-way voice communication
- Microphone with increased sensitivity
- Excellent quality speaker
- Cellular Technology
- No Landline Required
- Waterproof Pendant (Wristband or Necklace)
- Has a detection range of up to 600 feet from base in any direction
- UP To 80 Hour Backup
- Fall Detection Capability (with pendant)
- No long term contract
- No activation fee
- Monitored 24 hours a day 7 days a week
- 30 day, zero hassle return policy

Two-way voice communication

Microphone with increased sensitivity

Excellent Quality Speaker

Works on Cellular Network

GPS technology can pinpoint your exact location

Fall Detection (with pendant)

Life Assure™
Medical Alert Systems

Life Assure **Premium Mobile**

The Life Assure Premium Mobile is an all-encompassing medical alert device. Featuring instant two-way hands free voice communication directly through the pendant, automatic fall detection, and GPS network location services to determine your location, this device allows you to leave the home and still remain protected virtually anywhere at any time. At home, on vacation, or out shopping for the day, the Premium Mobile unit assures that you're always covered and allows you to keep the independence you deserve. Life Assure Everthere allows you to track the location of a user online, records event activity, updates device location and shows battery level and signal strength.

Everthere Location Tracking's Tracks Online Location of User

- No Landline Required
- Can be Used Virtually Anywhere
- Uses Both GPS and Cellular Networks to Determine Location
- Two Way Voice Communication Directly Through The Mobile Device
- Fail Detection Compatibility
- 36 Hour Standby Battery
- Charges Fully Within 4 hours
- Water Resistant
- Monitored 24 hours a day 7 days a week
- Even There Location Track

Two-way voice communication

Microphone with increased sensitivity

Excellent Quality Speaker

Works on Cellular Network

GPS technology can pinpoint your exact location

Fall Detection

Life Assure™
Medical Alert Systems

What Is The Best Device For You?

PRICING

Unlike other companies, Life Assure Medical Alert guarantees a low monthly price for the entirety of your service. Many other brands may have hidden costs and extra fees but with Life Assure Medical Alert, what you see is what you get. Our high end Medical Alert products, partnered with our unbeatable customer service and low monthly costs make your decision a no-brainer.

CONTRACTS

Always beware of sticky long term contracts. Our no contract guarantee is exactly how it sounds. If you're not happy with the service we provide, simply return the equipment and you will not be billed further. Our relationship with our customers, as well as their safety is always our first priority.

GUARANTEES

We guarantee you'll find great value in our service. Keep in mind; you're never tied down with Life Assure Medical Alert. Not having a contract gives you the freedom that you deserve to make the choices that are best for you.

TYPES OF PHONE LINES

The Life Assure Classic Home model works on all home phone lines including Voice over Internet Protocol (VoIP) and Digital Subscriber Line (DSL). Our Life Assure Total and Life Assure Premium Mobile require no home phone whatsoever. These units both use cellular signals

POWER / BATTERY BACKUP

The Life Assure Classic Home and Total Home, and the Life Assure Premium Mobile both contain backup batteries in case of a power emergency. In this case, the backup battery for the Classic Home and Total Home will power the unit uninterrupted for up to 80 hours if the power is lost, while the Premium Mobile will remain powered for up to 36 hours. We also offer a lifetime guarantee on all equipment.

RANGE OF WIRELESS DEVICE

The Life Assure Classic Home and Life Assure Total Home models can receive signals from the personal help button when it's up to 600 feet away from the base unit. The Life Assure Premium Mobile uses cellular networks and can be used virtually anywhere

Life Assure
Medical Alert Systems

Life Assure
Product Comparison



Product Comparison	Classic Home	Total Home	Premium Mobile
Lifetime Warranty	✓	✓	✓
Water Resistant Pendant	✓	✓	✓
2 Way Voice Communication	✓	✓	✓
Compatible with Fall Detection	✓	✓	✓
Monitored 24 Hours a Day, 7 Days a Week	✓	✓	✓
Cellular Technology	✗	✓	✓
No Landline Required	✗	✓	✓
Charge Fully Within 4 Hours	✗	✗	✓
Includes Automatic Fall Detection	✗	✗	✓
Voice Communication Directly Through The pendant	✗	✗	✓
Can Be Used Virtually Anywhere	✗	✗	✓
Uses Both GPS and Cellular Networks to Determine Location	✗	✗	✓
Everthere Location Tracking	✗	✗	✓

Life Assure™
Medical Alert Systems

Frequently Asked **Questions**

1 Do I need a phone line?

No. Only the Life Assure Classic Home model requires a home telephone line. The Life Assure Total Home and Premium Mobile unit uses a cellular signal and can be used without a home telephone line.

2 How much is it?

Our prices start at nearly $1 a day depending on which unit you choose

3 Is there a contract?

There is no contract whatsoever with any of our products. You can cancel at any time during your service. In fact, if you're not happy with the services that you're getting, simply return the equipment and the billing stops. It's as easy as that.

4 How is the unit installed?

Our systems can be installed in just minutes. Simply plug the unit into a telephone jack and an electrical outlet, Press the button test the connection with our monitoring center and you're ready to go!

5 What if I want to return the system?

The unit can be returned for any reason at any point during your service, with no further charges. It's that simple!

6 How will the emergency personnel get access to my home?

Along with the Medical Alert Devices, we also rent a lockbox and lockbox hanger that attaches to your door. We then provide the combination to the lockbox to the Emergency Services when you call for help. This way, you don't need to worry about a broken door!

7 What if I lose power?

Our Classic Home and our Total Home units both have a backup battery that lasts up to 80 hours if the AC power is lost, while the Premium Mobile will last up to 36 hours

8 Will Life Assure Medical Alert affect my telephone service?

No, Life Assure Medical Alert will not affect your phone service or bill. All calls made are toll free and will not appear on your bill.

9 Do I have a warranty?

All our equipment comes with a full warranty for the entirety of your service.

10 How far can the pendants go?

Both the Classic Home and Total Home units have a range of up to 600 feet in any direction, while the Premium Mobile can be used virtually anywhere.

11 Can I have more than one person connected to the same unit?

Yes, you can add up to 3 additional pendants to each unit at any time on the Classic Home and Total Home.

Certifications

Business has determined that Life Assure meets Business accreditation standards, which include a commitment to make a good faith effort to resolve any consumer complaints. As a Business Accredited Business Life Assure is monitored and evaluated to maintain all standards as recommended by the Business.

Established in 1977, the Canadian Security Association (CANASA) is a national not-for-profit organization dedicated to advancing the security industry and supporting security professionals in Canada. CANASA protects and promotes the interests of its members and the safety of all Canadians through education, advocacy, and leadership.

ULC certificated alarm systems have a better record than non-certificated systems when it comes to critical issues such as response times and false alarms. This is likely owing to the fact that each element of the entire system functions as defined by ULC Standards national equipment, installation and monitoring standards, and where applicable, guard response standards, so the resulting service meets defined performance criteria.

The Central Station Alarm Association International (CSAA) is an internationally-recognized non-profit trade association that represents professional monitoring companies that are listed by a CSAA-approved Nationally Recognized Testing Laboratory, such as FM Approvals, Intertek/ETL or UL. CSAA is legally entitled to represent its members before Congress and regulatory agencies on the local, state and federal levels, and other authorities having jurisdiction (AHJs) over the industry. Since its incorporation in 1950, CSAA has served its members' interests through education, online training, meetings and conventions, certification, insurance, and industry standards.

Life Assure™
Medical Alert Systems

Life Assure Classic Home

Life Assure Total Home

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Some general questions to ask before you head home after your stay in the hospital. If there are questions you want to ask that are not listed, please ask them. It is best to ask and feel confident before you head home.

1. What is the average length of recovery and are there any restrictions for when I am home?

2. What are possible side effects, with regards to my surgery, that I should look out for and who do I call if I have any concerns?

3. When was my last dose of medication and when am I due for my next dose?

4. Will I need any special equipment for when I go home and if yes, who arranges this for me?

5. Are there any exercises that I will need to continue when I am discharged? If yes, could someone review them with me before I am discharged?

6. If I am to continue with physiotherapy, is there a place that is recommended or do I come back to the hospital to get my physio?

7. Can you provide with the numbers to the x-ray department, ortho clinic and surgeons office, in case there are an emergencies and I need to re-schedule appointments.

8. Am I being sent home with any new prescriptions? If yes, can these be reviewed with me before I leave (what they are prescribed for, side effects, etc.)

9. Is there anything you can think of to tell me before I go home?

Bilingual Communication content for physicians

What is Rehabilitation and Reablement (R&R)?

It is an enhancement to service currently offered by the Extra-Mural Program and the Department of Social Development. It is short term, intensive service delivered in the patient's home or special care home with the overall goal of rehabilitation and enabling seniors to remain in their own home.

Who is it for?

Seniors (65 years of age or older) who are recovering from an illness or injury (Rehabilitation), and may or may not need more time to restore/optimize their independence and remain at home (Reablement).
Those with Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Diabetes, Mild to Moderate Stroke, Transient Ischemic Attack (TIA), dementia, and other chronic illnesses will be eligible.
Patients who are in hospital or at home who are convalescing after unplanned surgery, falls, trauma, or a prolonged medical illness.

AND

Have health needs that are expected to improve with short term intensive intervention and be able to live at home.
R&R will be patient focu sed with seniors and their families as active participants in identifying their goals and determining the plan of care needed to meet their goals.

Who is it NOT for?

Patients less than 65 years of age.
Patients who would best have their needs met through existing EMP/DSD services.
Patients who require tertiary level care and those who require specialized equipment that is only available in a hospital setting.

What are the services available to potential R&R clients?

Rehabilitation Phase (up to 21 days)

For those patients who are able to be discharged from hospital who can live in their own home with up to 6 hours of formal home support (home support workers) per day and EMP services.
For seniors identified at home, intensive rehabilitation focused care can be provided for up to 3 days at home with formal support up to 10 hours per day along with the EMP services. For the remainder of the 3 weeks seniors will receive up to 6 hours per day of formal support.
For seniors whose needs require more care than what home support, EMP and the family can provide at home. These patients will receive rehabilitation focused care by the EMP team in a Special Care Home (as a transitional care setting) for up to 21 days.

Reablement Phase (up to 6 weeks)

For those seniors who require some additional time and supports to acquire strategies that will allow them to continue to live independently with supports.

Who provides the care?

Allied Health Professionals and Nurses through EMP in the usual manner but with increased intensity and rapid response.
Home support workers – organized by EMP and funded by DSD, Special Care Home (SCH) staff in those Special Care Homes with transitional rehabilitation beds.
Physician care as usual through EMP

How is this different than the usual EMP/DSD Services?

There will NOT be a wait time to access home support workers
There will NOT be a co-pay for the clients to receive home support workers for the duration of the service.
There will NOT be a wait time to be seen by EMP Nurses/Physiotherapy/Occupational Therapy/ Rehabilitation Assistants/ Respiratory Therapists/Speech and Language Pathology/ Nutritional Services/ Social Work.
The frequency of the visits for the professional EMP providers will be more intense compared to usual care based on the patient's needs. Services will be available 7 days a week.

How will patients be recruited to R&R?

From the Hospital

The EMP liaison nurses work closely with the health care teams on the inpatient units to identify patients. Those seniors who are identified will be reviewed with their attending physician/family physician before enrolment in the service.
Physicians can also refer to EMP R&R services and they will be reviewed by the EMP liaison nurse for eligibility.

Community

Physicians can refer to EMP using the usual manner of referral (same referral form) and EMP will review and determine if eligible for R&R or for other EMP services. Given this is a service that requires a rapid response in order to prevent hospitalization or visit to Emergency departments; physicians are encouraged to call the EMP unit and speak with a manager.

How will the R&R services be evaluated?

An evaluative component for the services has been developed and standardized tools and assessment will be used by the EMP providers. Findings from the demonstration site evaluation will be used to inform provincial implementation and to ensure the appropriate range of services to meet the needs of seniors in the most efficient and effective way.

What happens after the end of the R&R Service?

Patients will continue to receive the services that are individually required within the current services offered by EMP and DSD after the R&R services is completed.

Contenu de la communication à l'intention des médecins

En quoi consiste le services de réadaptation et de revalidation?

Il s'agit d'une amélioration au service actuellement offert par le Programme extra-mural et le ministère du Développement social. C'est un service intensif de courte durée offert au domicile du patient ou dans un foyer de soins spéciaux dans le but ultime d'assurer la réadaptation des aînés et de leur permettre de continuer à demeurer chez eux.

À qui le service est-il destiné?

Les aînés (65 ans et plus) qui récupèrent d'une maladie ou d'une blessure (réadaptation) et qui pourraient avoir besoin de plus de temps pour retrouver/optimiser leur autonomie et demeurer chez eux (revalidation).

Les personnes ayant une maladie pulmonaire obstructive chronique (MPOC), une insuffisance cardiaque congestive (ICC) ou le diabète, qui ont subi un AVC léger ou moyen ou un accident ischémique transitoire (AIT) ou qui sont atteintes de démence ou d'autres maladies chroniques.

Les patients qui sont en convalescence à la suite d'une chirurgie non planifiée, de chutes, de traumatismes ou d'une longue maladie, qu'ils soient hospitalisés ou à domicile

ET

qui ont des besoins en matière de santé qui devraient s'améliorer à l'aide d'une intervention intensive de courte durée et être en mesure de rester à la maison.

Les services de réadaptation et de revalidation seront axés sur le patient et feront participer activement les aînés et leur famille dans la détermination des objectifs et la définition du plan de soins nécessaire pour atteindre les objectifs.

Qui n'est PAS visé par le service?

Les patients qui ont moins de 65 ans.

Les patients dont les besoins seraient mieux comblés par les services existants du PEM/MDS.

Les patients qui ont besoin de soins tertiaires et ceux qui ont besoin de matériel spécialisé uniquement offert en milieu hospitalier.

Quels services sont offerts aux patients potentiels de réadaptation et de revalidation?

Phase de réadaptation (maximum de 21 jours)

Destinée aux patients qui peuvent recevoir leur congé de l'hôpital et qui sont en mesure de demeurer chez eux avec un maximum de six heures de soutien à domicile professionnel (aides de maintien à domicile) par jour et des services du PEM.

Pour aînés identifiée à domicile, réadaptation intensive concentré peut être fourni pour des soins jusqu'à 3 jours à la maison avec un appui formel jusqu'à 10 heures par jour avec les services du PEM. Pour le reste des 3 semaines les aînés recevront jusqu'à 6 heures par jour de soutien formel.

Destinée aux aînés qui ont besoin d'un niveau de soins supérieur à ce que le soutien à domicile, le PEM et la famille sont en mesure d'offrir à domicile. Ces patients recevront des soins axés sur la réadaptation par l'équipe du PEM depuis un foyer de soins spéciaux (milieu de soins transitoire) pour un maximum de 21 jours.

Phase de revalidation (maximum de six semaines)

Destinée aux aînés qui ont besoin de temps et de soutien supplémentaires pour acquérir des stratégies qui leur permettront de continuer à vivre de façon autonome avec du soutien.

Qui assure les soins?

Les professionnels de santé complémentaires et parallèles ainsi que les infirmières par l'intermédiaire du PEM selon la procédure habituelle, mais l'intensité des soins est accrue.

Les aides de maintien à domicile – service organisé par le PEM et financé par le MDS, personnel des foyers de soins spéciaux ayant des lits de réadaptation transitoires. Les médecins, selon la procédure habituelle par le PEM

En quoi ce service diffère-t-il des services du PEM/MDS habituels?

Il n'y aura AUCUN temps d'attente pour accéder à des aides de maintien à domicile.

Les patients n'auront AUCUNE quote-part à payer pour recevoir les services d'aides de maintien à domicile pour la durée du service. Il n'y aura PAS d'attente pour consulter les infirmières du PEM, un physiothérapeute, un ergothérapeute, un assistant en réadaptation, un inhalothérapeute, un orthophoniste, un nutritionniste ou un travailleur social.

La fréquence des visites faites par les fournisseurs de soins du PEM sera plus intense comparativement aux soins habituels basés sur les besoins du patient.

Les services seront disponibles 7 jours par semaine.

Comment les patients seront-ils recrutés pour les services de réadaptation et de revalidation?

À l'hôpital

Les infirmières de liaison du PEM travaillent en collaboration avec les équipes de soins de santé des unités de soins pour identifier les patients. Les aînés identifiés seront examinés avec leur médecin traitant/médecin de famille avant l'inscription au service.

Les médecins peuvent aussi aiguiller des patients vers les services de réadaptation et de revalidation du PEM. L'infirmière de liaison du PEM déterminera leur admissibilité.

Dans la collectivité

Les médecins peuvent aiguiller un patient vers le PEM de la manière habituelle (en utilisant le même formulaire d'aiguillage). Étant donné c'est un service qui nécessite une réponse rapide afin de prévenir l'hospitalisation ou visite aux services d'urgence; les médecins sont invités à appeler l'unité PEM et communiquer avec un gestionnaire.

De quelle façon les services de réadaptation et de revalidation seront-ils évalués?

On a élaboré un volet d'évaluation pour les services, et des outils et une évaluation uniformisés seront utilisés par les fournisseurs de soins du PEM. Les résultats de l'évaluation du site de démonstration seront utilisés pour guider la mise en œuvre provinciale et offrir la gamme appropriée de services afin de répondre aux besoins des aînés de la façon la plus efficace et la plus rentable.

Que se passe-t-il une fois que les services de réadaptation et de revalidation sont terminés?

Les patients continueront de recevoir les services dont ils ont besoin et qui sont dans les limites des services actuellement offerts par le PEM et le MDS une fois les services de réadaptation et de revalidation terminés.

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Canadian Guidelines for the Assessment and Treatment of Anxiety in Older Adults

2024

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CCSMH
Canadian Coalition for Seniors' Mental Health

CCSMPA
Coalition canadienne pour la santé mentale des personnes âgées

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Disclaimer

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A full list of competing interests of guidelines development group members and how they were addressed can be found at *ccsmh.ca/wp-content/uploads/2024/01/COI-ENG-Summary-Table-FINAL.pdf*

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Contents

Summary of Recommendations

In this guideline, we used two methods to signal the strength of evidence underlying our recommendations. The first method was applied to the recommendations addressed by systematic reviews and includes a rating of the certainty of evidence and the direction and strength of the recommendation. For best practice recommendations and those which were not directly related to our systematic review questions, we assigned a letter grade to the recommendation based on the level of evidence used to support it (from A for systematic review to D for expert opinion). Full details are provided on page 17 and in Table 1.

Recommendation #1

Health care providers should be familiar with risk factors for anxiety in older adults. **(D)**

Recommendation #2

Health care providers should familiarize themselves with tools to detect anxiety symptoms and disorders in older adults and consider using these tools to facilitate case finding in individuals at risk or who describe symptoms of anxiety. **(D)**

Recommendation #3:

We recommend the use of the Geriatric Anxiety Inventory - 20 item version (GAI-20) for identifying clinically important anxiety symptoms or disorders within clinical settings and for individuals at risk. **(GRADE Certainty of Evidence: Moderate; Strength of recommendation: Strong)**

Recommendation #4

Consider the use of the Geriatric Anxiety Inventory – 20 item version (GAI-20) or short-form (GAI-SF) for case-finding for GAD within clinical settings and for individuals at risk. **(GRADE Certainty of Evidence: Low; Strength of recommendation: Conditional)**

Recommendation #5

We recommend the use of Rating Anxiety in Dementia (RAID) for identifying clinically important anxiety symptoms in older adults with dementia within specialty care settings. **(GRADE Certainty of Evidence: Moderate; Strength of recommendation: Strong)**

Recommendation #6

Health care providers should ask about fear of falling and activity avoidance as part of the geriatric falls risk assessment. **(D)**

Recommendation #7

Older adults who screen positive for anxiety, or who are presenting with new or worsening anxiety that affects their daily functioning or well-being, should undergo a comprehensive assessment, including a history, physical examination, and appropriate investigations. **(D)**

Recommendation #8

The anxiety history should include the nature of the symptoms, their onset and duration, the severity of the symptoms (in terms of impact on daily functioning, presence of avoidance behaviours, and degree of distress associated with symptoms), the psychosocial stressors contributing to the symptoms, and the past mental health history. **(D)**

Recommendation #9

Older adults presenting with anxiety should be screened for depression and suicidality. **(D)**

Recommendation #10

A medical history and physical examination should be used to identify medical conditions that may be contributing to the symptoms of anxiety. Consider investigations that may help to rule out the presence of medical conditions that can cause symptoms of anxiety. **(D)**

Recommendation #11

A medication and substance-use history should be gathered in all older adults presenting with anxiety, including prescribed, over-the-counter and recreational drugs, and caffeine. **(D)**

Recommendation #12

Non-pharmacological interventions should be offered first, given the potential risk of adverse events associated with pharmacotherapy, except in circumstances dictated by patient preference, severity of symptoms and risk assessment. **(D)**

Recommendation #13

Stepped care, beginning with bibliotherapy, psychoeducation, and/or self-guided Cognitive Behavioural Therapy (CBT), should be considered to reduce anxiety symptoms and prevent the development of anxiety disorders in older adults. **(B)**

Recommendation #14

Psychosocial support should be offered to older adults presenting with anxiety symptoms, tailored to address risk factors and contributing stressors. **(D)**

Recommendation #15

Treatment response and efficacy should be monitored using standardized rating scales. **(D)**

Recommendation #16

Psychotherapy should be made available to older adults with anxiety in all settings (community, long-term care, etc.). **(D)**

Recommendation #17

CBT should be offered to older adults to treat anxiety. **(GRADE: Certainty of Evidence: Low; Strength: Strong)**

Recommendation #18

Both individual and group CBT are effective and can be offered to treat anxiety in older adults. **(A)**

Recommendation #19

Both brief and full CBT are effective and can be offered to treat anxiety in older adults. **(A)**

Recommendation #20

Remote CBT is effective and should be offered as a treatment option for anxiety in older adults. **(GRADE: Certainty of Evidence: Low; Strength: Strong)**

Recommendation #21

Specific CBT strategies can be used on their own to treat anxiety in older adults including exposure, relaxation therapy, abdominal breathing, cognitive restructuring, and problem-solving training. **(B)**

Recommendation #22

CBT should be delivered by or under the supervision of mental health professionals (e.g., registered psychologists, psychotherapists, psychiatrists, social workers, nurses) with appropriate training. **(D)**

Recommendation #23

Clinicians should consider the use of CBT for older adults who are experiencing a fear of falling, particularly for individuals whose function or quality of life is severely limited due to anxiety around falls. **(GRADE: Certainty of Evidence: Very Low; Strength: Conditional)**

Recommendation #24

Mindfulness interventions may be used to effectively treat anxiety in older adults. **(GRADE: Certainty of Evidence: Low; Strength: Conditional)**

Recommendation #25

Other forms of psychotherapy or psychosocial treatments (e.g., supportive therapy, acceptance and commitment therapy, reminiscence therapy, relaxation therapy) may be offered to older adults with anxiety. **(GRADE: Certainty of Evidence: Very low; Strength: Conditional)**

Recommendation #26

Exercise, including both aerobic exercise and strength training, reduces anxiety and may be recommended to older adults with anxiety symptoms. **(GRADE: Certainty of Evidence: Very Low; Strength: Conditional)**

Recommendation #27

Exercise, including Tai Chi and yoga, is effective to reduce fear of falling and may be recommended to older adults with fear of falling. **(A)**

Recommendation #28

Selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs) should be used as the first-line pharmacologic treatment for anxiety disorders in older adults. **(GRADE: Certainty of Evidence: Low; Strength: Strong)**

Recommendation #29

Benzodiazepines should not be used in the management of anxiety in older adults, except where non-pharmacological interventions and first-line pharmacological alternatives have failed, or for short-term use (2-4 weeks) until first-line treatments become effective. **(GRADE: Certainty of Evidence: Very low; Strength: Conditional against)**

Recommendation #30

Buspirone may be considered for the treatment of mild-to-moderate generalized anxiety disorder in older adults, in individuals where first-line treatments are not effective or tolerated. **(GRADE: Certainty of Evidence: Low; Strength: Conditional)**

Recommendation #31

Quetiapine should not be routinely used in the management of anxiety disorders in older adults, except where non-pharmacologic and first-line treatments have failed. **(GRADE: Certainty of Evidence: Low; Strength: Conditional against)**

Recommendation #32

Pregabalin should not be routinely used in the management of anxiety in older adults, except where non-pharmacologic and first-line treatments have failed. **(GRADE: Certainty of Evidence: Very low; Strength: Conditional against)**

Overview

The objective of these guidelines is to provide practical and evidence-based guidance on the prevention, diagnosis, and management of anxiety in older adults. The target audience is health care providers caring for the mental health of older adults, including primary care physicians, nurses and nurse practitioners, psychiatrists, psychologists, social workers, and other allied health professionals.

Anxiety is a reaction to stress and danger. It can be adaptive when it motivates someone to take the necessary steps to manage their stress or to reduce risk-taking to avoid real danger. Anxiety is maladaptive when it is excessive based on the actual stress or risk, is persistent, and leads to the avoidance of situations that are harmless (American Psychiatric Association, 2013). When anxiety is excessive or prolonged, it can have a large impact on older adults' quality of life and their ability to function day-to-day. It can interfere with relationships, activity levels, social engagement, and well-being (Porensky et al., 2009). Anxiety also has a negative impact on other aspects of health, including increasing the risk of heart disease and dementia (Burton et al., 2013; Roest et al., 2012). While many older adults will have had lifelong anxiety, some anxiety disorders begin in late-life. Late-life anxiety is often associated with depression, aging-related stressors and physiological changes such as medical illness, disability, and cognitive decline.

Anxiety disorders represent the most common mental health problem across the lifespan, including in late life. Every year, 18% of older Canadians experience symptoms of anxiety or depression that they find difficult to cope with (Canadian Institute for Health Information, 2022), and 6% of older Canadians have a diagnosed anxiety disorder (Statistics Canada, 2021), with generalized anxiety disorder (GAD) and phobias being the most common (Grenier et al., 2019). While guidelines exist for the treatment of anxiety disorders in the general adult population, older adults require special considerations. For example, differences in presentation of anxiety, ageism and stigma contribute to under-recognition and under-diagnosis of anxiety disorders in older adults (Bower et al., 2015). Older adults are less likely to report mental health struggles and seek care, and less likely to be referred for care (Cosco et al., 2022). The relationship between anxiety and medical diseases of aging can be complex. There are also challenges in balancing the potential benefits and harms of treatments for anxiety in older adults.

Evidence-based clinical practice guidelines for anxiety specific to older adults have the potential to improve care by increasing awareness of best practices and promoting a more consistent delivery of quality mental health services. In addition to older age, other determinants of health that contribute to disparities in mental health care include sex, race/ethnicity, indigeneity, migration, geography, sexual and gender identity, physical disability, educational attainment and socioeconomic status. These determinants are interdependent and interact to marginalize certain groups within our health care system. There is a need to create mental health resources that are accessible to underserved populations, by addressing structural and cultural barriers, mistrust, and stigma.

As part of our review of the evidence within the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology (Schünemann et al., 2013), the working group considered issues of accessibility of interventions and the impact of recommendations on health equity. The geography and population distribution of Canada presents specific equity challenges which contributed to our decision to examine the evidence for remote delivered interventions. We also considered the indirectness of our evidence to disadvantaged groups, who are dramatically under-represented in clinical trials. Overall, we identified a significant gap in research on the assessment and treatment of anxiety in older adults from disadvantaged groups.

Scope

For the purpose of these guidelines, we focused on symptoms of anxiety and DSM-5 anxiety disorders in older adults, specifically generalized anxiety disorder (GAD), panic disorder, agoraphobia, specific phobia, and social anxiety disorder (social phobia). Thus, posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) were not included, though they are important topics that warrant consideration in future guidelines. We have also included recommendations about fear of falling, which is an important cause of anxiety later in life, with its own unique clinical features and treatment approaches.

Given the challenges in diagnosing anxiety disorders in older adults, and the recognition that subthreshold anxiety symptoms can still cause significant distress and suffering (Grenier & Richer, 2021), we chose to include studies of clinically important anxiety symptoms in older adults in our literature search and review of evidence.

Definition of Key Concepts

For the purpose of these guidelines, older adults are defined as those 65 and older, although we have included studies with a cut-off of 60 and older, to ensure that all of the relevant evidence in older adults was captured.

Throughout this document, as appropriate, we either name the specific anxiety disorder (e.g., GAD), use the term "anxiety disorders" to refer to DSM-5 anxiety disorders, or use the term "anxiety symptoms" for clinically important but subthreshold anxiety symptoms. For brevity, when referring to both clinically important anxiety symptoms and anxiety disorders, we use the term "anxiety" alone (e.g., "older adults with anxiety").

Methods

The guidelines process followed the Guidelines International Network (GIN)-McMaster Guideline Development checklist (Guidelines International Network & McMaster University, 2002). A working group of multidisciplinary experts on seniors' mental health and anxiety disorders was gathered from across Canada and established the scope of the guidelines and the main questions to be addressed. A priority setting exercise was conducted by the working group, with input from an expert guidance group to define the scope of the guidelines, specific PICO research questions, and priority outcomes. The guidelines questions were as follows:

Prevention/Identification

1. What factors are associated with risk for anxiety in older adults
2. What are effective tools to detect anxiety in older adults in a clinical setting?*
3. What is known about a comprehensive approach to diagnosing anxiety in older adults?

Treatment

4. Does cognitive behavioural therapy reduce symptoms of anxiety in older adults compared to control?*
5. Does remote cognitive behavioural therapy reduce symptoms of anxiety in older adults compared to control?*
6. Does cognitive behavioural therapy reduce symptoms of fear of falling in older adults compared to control?*
7. Does mindfulness or meditation reduce symptoms of anxiety in older adults compared to control?*
8. Does psychotherapy (other than cognitive behavioural therapy) reduce symptoms of anxiety in older adults compared to control?*
9. Does physical activity reduce symptoms of anxiety in older adults compared to control?*
10. Do antidepressants, antipsychotics, benzodiazepines, buspirone, and/or gabapentinoids reduce anxiety in older adults compared to placebo?*

For questions where there was no recent high-quality systematic review available (indicated with asterisks above), we conducted our own systematic reviews. The full protocols for these reviews are registered in PROSPERO (CRD42023407837, CRD42023432100, CRD42023444208). References to these systematic reviews can be found here: *ccsmh.ca/anxiety-publications/*.

For the systematic literature search, "anxiety" was defined as both anxiety disorders (e.g., a diagnosis of Generalized Anxiety Disorder) and symptoms of anxiety and included specific search terms for fear of falling. Criteria for inclusion in the treatment systematic reviews were: 1) randomized controlled trials; 2) older adults (defined as eligibility criteria aged 60+ or mean age of sample 65+), and 3) studies where reduction in anxiety was the primary outcome. A rapid review on risk factors for anxiety was also undertaken. The remaining question (#3) on assessment and diagnosis of anxiety was addressed with a librarian-guided, focused search of best practice databases (BMJ Best Practice, CPG Infobase, TRIP Medical Database, JBI EBP Database, Ageline EBSCO), AccessMedicine (McGraw), and MEDLINE/PubMed (NLM) for literature on best practices in the diagnosis of anxiety disorders in older adults.

We used two methods in this guideline for signaling the strength of evidence underlying our recommendations. The first method was applied to all screening and treatment recommendations addressed through systematic review (those with asterisks above).

The certainty of evidence from our systematic reviews and meta-analyses was evaluated using the GRADE methodology (Table 1; Schünemann et al., 2013). GRADEPro software was used (GRADEpro GDT, 2023). The evidence was graded as high-, moderate-, low-, or very-low certainty, based on how likely future research would change the confidence of the working group in the estimate of the effect. Working group members met and voted on the direction and strength of recommendations, which reflected the extent to which the panel was confident that the desirable effects of an intervention outweighed the undesirable effects.

For best practice recommendations and those which were not directly addressing a systematic review question, we used an approach similar to previous CCSMH guidelines to signal the strength of the recommendation based on the level of evidence used to guide it (Shekelle et al., 1999). The available evidence was reviewed and its level classified based on its susceptibility to bias. These recommendations and their strength were voted on by working group members. The draft recommendations were reviewed by the external expert guidance group, a panel of older adults and caregivers with lived experience of anxiety, and in consultation with health care providers and academic experts.

Table 1. Strength of recommendations in this guideline.

Screening and treatment recommendations – GRADE from Schünemann et al. (2013).	
Certainty of evidence	
High	Research provides a very good indication of likely effect. The likelihood that the effect will be substantially different is low.
Moderate	Research provides a good indication of likely effect. The likelihood that the effect will be sustantially different is moderate.
Low	Research provides some indication of likely effect. However, the likelihood that it will be sustantially different is high.
Very Low	This research does not provide a reliable indication of the likely effect. The likelihood that the effect will be substantially different is very high.

Direction		
Strength	**For intervention**	**Against intervention**
Strong	Most individuals will benefit from this intervention	Most individuals will not benefit from this intervention
Conditional - need to consider the individual patient circumstances, their values and preferences	Some individuals may benefit from this intervention	While risks outweigh benefits in most cases, there may be circumstances where this intervention may be considered

Best practice recommendations	
Strength of recommendation	
A	Based on systematic review or meta-analyses of evidence
B	Based on controlled studies
C	Based on non-experimental/observational studies
D	Based on expert opinion or extrapolated from other categories of evidence above

Risk Factors and Case-Finding

Recommendation #1

Health care providers should be familiar with risk factors for anxiety in older adults. (D)

Case-finding for anxiety is most effective when targeted at higher risk older adults. The presence of risk factors associated with anxiety may prompt clinicians to consider the use of a screening tool to support case-finding or to inquire further about symptoms that comprise the diagnostic criteria for anxiety disorders. In a rapid review, we identified a number of factors associated with anxiety and/or fear of falling in older adults. These include (in alphabetical order):

- Cognitive impairment or decline
- Depression
- Female sex
- Functional limitations
- Insomnia
- Multimorbidity
- Pain
- Polypharmacy
- Poor health status (objective or subjective)
- Social isolation or loneliness
- Older age*
- History of falls or impaired balance*

**factors associated only with fear of falling*

One or a combination of these factors may contribute to the risk of anxiety or fear of falling which increases with age. These risk factors can cause heightened feelings of vulnerability and danger, worry about independence, or compromised ability to cope or access support (Brenes et al., 2008; Silva et al., 2022; Vink et al., 2008).

Aging on its own is not a risk factor for anxiety, other than for fear of falling. However, the relationship between multimorbidity and symptoms of anxiety in older adults is well described (Creighton et al., 2017; Vo et al., 2023). Chronic conditions, such as high blood pressure, COPD, cardiac disease, sleep disorders, and Parkinson's disease, or impairments, such as vision or hearing loss, are associated with an increased risk of anxiety (Silva et al., 2022; Vink et al., 2008). Further, there is a known link between pre-frailty or frailty in older adults and symptoms of anxiety (Tan et al., 2023). The specific medical and psychiatric comorbidities associated with anxiety, in particular depression and cognitive impairment, are discussed in more detail in the Assessment and Diagnosis section below.

High levels of stress, whether acute or chronic, are also associated with anxiety. For example, there is some evidence that psychosocial stressors such as living with low income, living in precarious housing, having unmet care needs, or experiencing ageism or discrimination, contribute to anxiety in older adults (Carden et al., 2022; Kang & Kim, 2022). There is a gap in evidence around risk factors for anxiety specific to ethnically and culturally diverse older populations. The mental health impacts, in Indigenous communities, of racism, colonialism and the residential school system, and the resulting social and economic disadvantages and loss of cultural ties, are well documented (Nelson & Wilson, 2017). The mental health of older Black and racialized adults is impacted by their lifetime experiences of racism and the effects of racism on their lives, including fewer economic opportunities and higher rates of trauma (L. L. Brown et al., 2020; D. R. Williams et al., 2003, 2010).

Immigrant older adults are also at risk for mental health issues, related to language and cultural barriers, and to intersecting factors such as poverty and discrimination (Lin, 2023).

Importantly, in our rapid review, we found some known protective factors for anxiety in older adults, including life satisfaction or described meaning in life, positive affect, and positive attachment (Hwang et al., 2020; Pai et al., 2019). Spirituality or religious affiliation is an important protective factor, particularly in the lives of Black and ethnically diverse older adults, where religious involvement supports social integration within a group centered around similar values and traditions (Nguyen, 2020). Social and community ties, and connection to culture are also key protective factors for Indigenous Elders.

Case-finding

Recommendation #2

Health care providers should familiarize themselves with tools to detect anxiety symptoms and disorders in older adults and consider using these tools to facilitate case finding in individuals at risk or who describe symptoms of anxiety. (D)

The use of clinical history is the cornerstone of medical care, but variations in practice can lead to mental health concerns being easily overlooked. Anxiety disorders in older adults are under-diagnosed, so a rigorous approach is needed (Bower et al., 2015). The use of screening tools can help clinicians complete a thorough assessment and support patients in recognizing symptoms of anxiety.

General population screening of anxiety symptoms or disorders among older adults cannot be recommended due to a lack of evidence that demonstrates a favourable balance of the benefits, risks, potential costs and feasibility. However, we recommend a case-finding approach whereby health care providers target screening for anxiety based on risk factors (in those with higher prior probability of having anxiety). Compared to the general population of older adults, the prevalence of anxiety symptoms increases when there are other risk factors (see list of risk factors in prior section). When assessing an older adult, if risk factors are present, either inquire about potential anxiety symptoms or use a detection tool. This approach allows for providers to be systematic in their approach to anxiety while also considering each patient as an individual.

It is important to note that most evidence-based anxiety assessment tools were developed in the English language and using Western medical and cultural frames. While translations into different languages are available, few have been culturally adapted or validated cross-culturally, and thus should be used with appropriate considerations across different ethnic and cultural groups (Bellamy & Hardy, 2015).

Recommendation #3

We recommend the use of the Geriatric Anxiety Inventory - 20 item version (GAI-20) for identifying clinically important anxiety symptoms or disorders within clinical settings and for individuals at risk. (GRADE Certainty of Evidence: Moderate; Strength of recommendation: Strong)

Recommendation #4

Consider the use of the Geriatric Anxiety Inventory - 20 item version (GAI-20) or short-form (GAI-SF) for case-finding for GAD within clinical settings and for individuals at risk. (GRADE Certainty of Evidence: Low; Strength of recommendation: Conditional)

To enable a case-finding approach, clinicians need accurate tools to detect anxiety symptoms in older adults. It is important to recognize that these tools are not diagnostic and are instead a first step to detect clinically important anxiety symptoms and the need for further assessment.

In a systematic review of tools for the detection of anxiety symptoms and disorders as compared to a reference standard (e.g., DSM-5 criteria), we identified 32 studies examining 23 unique tools. Based on this review, we identified that the Geriatric Anxiety Inventory - 20 item version (GAI-20) with a cut-off score of ≥9 can be used to screen broadly for clinically important anxiety symptoms and anxiety disorders (*Suppl. Table 1*). The GAI-20 also had the highest accuracy for identifying GAD in older adults, although the cut-offs studied varied between ≥11-14 (*Suppl. Table 2*). The Geriatric Anxiety Inventory - Short Form (GAI-SF) is a brief version of 5 items, which has similar accuracy for identifying GAD using a cut-off of ≥3 (*Suppl. Table 3*; Pachana et al., 2007).

Another tool that is commonly used in older adults is the Hospital Anxiety and Depression Scale - Anxiety Subscale (HADS-A; Zigmond & Snaith, 1983). With a cut-off of ≥8, it can also be used to screen for clinically important anxiety symptoms and disorders, although our review identified that it is less accurate than the GAI-20.

Other tools commonly used in general adult populations either have few validation studies in older adults, such as the Generalized Anxiety Disorder Assessment (GAD-7; Spitzer et al., 2006) or were found to be less accurate in older adults; for example, the Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990). While these screening tools are not specifically recommended, clinicians without access to the GAI-20 may use them with the understanding that there is less evidence for their validity.

When considering the use of case-finding tools, there are several requirements to consider, including time and feasibility within clinical practice. A potential barrier to the use of any tool is access and cost. The GAI is copyrighted with a cost for clinical use, which is a barrier in resource limited settings. Other tools such as the GAD-7 and PSWQ are freely available for use, and further study is needed on these and other tools to support their validity in older adults. Other requirements regarding the use of case-finding tools include ensuring that providers are trained on the use of the tool and integrating the use of tools within the clinical workflow.

Recommendation #5

We recommend the use of Rating Anxiety in Dementia (RAID) for identifying clinically important anxiety symptoms in older adults with dementia within specialty care settings. (GRADE Certainty of Evidence: Moderate; Strength of recommendation: Strong)

Individuals with dementia may have difficulty recalling or describing their symptoms. An informant-rated scale may be more appropriate in these circumstances. Tools that incorporate both the patient's views as well as those of the care-partner have better validity. The most studied and accurate tool is the Rating Anxiety in Dementia (RAID) scale (Shankar et al., 1999; *Suppl. Table 4*). A cut-off of ≥11 best optimized its sensitivity. The RAID has mostly been validated in nursing homes and specialty clinics (Geriatrics, Memory and Veterans' clinics); thus, further evidence is needed to recommend its use in other clinical settings.

Recommendation #6

Health care providers should ask about fear of falling and activity avoidance as part of the geriatric falls risk assessment. (D)

A falls history and falls risk assessment are key elements of the comprehensive geriatric assessment. Important screening questions for fear of falling are: *"Are you afraid of falling?"* and if yes, *"Have you restricted any activities because of this fear?"* (Belloni et al., 2020). These questions can help to identify older adults at risk of developing significant fall-related psychological issues or avoidance behaviours who may benefit from intervention. For a more comprehensive assessment of fear of falling, the falls efficacy scale-international (FES-I; 16- or 7-item) has strong evidence to support its validity (McGarrigle et al., 2023).

Assessment & Diagnosis

Recommendation #7

Older adults who screen positive for anxiety, or who are presenting with new or worsening anxiety that affects their daily functioning or well-being, should undergo a comprehensive assessment, including a history, physical examination, and appropriate investigations. (D)

Recommendation #8

The anxiety history should include the nature of the symptoms, their onset and duration, the severity of the symptoms (in terms of impact on daily functioning, presence of avoidance behaviours, and degree of distress associated with symptoms), the psychosocial stressors contributing to the symptoms, and the past mental health history. (D)

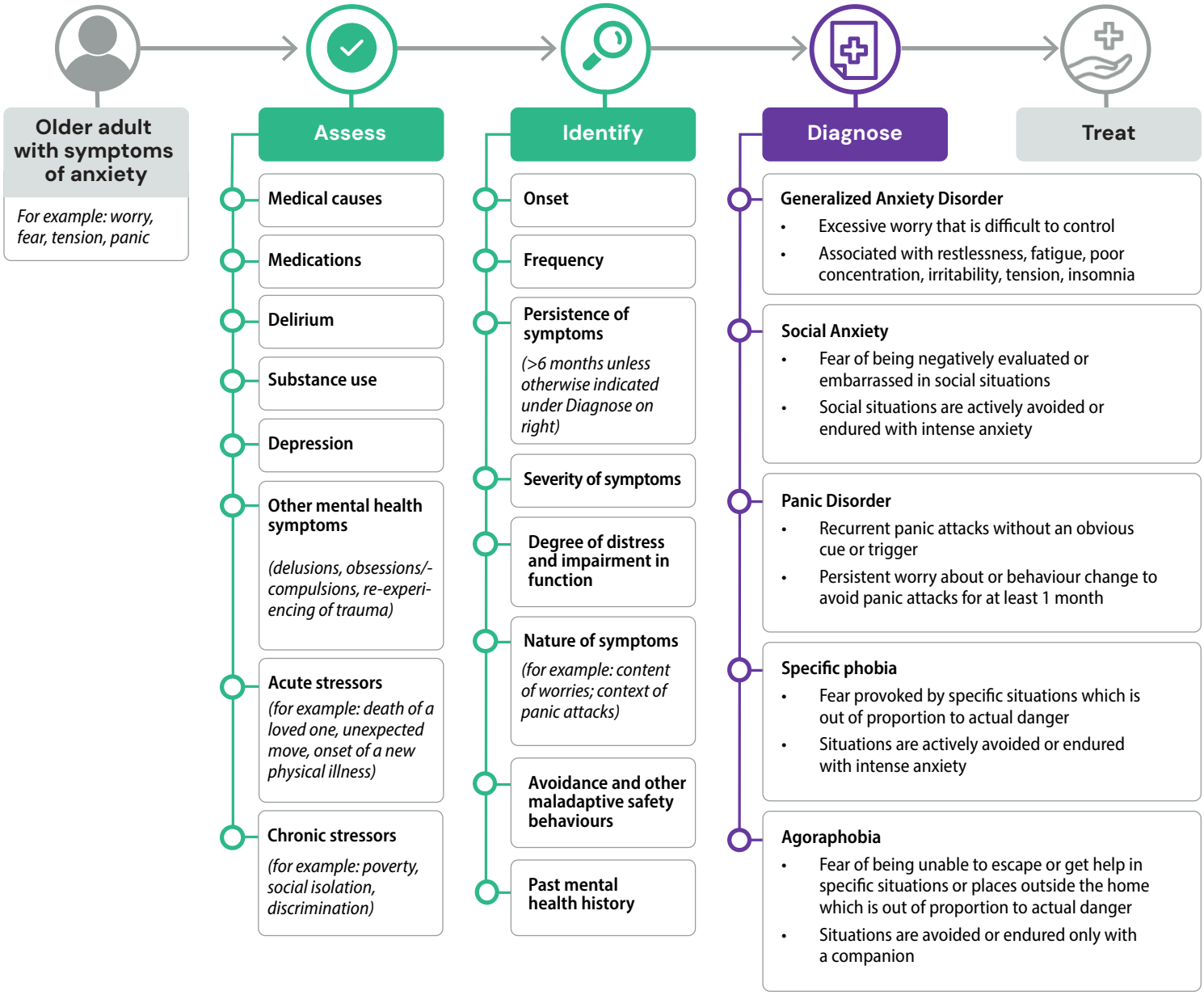
Older adults with anxiety most often present in primary care settings, but may not specifically endorse anxiety (Moult et al., 2020). Anxiety in older adults tends to manifest with more somatic symptoms and health worry (Hunt et al., 2003). Older adults may experience panicky feelings but are less likely to endorse full symptom panic attacks than younger people (Sheikh et al., 2004).

Older adults' changing social environment and roles mean that they can often find ways to avoid anxiety-provoking factors. Assessment of these avoidance behaviours can be difficult, particularly when it comes to distinguishing activity restrictions that are due to anxiety from those related to physical limitations. Older adults may not recognize that they are having symptoms of anxiety (Wetherell et al., 2009) and it is important to provide education about anxiety symptoms without stigmatizing or invalidating their experience. Collateral information from caregivers is useful in understanding the extent and impact of anxiety on daily function.

Ageist beliefs can also be a barrier to identifying that a fear is excessive or unreasonable or that avoidance behaviours are present. This is particularly challenging when some risk is present. An example is assessment of fear of falling in someone who has recently had a fall. Clues that fear may be excessive is when the person's appraisal of the risk is out of keeping with their actual risk, based on objective findings on examination. For example, older adults may adopt a hypervigilant or overly cautious gait that is inconsistent with their actual deficits in strength and balance.

Different cultural understandings around mental health also impact on reporting of symptoms, with many Indigenous and non-Western cultures drawing fewer distinctions between the mind and body, resulting in the experience of emotional distress through physical symptoms (Kim et al., 2012; Marques et al., 2011). Stigma around mental illness, language barriers, preferences to confide in someone familiar, and mistrust based on discriminatory healthcare experiences are all important factors that can serve as barriers to an assessment of anxiety symptoms in racialized and Indigenous older adults (Goetz et al., 2023; Lin, 2023; M. T. Williams et al., 2013).

Figure 1. Diagnostic Algorithm



Recommendation #9

Older adults presenting with anxiety should be screened for depression and suicidality. (D)

New onset of anxiety symptoms such as intense worry or panic may be a symptom of depression in older adults. About half of older adults with depression have a comorbid anxiety disorder, while 20% of those with a primary anxiety disorder will also meet criteria for depression (Wolitzky-Taylor et al., 2010). It is crucial to assess for depression in an older adult with new or worsening anxiety symptoms.

Anxiety is also a risk factor for suicide, both in conjunction with depressive symptoms and in the absence of depressive symptoms (Beghi et al., 2021; Fernandez-Rodrigues et al., 2022). CCSMH guidelines for assessment and treatment of depression and suicidality are available to support care (*CCSMH*, 2021; *CCSMH*, 2006).

Recommendation #10

A medical history and physical examination should be used to identify medical conditions that may be contributing to the symptoms of anxiety. Consider investigations that may help to rule out the presence of medical conditions that can cause symptoms of anxiety. (D)

Maintaining a broad differential diagnosis for late-life anxiety is important, as symptoms can be a prodrome or manifestation of medical or neurological disorders (e.g., Parkinson's disease, dementia, arrythmias, thyroid disorders, obstructive sleep apnea; Ann et al., 2023; Gallagher et al., 2011; Schrag et al., 2015). There are multiple ways in which anxiety and medical illness are related (American Psychiatric Association, 2013). For example:

1. Anxiety symptoms can be a direct physiological consequence of a medical condition, such as sensations of breathlessness in COPD or wearing-off symptoms in Parkinson's disease.
2. From a psychological perspective, anxiety can be a symptom of adjustment to a medical condition or disability.
3. An exacerbation of illness can lead to delirium which often presents with anxiety.
4. Anxiety can be persistent after resolution of an acute illness. For example, anxiety is common and can persist for months post-COVID infection (Bull-Otterson et al., 2022).

Older adults with medical comorbidities can also develop a primary anxiety disorder unrelated to their medical condition, with physical symptoms that they may or may not attribute to an existing medical condition. Anxiety is important to address in the context of other medical conditions as it can exacerbate certain conditions (e.g., cardiovascular disease) and impact older adults' ability to participate in and tolerate treatment (e.g., medical phobias).

To help understand the relationship between anxiety and medical conditions in older adults, it is important to take a history about the onset of anxiety and relationship to the course of the medical illness and any changes in treatment. Acute or subacute late-onset anxiety with atypical features (e.g., neurological findings, acute cognitive changes, loss of consciousness, incontinence, among others) should raise suspicion for anxiety due to a medical condition.

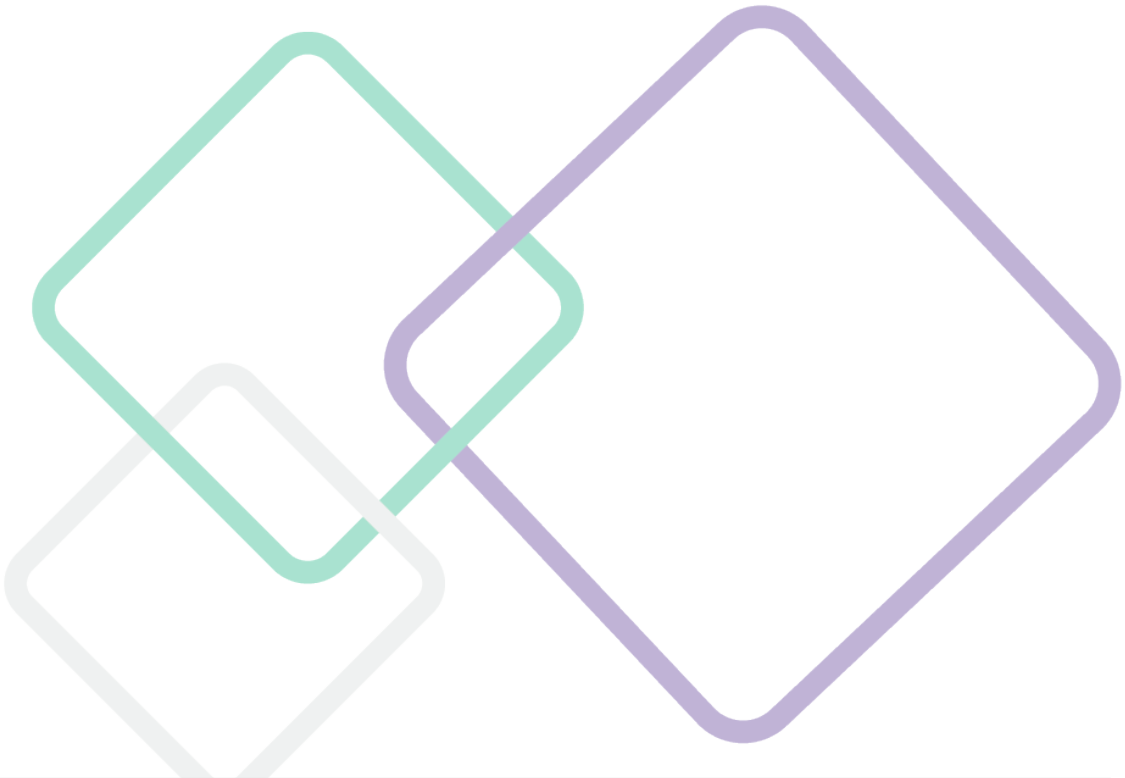


Table 2. Medical conditions associated with anxiety in older adults

Category	Example of medical conditions	
Endocrine	• Hyperthyroidism • Hypothyroidism	• Adrenal disease (including pheochromocytoma) • Parathyroid disease
Cardiovascular	• Myocardial infarction • Heart failure	• Angina • Arrhythmia • Heart valve disease
Respiratory	• COPD • Asthma	• Pneumonia • Obstructive sleep apnea
Metabolic	• Vitamin B12 deficiency • Hypoglycemia	• Electrolyte abnormalities
Neurologic	• Parkinson's disease • Dementia (e.g., Alzheimer's, vascular) • Delirium	• Vestibular dysfunction • Seizure disorder • Central lesion (brain tumor) • Encephalopathy

Adapted from American Psychiatric Association (2013) and Romanazzo et al. (2022).

There is an important bidirectional relationship between anxiety and cognitive impairment in older adults. A cognitive screening assessment should thus be considered when assessing anxiety symptoms. High levels of anxiety have a negative effect on cognitive performance by impairing attention and executive function. Anxiety can also be an early presenting symptom of dementia, in part arising out of awareness of and the stress of worsening memory slips and mistakes. It can be a signal that the cognitive demands of daily life are now exceeding an individual's capacities. There is also evidence that chronic anxiety, resulting in prolonged exposure to physiological stress responses such as hypothalamic-pituitary-adrenal (HPA) axis hyperactivity, sustained autonomic reactivity and immune system response, has a negative impact on brain and vascular health, and is a risk factor for dementia (Brosschot et al., 2006).

There are no routine investigations for late-life anxiety, although some medical conditions can be difficult to identify through physical examination alone. Indicated investigations depend on the patient presentation and assessment, and could include:

- Complete blood count, electrolytes (including calcium, magnesium, and phosphate), renal, liver and thyroid function tests, vitamin B12, glucose
- Urinalysis
- Oxygen saturation (pulse oximetry), chest x-ray
- Drug screening (urine or serum)
- Electrocardiogram, Holter monitor
- Cognitive screening assessment, for example; the Montreal Cognitive Assessment (MoCA; Nasreddine et al., 2005) and the Mini Mental Status Examination (MMSE; Folstein et al., 1975)
- Neuroimaging (e.g., head CT) is not usually indicated in the work-up for anxiety, unless separately indicated as part of the work-up for a related condition (e.g., cognitive impairment), or if there are focal neurological findings on history or examination.

Recommendation #11

A medication and substance-use history should be gathered in all older adults presenting with anxiety, including prescribed, over-the-counter and recreational drugs, and caffeine. (D)

Anxiety symptoms can be secondary to medications or recreational drugs. It is important to take a thorough medication history to establish a temporal relationship (if any) between medication initiation and onset of anxiety symptoms. As an example, some psychotropic medications can cause akathisia which can be experienced or described as anxiety. Medication adherence is also important to assess in older adults, particularly where medication errors might lead to delirium/toxicity presenting as anxiety (i.e., thyroid medication, insulin) or where missed medication doses may result in withdrawal (i.e., benzodiazepines, opioids, antidepressants).

It is also important to screen for substance use (e.g., alcohol, cannabis, nicotine use) and any potential role of substance intoxication, withdrawal, and chronic use on symptoms of anxiety. Ask about the use of over-the-counter medications, in particular anticholinergic agents. Recreational substances and over-the-counter medications are commonly misused to self-medicate for anxiety or other symptoms such as insomnia. Other natural products with psychoactive properties can also contribute to anxiety, such as ginseng and ginkgo biloba (Le et al., 2022).

Table 3. Medications and substances that may contribute to anxiety symptoms in older adults

Medications		
Class	**Examples**	**Comments**
Anticholinergics	• atropine • benztropine • bladder anticholinergics (e.g., oxybutynin) • antihistamines (e.g., diphenhydramine)	Anticholinergics can cause systemic side effects including tachycardia, hypertension, anxiety, and delirium.
Antidepressants	• SSRIs (e.g., paroxetine) • SNRIs (e.g., venlafaxine) • TCAs (e.g., amitriptyline)	Stimulating effects of some antidepressants can mimic anxiety causing restlessness or agitation, especially in the early stages of treatment.
Antimalarias	• chloroquine • hydroxychloroquine • mefloquine	Antimalarial medications can cause insomnia, vivid dreams, anxiety, depression, panic attacks, and hallucinations.
Benzodiazepines	• alprazolam • lorazepam	Benzodiazepines may cause anxiety in the context of withdrawal symptoms.
Beta-2 receptor agonists	• salbutamol	Common adverse effects of salbutamol are tremors (10-20%) and anxiety (9-20%).
Cardiac drug therapies	• diuretic class • digoxin • amiodarone • beta-blockers	In observational research, there is a 10-20% increased odds of anxiety in people on cardiovascular medications such as diuretics, nitrates, lipid-lowering drugs, digoxin, and beta-blockers (Rotvig et al., 2022).
Corticosteroids	• prednisvone • dexamethasone	Corticosteroid therapy has been associated with non-specific psychiatric symptoms including psychosis, hyperactivity, irritability, anxiety, insomnia, and depression.
Dopamine receptor antagonists	• antipsychotics • metoclopramide	Dopamine receptor antagonists can cause akathisia, which may manifest as psychomotor agitation and anxiety.
Dopamine receptor agonists	• levodopa • pramipexole	Anxiety and panic attacks are potential side effects of dopaminergic agonists.

Medications		
Class	**Examples**	**Comments**
Antiretrovirals	• efavirenz	Neuropsychiatric adverse effects, including anxiety occur in 25-70% of people living with HIV treated with efavirenz.
Stimulants	• amphetamine • methylphenidate	Anxiety is a common adverse effect related to stimulants.
Endocrine	• thyroid hormone (e.g., levothyroxine) • insulin • testosterone • estrogen (e.g., estradiol)	Supplemental hormones can contribute to symptoms of anxiety, as can discontinuation of hormones.
Opioids	• hydromorphone	Opioids can cause confusion and delirium presenting as anxiety. Opioid withdrawal can include symptoms of anxiety.
Substances		
Alcohol	• beer • wine • spirits	Small amounts of alcohol stimulate GABA and cause feelings of relaxation. Heavy drinking depletes GABA, causing increased tension and feelings of panic. Alcohol withdrawal can also cause symptoms of anxiety.
Caffeine	• coffee • soft drinks • energy drinks • tea	Caffeine is a central nervous system stimulant and can cause restlessness, feelings of uneasiness, and rapid heartbeat that mimic anxiety.
Cannabis	• THC	Both cannabis use and withdrawal may cause symptoms of anxiety.

Legend: SSRIs - selective serotonin reuptake inhibitors; SNRIs - serotonin and norepinephrine reuptake inhibitors; TCAs - tricyclic antidepressants, THC - Tetrahydrocannabinol

Note: This table of medication and substances is not exhaustive.

Adapted from American Psychiatric Association (2013) and Dong et al. (2015).

Treatment of Anxiety Symptoms and Disorders

This section focuses on interventions for the prevention and treatment of anxiety symptoms and disorders in older adults. The choice of treatment in older adults can be complicated by comorbid mental health, physical, or social issues. A range of treatment approaches and intensities should be considered to best match the patient with the optimal intervention(s).

In this section, we begin with consensus-based recommendations around the sequence and delivery of interventions, followed by specific evidence-based recommendations for non-pharmacological and pharmacological interventions.

Recommendation #12

Non-pharmacological interventions should be offered first, given the potential risk of adverse events associated with pharmacotherapy, except in circumstances dictated by patient preference, severity of symptoms and risk assessment. (D)

Many older adults experience anxiety symptoms, and in some cases, these symptoms improve on their own or with the provision of low-intensity supportive interventions. One study found that up to one-third of older individuals with subthreshold depressive and/or anxiety symptoms improve after a 3-month watchful waiting period. However, another one-fifth converted to a diagnosable anxiety or depressive disorder (Van Der Aa et al., 2015). Studies have identified a high rate of placebo response in clinical trials of late-life GAD, highlighting the contribution of non-pharmacological factors to symptomatic improvement. Similarly, in psychotherapy trials for anxiety in older adults, there are also robust responses in "active" control arms, such as supportive counselling. While the overall effect sizes for psychotherapy and medications for anxiety are similar (Pinquart & Duberstein, 2007), given that some older adults with anxiety symptoms improve with non-pharmacological interventions and psychosocial supports alone, we recommend that these be offered first, before the use of pharmacotherapy.

For individuals diagnosed with GAD, spontaneous remission is unlikely (Braam et al., 2014; Lenze, Mulsant, Mohlman, et al., 2005). It is important to monitor symptoms and response to non-pharmacological interventions and continue to revisit and optimize the treatment plan when there is a poor response. Individuals whose anxiety symptoms are persistent and severe should be considered for treatment with medication or medication plus psychotherapy (Schuurmans et al., 2009; Wetherell et al., 2013).

When anxiety symptoms are secondary to a medical condition, adjustment of the treatment or management of the medical condition should be implemented first (American Psychiatric Association, 2013). Similarly, treatment of anxiety secondary to substance use should focus on addressing the substance use. For example, an individual experiencing anxiety in the context of benzodiazepine withdrawal should be treated according to guideline recommendations for benzodiazepine withdrawal first. The CCSMH has existing guidelines that provide clinicians with guidance on the assessment and management of opioid, alcohol, benzodiazepine, and cannabis use disorders (*CCSMH*, 2019a; *CCSMH*, 2019b; *CCSMH*, 2019c; *CCSMH*, 2019d).

Patient values and preferences should always be considered when choosing a treatment, as numerous studies suggest that patients are more willing to initiate and adhere to treatments that match their preferences (McHugh et al., 2013; Swift et al., 2018, 2021; Winter & Barber, 2013). It is also important to keep in mind the patient's previous psychiatric history (e.g., history of bipolar disorder that increases the risk of hypomania or mania with antidepressant use, or previous adverse events with specific psychotropic medications or classes) when considering treatment options.

Recommendation #13

Stepped care, beginning with bibliotherapy, psychoeducation, and/or self-guided Cognitive Behavioural Therapy (CBT), should be considered to reduce anxiety symptoms and prevent the development of anxiety disorders in older adults. (B)

For individuals in community settings with subthreshold anxiety symptoms, there is evidence that a stepped care approach may yield benefits in improving anxiety symptoms and preventing the development of anxiety disorders compared to treatment as usual (Meuldijk & Wuthrich, 2019; Van Der Aa, Van Rens, et al., 2015; van't Veer-Tazelaar et al., 2009). Stepped care refers to a model where patients are provided easy access to low-intensity psychological treatments and supports, and those who remain symptomatic after this step are offered more intensive interventions in an escalating fashion. It is important to note that there is no evidence for this model of care for people with diagnosed anxiety disorders, and our recommendation excludes this population.

Typical stepped care programs begin initially with low-intensity interventions including guided self-help (including CBT), bibliotherapy, relaxation techniques, social prescribing, and psychoeducation. Response to these low-intensity interventions is then monitored over time. If symptoms do not improve, more intensive interventions such as therapist-led group or individual CBT are then offered. At this stage, medications may also be prescribed with primary care involvement. Finally, high-intensity services such as specialist referrals (e.g., psychologists, psychiatrists, geriatric psychiatrists, geriatricians) follow.

Stepped care is the approach used by the national Improving Access to Psychological Therapies (IAPT) program in the UK (Clark, 2011) and has had an important impact on access to psychological interventions. However, a knowledge gap persists in understanding the benefits of stepped care for older adults with anxiety disorders.

Studies of stepped care typically exclude older adults with cognitive impairment. However, almost all older adults can benefit from psychological interventions for anxiety. Learning disabilities, cognitive impairment, or dementia are not absolute contraindications to psychotherapy but warrant modifications including simplifying materials or shifting the focus to behavioural interventions (Rossiter & Holmes, 2013; Tay et al., 2019).

Recommendation #14

Psychosocial support should be offered to older adults presenting with anxiety symptoms, tailored to address risk factors and contributing stressors. (D)

It is important to be aware of the social determinants of health when developing a plan to treat anxiety. Anxiety can be a reaction to overwhelming psychosocial stressors and signal that there is a gap in the supports needed to cope. In such situations, identifying these stressors (e.g., finances, food insecurity, housing, social isolation, unmet care needs, discrimination, abuse or neglect) is critical (Davison et al., 2020; Ross et al., 2017; Thapa et al., 2020). It is important to work collaboratively with the older adult towards problem-solving and to empower them to identify the appropriate actions and take the correct actions. Social prescribing is a care approach in which care providers work to enhance and expand the existing support network of an older adult to appropriately address psychosocial stressors (Percival et al., 2022). Facilitating successful connections through social prescribing to non-medical community programs may mitigate some psychosocial risk factors for anxiety such as social isolation. Other key elements to the provision of support are scheduling regular contact and using active listening and validation skills. Tailored referrals to community-based seniors serving agencies are also valuable to ensure that an older adult has improved access to the appropriate social and instrumental supports.

Recommendation #15

Treatment response and efficacy should be monitored using standardized rating scales. (D)

Regardless of the modality of treatment implemented, the use of measurement-based care with regular and timely feedback of patient-reported symptoms to the treating provider has been well-established to significantly improve patient-reported symptom improvement and higher remission rates (Fortney et al., 2017). Scales can be used prior to treatment initiation and at regular time points during the treatment itself. However, clinicians should note that there is limited evidence about the responsiveness to change of commonly used scales for anxiety in older adults or the minimal clinically important differences in scores. With awareness of these limitations, scales that can be used to monitor treatment response include those recommended for case-finding (GAI-20, GAI-SF, RAID), or other commonly used scales such as the HADS or GAD-7. These scales are discussed in the Case-Finding section of these guidelines.

Non-Pharmacological Treatments

As part of the guideline priority-setting process, several non-pharmacological interventions for anxiety symptoms and disorders were selected for review. These included CBT (for anxiety and fear of falling), mindfulness, physical activity (for anxiety and fear of falling), and other psychotherapies excluding CBT. Interventions identified as lower priority (e.g., biofeedback, digital therapies, neurostimulation, and virtual reality, among others) were not reviewed, although these may form part of an update of future guidelines.

Access to psychotherapy is an important equity consideration discussed during the guideline process, particularly for low-income, rural, or culturally diverse older adults. Psychotherapies developed in the West are underpinned by Western cultural values and illness models and the studies reviewed either did not report on the ethnic or cultural background of participants, or the participants were predominantly White. There is thus some uncertainty about the effectiveness of the interventions reviewed in different ethnocultural groups. We did not find any evidence about cross-cultural adaptations of CBT specific to older adults with anxiety, although there is a broader literature in this area (Naeem, 2019). The increase in virtual delivery of psychotherapy services is a barrier to older adults without access to the internet due to cost or poor service in rural and remote areas.

Recommendation #16

Psychotherapy should be made available to older adults with anxiety in all settings (community, long-term care, etc.). (D)

Improving equitable access to psychotherapy for older adults in Canada was identified as a priority by our working group. The Mental Health Commission of Canada has set out some important recommendations and policy considerations for a national psychotherapy program, with the UK and Australian programs as possible models (Mental Health Commission of Canada, 2021). National investments in mental health care have led to the creation of some small stepped-care-based programs at the provincial level although the capacity and effectiveness of these programs, and their ability to increase psychotherapy access for older adults is still unclear. Older adults with anxiety disorders should be able to access psychotherapy irrespective of their financial resources, physical abilities/mobility, residential setting, and region of Canada.

Recommendation #17

CBT should be offered to older adults to treat anxiety. (GRADE: Certainty of Evidence: Low; Strength: Strong)

Cognitive-behavioural therapy (CBT) is a form of psychological treatment that seeks to identify and modify the factors (e.g., negative thoughts, avoidance behaviours) that trigger and maintain late-life anxiety. These objectives are achieved by teaching strategies that enable the anxious older person to establish links between his or her thoughts, feelings and actions. In our meta-analysis, to be considered CBT, the intervention had to include cognitive and behavioral strategies.

Compared to no intervention (i.e., waiting list or usual care), CBT has a large effect size in reducing anxiety symptoms, achieving response or remission of anxiety disorders, improving quality of life, and reducing depressive symptoms associated with anxiety (*Suppl. Table 5*). Interestingly, there was no significant difference between CBT and active comparator interventions (e.g., enhanced care, supportive therapy, or other psychotherapeutic intervention), for reduction of anxiety symptoms, although there were still benefits of CBT for quality of life and depression.

The majority of studies have been in older adults with a primary diagnosis of GAD or with symptoms of GAD. There are two studies (Hendriks et al., 2010; Livermore et al., 2010) that provide evidence that CBT can reduce symptoms of panic and anxiety in older adults with panic disorder.

Most evidence for the efficacy of CBT in the treatment of anxiety in older adults is derived from studies of relatively healthy older adults. Three RCTs demonstrated a benefit for CBT in the treatment of anxiety or panic in people with COPD (Bove et al., 2016; Heslop-Marshall et al., 2018; Livermore et al., 2010) and Parkinson's disease (Lawson et al., 2013). In people with cancer (Trevino et al., 2021), dementia (Spector et al., 2015) or caregivers of people with dementia (Tamura et al., 2023), the evidence was less conclusive regarding the efficacy of CBT in relieving anxiety.

While there was limited empirical evidence from our systematic review about treating older adults with anxiety and comorbid physical or cognitive impairment, CBT should still be considered as a treatment option for this population. Outside of our review, there is evidence that CBT can be successfully adapted to a wide range of older people with different anxiety disorders, and different physical and cognitive abilities, including individuals with mild cognitive impairment (MCI) and dementia (Jin et al., 2021).

As a general rule, so long as the older adult is willing to participate and find concrete ways of managing their anxiety in the here and now, CBT can be offered as an intervention. However, it is necessary to adapt CBT by simplifying and repeating emotion management strategies, and adding strategies that promote learning (e.g., the older person with cognitive impairment is encouraged to record emotion management exercises on a memory aid to be displayed at home). Other forms of accommodation that may be useful for people with cognitive impairment include telephone calls between CBT sessions to resolve problems and remind people of exercises to do at home, as well as reducing the length of CBT sessions and group size. The inclusion of a caregiver in the therapeutic process, who helps the person with cognitive impairments use the CBT strategies taught, may also be beneficial.

Recommendation #18

Both individual and group CBT are effective and can be offered to treat anxiety in older adults. (A)

In our systematic review, there was no statistically significant difference between individual and group CBT in the reduction of symptoms of anxiety when compared to usual care. However, individual CBT was associated with higher likelihood of achieving response criteria for anxiety symptoms or achieving remission of GAD compared to group therapy.

The most appropriate format will depend on the clinical setting, the feasibility and resources available, and the patients' needs and preferences. From a healthcare delivery perspective, group CBT may increase accessibility of treatment to a larger number of older adults, which is advantageous when there are limited resources. However, CBT in an individual format enables the clinician to better adapt the therapeutic strategies/tools taught to the needs and preferences of the older adult.

Recommendation #19

Both brief and full CBT are effective and can be offered to treat anxiety in older adults. (A)

In our systematic review, brief CBT was defined as CBT requiring fewer therapeutic contacts (maximum 6 hours of contact and sessions) compared to full CBT, and which can be delivered by trained clinicians or providers with less specialized training, often using online materials. The results showed that brief and full CBT were not significantly different in their benefits for symptoms of anxiety or depression when compared to usual care. The intensity of the brief CBT interventions studied ranged from a single-session CBT (1 hour at home) followed by a 20-minute booster session (Bove et al., 2016) to 6 biweekly 30 minutes CBT sessions over three months (Heslop-Marshall et al., 2018), both studied in older adults with chronic obstructive pulmonary disease (COPD) and anxiety. The other three studies (Dear et al., 2015; Jones et al., 2016; Silfvernagel et al., 2018) classified as brief CBT tested the efficacy of online CBT in healthy older adults with anxiety.

Brief CBT is a good option for older adults with new or mild-to-moderate anxiety and those with comorbidities who may find it challenging to participate in a full course of CBT.

Recommendation #20

Remote CBT is effective and should be offered as a treatment option for anxiety in older adults. (GRADE: Certainty of Evidence: Low; Strength: Strong)

For the purpose of our systematic review, remote CBT was defined as any form of CBT where there was no in-person contact with a therapist. We included five studies of remote CBT in older adults with anxiety symptoms or GAD, including internet-based CBT (iCBT) and telephone CBT. The results demonstrated that remote CBT was effective in reducing symptoms of anxiety in older adults compared to usual care (*Suppl. Table 6*). When comparing remote and in-person CBT, there was no difference between the modalities for reduction of symptoms of anxiety, but in-person had a larger impact on reduction of symptoms of depression compared to remote.

More and more Canadian seniors are now connected to the internet and have access to computers, tablets or smartphones. Remote CBT is effective to treat anxiety in older adults and improves access to psychotherapy for older people living in underserved areas or for those with mobility problems.

Recommendation #21

Specific CBT strategies can be used on their own to treat anxiety in older adults including exposure, relaxation therapy, abdominal breathing, cognitive restructuring, and problem-solving training. (B)

CBT strategies used by clinicians can be divided into two categories: cognitive strategies (e.g., cognitive restructuring, psychoeducation) and behavioural strategies (e.g., exposure, relaxation therapy). While these strategies are typically used in combination, they can also be used individually as skills and techniques to treat anxiety in older adults. For example, a systematic review (Jayasinghe et al., 2017) found that a range of exposure techniques (*in vivo*, interoceptive, imaginal) in older adults were effective to treat GAD, specific phobias, and panic. Relaxation therapy on its own, such as instruction in diaphragmatic breathing, progressive muscle relaxation, and guided imagery, is also an effective and acceptable intervention for older adults.

CBT strategies can help older adults acquire the tools they need to find solutions to their problems in the here and now. For example, the clinician can provide psychoeducation to introduce the concept of the anxiety cycle, to help an older adult understand the relationship between their thoughts, feelings, and behaviours. The clinician can also teach the older person new behaviours (e.g., coping strategies instead of avoidance) and new skills (relaxation, abdominal breathing) that will help them confront fears and reduce their anxiety.

Recommendation #22

CBT should be delivered by or under the supervision of mental health professionals (e.g., registered psychologists, psychotherapists, psychiatrists, social workers, nurses) with appropriate training. (D)

There is a need for mental health workforce planning such that there is adequate capacity of trained and skilled therapists with knowledge of CBT and mental health and aging. It is important that therapists have some knowledge and skills in how to adapt therapy for older adults, including for those with cognitive impairment (Laidlaw, 2021). For example, it may be important to take sensory losses into account, to use cognitive therapy to challenge self-directed ageist beliefs, or to include strategies in therapy to help the older adult better cope with life changes/losses/transitions that can trigger anxiety. Therapists also need to learn to identify and challenge their own ageist beliefs, which may serve as a barrier to effective treatment (Bodner et al., 2018). In addition to theory, training should include clinical supervision so that newly trained professionals can be observed by an experienced mental health professional during the application of knowledge/strategies specific to seniors' mental health.

Recommendation #23

Clinicians should consider the use of CBT for older adults who are experiencing a fear of falling, particularly for individuals whose function or quality of life is severely limited due to anxiety around falls. (GRADE: Certainty of Evidence: Very Low; Strength: Conditional)

Fear of falling should be assessed in conjunction with a comprehensive evaluation of the risk of falling. When the fear of falling is excessive, i.e., exceeds the actual risk of falling, and has a negative impact on function and quality of life, CBT may be considered.

In existing systematic reviews (Liu et al., 2018; Papadimitriou & Perry, 2020) and our updated review, CBT has been shown to be beneficial for reducing the fear of falling and improving falls efficacy (defined as confidence in one's ability to remain upright and not fall) with a small effect size (*Suppl. Table 7*). These benefits endure beyond the end of the intervention. CBT for fear of falling includes cognitive interventions to restructure faulty beliefs about falling and behavioural interventions to support behaviours that reduce fear, primarily exposure to physical activity. The majority of studies used an adaptation of the program Matter of Balance: Managing Concerns About Falls (Haynes et al., 2014). This program is a manualized approach of 8 modules that incorporate CBT elements, delivered by 2 trained coaches. Almost all studies also included some form of exercise or physical activity, although the aim of the activity varied (e.g., balance training, strength/endurance).

While clinicians should consider the use of CBT to support older adults experiencing a fear of falling, the recommendation is conditional as it is unclear whether the intervention is generalizable to the wider population and lack of evidence for CBT as a stand-alone intervention. The studies focused primarily on community-dwelling older adults, leaving less known about older adults in other settings where fear of falling is more common, such as acute or long-term care, and in those with cognitive impairment.

Recommendation #24

Mindfulness interventions may be used to effectively treat anxiety in older adults. (GRADE: Certainty of Evidence: Low; Strength: Conditional)

Mindfulness-based interventions (MBIs) can take various forms, including (but not limited to) Mindfulness-Based Stress Reduction (MBSR), Mindfulness-Based Cognitive Therapy (MBCT), and Emotion-Focused Mindfulness Therapy (EFMT). Mindfulness represents the core skill within MBIs, focusing on the present moment with a particular orientation toward openness, curiosity, and acceptance (Bishop et al., 2004; Kabat-Zinn, 2003). Through awareness and meditation practices (e.g., noticing, accepting, quieting the mind, mindful breathing), MBIs promote positive change in cognitive biases, affective dysregulation and emotional reactivity, physiological reactivity and arousal, and interpersonal effectiveness (K. W. Brown et al., 2007; Curtiss et al., 2017; Feldman et al., 2016; Hicks et al., 2020).

Our conditional recommendation in favour of mindfulness in the treatment of anxiety in older adults is based on the available evidence of three randomized controlled trials of MBSR, MBCT, and EFMT. In all three trials, there was a significant improvement in anxiety symptoms and quality of life (*Suppl. Table 8*). There is more to be learned about the characteristics of older adults who may benefit from mindfulness in comparison to other treatment options. Additional research on the long-term benefits of mindfulness on preventing relapse of anxiety among older adults is needed.

Availability and accessibility of MBIs vary by region. Self-guided, online and virtual MBIs can help to promote accessibility, although more research is needed to understand their impact on anxiety symptoms and anxiety disorders of older adults, including their acceptability, effectiveness, and recommendations about who may benefit most (Denkova et al., 2023; Hatch et al., 2023).

Recommendation #25

Other forms of psychotherapy or psychosocial treatments (e.g., supportive therapy, acceptance and commitment therapy, reminiscence therapy, relaxation therapy) may be offered to older adults with anxiety. (GRADE: Certainty of Evidence: Very low; Strength: Conditional)

While CBT is the most well-studied psychotherapeutic intervention for anxiety there are other psychotherapies with evidence of efficacy in treating anxiety in older adults including relaxation therapy, various forms of supportive therapy/counselling, reminiscence therapy, and Acceptance and Commitment therapy (ACT; *Suppl. Table 9*). The commonality between these interventions is that they offer psychological support that goes beyond what is offered in usual care.

Generally, the available evidence for non-CBT psychotherapies and psychosocial interventions is small but highlights important treatment options that can be offered to older adults with anxiety symptoms or disorders, particularly when first-line treatments like CBT are not available or accessible. Additional data are needed to assess the longer-term outcomes of these studies and generalizability across larger populations and diverse settings, including for older adults with cognitive impairment who were excluded from most studies. Studies are also needed to inform the use of other non-CBT therapies (e.g., interpersonal psychotherapy, problem-solving therapy, psychodynamic therapy) in older adult populations with anxiety.

Recommendation #26

Exercise, including both aerobic exercise and strength training, reduces anxiety and can be recommended to older adults with anxiety symptoms. (GRADE: Certainty of Evidence: Very Low; Strength: Conditional)

Based on our systematic review and meta-analysis, exercise improves anxiety symptoms with a moderate effect size although our confidence in the effect was reduced by serious inconsistency and risk of bias (*Suppl. Table 10*). Exercise interventions included gym-based programs, home exercise programs and both individual and group-based programs. Studies examined aerobic exercise, strength-training, or a combination of both. When looking at subgroups of resistance or aerobic exercise, or limiting to studies of healthy older adults, the benefit for anxiety persisted but there was less inconsistency.

For the most part, the studies included community-dwelling older adults with mild-to-moderate anxiety symptoms at baseline, and only one study included older adults with anxiety disorders. Thus, we do not have evidence to recommend exercise specifically for the treatment of anxiety disorders.

We have made a conditional recommendation of exercise for anxiety symptoms based on the very low certainty evidence. However, paired with other, higher quality evidence for exercise, such as for reduction in falls, osteoporosis, cardiovascular disease and depression (Hallal et al., 2012; Heart and Stroke Canada, 2023; Osteoporosis Canada, 2023; Tricco et al., 2017), we conclude that exercise is an important and impactful intervention in older adults with relatively few risks or downsides.

While there are many health benefits to increased physical activity in older adults, 60% of Canadians over the age of 65 do not achieve recommended levels of physical activity (Statistics Canada, 2023). Interventions focused on behaviour change are important in increasing physical activity levels of older adults (Grande et al., 2020). For example, The Fountain of Health is a manualized intervention developed in Canada and designed to help clinicians have conversations with patients to support health behaviour change, such as increased activity (Thoo et al., 2015).

There are barriers to accessing exercise programs or interventions for older adults, however these can be mitigated (Bethancourt et al., 2014; Costello et al., 2011). There are free or low-cost options (e.g., walking), providers can refer to group exercises, or physiotherapy as appropriate to develop an exercise program they can continue on their own. Many institutions have reduced cost passes for older adults, and older adult classes available. There are many available Canadian resources to help older adults choose exercises based on their physical fitness and abilities (Active Ageing Canada, 2023; Canadian Society for Exercise Physiology, 2011; Canadian Society for Exercise Physiology, 2021). National guidelines for physical activity for older adults are also available (*CSEP*, 2021). Providers can empower patients, provide exercise prescriptions, refer to local programs and ensure that they understand the importance of exercise as it pertains to their mental and physical health (Mathews et al., 2010).

Recommendation #27

Exercise, including Tai Chi and yoga, is effective to reduce fear of falling and may be recommended to older adults with fear of falling. (A)

Several systematic reviews have confirmed that exercise interventions are effective to reduce the fear of falling in older adults, with small to moderate effect sizes, although it's unclear how long these benefits persist once the exercise program ends. Some exercise programs not only reduce the fear of falling but lead to objective improvements in balance and a reduction in falls rates (Kendrick et al., 2014; Kumar et al., 2016; Zhang et al., 2023).

Pharmacological Treatments

These guidelines focus on medications that have been investigated in randomized placebo-controlled trials for the treatment of older adults (over 60 years of age) with anxiety disorders and clinically significant anxiety symptoms. Drugs without this level of evidence in older adults are not included in our recommendations at this time. While some medications are commonly used in clinical practice (e.g., mirtazapine, trazodone), it is important to note that there is no specific evidence-base for their efficacy, tolerability, or safety in older adults who are being treated for anxiety disorders. Other substances such as cannabidiol (CBD) were also not included in our review: the recent CCSMH guidelines on cannabis use did not identify any quality evidence supporting the use of CBD or other cannabinoids in the treatment of anxiety in older adults (*CCSMH*, 2019d). This will be revisited in future updates.

Most of the medication trials included individuals with diagnosed anxiety disorder (primarily GAD and panic disorder), although a few studies included individuals with clinically significant (highly distressing and impairing), but subthreshold, anxiety symptoms. It is important to note that we did not find evidence for the use of medications for specific phobias or fear of falling in older adults: the treatment for phobias is based on CBT, particularly exposure therapy.

Our recommendations regarding medication use to manage anxiety rely upon access to the recommended medications. One in six older adults in Canada is unable to take their medications as prescribed due to issues with affordability (Advisory Council on the Implementation of National Pharmacare, 2019). Additionally, we are in a period of unprecedented challenges with drug shortages that make affordable medication unattainable in some circumstances (Lau et al., 2022). Access to pharmacies, particularly in rural communities, is another barrier (Grootendorst, 2022; Timony et al., 2022). Healthcare providers should be aware of these barriers and advocate for access to medications.

The appropriateness of prescribing is another important equity issue. Women and low-income older adults are more likely to encounter inappropriate prescribing, particularly of benzodiazepines, which increases risk of polypharmacy, adverse drug events, or drug-drug interactions (Canadian Institute for Health Information, 2016).

Detailed prescribing and monitoring information for the medications recommended here are available at this link: *www.gerimedrisk.com/CCSMH.htm*

Recommendation #28

Selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs) should be used as the first-line pharmacologic treatment for anxiety disorders in older adults. (GRADE: Certainty of Evidence: Low; Strength: Strong)

Our meta-analysis included seven placebo-controlled studies of SSRI or SNRI medications in older adults. Four studies investigated the treatment of GAD (Alaka et al., 2014; Davidson et al., 2008; Katz et al., 2002; Lenze et al., 2009), two studies a mix of anxiety disorders (Lenze, Mulsant, Shear, et al., 2005; Schuurmans et al., 2006), and one study anxiety symptoms in chronic obstructive airways disease (Usmani et al., 2018). Antidepressants were found to be superior to placebo with respect to improvement in anxiety symptoms, response or remission of the anxiety disorder, function, and quality of life (*Suppl. Table 11*). The clinical trials of SSRIs and SNRIs did not find any differences between drug and placebo in discontinuation due to side effects. Overall, these findings suggest that appropriately selected SSRIs and SNRIs are efficacious, and well tolerated in the acute treatment of GAD in older adults. By looking at both the small amount of evidence for the treatment of other anxiety disorders in older adults and the larger evidence base in young and middle-aged adults, we also recommend antidepressants for the treatment of panic disorder and social anxiety disorder in older adults.

See Table 4 for specific drug and dose recommendations and links to expert-reviewed and evidence-based drug summaries to guide prescription and monitoring. Any of the first-line agents listed in Table 4 would be a reasonable choice for the treatment of GAD in later life. Escitalopram, sertraline, and venlafaxine have favorable pharmacokinetic and tolerability profiles in older adults with minimal propensity for drug-drug interactions. In addition to treatment for GAD, sertraline is the first-line SSRI for panic disorder and social anxiety disorder, given that it has Health Canada/ Federal Drug Administration approval for the treatment of these disorders, based on studies of mixed-age samples. Sertraline also has considerable flexibility in dosing without the risk of QTc prolongation at higher doses that is a concern with escitalopram and citalopram.

Duloxetine is both an inhibitor and substrate of CYP2D6 and thus has the potential for interaction with other drugs metabolized by this enzyme; this property of duloxetine has led us to recommend it as a second-line agent.

When prescribing an antidepressant, it is important to consider the risks and benefits in the context of the individual, their medical conditions, and other prescribed medications. Rare, but serious, adverse events associated with SSRIS and SNRIs include hyponatremia (particularly in individuals with low sodium), bleeding risk (particularly in individuals at risk for bleeding or with a history of recent bleed), and serotonin syndrome (in individuals on multiple serotonergic agents).

If started at too high a dose, serotonergic drugs may initially exacerbate symptoms of anxiety and, therefore, a starting dose at the bottom of the range in Table 4 (or even half of starting dose in individuals with a history of anxiety exacerbation with antidepressants) is often indicated in older adults. Once it has been established that the patient is tolerating the starting dose, the dose should then be gradually increased to the usual therapeutic range.

Anxious patients frequently misattribute somatic symptoms of anxiety to the adverse effects of medication. Adherence with medication can be enhanced by discussing potential side effects (as well as the misattribution of symptoms of anxiety to side effects) at the time of starting treatment, providing frequent monitoring of the patient during the first few weeks of treatment, and ensuring availability of the clinician by telephone between appointments to address any questions or concerns that the patient may have about treatment. It is also important to address expectations about the onset of benefit—most clinical trials do not see improvement in symptoms until 4-6 weeks after reaching a treatment dose, and most improvement takes place between 6-8 weeks of treatment.

When there is an incomplete response to treatment, ensure that there has been an adequate treatment trial in terms of dose, duration, and adherence. Given that SSRIs and SNRIs are different drug classes, switching from one class to the other is a reasonable approach in the case of inadequate response to a therapeutic trial of the first drug—usually, the SSRI is started as the first-line drug. Treatment can be augmented by adding psychotherapy (Wetherell et al., 2013). There is no current evidence to guide

treatment augmentation with medications for anxiety in older adults, and individuals with treatment-resistant anxiety disorders should be considered for referral to specialist psychiatric consultation.

Antidepressants not included in this treatment recommendation include paroxetine, mirtazapine, vortioxetine, bupropion, and trazodone. Paroxetine has a less favorable pharmacokinetic profile in older adults (including potent CYP2D6 inhibition) and has the potential to cause anticholinergic adverse effects. The other medications listed above either do not have specific evidence or indications for anxiety or lack evidence in older adults.

Recommendation #29

Benzodiazepines should not be used in the management of anxiety in older adults, except where non-pharmacological interventions and first-line pharmacological alternatives have failed, or for short-term use (2-4 weeks) until first-line treatments become effective. (GRADE: Certainty of Evidence: Very low; Strength: Conditional against)

There is no evidence supporting the long-term efficacy of benzodiazepines for anxiety disorders in older adults. All studies found in our review are of four or less weeks in duration and have a significant risk of bias (*Suppl. Table 12*). Decades of observational research show that benzodiazepines are poorly tolerated in older adults, and are associated with a risk of harm including falls, fractures, cognitive impairment, dementia, delirium, sedation and motor vehicle accidents (*CCSMH*, 2019b). In addition, chronic use of benzodiazepines can lead to physiological dependence (i.e., tolerance and/or withdrawal) and psychological dependence. The potential for abuse, misuse or addiction is high, particularly in individuals with anxiety disorders. While benzodiazepines provide some short-term relief from anxiety symptoms, there is often a paradoxical long-term worsening of anxiety, possibly through rebound anxiety, inhibition of cognitive processing, promotion of avoidance and prevention of fear extinction (Guina & Merrill, 2018).

When short-term prescription of benzodiazepines is being considered, there are evidence-based approaches to prescribing that will help to reduce the risks of harms including prevention of benzodiazepine use disorders. These are outlined in more detail in the Canadian Coalition for Seniors' Mental Health guidelines on benzodiazepine use disorders (*CCSMH*, 2019b) and include:

1. Assessing for risk of benzodiazepine use disorder and risk of harms.
2. Informing the older adult about the risks and limited benefits of benzodiazepines and alternative treatments.
3. Developing a shared understanding about how to use the benzodiazepine (duration of no more than 2-4 weeks) and plan for monitoring treatment response, adverse effects, and/or development of benzodiazepine use disorder.

In terms of choice of agent, benzodiazepines with very long or very short half-lives should be avoided, and doses should be carefully moderated as the risks are dose-dependent (Table 4).

Several guidelines (Pottie et al., 2018; *www.cfp.ca/content/64/5/339)* and educational tools (Canadian Medication Appropriateness and Deprescribing Network, 2023; *www.deprescribingnetwork.ca/patients-and-public)* are available to support benzodiazepine deprescribing in older adults. It is important to support patients to build confidence in their coping skills without the drug, and to provide education to distinguish between the time-limited withdrawal anxiety symptoms they may experience during deprescribing and worsening of their baseline anxiety symptoms.

Recommendation #30

Buspirone may be considered for the treatment of mild-to-moderate generalized anxiety disorder in older adults, in individuals where first-line treatments are not effective or tolerated. (GRADE: Certainty of Evidence: Low; Strength: Conditional)

In three small studies, buspirone had a small benefit for GAD of mild-to-moderate severity with few and mild side effects (*Suppl. Table 13*). Three times per day dosing limits treatment feasibility. Buspirone may be considered in individuals with mild-to-moderate GAD who do not tolerate antidepressant therapies, but there is no evidence to support its role for severe or difficult to treat anxiety disorders in older adults.

Recommendation #31

Quetiapine should not be routinely used in the management of anxiety disorders in older adults, except where non-pharmacologic and first-line treatments have failed. (GRADE: Certainty of Evidence: Low; Strength: Conditional against)

There is no evidence to support the use of antipsychotics for anxiety disorders in older adults outside of a single study of extended-release quetiapine (Mezhebovsky et al., 2013). This randomized, double-blind trial compared extended-release quetiapine fumarate monotherapy to placebo over 11 weeks in 450 older adults (mean age 71 years) with GAD, titrated to a maximum of 300 mg daily (mean dose 168 mg daily). While the treatment group had a statistically significant reduction in symptoms of anxiety, increased rate of remission, and an increase in quality of life, the magnitude of the benefit was modest (*Suppl. Table 14*). There were few dropouts but an increased level of sedation in the quetiapine group. Known risks associated with quetiapine, including sedation, falls, hypotension, cognitive impairment, metabolic side effects and QTc prolongation in older adults, and risk of stroke/death in older adults with dementia, make it difficult to recommend quetiapine based on this single study.

Overall, we recommend antipsychotic medications should not be used routinely in the treatment of an anxiety disorder in older adults. If reasonable trials of first-line management options including psychotherapy and medications fail, quetiapine may be considered an option, with careful discussion with patients about the risks and side effects, and slow and careful dose titration while monitoring for side effects.

Recommendation #32

Pregabalin should not be routinely used in the management of anxiety in older adults, except where non-pharmacologic and first-line treatments have failed. (GRADE: Certainty of Evidence: Very low; Strength: Conditional against)

We recommend against the routine use of gabapentanoid medications (pregabalin, gabapentin) in the management of anxiety disorders in older adults, based on the limited evidence for efficacy in this population and concerns about tolerability.

The one available study of pregabalin (mean total dose 270 mg/day) in older adults (mean age 72 years) for the treatment of GAD showed a statistically significant benefit of questionable clinical significance on anxiety symptoms and no benefit for anxiety remission over 8 weeks of treatment (*Suppl. Table 15*). There were no differences in serious adverse events but concerns around tolerability exist given the number of dropouts.

These findings in older adults are in contrast to the body of evidence for the use of pregabalin for the treatment of anxiety disorders in younger adults (typically aged 18-65 years; Feltner et al., 2011; Greist et al., 2011; Hadley et al., 2012; Kasper et al., 2014), and its approval for this indication in some countries (but not North America). The adverse effects found with pregabalin increase with age, comorbidity (e.g., renal and cardiac disease), frailty, and are dose-dependent (Muanda et al., 2022). Adverse effects such as gastrointestinal distress and dizziness are common, but there are also more serious risks such as cardiovascular events (Pan et al., 2022). Given concerns about tolerability and potential for adverse effects, there is a need for an individualized assessment of risk based on age, health status and previous history of response to treatment. There may be separate indications for gabapentanoids in older adults with chronic pain, but the efficacy and tolerability for this indication and patient population did not form part of our review.

Overall, pregabalin should not be used routinely, but can be considered in older adults with difficult-to-treat anxiety, with a full discussion about the risks and benefits. There were no studies that investigated gabapentin for the treatment of anxiety disorders in older adults and therefore no recommendations about gabapentin can be made.

Table 4. Summary of pharmacotherapy for anxiety disorders in older adults

Detailed prescribing and monitoring information for the medications recommended here are available at *www.gerimedrisk.com/CCSMH.htm*

	Starting dose	Therapeutic dose	Maximum dose	Considerations
First line (any of the following)				
Escitalopram	2.5-5 mg daily	10-20 mg daily	10 mg* daily	QTc prolongation
Citalopram	5-10 mg daily	20-30 mg daily	20 mg* daily	
Sertraline	25-50 mg daily	50-200 mg daily	200 mg daily	Indications in GAD, Panic, SAD
Venlafaxine	37.5 mg daily	150-300 mg daily	300 mg daily	
Second Line				
Duloxetine	30 mg daily	60-120 mg daily	120 mg daily	CYP2D6 inhibitor and substrate, risk for drug-drug interactions
Buspirone	5 mg BID to TID	10 mg TID	10 mg TID	In moderate anxiety, if first line not tolerated
Not routinely recommended (except in specific circumstances)				
Quetiapine fumarate extended release	50 mg daily	100-200 mg daily	300 mg daily	Poorly tolerated in frail older adults
Quetiapine fumarate	12.5-25 mg once to twice daily	50-100 mg BID	150 mg BID	
Pregabalin	25 mg daily	75-150 mg BID	150 mg BID	Tolerability issues, limited evidence for efficacy
Lorazepam	0.25-0.5mg OD	0.25-0.5 mg BID	Not to exceed 2 mg daily	Short-term, time-limited
Clonazepam	0.125-0.25 mg daily	0.125 mg-0.25 mg BID	Not to exceed 1 mg daily	Long-acting. To be avoided in older adults

**Health Canada provides maximum doses based on observational evidence about prolonged QTc in older adults, although there remains controversy about the clinical meaningfulness of these findings (Crépeau-Gendron et al., 2019; Kimura et al., 2023). If choosing to optimize the dose beyond the Health Canada maximum, discuss this potential risk with the patient, monitor QTc periodically, and avoid other QTc prolonging medications.*

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CCSMH Canadian Coalition for Seniors' Mental Health | CCSMPA Coalition canadienne pour la santé mentale des personnes âgées

Decade of healthy ageing

ADVOCACY BRIEF:

Social isolation and loneliness among older people

World Health Organization

ITU

United Nations | Department of Economic and Social Affairs

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Social isolation and loneliness among older people: advocacy brief

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Decade of healthy ageing

Advocacy brief: Social isolation and loneliness among older people

Summary

- Social isolation and loneliness among older people are growing public health and public policy concerns which have been made more salient by the COVID-19 pandemic.
- Social isolation and loneliness among older people are widespread. For instance, 20–34% of older people in China, Europe, Latin America, and the United States of America are lonely.
- Social isolation and loneliness are harmful. They shorten older people's lives, and damage their mental and physical health and quality of life.
- But they can be reduced:
  - Through face-to-face or digital interventions such as cognitive behaviour therapy, social skills training and befriending;
  - By improving infrastructure (e.g. transport, digital inclusion, built environment) and promoting age-friendly communities;
  - Through laws and policies to address, for instance, ageism, inequality and the digital divide.
- A strategy for reducing social isolation and loneliness among older people should aim to:
  - Implement and scale up effective interventions to reduce social isolation and loneliness;
  - Improve research and strengthen the evidence for what works; and
  - Create a global coalition to increase the political priority of social isolation and loneliness among older people.

Decade of healthy ageing

Human beings are fundamentally social animals. To have survived for millennia as hunter-gatherers in often harsh environments, individuals depended for their lives on strong bonds with a tightly knit social group. High-quality social connections are essential for our mental and physical health and our well-being – at all ages.

Social isolation and loneliness have serious consequences for longevity, health and well-being. In older age, social isolation and loneliness increase the risks of cardiovascular disease, stroke, diabetes, cognitive decline, dementia, depression, anxiety and suicide. They also shorten lives and reduce the quality of life. Life transitions and disruptive life events [such as retirement; loss of a spouse, partner or friends; migration of children or migration to join children; and disability or loss of mobility], which are more likely to affect older people, put them at particular risk *[1, 2]*.

Until recently, however, social isolation and loneliness, including among older people, were neglected social determinants of health. In some countries, these problems have started to be considered pressing public policy and public health issues. The COVID-19 pandemic and the attendant physical distancing measures have increased the salience of these topics *[3–5]*. For instance, in 2018, the United Kingdom Government appointed a "loneliness minister" and published "A connected society – a strategy for tackling loneliness" *[6]*. In 2021, Japan followed suit, partly in response to the pandemic; the Prime Minister added a "loneliness minister" to his cabinet and created an inter-ministerial task force to address the issue *[7]*. In the United States of America in 2020, the National Academies of Sciences, Engineering and Medicine published a consensus report entitled "Social isolation and loneliness in older adults: opportunities for the health care system"*[2]*.

Several windows have opened for international, regional and national policies, described below, to change the way in which social isolation and loneliness are addressed. One of the most prominent is the United Nations Decade of Healthy Ageing 2021–2030 *[8]*, which includes four interconnected action areas for safeguarding the health and well-being of older people, their families and their communities: [i] change how we think, feel and act towards age and ageing; [ii] ensure that communities foster the abilities of older people; [iii] deliver integrated care and primary health services tailored to older people; and [iv] ensure access to long-term care for older people. Although social isolation and loneliness occur throughout the life-course, this advocacy brief focuses on older people.

What we know about social isolation and loneliness among older people

We know enough to state with confidence that social isolation and loneliness are widespread among older people in most regions of the world, that they have serious consequences for their physical and mental health and longevity and that we should, therefore, invest in effective interventions and strategies to reduce social isolation and loneliness in this population. Many questions and uncertainties remain, however, which should be addressed by the research community *[2, 9, 10]*.

Social isolation and loneliness are distinct but related concepts. "Loneliness" is the painful subjective feeling – or "social pain" – that results from a discrepancy between desired and actual social connections *[11–13]*. "Social isolation" is the objective state of having a small network of kin and non-kin relationships and thus few or infrequent interactions with others. Some studies have found only a weak correlation between social isolation and loneliness *[14–16]*: socially isolated people are not necessarily lonely and vice versa. How lonely a person feels depends partly on their own and their culture's expectations

of relationships *[17]*. For some aspects of the problem – such as its scale, distribution and trends – more evidence is available on loneliness than on social isolation.

The scale of social isolation and loneliness

Although there are currently no global estimates of the proportion of older people in the community who are experiencing loneliness and social isolation, estimates for some regions and countries are available. For instance, 20–34% of older people in 25 European countries *[18]* and 25–29% in the USA *[10]* reported being lonely. A study in 2021 indicated a prevalence of loneliness of 25–32% in Latin America, 18% in India but only 3.8% in China *[19]*. Other estimates of the prevalence of loneliness among older people, however, were 29.6% in China *[20]* and 44% in India *[21]* – on a par with or higher than in the rest of the world. Few comparable estimates of the prevalence of social isolation are available. Those available are 24% in the USA *[22]*, 10%–43% in North America *[23]* and 20% in India *[24]*.

Differences in methods may account for some of the differences in the estimates, such as the type of measure used, the mode of data collection [e.g. face-to-face or self-administered questionnaires], the representativeness of the sample and the inclusion criteria [e.g. older people in institutions, homeless people, and ethnic minorities] *[10, 19, 25]*. In general, there are few comparable estimates for low- and middle-income countries *[19]*. Although there are many instruments for measuring social isolation and loneliness, there is no standard, international, widely used, cross-culturally valid measure of the two concepts *[19, 26, 27]*.

The prevalence of loneliness among people living in long-term care institutions appears to be higher than that in the community. A review of 11 studies – three in middle-income and eight in high-income countries – indicated that 35% of older people in residential and nursing care homes were very lonely. All four studies that made direct comparisons between care-home residents and people living in their own homes in the community reported a higher prevalence of loneliness in care homes *[28]*.

Age and loneliness

It is not clear whether loneliness increases or decreases with age. Some studies show a U-shaped curve along the life-course, loneliness being more prevalent at younger and older ages *[18, 29–31]*. Others suggest a steady decrease in loneliness through life *[25, 32]*, sometimes with an increase after 75 years *[33]*. Yet others suggest that the relation between loneliness and age is non-linear and fluctuates during the life-course *[34–36]*. A nationally representative study in the USA, for instance, found peaks in the oldest and young adults and in those aged 50–60 years *[34]*.

Gender and loneliness

A recent review of 575 studies on gender differences in loneliness indicated similar levels in males and females across the lifespan. Males were slightly more lonely in childhood, adolescence and young adulthood [with the largest differences], but these small gender differences disappeared in middle adulthood and at older age *[37]*. Loneliness among older women is a concern, as life changes such as widowhood and relocation, which are associated with greater vulnerability to social isolation and loneliness, affect women more than men *[38]*.

Recent trends

It is not known whether global rates of loneliness among older people are increasing overall. A review of 25 studies in China found large increases in loneliness between 1995 and 2011, which were correlated with increasing rates of urbanization, divorce, unemployment and social inequality *[38]*. In a study in the USA, the prevalence of loneliness increased

by 7% between 2018 and 2019 *[39, 40]*. In contrast, no increase in the rate of loneliness among older people in recent decades was found in Sweden *[41]*, and studies in Finland and Germany suggest that loneliness may have decreased *[42, 43]*. The increasing longevity and ageing of the global population could nonetheless result in more older people experiencing loneliness and social isolation [Box 1].

Social isolation and loneliness shorten lives

A review conducted in 2015 indicated that social isolation and loneliness were associated with a 29% and 26% increased likelihood of mortality, respectively. Both significantly predicted premature mortality, and equivalently so, and middle-aged adults may be at greater risk of mortality than older adults when they are socially isolated or lonely *[50, 51]*.

The relation between social isolation and loneliness and mortality [and the other negative health outcomes described below] might be causal, but it is difficult to demonstrate *[2, 52, 53]*. Social isolation and loneliness affect mortality similarly to well-established risk factors such as obesity, lack of physical activity, smoking, other forms of substance abuse and poor access to health care *[2, 50]*.

Social isolation and loneliness damage older people's health and quality of life

There is strong evidence that social isolation and loneliness increase the risks of older adults for physical health conditions such as cardiovascular disease and stroke and for mental health conditions such as cognitive decline, dementia, depression, anxiety, suicidal ideation and suicide *[2, 43, 54–57]*. There is also evidence, although it is not as strong, that social isolation and loneliness increase the risks of other health conditions [e.g. type-2 diabetes mellitus, high cholesterol] and limit mobility and activities of daily

Box 1. Living arrangements, loneliness and social isolation of older people

"Living alone" is defined as occupying a one-person household. Most studies show that living alone is a risk factor for both social isolation and loneliness, with some mixed results *[44–48]*.

Not only population ageing but also social and economic changes are reshaping the context in which older people live, including the size and composition of their households and their living arrangements. The changes also include decreased fertility; changes in patterns of marriage, cohabitation and divorce; higher educational levels of younger generations; continued rural-to-urban and international migration; and rapid economic development *[49]*.

Globally, more older people live alone. In western Europe and the USA, intergenerational residence has decreased dramatically, and most older people now live either in single-person households or in households consisting of a couple only or a couple and their unmarried children. In many less developed countries, despite the persistence of traditional family structures and cultural norms that favour multi-generational households, a slow shift is occurring towards smaller families and different types of household, including living alone *[49]*.

Globally, more older women than men live alone. Between 2006 and 2015, older women were twice as likely as older men to live alone [24% vs 11%]. The gender gap was widest in Europe and Northern America [37% vs 18%], followed by Australia and New Zealand [33% vs 18%]. Whereas, globally, 15% more older men than older women lived with a spouse [38% of men, 23% of women], the gap was wider in Europe and North America [56% vs 33%] *[49]*.

living *[2, 57]*. Social isolation and loneliness are also risk factors for violence and abuse against older men and women, the prevalence of which, at least in the USA, appears to have increased during the COVID-19 pandemic *[2, 58]*. Some more limited evidence indicates that social isolation and loneliness worsen the quality of life of older adults *[2, 57]*.

The effect of social isolation on mortality has been studied more extensively than that of loneliness, while the effect of loneliness on health has been studied more extensively than that of social isolation. The relative effects of each on health are, however, complex and not fully understood. Little attention has been paid to the discordance between social isolation and loneliness [e.g. high social isolation but low loneliness] and its impact on health *[2, 59, 60]*.

Currently, three plausible causal mechanisms have been proposed for the effects of social isolation and loneliness on health [Fig. 1]. First, they lead to excess stress reactivity, and, in the absence of the stress-buffering effect of social support, the physiological systems of lonely and isolated individuals may absorb more of the stressors encountered in daily life *[2, 10, 61, 62]*. Secondly, they result in inadequate or inefficient physiological repair and maintenance processes. For example, social isolation and loneliness affect the quality and quantity of sleep, which influence a variety of physical health conditions [e.g. cardiovascular disease, diabetes]; and poor sleep is associated with increased mortality *[2, 61]*. Thirdly, some, albeit mixed, evidence indicates that social isolation and loneliness lead to behavioural risk factors, such as lower physical activity, poorer diet, poor adherence to medical treatments and more smoking and alcohol consumption *[2, 10, 57, 61]*.

The costs of social isolation and loneliness

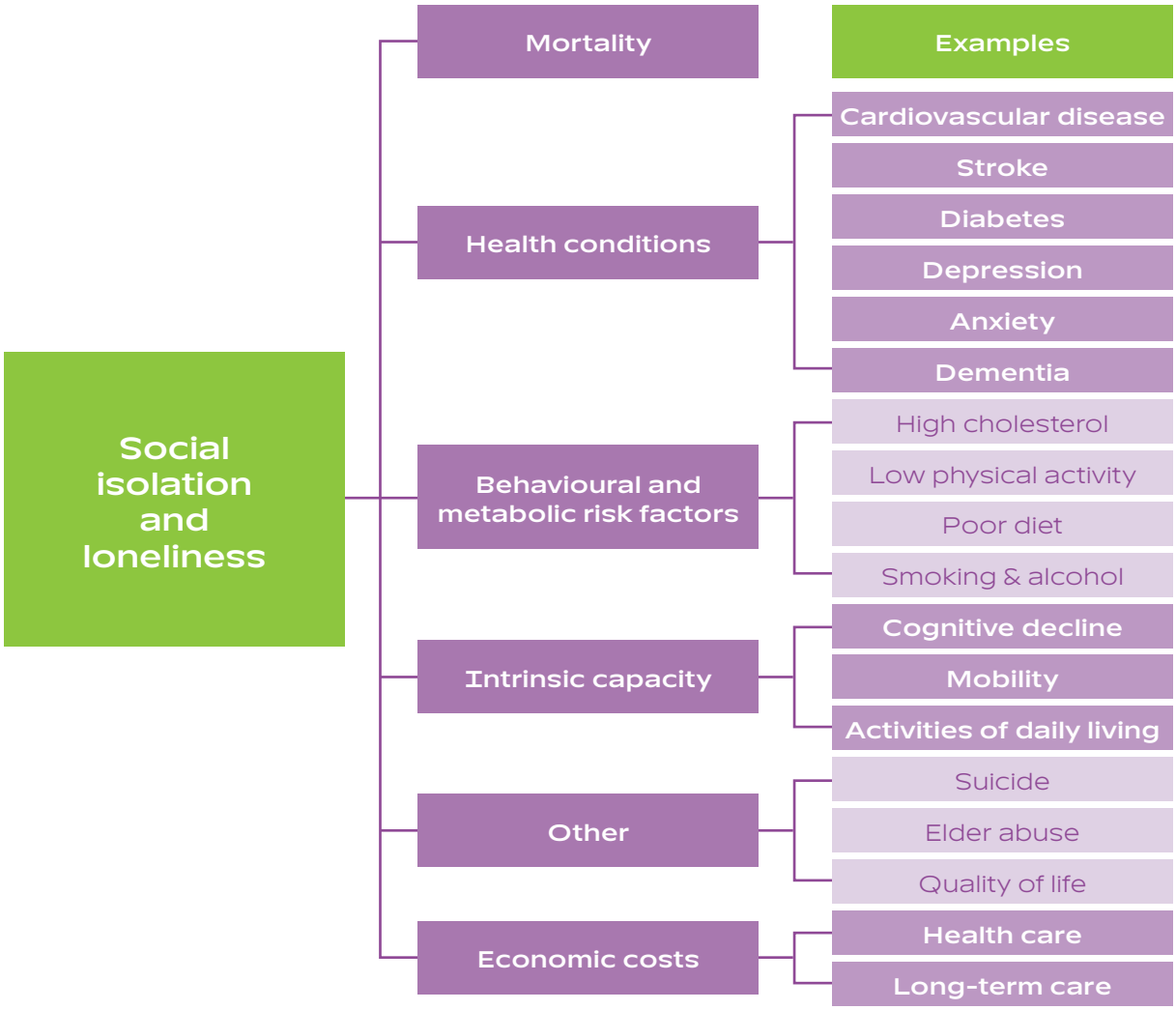
Social isolation and loneliness appear to impose a heavy financial burden on society, but the extent of the burden is not well understood. A review of studies on the economic costs of loneliness at all ages included only four studies on the costs of social isolation and loneliness in older people and addressed the costs of health and/or long-term care in high-income countries *[63]*. In a study in the United Kingdom, the excess costs for health and long-term care due to loneliness was estimated to be GBP 11 725 per person over 15 years *[64]*. Lonely older people are more likely to visit their doctor for social contact rather than for medical treatment, thus increasing medical costs *[65, 66]*. In the USA, an estimated US$ 6.7 billion in annual federal spending has been attributed to social isolation among older adults *[67]*.

Why are older people at risk of social isolation and loneliness?

A complex range of individual, relationship, community, societal and system level factors put people at risk of social isolation and loneliness *[68–70]*. Identifying risk factors at these four nested and interacting levels helps to make sense of the many interventions and strategies which target these risk factors to reduce social isolation and loneliness [Fig. 2].

At the level of the individual, physical factors such as having heart disease, stroke or cancer can increase the risks of both social isolation and loneliness, although the relation is often bi-directional *[2]*. Decreases in intrinsic capacity, such as sensory impairment and hearing loss, increase the risks, as do psychiatric disorders such as depression, anxiety and dementia *[2]*. Certain personality traits – such as neuroticism [i.e. negative affect], disagreeableness and low levels of conscientiousness – increase the risk of loneliness, and these are partly genetically determined *[71–73]*.

Fig. 1. Consequences of social isolation and loneliness

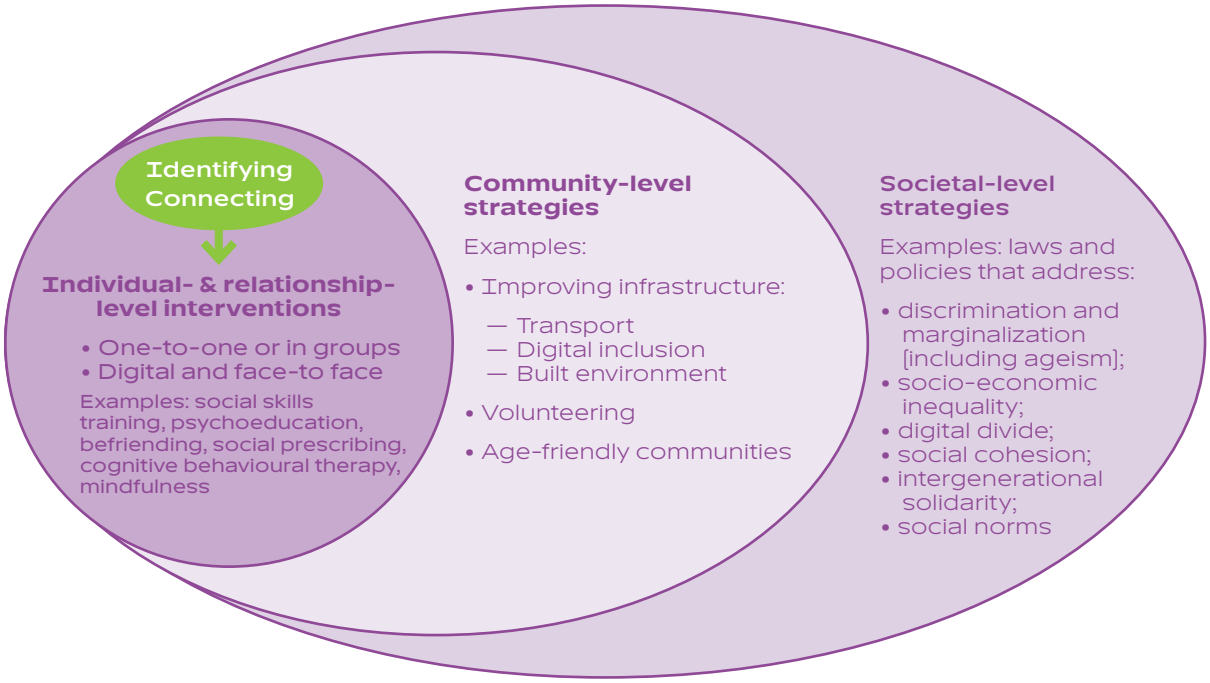


The absence of supportive relationships and difficult or unfulfilling relationships can increase loneliness. Life transitions and disruptive life events such as retirement and bereavement can increase the risks of both social isolation and loneliness among older people *[2, 10, 69]*.

Social groups at greater risk of social isolation and loneliness, which are sometimes poorly served by mainstream services, include ethnic minorities; lesbian, gay, bisexual and trans+ people; people with physical and learning disabilities and long-term health conditions; care-givers; and older people in residential and nursing care *[2, 74]*. Being an immigrant is also a risk factor, as immigrants tend to have fewer – especially long-standing – social ties and less social integration and often face language and communication barriers *[2, 74]*.

At community and societal levels, lacking socio-economic resources, limited education, inadequate transportation, lack of access to digital technology, poor housing, ageism, marginalization and remote residence can all lead to loneliness and social isolation *[2, 10, 69, 75]*.

Fig. 2. Interventions and strategies to reduce social isolation and loneliness



Sources: references *1, 69, 70, 74*

What works to address social isolation and loneliness?

Many interventions and strategies have shown promise, but we do not yet know which are the most effective and for whom. Fig. 2 suggests that various sectors must be involved for a population-level impact on social isolation and loneliness, e.g. health, social work, information and communications technology, transportation and housing; and stakeholders such as government, older people, civil society organizations, practitioners, academia and the private sector must act at multiple levels at the same time.

As for strategies to address other health and social problems, however, current evidence for what works to reduce social isolation and loneliness is primarily for individual- and relationship-level interventions, with little evidence for community- or societal-level interventions *[1, 2, 74, 76, 77]*. Furthermore, social isolation and loneliness can occur at any age, and interventions and strategies to address them starting earlier may be needed *[78]*.

Identifying and connecting: Before older people who are socially isolated and lonely can be offered help, they must be identified and connected to services [see Fig. 2]. The health sector has an important role to play in identifying older people at risk of or already experiencing loneliness. "Connector services" reach those at risk of loneliness and social isolation, understand their predicament and support them in accessing appropriate services and interventions, including to overcome practical and emotional barriers stemming from ageism and stigmatization. Connector services include outreach services

[e.g. knocking on doors in the community], guided conversations and motivational interviews. Evidence for how well such services work is, however, limited *[74]*.

Individual- and relationship-level interventions: Interventions at this level are based on three main mechanisms: [i] maintaining and improving people's relationships, [ii] supporting people to develop new relationships and [iii] changing how people think and feel about their relationships *[74, 79]*.

Many studies and at least 24 reviews have evaluated the effectiveness of interventions at the individual- and relationship-levels *[80]*. Although some of the findings are encouraging, there is too little high-quality evidence to identify the most effective type conclusively *[2, 10, 81-84]*. Interventions for maladaptive social cognition with cognitive behavioural therapy appear promising for reducing loneliness. "Maladaptive social cognition" refers to inflexible, inappropriate expectations, thoughts and feelings that people have about their relationships, particularly hypervigilance – increased attention and surveillance – for social threats, such as rejection or exclusion *[17, 85, 86]*.

Interventions for social isolation and loneliness among older people can be delivered either one-to-one or in groups and either digitally or face to face. They include social skills training; psychoeducation [providing information and support to better understand and cope]; peer-support and social activity groups; "befriending" services, which offer supportive relationships either in person or over the phone, usually by volunteers; social prescribing, which helps patients to access local non-clinical sources of support; cognitive behavioural therapy; mindfulness training; psychopharmacology, including anti-depressants; and coalitions and campaigns to increase awareness of the issues *[2, 80, 82]*.

The evidence for effective interventions has several serious limitations, which should be addressed in future research [see Box 2]. Few randomized controlled trials have been conducted; the samples are often too small; interventions often do not address loneliness among the most vulnerable older adults; and few studies have been conducted in low- and middle-income countries *[2, 10, 80, 82–84]*. Also, social isolation and loneliness are often not clearly distinguished [particularly in reviews] and are sometimes conflated into a single concept. It cannot be assumed that interventions that work for one will necessarily work for the other *[2, 80, 83]*.

Features of interventions that appear to be the most promising include an educational approach, the involvement of the individuals targeted in designing the intervention and a strong theoretical basis *[2, 10, 80, 82–84]*. Lonely people appear to be more interested in connecting with others when they pursue activities based on shared interests [e.g. exercise groups] than in meeting for purely social reasons *[74, 89]*. Preliminary evidence also suggests that interventions that increase social contact [e.g. befriending and peer-visiting] may be particularly cost–effective *[63]*.

Digital interventions are of particular interest because of both the increase in their use during the COVID-19 pandemic and the rapidly increasing role of technology in the past 10–15 years – particularly the Internet, smart phones and social media – in mediating social relations. Digital interventions include training in use of the Internet and computers, support for video communication, messaging services, online discussion groups and forums, telephone befriending, social networking sites, chatbots and virtual artificial intelligence "companions" *[90–92]*. Although they have sometimes been found to be effective, the findings are often mixed or inconclusive *[86, 90–96]*.

Digital interventions are associated with several ethical concerns, such as potential infringement on privacy, informed consent

Box 2. Opportunities for improving data and research and strengthening the evidence

Opportunities for improving data and research and addressing the many gaps and uncertainties in the evidence base for social isolation and loneliness include the following.

1. *Develop a standard, international instrument for measuring both social isolation and loneliness:* Although many measures exist, there are currently no widely used, cross-culturally valid, international instruments for measuring the two concepts *[19, 26, 27]*.
2. *Improve understanding of prevalence, distribution and trends:* An agreed international measuring instrument would generate comparable cross-national prevalence data for better estimates of the distribution of the problem [including across the life span] and trends over time, allowing better planning and evaluation to reduce the problem.
3. *Generate better evidence for effective interventions:* The first priority is to strengthen the evidence of what works to reduce social isolation and loneliness at all levels, from the individual and relationship levels to the community and societal levels *[2, 74, 84]*.
    - The current large but uneven evidence base should be carefully mapped to identify strengths and weaknesses, so future research can be commissioned in a more cost-efficient and strategic way.
    - In order to produce conclusive evidence, evaluations should be large, theory-based and of high quality [randomized controlled trials if possible] and should clearly distinguish between social isolation and loneliness *[80, 83, 84]*.
    - Better understanding of digital interventions is necessary and especially of digital divides, potential harmful effects of digital interventions and whether virtual connections can supplement face-to-face social connections.
4. *Increase research in low- and middle-income countries:* More research should be conducted on all aspects of social isolation and loneliness in low- and middle-income countries: their prevalence, consequences and determinants, which may be different from those in high-income countries, and on interventions that are effective in different contexts *[10, 19]*.
5. *Elucidate the mechanism underlying health impacts:* Research of appropriate design, e.g. prospective longitudinal and controlled experiments, should be conducted to elucidate the causal mechanisms underlying the health impacts of social isolation and loneliness, including possible bi-directionality *[2, 61]*.
6. *Estimate costs and cost-effectiveness:* Information on the cost of the problem and the cost–effectiveness of interventions is limited. Both are critical for making a persuasive case to raise the priority of the issue.
7. *Translate evidence to make it more accessible:* High-quality evidence should be synthesized and stored on accessible databases, platforms and portals and distilled into forms likely to be used by policy- and decision-makers, such as evidence-based policy briefs, guidelines and checklists *[87, 88]*.

and autonomy and disparities in access, including for older people with disabilities. Furthermore, the extent to which online relations can supplement face-to-face interactions and the potential harmful effects of digital interventions, particularly the risk of further isolating older people, are currently poorly understood *[2]*. It is important to protect the right to remain offline and develop alternatives for those who cannot or do not wish to connect digitally.

Community-level strategies: Several strategies at the community level have the potential to help reduce loneliness and social isolation. Some address the infrastructure – such as transportation, digital inclusion and the built environment – required to ensure that people can maintain their existing and form new relationships and to deliver interventions to reduce social isolation and loneliness.

Appropriate, accessible, affordable transportation is vital to keep people connected *[74]*. Although empirical evidence of the impact of transportation policy on social isolation and loneliness is limited, a study in the United Kingdom showed that the introduction of free bus travel for people aged 60 years and over reduced loneliness and depressive symptoms *[97]*.

The built environment in communities can either foster or hinder social connection. The design of housing [e.g. communal areas], of public spaces [e.g. good lighting, benches, public toilets] and of restaurants, shops and cultural institutions such as libraries and museums [e.g. accessibility and inclusivity] may all affect social isolation and loneliness *[74, 98]*.

Digital inclusion strategies, while critically important are not easy to implement. They raise the issue of several digital divides – for instance, between younger and older people, between older people [e.g. those ≥60 years and those ≥80 years], between those who cannot afford or lack the ability to use digital technology and those who can, and between higher and lower-income countries *[74, 90–92, 95]*. Nonetheless, governments, policy makers and all stakeholders, including the private sector, should make information and communication technologies [ICTs] available, affordable and accessible to older people who wish to be connected and ensure that those who wish to remain offline do not suffer exclusion as a result. Furthermore, in their policies, strategies and programmes related to ICTs, they should include accessibility requirements relevant to digital information, products and services aimed at reducing social isolation and loneliness among older people. They should also provide appropriate digital knowledge and training to allow older people to adopt new technologies *[99]*.

Several other community strategies might reduce social isolation and loneliness among older people *[74]*. One is volunteering, which can increase the well-being and social connections of those who volunteer and provide the personnel for interventions to address loneliness *[74]*. Another is promoting "age-friendly communities", which, in line with the WHO framework *[100]*, are designed to foster healthy, active ageing. They can help raise awareness and promote collaboration across a range of key stakeholders within a local area to address social isolation and loneliness.

Societal-level strategies: Societal level strategies to reduce isolation and loneliness include laws and policies to address discrimination and marginalization [including ageism], socio-economic inequality, digital divides, social cohesion and intergenerational solidarity. They may also seek to change social norms that prevent social connection, such as prioritizing accumulation of financial rather than social capital. Evidence for the effectiveness of such measures is, however, limited *[1, 74, 101]*.

"Social in all policies", similar to WHO's "health in all policies", has been suggested as a means of tackling social isolation

and loneliness. Cross-cutting "social in all policies" would include social isolation and loneliness in all relevant sectors and policy areas, including transportation, labour and pensions, education, housing, employment and the environment *[102]*. For instance, policies could be implemented that include flexibility in the labour market, allowing older people more choice in how and when they retire. This could ease the transition from working life to retirement and promote intergenerational support, with retired workers acting as mentors to younger workers.

Policy windows

United Nations Decade of Healthy Ageing

The United Nations Decade of Healthy Ageing 2021–2030 offers a unique opportunity to intensify work on social isolation and loneliness globally. The aim of the Decade is to bring together governments, civil society, international agencies, professionals, academia, the media and the private sector for 10 years of concerted, catalytic, collaborative action to improve the lives of older people, their families and the communities in which they live *[8]*.

The Decade also intends to achieve the pledge of the Sustainable Development Goals that no one – including older people – will be left behind. Older people make key contributions to achieving the Goals, building on what has been started in many countries. The Goals are an important process that can be used to address social isolation and loneliness among older people.

Fourth review and appraisal of the Madrid International Plan of Action on Ageing

The Madrid International Plan of Action on Ageing, adopted by the Second World Assembly on Ageing, held in Madrid, Spain, in 2002, includes a bold, comprehensive agenda for three priorities: older people and development; advancing health and well-being into old age; and ensuring enabling, supportive environments *[103]*. Several of the recommendations highlight the risks posed by social isolation and loneliness and call for action. The Plan is reviewed and its implementation appraised every five years. Reducing older people's social isolation and loneliness, particularly through digital technology, has been identified as an important issue for the fourth review and appraisal, due to be completed in 2023 *[104]*.

United Nations General Assembly Open-ended Working Group for the Purpose of Strengthening the Protection of the Human Rights of Older Persons

The Open-ended Working Group on Ageing was established by the United Nations General Assembly in 2010 to consider the international framework of the human rights of older people and to identify any gaps and how best to address them. The Group is considering the feasibility of further instruments and measures, including a convention on the rights of older persons *[105]*. The Group will increase awareness of social isolation and loneliness, not only as public health issues but also as moral and human rights imperatives and socio-economic necessities.

A three-point strategy for reducing social isolation and loneliness during United Nations Decade of Healthy Ageing

1. Create a global coalition to increase the political priority

A global coalition should raise awareness about social isolation and loneliness and increase their political priority to ensure that financial, technical and human resources are invested on a

scale commensurate with the severity of the issue. As part of the United Nations Decade of Healthy Ageing, this multi-stakeholder and multi-sectoral coalition, with the engagement of older people, should strengthen collaboration among the main international, regional, national and local stakeholders.

The coalition should involve the United Nations Interagency Group on Ageing *[106]*, which ensures inclusion of older people in the work of the United Nations system. The Group can act as an important agent to strengthen information sharing and cooperation among United Nations agencies and to raise awareness of the issue.

2. Improve research and strengthen the evidence for effective interventions.

Filling the significant gaps in our understanding of social isolation and loneliness should be a key component of the strategy. More important still will be to strengthen the evidence on effective interventions to reduce social isolation and loneliness. Box 2 lists seven opportunities for improving data and research and strengthening the evidence.

3. Implement and scale up effective interventions.

Social isolation and loneliness will be reduced only if effective interventions and strategies are implemented at scale in a multi-stakeholder, multi-sectoral effort. This will require identification of effective interventions and strategies (existing or new) and addressing all the factors required to scale them up to achieve an impact at population level, including a cycle of continuous evaluation and optimization, estimation of intervention costs and benefits, adapting interventions for scale-up, determining their reach and acceptability, developing implementation infrastructure and a workforce and ensuring sustainability *[2, 107]*.

Social isolation and loneliness, which affect a considerable proportion of the population of older people globally, shorten their lives and take a heavy toll on their mental and physical health and their well-being. COVID-19 and the resulting lockdown and physical distancing measures have been a stark reminder of the importance of social connections in the lives of older people. The United Nations Decade of Healthy Ageing 2021–2030 offers a unique opportunity for United Nations agencies and stakeholders in all sectors to act together internationally, regionally, nationally and locally to reduce social isolation and loneliness among older people.

Decade of healthy ageing

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Decade of healthy ageing

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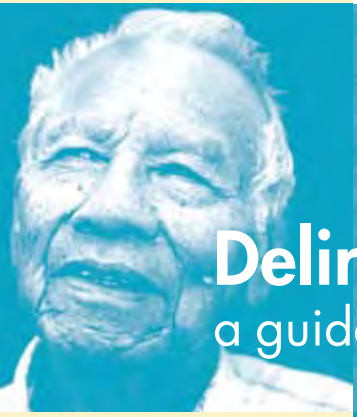
BRING SOLUTIONS TO LIGHT

METTRE EN LUMIÈRE LES SOLUTIONS

Canadian Coalition for Seniors' Mental Health



Delirium in Older Adults:
a guide for seniors and their families

Based on the Canadian Coalition for Seniors' Mental Health (CCSMH) *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Delirium.*

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Introduction

We're very glad you picked up this booklet. Canadians are not only living longer, but also staying healthy and independent longer than ever before. We want all older adults – and their family members – to have high quality information about health issues that might affect them. We believe that with this information, older adults will be empowered to make informed decisions about their health care and build effective relationships with their health care providers.

What is the Canadian Coalition for Seniors' Mental Health?

The Canadian Coalition for Seniors' Mental Health (CCSMH) started in 2002 **to promote the mental health of seniors by connecting people, ideas and resources**. Members of the CCSMH are organizations and individuals who represent seniors, family members and informal caregivers, health care professionals, researchers and policy makers.

In 2006, the CCSMH created the first set of national guidelines on seniors' mental health based on the most current research. These guidelines were written for health care professionals who work with older adults. They recommend ways to improve the assessment, prevention, treatment and management of key mental health problems for older adults: mental health issues in long-term care homes, depression, suicide and delirium. This booklet is part of a series that covers the same topics for seniors, their family members and others who care about them.

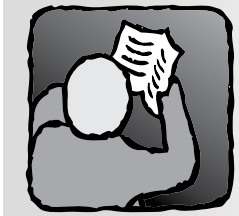
The CCSMH will happily provide these resources on request. Call 416-785-2500, ext. 6331 or visit www.ccsmh.ca to download them at no cost.

Mental health problems are NOT a normal part of aging

Many people think that mental health problems are just a normal part of aging. This simply isn't true. Difficulties with mood, thinking and behaviour are not an inevitable part of aging. Nor are they signs of personal weakness. They are usually signs that something is wrong that requires attention from a health care professional.

Some people may argue that there is no point investigating these problems in older adults because these problems can't be fixed. Some problems associated with aging cannot be cured *yet*, but there is still a lot that can be done. Mental health problems can be treated.

Older adults experiencing changes in their mood, thinking and behaviour may not be aware of the changes that are taking place, may misunderstand the nature of the changes that are occurring, or may be ashamed of the idea that they're developing "mental health problems." Family members may misunderstand and think that these changes are normal parts of aging, aspects of their relative's personality or signs of personal weakness and may not know how best to help.



We hope this guide will help inform older adults and their families about what they can do if they have mental health concerns.

Who should use this guide?

This guide will help older adults who are concerned about delirium. It will also help family members and others who care about them. The guide gives information about the causes and symptoms of delirium. It also describes what to do if you, or someone you care about, is experiencing delirium.

Definitions

Ageism is a way of thinking about older people based on negative attitudes and stereotypes about aging. Ageism can lead to age discrimination – treating people in an unequal fashion because of their age. Age discrimination can negatively affect older adults in all aspects of life.

Mental health is the capacity of each person to feel, think and act in ways that allow them to enjoy life and deal with all the challenges they face.

The terms **"seniors"** and **"older adults"** are used in this guide to refer to individuals over the age of 65.

Stigma is defined as a mark of shame or disgrace. It often involves stereotypes, hurtful words and discrimination. Stigma around mental health is often based on society's misunderstanding and lack of knowledge about mental health problems. Many people living with mental health problems say that society's negative reactions to them can be worse than the illness itself. Because of the stigma of mental health problems, many people don't seek – or receive – the health care they need.

Delirium is a confusional state. This means that people with delirium are disoriented, with an altered level of consciousness and trouble understanding the environment. Delirium develops *quickly* over a period of hours or days. The symptoms of delirium may come and go and are often worse at night. Delirium is a medical emergency caused by difficulties in brain functioning.

All three of these conditions can occur at the same time. It helps to understand the differences between these conditions so that you can identify them and get the proper help right away.

Dementia is an illness characterized by the loss of intellectual abilities that is severe enough to interfere with a person's ability to function. Dementia results in changes in the way the person thinks, feels and behaves, along with memory impairment. It tends to develop slowly over a period of months or years and progresses over time. Alzheimer's disease is an example of dementia.

Depression can cause people to feel persistently low in spirits and lose interest in things that used to give them pleasure. This is sometimes triggered by stressful events in a person's life that impact their state of mind, their health, or their ability to connect with other people. However, sometimes it can happen for no apparent reason. When a person is severely (i.e. clinically) depressed, the chemicals in his or her brain may be out of balance. Other symptoms often include sleep and appetite changes and anxiety.

What is delirium?

- **Delirium is a confusional state that develops quickly** (over a period of hours or days). It causes dramatic changes in a person's thinking, behaviour and mood. The symptoms of delirium may come and go during the day and are often worse at night. A person may seem clear one minute and mixed up the next.

- **Delirium is a medical emergency that needs to be treated quickly**. It is usually caused by an illness or a reaction to medications. Some environmental factors (like not using eyeglasses or hearing aids if they're needed) can also contribute to the development of delirium.

- **Delirium is a serious condition that is more common among older people**. If the underlying cause is not diagnosed or treated quickly, the risk of permanent disability or death is high.

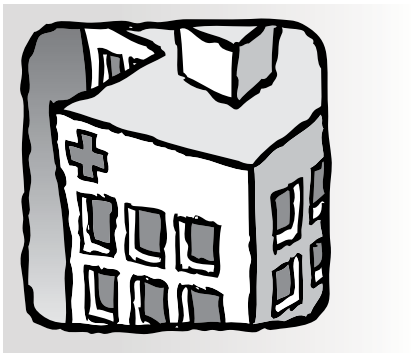
- **Delirium is very common with older adults who are in the hospital**. At the hospital, older adults are medically ill, having operations and going on new medications. All of these things put older adults at a higher risk of delirium.

- Delirium can be frightening for an older person and their family. But there is good news:
  - It **can often be prevented**.
  - It **can often be reversed** with proper assessment and early treatment.
  - It is **usually temporary**. It can last from a few days to several weeks or months, though it can take even longer to recover.

- **Delirium is often not recognized or is misdiagnosed** as another condition, such as dementia or depression. Health care providers may not consider the possibility of delirium. It can also be difficult for health care providers to diagnose delirium. They often don't know enough about the way an older person usually thinks or acts to recognize sudden changes. Family members and other caregivers can provide important observations to help health care providers recognize delirium and treat it.

You are not alone!

Did you know that delirium is much more common in older adults than in younger people? Nearly half of the seniors admitted into an acute care setting experience an episode of delirium. It sometimes happens after having surgery. It is especially common after hip surgery. A significant number of residents in nursing homes and similar settings will develop delirium at some point.



What are the symptoms of delirium in older adults?

As a family member, you are in the best position to notice changes in the behaviour and mental state of your relative. You may notice them – over a short period of time – doing things that they wouldn't normally do. With delirium, symptoms appear suddenly, over the course of hours, days or weeks (not months or years).

Some symptoms are easier to recognize than others. If you notice any of these symptoms, make a note and see a health care professional right away. Older people with delirium may suddenly:

- Be restless and anxious
- Seem agitated and hostile
- Be angry or aggressive
- Hear voices or see people or things that do not exist
- Be afraid and believe that others are trying to harm them
- Not know where they are
- Be unable to concentrate
- Slur their speech
- Not make any sense
- Lose bladder control
- Not get up and walk as well
- Have vivid dreams or nightmares
- Seem drowsy, have trouble staying awake, drift in and out of sleep*
- Sleep during the day and be awake at night*
- Withdraw completely*
- Be inactive and quiet*
- Respond slowly to questions*

*Delirium often isn't recognized in older adults with these "quiet" symptoms. Sometimes they are misdiagnosed and treated for depression.

What causes delirium in older adults?

Delirium is usually caused by a combination of factors. Getting older is one of the risk factors for delirium. A brain that has been exposed to illness or injury is more vulnerable and is at a higher risk for delirium, especially when combined with the conditions listed below.

Mental health problems

Pre-existing dementia (like Alzheimer's disease, or vascular dementia that is caused by a stroke) is one of the most important risk factors for the development of delirium.

Depression. When a person is depressed, their physical health can suffer and they are at higher risk for medical illness.

Previous delirium. If an older person has had a delirious episode, there is a very high chance it will happen again.

Medical illness

Some medical illnesses (like stroke, cancer, diabetes or heart disease) can influence brain function in a way that makes it more vulnerable. Having more than one illness increases the chance of having delirium.

One of the best ways to prevent delirium is to stay healthy. This includes taking care of medical problems (like high blood pressure and heart disease), eating well, and staying active and engaged in life.

Surgery

Surgery is very stressful on the body. The impact of surgery and anaesthesia (the drugs used to put a person "to sleep" during the operation) is even greater for older adults. Delirium after a surgery is common in older adults. It can develop immediately after an operation or a few days later.

Use of medications

Older people are more sensitive than young people to the effects of both prescribed and over-the-counter medications. Medications that treat the older adult's illness can cause delirium or make a delirious episode worse.

If an older adult has more than one illness, they might need many different medications. These medications might interact in a way that causes delirium.

Some commonly used medications that can contribute to delirium are: sleeping pills, pain medications, certain antidepressants and tranquilizers, and drugs used to treat abdominal symptoms, epilepsy and Parkinson's disease.

Poor nutrition and not getting enough water

Older people may not get the nutrition they need because of:

- Depression, which can make a person lose their appetite
- A swallowing problem
- Dentures that don't fit comfortably
- An inability to eat on their own
- An inability to shop for food or afford good food
- Drinking alcohol, coffee or tea, which can decrease a person's appetite

Dehydration is a loss of water in the body. It can be caused by:

- Not drinking enough water or juices
- Drinking coffee, tea or alcohol
- Regular use of laxatives

Use of alcohol and drugs

Even small amounts of alcohol can cause changes in a person's thinking, mood and behaviour. The risk is greater if the person uses sleeping pills or tranquilizers at the same time as alcohol.

A regular drinker who suddenly stops drinking may have withdrawal symptoms, including delirium, immediately or after a few days.

Physical health problems

Physical health problems can increase a person's risk of delirium. These can include:

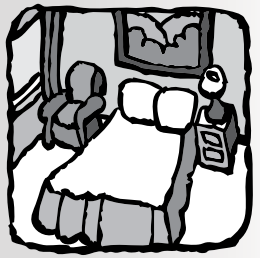
- Fever
- Low blood pressure
- Pain
- Infections, especially bladder and kidney infections, shingles, pneumonia and the flu
- Constipation
- Retention of urine by the bladder
- Not being able to see or hear well
- Some types of disability
- Being inactive

If the older adult uses eyeglasses, hearing aids or other adaptive equipment to help them see or hear, these should be used to avoid sensory deprivation.

The older person's environment

Living in an institution away from familiar people, places and routines can be disorienting.

A noisy room, too many visitors or other distractions can cause a person to become over-stimulated and agitated. On the other hand, a lack of physical or mental stimulation can cause a person to experience sensory deprivation or feel isolated, which can contribute to delirium.



How is delirium detected?

Members of the health care team can help detect, diagnose and treat delirium. If delirium is suspected, the appropriate member of the health care team will:

- Do a complete physical exam and order some lab tests.
- Review the person's behaviour, thinking and mood.
- Update their medical history and find out if the person has any of the risk factors for delirium (page 8).
- Assess the person's ability to understand what is happening and make decisions about their treatment.
- If the health care provider believes the person has delirium, he or she will find out what type of delirium they have and develop a treatment plan.

Because delirium can come and go during the day, and since many older people will not be able to provide an accurate history, the health care provider may need family members to help with the assessment. Bringing a completed information sheet (page 14) with you when you meet with the health care provider will be extremely useful.

What should I do if I suspect my family member has delirium?

If you notice any new, sudden changes in your family member's mood, thinking or behaviour, make note of the changes and get medical help right away.

You may find it helpful to fill out the form on the next page and take it with you to the health care provider. They may also want to know about:

- Recent surgeries
- Patterns of drinking alcohol or using drugs
- When the delirium started and what has been happening since it started
- Any current psychiatric disorders and symptoms
- Any infections, sores, fever or pain
- Use of hearing aids, eyeglasses or other assistive devices
- Any changes in eating or drinking
- Difficulties going to the bathroom
- Your family member's marital status, where they live, and any transitions, suffering or losses they may be dealing with

Medical info about my family member

If you have noticed rapid changes in your relative's thinking, behaviour or mood, get them to the health care provider quickly. It might be helpful to take this information with you.

Current symptoms:

- ☐ More distractable
- ☐ Slurred speech
- ☐ Seeing or hearing things that aren't there
- ☐ Mixing up days and nights
- ☐ Cannot concentrate
- ☐ Difficulty staying awake
- ☐ Restless and upset
- ☐ Not making sense
- ☐ Doesn't know where he/she is
- ☐ Sleepy, then alert
- ☐ Other: _____
  _____
  _____

Is there a known history of:

Dementia ☐ Yes ☐ No ☐ Not sure

Depression ☐ Yes ☐ No ☐ Not sure

Delirium ☐ Yes ☐ No ☐ Not sure

Cognitive difficulty ☐ Yes ☐ No ☐ Not sure

Confusion ☐ Yes ☐ No ☐ Not sure

Doctor's name: _____

Doctor's phone number: _____

Pharmacy: _____

Pharmacy phone number: _____

List all medications (prescribed, over-the-counter, and any herbal remedies). Please note which medications were recently started or stopped. **Circle one**

1. _____ started / stopped
2. _____ started / stopped
3. _____ started / stopped
4. _____ started / stopped
5. _____ started / stopped

Describe your family member's behaviour, before you noticed the recent changes:

Thinking ability: Describe their attention level, memory, concentration and problem-solving abilities.

_____

_____

Daily routines: How do they go about their housekeeping, meal preparation, and other daily tasks?

_____

_____

Communicating: How do they usually relate to others? Do they use the telephone, a computer, write letters?

_____

_____

Mood: Describe their character. Are they easy-going or a worrier? Optimistic or pessimistic? Happy or sad?

_____

_____

Sleep habits: Describe their usual patterns and things that help them sleep.

_____

_____

If the person has a dementia, please describe the abilities *before* the beginning of delirium symptoms.

Adapted from *"Delirium in the Older Person: A Medical Emergency / My family member is not usually like this"* Vancouver Island Health Authority.

How is delirium treated and managed?

Since delirium is considered a medical emergency, it is critical that the person gets medical attention. Ideally, many different health care providers will work together to treat delirium. Effective treatment and clinical management of an older person with delirium includes:

- Being calm, supportive and non-confrontational
- Figuring out what the cause(s) are and treating them. This might include:
  - Making sure the person is hydrated
  - Taking care of pain
  - Helping the person sleep
  - Providing hearing aids or eyeglasses (if needed)
- 24-hour monitoring of the person's behaviour, mood and thinking
- Making sure the person is safe and preventing common complications (like falls and adverse drug effects)
- Easing the person's distress and managing behavioural problems

Physical restraints should only be used as a last resort since they can cause serious problems. If they're needed because the older adult is a danger to themselves or others, the least restrictive type should be used first and they should be used for the shortest amount of time possible.

- Promoting meaningful activities to get the older adult moving and encouraging them to take care of themselves. This helps the person stay independent and may boost their self-esteem.

The older person should be involved in their own care as much as possible.

- Adjusting the older adult's environment. A quiet space with appropriate lighting is helpful. Having clocks, calendars and familiar objects from home can also help orient them. Where possible it's best to avoid room transfers.

What about medications?

In addition to the treatments listed above, medication may, in some cases, be necessary to control the agitation that can accompany delirium. Medication may also be needed to treat the underlying causes of delirium. The health care provider would carefully assess the older person and their symptoms to develop a medication plan that meets their individual needs. The health care provider would then closely monitor the effects of the medication.

What can I do to help my family member?

No matter where your family member is being treated, you can help re-orient, calm, assist, protect and support them. In hospitals and other health care facilities, you can work with staff to help ensure effective communication and advocate for your family member. This is especially important if there is a language barrier or if there are other cultural considerations.

You can work with the health care provider(s) to find the best ways to help your family member in a health care setting or at home. Here are some suggestions:

Stay with the older person when possible, especially at night.

Sometimes people think that their family member is "out of it" and wonder if it's even worth visiting.You may be tempted not to visit, but the delirious older adult really needs their family's support. A visit can help the person calm down, and talking with them can help orient them.

Bring familiar things from home to help orient and calm your relative: family pictures, sleepwear, religious images, and objects from the bedside.

If you can't stay with your family member, consider the use of a private-duty nurse who has experience caring for older adults with delirium.

Be reassuring.

Convey an attitude of warmth, calmness and kind firmness. Acknowledge their emotions. Tell them that they are experiencing a delirium. Let them know that you understand that they are experiencing problems and that they may be frightened.

Talk with your family member.

It can be difficult to have "normal" conversations when your family member is delirious. Here are tips that might help:

- Speak softly, but don't whisper. Always talk to the person face-to-face.
- Give information that will help orient your relative. Use their name and tell them who you are. Let them know when you are leaving and when you are coming back. Remind them where they are, what the date is and why they are in the hospital.
- Talk about things that are familiar or of interest to them, like hobbies or family activities.
- Give explanations or instructions clearly and slowly. Try to keep things short and simple. Give the person time to absorb the information and respond. Repeat if necessary.
- It's best not to talk about abstract ideas. Your family member probably won't understand what you're talking about and might feel frustrated.
- Listen carefully. Be respectful. Even if the person isn't making sense, you can still provide emotional support.

- Don't argue about their irrational beliefs. What the person is seeing and hearing is real to them. Avoid confrontation, even when they say or do inappropriate things.
- A delirious person may not recognize you or may say things that are very hurtful. Although it's hard, try not to take it personally.
- If you are worried about their safety, try distracting your relative with another topic of conversation or activity.
- Avoid rapid movements and keep your hands in sight whenever possible. This will help reduce any fear they may have about your intended actions.
- Once the delirium has passed, don't remind your relative of how they acted when they were delirious. They might feel embarrassed or upset about things they said or did. If their memories of the delirious episode are traumatic, they may need more support.

Ensure their space is safe.

Remove potentially harmful objects and unfamiliar equipment or devices.

Proper lighting can help keep a person from feeling disoriented and having an accident, like a fall.

Installing an alarm system on the door would alert family members if your relative wandered outside at night.

Make eyeglasses, hearing aids and dentures available.

Sensory deprivation is a common cause of delirium. Not being able to see or hear properly can be stressful. Encourage your relative to use their eyeglasses or hearing aids. Make sure the eyeglasses are clean and the hearing aid works (make sure it has fresh batteries). Having their dentures will also make it much easier for your family member to enjoy healthy food.

Note: If your relative is in a health care setting, check with your health care provider before giving these to your relative directly.

Stick to a regular routine.

Encourage your relative to take care of themselves to the extent that they can.

Keep your family member engaged. If they're agitated, distract them if you can from whatever they're upset about.

Encourage them to eat and drink. If they find it difficult to eat or drink, ask your health care provider for specific strategies or tools.

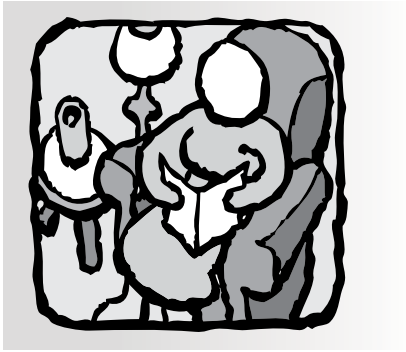
Older adults need plenty of rest. Here are some tips that can help a person prepare for a good night's sleep:

- a five-minute, slow-stroke back massage
- a warm drink of the person's choice
- relaxation tapes, classical music, nature sounds, or their favourite music
- a comfortable pillow and a warm blanket

Make the space as comfortable as possible.

The older adult's environment can improve delirium or make it worse. Pay attention to triggers and be flexible in your approach:

- Make sure your family member has a clock, calendar and/or chart of the day's schedule to help orient them.
- Ensure proper lighting. A room with a window can provide pleasant natural light. Brighter light can make it easier to see things clearly and communicate. Lower light can promote rest and sleep at night.
- Control noise.
- Bring your relative books, magazines, or music that they might enjoy.



Issues of capacity and consent

People who are experiencing delirium might not be cognitively capable of making decisions for themselves. This may be a permanent or temporary condition, because capacity may fluctuate with delirium.

Under these circumstances, family members are often conflicted. They want to ensure that their family member is taken care of while preserving their family member's right for autonomy. One of the important issues for family members to sort out is what to do if their older relative doesn't understand their own health care needs and requires someone else to make decisions for them. Ideally, it's best for families to have this conversation before anyone becomes ill.

Since legislation varies from province-to-province, it's best for you to learn about the laws concerning substitute decision-making in your province or territory. The most commonly used legal standards for capacity include some combination of the following:

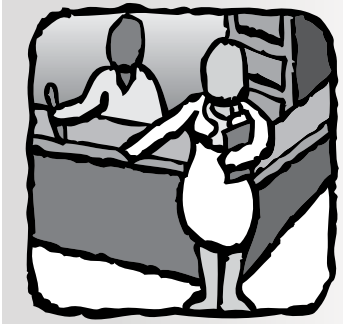
- A person's ability to **communicate a decision**
- A person's ability to **understand the information that is needed to make a decision**
- A person's ability to **appreciate the consequences of their decision**

The law also varies from province-to-province with respect to who can be a substitute decision-maker and what their legal obligations are. If you're in the position of being a substitute decision-maker, you need to educate yourself about these legal requirements.

Health care professionals with skills and expertise in issues related to capacity and adjustment to illness can also help you and your family.

How can I work with the health care team?

- A person's language abilities, literacy level, religious and cultural background can affect their perceptions, their interaction with health care providers and their access to treatment. Limited English proficiency can be a barrier to treatment. Inform your health care team of any language barriers and/or cultural considerations that could influence the health care of your relative.
- You might want to consider appointing one family member to act as the person who will communicate with the health care team. Many phone calls and requests for information from several different family members can be confusing.
- Seek out and introduce yourself to the nurses in charge on your relative's hospital unit. These are the people who arrange the day-to-day care of your relative. They can tell you what tests have been scheduled, what drugs your relative is receiving, and what the possible side effects are.



- Be an advocate for your relative. If you notice sudden changes in your relative's mood, thinking or behaviour, tell a health care provider right away. Don't be afraid to ask questions about the treatment that is being provided or recommended.
- Ask the nurse in charge for the name of the doctor treating your older relative. Find out how to contact the doctor. The doctor will explain the medical problem for which drugs have been prescribed and tests ordered.

- Ask the nurse to contact the attending physician to make an appointment for you to discuss your relative's condition. If the geriatric team is involved, a nurse and/or physician from the team may be available to discuss the care of your relative with you.
- Communication is a two-way street. Family members can provide the health care provider with important information about the older adult. Don't be afraid to ask members of the health care team for more information about delirium and tips on how to help your family member.
- Set up regular doctor's appointments and home visits for treatment, monitoring and follow-up.

Adapted from *Information for Patients and Families: Delirium (acute confusion)*, Alberta Health Services (formerly Capital Health Edmonton Area).

TIP! Ask your health care provider about specific ways you can help prevent delirium.

Will my family member recover from delirium?

Many older people with delirium recover fully. Sometimes, delirium goes away in a few days, but sometimes the symptoms can last for weeks or months.

The cause of the delirium can affect how long it takes a person to recover. For example, if a simple infection is the cause of the delirium, taking an antibiotic may resolve the delirium very quickly. On the other hand, if the cause is a severe illness, the recovery may take longer.

On occasion, some older people do not recover fully from delirium. Memory problems and personality changes may stay. They may require continued monitoring and ongoing interventions. Talk with your health care provider about the need for any ongoing support and follow-up for your relative.

If an older person has had a delirious episode, there is a very high chance it will happen again. Family members and other caregivers continue to play an important role. By knowing about the causes and symptoms of delirium, family members can help detect early changes and tell health care providers right away.

A final note about living well & aging well

Health and wellbeing is a journey, from birth, through childhood, and into old age. Many different things impact our mental and physical health – our age, genetics, lifestyle, and access to health services – and that's just for starters. We can't control everything, but we can make choices at every stage of our lives to protect and improve our mental and physical health.

Here is a list of things you can do at any age to live well:

- Eat healthy foods in healthy amounts
- Be physically and mentally active
- Get rest
- Manage your stress
- Don't smoke
- If you drink alcohol, drink only in moderation
- Get involved with things that interest you
- Spend time with people – family, friends and members of your community
- Follow the advice of your health care team
- Ask for help when you need it

Some of these things might be easier for you to do than others. Talk about your health care goals with family, friends and caregivers. They can help you find new and creative ways to reach your goals. You might inspire them to protect and improve their health too.

If you are caring for a family member, caring for yourself is one of the most important things you can do. When your needs are taken care of, the person you care for will benefit too.

Additional resources

In addition to this family guide, the **Canadian Coalition for Seniors' Mental Health (CCSMH)** has produced three other booklets for seniors and their family members on the topics of mental health issues in long-term care homes, depression and suicide prevention. These booklets were based on the CCSMH national guidelines for seniors' mental health that were created for health professionals.
Phone: 416-785-2500 ext. 6331
Website: www.ccsmh.ca

Alberta Caregiver College website has a section on Delirium (Acute Confusion) for caregivers of older adults. It has an audio feature so that you can also listen to the information.
Phone: 780-735-7912
Website: www.caregivercollege.org (click on "Topics" to find the "Delirium (Acute Confusion)" button)

The **Canadian Mental Health Association (CMHA)** is a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. To locate a CMHA office near you, contact the head office in Ottawa or visit the CMHA website.
Phone: 613-745-7750
Website: www.cmha.ca

The **Canadian Mental Health Association, Ontario branch** has produced a helpful fact sheet called "Seniors and Delirium."
Phone: 416-977-5580 (toll free in Ontario 1-800-875-6213)
Website: www.ontario.cmha.ca/seniors.asp?cID=5803

The Hospital Elder Life Program (HELP): For Older Adults & Caregivers is a website that provides information about recognizing delirium. A special section of the website is for family and friends caring for older adults.
Website: http://elderlife.med.yale.edu/public/patient-family.php

Vancouver Island Health Authority (VIHA) is a network of hospitals, clinics, centres, health units and residential facilities. They have produced a number of highly-acclaimed resources on delirium:

- Delirium in the older person: A medical emergency (DVD)
- Delirium in the older person: Family Guide (DVD)
- Delirium in the older person: A medical emergency / "My family member is not usually like this" (brochure)

Phone: 250-370-8204 (to order a copy of the DVDs)
Website: www.viha.ca/mhas/resources/delirium/

(information accurate at time of printing)

Local resources

Use this area to record contact information for organizations and support services in your region.

The CCSMH would like to acknowledge the continued dedication of its Steering Committee members:

Canadian Academy of Geriatric Psychiatry (chair)

Alzheimer Society of Canada

Canadian Association of Social Workers

Canadian Caregiver Coalition

Canadian Geriatrics Society

Canadian Healthcare Association

Canadian Mental Health Association

Canadian Nurses Association

Canadian Pensioners Concerned

Canadian Psychological Association

Canadian Society of Consultant Pharmacists

College of Family Physicians of Canada

Public Health Agency of Canada (advisory)

BRING SOLUTIONS TO LIGHT

METTRE EN LUMIÈRE LES SOLUTIONS

Canadian Coalition for Seniors' Mental Health

The mission of the **Canadian Coalition for Seniors' Mental Health** is to promote the mental health of seniors by connecting people, ideas and resources.

To find out more about the CCSMH, visit **www.ccsmh.ca** or call 416-785-2500 ext. 6331.

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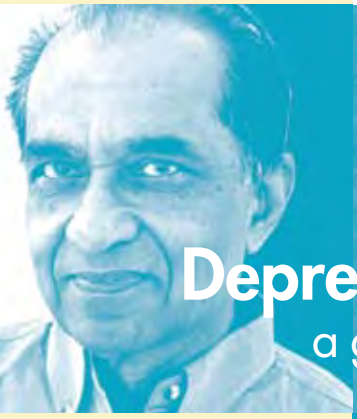
METTRE EN LUMIÈRE LES SOLUTIONS

Canadian Coalition for Seniors' Mental Health



Depression in Older Adults:
a guide for seniors and their families

Based on the Canadian Coalition for Seniors' Mental Health (CCSMH) *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Depression.*

Production of this guide has been made possible through a financial contribution from the
PUBLIC HEALTH AGENCY OF CANADA.

Disclaimer: This guide is intended for information purposes only and is not intended to be interpreted or used as a standard of medical practice.

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Acknowledgements

The CCSMH is grateful to the following people – health care professionals, older adults and family members – who participated in the review of this booklet:

Dr. David K. Conn (Baycrest & University of Toronto, Co-Chair of the CCSMH), Dr. J. Kenneth Le Clair (Providence Care & Queen's University, Co-Chair of the CCSMH), Dr. Diane Buchanan (Queen's University), Joan Cumming, Laura Evans (Canadian Mental Health Association), Beth Floyd (Seniors Advisory Committee, Mental Heath Commission of Canada), Dr. Chris Frank (Canadian Geriatrics Society), Winnie Fraser-Mackay (Canadian Pensioners Concerned), Margaret Green, Dr. Ken Hahlweg (University of Manitoba), Anne Helsdingen, Nick Helsdingen, Ian MacDonald, Pat Malone, Nona Moscovitz (CSSS Cavendish), Simone Powell (Public Health Agency of Canada), Mary Ritchie (Seniors Mental Health, Capital District Mental Health Program, NS, Nova Scotia Hospital Site), Rhonda Seidman-Carlson (Markham Stouffville Hospital Corporation), Gregg Schiller (411 Seniors Centre Society) and Jane Wilson.

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Introduction

We're very glad you picked up this booklet. Canadians are not only living longer, but also staying healthy and independent longer than ever before. We want all older adults – and their family members – to have high-quality information about health issues that might affect them. We believe that with this information, older adults will be empowered to make informed decisions about their health care and build effective relationships with their health care providers.

What is the Canadian Coalition for Seniors' Mental Health?

The Canadian Coalition for Seniors' Mental Health (CCSMH) started in 2002 **to promote the mental health of seniors by connecting people, ideas, and resources**. Members of the CCSMH are organizations and individuals who represent seniors, family members and informal caregivers, health care professionals, researchers and policy makers.

In 2006, the CCSMH created the first set of national guidelines on seniors' mental health based on the most current research. These guidelines were written for health care professionals who work with older adults. They recommend ways to improve the assessment, prevention, treatment and management of key mental health problems for older adults: mental health issues in long term care homes, delirium, suicide and depression. This booklet is part of a series that covers the same topics for seniors, their family members, and others who care about them.

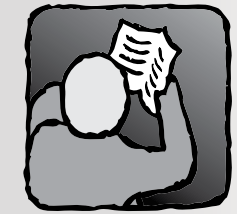
The CCSMH will happily provide these resources on request. Call 416-785-2500, ext. 6331, or visit www.ccsmh.ca to download them at no cost.

Mental health problems are NOT a normal part of aging

Many people think that mental health problems are just a normal part of aging. This simply isn't true. Difficulties with mood, thinking and behaviour are not an inevitable part of aging. Nor are they signs of personal weakness. They are usually signs that something is wrong that requires attention from a health care professional.

Some people may argue that there is no point investigating these problems in older adults because these problems can't be fixed. Some problems associated with aging cannot be cured *yet*, but there is still a lot that can be done. Mental health problems can be treated.

Older adults experiencing changes in their mood, thinking and behaviour may not be aware of the changes that are taking place, may misunderstand the nature of the changes that are occurring, or may be ashamed of the idea that they're developing "mental health problems." Family members may misunderstand and think that these changes are normal parts of aging, aspects of their relative's personality, or signs of personal weakness and may not know how best to help.



We hope this guide will help inform older adults and their families about what they can do if they have mental health concerns.

Who should use this guide?

This guide will help older adults who are feeling depressed. It will also help family members and others who care about them. The guide gives information about the causes and symptoms of depression. It also describes what to do if you, or someone you care about, is feeling depressed.

Definitions

Ageism is a way of thinking about older people based on negative attitudes and stereotypes about aging. Ageism can lead to age discrimination – treating people in an unequal fashion because of their age. Age discrimination can negatively affect older adults in all aspects of life.

Mental health is the capacity of each person to feel, think and act in ways that allow them to enjoy life and deal with all the challenges they face.

The terms **"seniors"** and **"older adults"** are used in this guide to refer to individuals over the age of 65.

Stigma is defined as a mark of shame or disgrace. It often involves stereotypes, hurtful words and discrimination. Stigma around mental health is often based on society's misunderstanding and lack of knowledge about mental health problems. Many people living with mental health problems say that society's negative reactions to them can be worse than the illness itself. Because of the stigma of mental health problems, many people don't seek – or receive – the health care they need.

All three of these conditions can occur at the same time. It helps to understand the differences between these conditions so that you can identify them and get the proper help right away.

Depression can cause people to feel persistently low in spirits and lose interest in things that used to give them pleasure. This is sometimes triggered by stressful events in a person's life that impact their state of mind, their health, or their ability to connect with other people. However, sometimes it can happen for no apparent reason. When a person is severely (i.e. clinically) depressed, the chemicals in his or her brain may be out of balance. Other symptoms often include sleep and appetite changes and anxiety.

Delirium is a confusional state. This means that people with delirium are disoriented, with an altered level of consciousness and trouble understanding the environment. Delirium develops *quickly* over a period of hours or days. The symptoms of delirium may come and go and are often worse at night. Delirium is a medical emergency caused by difficulties in brain functioning.

Dementia is an illness characterized by the loss of intellectual abilities that is severe enough to interfere with a person's ability to function. Dementia results in changes in the way the person thinks, feels and behaves, along with memory impairment. It tends to develop slowly over a period of months or years and progresses over time. Alzheimer's disease is an example of dementia.

What is depression?

Depression is more than having a bad day or feeling a little "blue." Depression can be described as feelings of sadness, hopelessness and a loss of interest or pleasure in things you usually like to do. You might be worried about depression if you've felt this way for a couple of weeks or longer.

Depression is the most common mental health problem in older adults. Although common, it is not a normal consequence of aging. Depression in later life is an illness that can be treated.

Older adults are less likely to talk about feeling depressed with their health care providers. They might feel shame about having an "emotional" illness or be afraid that they're "losing it."

Some symptoms of depression, such as low energy, and more aches and pains, are often falsely interpreted as symptoms of aging. A lack of knowledge about depression in later life can mean that treatable symptoms aren't recognized.

Depression can cause stress in the family and can affect not only the older adult living with depression, but also those who care for them.

Have you lost interest or pleasure in things you usually like to do?

Are you feeling sad, low, depressed and hopeless?

You are not alone!

Did you know that up to 1 in 5 seniors have symptoms of depression? The rates of depression among seniors are even higher in hospitals. In long-term care homes, up to 40% of residents may be experiencing depression.

Although depression can be quite common in later life, depression is not a typical part of aging. Symptoms can be successfully treated in almost all cases!

What are the risk factors for depression in older adults?

Do any of these risk factors apply to you?

- ☐ Being depressed in the past
- ☐ Having other biological relatives with depression
- ☐ Being female
- ☐ Being widowed or divorced
- ☐ Changes in the brain resulting from other illnesses such as a stroke, Parkinson's disease or Alzheimer's disease
- ☐ Trouble developing close relationships or having low self-esteem
- ☐ Illnesses that last a long time and cause difficulties like pain and disability
- ☐ Certain medications
- ☐ Drinking too much alcohol or abusing drugs
- ☐ Sleep problems that last a long time (either too much or too little sleep)
- ☐ Not having a strong social network and being isolated
- ☐ Taking care of a family member who has a serious illness such as dementia

Even if you have some or many of these risk factors, it does not mean that you are depressed or will experience depression in the future.

Life events that can trigger symptoms of depression:

- ☐ When an older adult is grieving the death of a loved one, it is normal to experience feelings of sadness and despair. For most people, these feelings will gradually decrease (usually within a year). If a person's despair is so bad that they are unable to function and their symptoms don't get better with time, they may be suffering from depression.

- ☐ Depression is common in the year after a person moves to a smaller place, an apartment, or a nursing home. It is also normal for a person to experience a sense of loss if they are moving away from their friends, family and other supports.
- ☐ Negative life events, such as a separation or divorce, a financial crisis or other loss can trigger symptoms of depression.

What are the symptoms of depression in older adults?

It is normal to experience ups and downs throughout life. Depression is more than having a bad day or feeling a little "blue." To be diagnosed with depression, you need to experience some or all of these symptoms for at least two weeks.

Do you have any of these symptoms of depression?

- ☐ Feeling sad
- ☐ No interest in or pleasure from things you used to enjoy
- ☐ Less energy and feeling tired
- ☐ Not feeling well, having aches and pains
- ☐ Feeling guilty or worthless
- ☐ Difficulties thinking and concentrating
- ☐ Problems sleeping (too much or not enough)
- ☐ Changes in appetite and weight
- ☐ Feeling agitated, restless and/or sluggish
- ☐ Thoughts of suicide or death

Depression usually doesn't get better on its own. If you have experienced many of these symptoms for a prolonged period of time, talk to a health care provider.

What should you do if you notice symptoms of depression?

Get help! If you think you are depressed, it is important to get help from a health care provider. If you do not have a family doctor, there are other options, like walk-in clinics, your local hospital or community health centres. Most specialized geriatric programs will see people who do not have a family doctor.

If you (or someone you care about) is feeling so low that you are thinking of hurting yourself or ending your own life, call 911 immediately, or go to the emergency room of your local hospital.

When you visit your health care provider, try to be as open and honest as possible about your symptoms. Remember that depression is an illness like any other. It's okay to talk about what you're experiencing. Some people may feel uneasy sharing their thoughts and feelings but it is an important step in getting the help you need to feel better. You are not alone. Many older adults experience these same feelings.

Depression isn't caused by personal weakness. It's a medical illness that can be treated.

A message for caregivers:

Helping a family member deal with depression is stressful. You may be worried about their safety and well-being. You might feel sad about the effect the illness is having on your relationship with them. Remember that most people with depression get better with proper treatment.

It is common for caregivers to feel overwhelmed, at least some of the time. If you are feeling stressed or hopeless, share your feelings with a caregivers' support group, a therapist, or a trusted friend or family member. If you feel ill or think you may be depressed, visit your health care provider.

It's not unusual for caregivers to develop mild or more serious depression as a result of the constant demands they face in providing care.

How is depression diagnosed?

To diagnose depression, your health care provider may:

- Do a physical exam and run some tests to rule out other problems that could be causing symptoms of depression.
- Ask questions about your thoughts and feelings and what's happening in your personal life. They may ask you to fill out a questionnaire that includes questions like:
  - Are you basically satisfied with your life?
  - Have you dropped many of your activities or interests?
  - Are you in good spirits most of the time?

Family members who are caring for an older adult with memory problems can be very helpful in providing information about recent changes in their mood or behaviour.

It might be difficult for an older adult who doesn't speak English as a first language to communicate with a health care provider about their symptoms and treatment options. Cultural or religious beliefs may also make it difficult to talk openly about mental health issues. Family members can help bridge the communication gap between their relative and the health care provider.

How is depression treated?

Depression can be treated in different ways. The type of depression, how severe it is, and the wishes of the older adult will all help determine the best treatment. Treatment can include improving one's lifestyle and social supports, counselling and therapy, and medication. A combination of these treatments may give the best results. Your health care provider can explain your options and help you choose the treatment that's best for you.

Types of treatment available:

1. Improving lifestyle and social supports

- Education (finding out more about depression)
- Visiting nurse and / or home care services
- Community-based activities / programs
- Exercise
- Nutrition

2. Counselling and therapy

There are many different types of therapies that help treat depression. You may need to explore more than one to find one best suited for you. Some examples of therapy are:

Only specially trained professionals should offer therapy. This may be a social worker, psychologist, physician, nurse or psychiatrist. Your family physician can refer you to someone who is qualified to work with older adults with depression.

- Individual counselling or therapy
- Family counselling or therapy
- Bereavement groups for people who are grieving the death of a loved one

3. Medication

Medications that treat depression are called **antidepressants**. They correct the chemical imbalance in your brain. Your health care professional can prescribe an antidepressant based on the type and severity of your depression. You may need to try different types of antidepressants to find the one that works best for you. Your health care provider will tell you how long you'll need to take the medication, and about any possible side effects.

Some antidepressants can interact with other medications and cause more health problems. Your physician needs to be aware of all the medications you are currently taking (including vitamins and herbal remedies) to make sure he or she prescribes the best antidepressant for you. Depression can be more difficult to treat when older adults misuse alcohol or drugs while taking antidepressants.

Important facts about antidepressants:

- They are not addictive.
- They need to be taken every day, as prescribed.
- Mild side effects are common but are usually temporary.
- It may take 4–6 weeks to notice any improvements in symptoms.
- You should not stop taking medication – or change the dose – without consulting with your doctor, even if you feel better.

4. Electroconvulsive therapy (ECT)

ECT is an effective treatment for people whose depression is so severe that medications and therapy don't do the job. It can improve symptoms more quickly than therapy and drugs.

In the past, ECT has had some bad press. The movie *One Flew Over the Cuckoo's Nest* showed the therapy as a punishment, not a treatment. Today, patients are anaesthetized (given drugs so they "sleep" through the procedure) and their muscles are relaxed before ECT is administered.

If your health care provider recommends ECT for you or a loved one, ask about the potential benefits as well as the risks and side effects, so you can make an informed choice.

How long does treatment typically last?

Treating depression takes time and there may be ups and downs. Eventually, you will feel better.

Making positive lifestyle changes and finding helpful social supports should be an ongoing process.

If you decide to see a counsellor or a therapist, or to join a support group, the length of this relationship will depend on a number of factors. Discuss this with your counsellor, therapist or group facilitator.

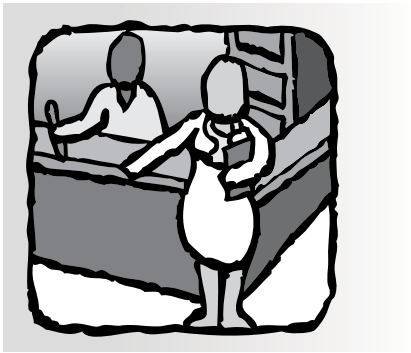
If you are taking an antidepressant, it should be taken as prescribed and not adjusted or stopped without consulting with the physician who prescribed them. After monitoring your reactions to the medication and the change in your symptoms, your doctor may adjust your dosage.

When the symptoms of depression are gone, your health care provider should monitor your medication to make sure the symptoms don't come back. Your physician may continue to prescribe medication for up to two years to ensure that you remain symptom-free. If you have had several episodes of depression or a severe episode, or have had ECT, it might be best to stay on antidepressants for much longer.

What is the best way to work with health care professionals?

It can be difficult for a health care provider to diagnose depression in older adults. In most cases, older people don't use mental health services. Instead, they go to their family doctors, community centres or hospitals. It can be difficult for their doctor to diagnose depression (and suicide risk) because older adults are more likely to talk about physical symptoms than emotional concerns. Since depression affects bodily functions like sleep and digestion, it's often hard to sort out whether the physical symptoms are due to depression or medical illness.

Depression is the most common mental health problem associated with suicide in older people. Most older adults who die by suicide have seen a health care provider in the months before their death. Their depression often goes undiscussed, undetected and untreated.



Who can help?

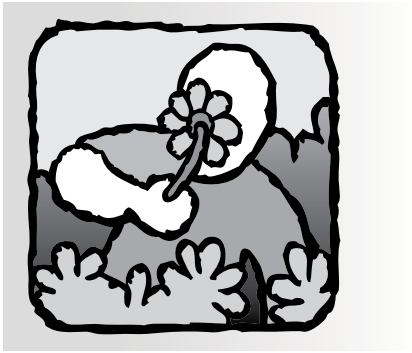
This might depend on where you live. People in urban centres usually have more resources than those who live in rural settings. Members of your health care team might include:

- Your doctor
- Nurse
- Psychiatrist (a medical doctor that specializes in mental health) – your family doctor can make a referral
- Psychologist (an expert who can assess mental health and do counselling)
- Social workers and specialized mental health counsellors (found in community mental health centres, community agencies or private practice)
- Faith leaders

Tips to make the most of your appointment with a health care provider:

- Bring this guide with you to help you start the discussion about depression.
- Tell the health care provider about your symptoms (page 9) and risk factors (page 7).
- Ask a friend or family member to attend appointments with you for support, if you think this would be helpful.
- Ask for referrals to mental health professionals in your community.
- Ask for more information about depression.
- Book a follow-up appointment in the near future.

Can people with depression get better?



Yes! When treated quickly and properly, more than 80% of older adults with depression can be treated successfully and can lead full and active lives.

Patience is important. It may take time before you notice improvement. It's very important to stick with your treatments to prevent depression from happening again. Some people may need to stay on antidepressants for extended periods of time. Talk with your health care provider about any concerns you have.

Be aware!
Suicide risk can increase when a person starts to recover from depression. Their energy level may improve before their mood does. They may now have the energy to carry out a suicide plan. During this period, they need ongoing support from family, friends and health care providers.

A final note about living well & aging well

Health and well-being is a journey, from birth, through childhood and into old age. Many different things impact our mental and physical health – our age, genetics, lifestyle and access to health services – and that's just for starters. We can't control everything, but we can make choices at every stage of our lives to protect and improve our mental and physical health.

Here's a list of things you can do at any age to live well:

- Eat healthy foods in healthy amounts
- Be physically and mentally active
- Get rest
- Manage your stress
- Don't smoke
- If you drink alcohol, drink only in moderation
- Get involved with things that interest you
- Spend time with people – family, friends and members of your community
- Follow the advice of your health care team
- Ask for help when you need it

If you are caring for a family member, caring for yourself is one of the most important things you can do. When your needs are taken care of, the person you care for will benefit too.

Some of these things might be easier for you to do than others. Talk about your health care goals with family, friends and caregivers. They can help you find new and creative ways to reach your goals. You might inspire them to protect and improve their health too.

Additional resources

In addition to this family guide, the **Canadian Coalition for Seniors' Mental Health (CCSMH)** has produced three other booklets for seniors and their family members on the topics of mental health issues in long-term care homes, delirium, and suicide prevention. These booklets were based on the CCSMH national guidelines for seniors' mental health that were created for health professionals.
Phone: 416-785-2500 ext. 6331
Website: www.ccsmh.ca

The **Canadian Caregiver Coalition** is a national organization that represents and promotes the voices, needs and interests of family caregivers to all levels of government and the community.
Phone: 1-888-866-2273 (toll free)
or 613-233-5694 ext. 2230
Website: www.ccc-ccan.ca

The **Canadian Mental Health Association (CMHA)** is a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. To locate a CMHA office near you, contact the head office in Ottawa or visit the CMHA website.
Phone: 613-745-7750
Website: www.cmha.ca

The **Mood Disorders Association of Canada** is a national, not-for-profit organizations that is committed to improving the quality of life of people affected by depression, bipolar disorder and other related disorders.
Phone: 519-824-5565
Website: www.mooddisorderscanada.ca

The **Mood Disorders Association of Ontario** created a website called Check Up from the Neck Up to raise awareness about mood disorders and connect people with resources, so they can get help if they need it.
Phone: 1-888-486-8236 (toll free) or 416-486-8046
Website: www.checkupfromtheneckup.ca

The **Older Person's Mental Health and Addictions Network of Ontario (OPMHAN)** has produced a helpful booklet called "Depression…It's Just Part of Getting Old, Right? Wrong!!! The Facts of Aging and Depression for Older Adults and Those Who Care About Them." They also developed a guide called "Peer Support Groups for Older Persons with Depression and Those Who Care About Them: A Manual to Get You Started." OPMHAN has closed due to lack of funding, but some of their resources are still available on their website.
Website: www.opmhan.ca

(information accurate at time of printing)

Local resources

Use this area to record contact information for organizations and support services in your region.

The CCSMH would like to acknowledge the continued dedication of its Steering Committee members:

Canadian Academy of Geriatric Psychiatry (chair)

Alzheimer Society of Canada

Canadian Association of Social Workers

Canadian Caregiver Coalition

Canadian Geriatrics Society

Canadian Healthcare Association

Canadian Mental Health Association

Canadian Nurses Association

Canadian Pensioners Concerned

Canadian Psychological Association

Canadian Society of Consultant Pharmacists

College of Family Physicians of Canada

Public Health Agency of Canada (advisory)

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Canadian Coalition for Seniors' Mental Health

The mission of the **Canadian Coalition for Seniors' Mental Health** is to promote the mental health of seniors by connecting people, ideas and resources.

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Mental Health Issues in Long-Term Care Homes:

a guide for seniors and their families

Based on the Canadian Coalition for Seniors' Mental Health (CCSMH) *National Guidelines for Seniors' Mental Health: The Assessment and Treatment of Mental Health Issues in Long-Term Care Homes (Focus on Mood and Behaviour Symptoms).*

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We hope this guide will help inform older adults and their families about what they can do if they have mental health concerns.

Who should use this guide?

This guide will help the family members of an older adult living in a long-term care facility. It will also help older adults who are preparing to move to one. It gives information about mental health issues that are common among residents of long-term care homes and suggests strategies to improve their quality of life.

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Depression can cause people to feel persistently low in spirits and lose interest in things that used to give them pleasure. This is sometimes triggered by stressful events in a person's life that impact their state of mind, their health, or their ability to connect with other people. However, sometimes it can happen for no apparent reason. When a person is severely (i.e. clinically) depressed, the chemicals in his or her brain may be out of balance. Other symptoms often include sleep and appetite changes and anxiety.

What are long-term care homes?

In this guide, "long-term care homes" refer to any residences for older adults who need assistance with daily activities and require skilled nursing care on a daily basis. Long-term care homes are also called "nursing homes," "personal care homes" or "complex care facilities."

In Canada, the provinces and territories are responsible for long-term care. As a result, long-term care services and facilities vary across the country.

Who lives in long-term care homes?

Older adults who live in long-term care homes often have disabilities. They need a lot of care and assistance with daily activities.

Most residents of long-term care homes also have some type of mental health problem. Research shows that more than half of residents may have dementia and other cognitive impairments. Some residents in long-term care homes may also suffer from depression and psychosis.

People with dementia may have some of the following behavioural symptoms:

- Agitation
- Aggression
- Wandering
- Shouting
- Repetitive or bizarre behaviour
- Making rude or hurtful comments
- Sexually inappropriate behaviour

Alzheimer's disease is the most common form of dementia. For more infomation, go to www.alzheimer.ca

Promoting health in long-term care homes

The staff in long-term care homes provide residents with:

- The general care residents require for activities of daily living.
- The care that is needed to manage and treat mood and behavioural symptoms.

The following principles promote the mental health of residents with mental illness. They also promote the general health and well-being of all residents in long-term care:

- Residents should receive **personalized care**. Whenever possible, care should be based on the directions and preferences of the resident.
- Families should be considered **partners in care**.
- Care should focus on the **resident's strengths** and minimize the impact of his or her limitations.
- Care should **take into account the physical, mental, social and spiritual needs** of the resident.
- Staff should receive **ongoing education and training** to provide care to residents.
- A **supportive and helpful environment** should be created that responds to the resident's changing needs.
- **Strategies to prevent mental illness** should be built into programming and included in training programs for staff and families.

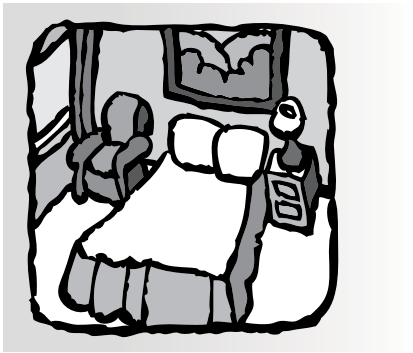
If you, or someone you know, has a concern about the way care is being provided, you can use this guide to help start a conversation with staff. All long-term care homes are also required to post a complaint procedure.

General care in long-term care homes: activities of daily living

Activities of daily living include tasks like bathing, getting dressed, going to the bathroom, and eating. If an older adult is no longer able to do these things independently, this can lead to a decision to move into a long-term care home.

Older adults who have physical or mental health problems may not be able to perform these daily activities like they used to. They may become agitated, restless or even aggressive. This can be an expression of an unmet need. They may be hungry or in pain or need to use the bathroom.

It is easy to understand why people who are not having their basic needs met may act out. Even if a person's needs are being met, it's understandable that they may feel uncomfortable about the way things are being done.



It can be very hard for family members to watch someone they care for become agitated or aggressive. The good news is that family members can help. An **individualized care plan** is created for each long-term care resident. Family members can tell staff about the older adult's routines and care patterns before the relative moves into a long-term care home. Sharing this type of information with staff can greatly improve the care that is delivered. This is especially important for older adults who are unable to express themselves verbally. Family members can help create the individualized care plan by completing the form on the next page.

Information about my family member:

Do they have a dementia? ☐ Yes ☐ No ☐ Not sure

If yes, please describe: _____

_____

Are they depressed? ☐ Yes ☐ No ☐ Not sure

Have they been delirious before? ☐ Yes ☐ No ☐ Not sure

Do they have a new illness(es)? ☐ Yes ☐ No ☐ Not sure

If yes, please describe: _____

_____

Doctor's name: _____

Doctor's phone number: _____

List all medications (prescribed, over-the-counter, and any herbal remedies):_____

_____

_____

_____

Behavioural symptoms:

- ☐ agitation
- ☐ aggression
- ☐ wandering
- ☐ repetitive or bizarre behaviour
- ☐ shouting
- ☐ making rude or hurtful comments
- ☐ sexually inappropriate behaviour
- ☐ other _____

Information about my family member:

How were these symptoms managed in the past?_____
_____
_____

Social history:
Marital status: _____
Where do family members live: _____
Religion / faith: _____
Country of birth: _____
First language:_____
Other: _____

Personal preferences:

	Likes	Dislikes
Food	_____	_____
Activities	_____	_____
Music	_____	_____
Other	_____	_____

Describe their daily routines: (housekeeping, meal preparation, social contacts, hygiene, etc.)
_____
_____
_____
_____
_____
_____

What is important to them?
_____
_____
_____
_____
_____

Understanding mental health problems in long-term care residents

All residents should be screened for depression and reasons for changes in behaviour shortly after they move to the long-term care home. Screening also occurs on a regular basis (annually) and in response to any significant changes, like the death of a spouse, or when a resident loses the ability to do their usual activities.

Screening is done to detect symptoms so that they can be investigated and to ensure that prevention methods are maintained. Families may be involved in the screening process, especially if a resident is unable to speak for themselves. As partners in care, family members should feel comfortable speaking with the long-term care staff. If family members notice changes in their relative's mood and behaviour, this should prompt a re-screening.

If the screening shows that the older adult might be depressed, a more detailed investigation should occur. This can involve a review of the older adult's medical history, a physical exam and laboratory tests. The purpose of this detailed investigation is to look for any other conditions that may impact the resident's mood and behaviour, such as a medical disorder causing a delirium, dementia or depression.

Focusing on what the resident is still able to do, instead of what they can no longer do, can help to improve their quality of life.

Changes in the social environment of a long-term care resident can affect their mood and behaviours. Such changes may include:

- Changes in the family situation
- New stressors or situations, like a change in staffing at the home
- Changes in patterns and schedules
- Changes in the physical environment, such as a change in rooms

If you are a family member of a long-term care resident and you are aware of any changes in the social environment of your relative (especially changes that may be happening outside of the long-term care home, like an illness in the family), it may help to share this news with a staff member.

Treating depression in older long-term care residents

If a resident in long-term care has demonstrated certain symptoms (such as a change in mood, feelings of sadness that won't go away, a loss of appetite, lost interest in things they used to enjoy, among other symptoms), he or she may be diagnosed with depression. Depression is very common among long-term care residents. Some research shows that up to 40% of residents may be experiencing symptoms of depression.

Although depression is common among older adults, it is important to remember that **depression is NOT a normal part of aging**. Symptoms can be treated in almost all cases!

The resident's treatment plan should be created based on the type of depression and how severe it is. Treatment should include lifestyle changes and social support and may include the use of medication.

More information on depression is available in the CCSMH **Depression in Older Adults: a guide for seniors and their families**. Visit www.ccsmh.ca or call 416-785-2500, ext. 6331, to get a copy.

Improving lifestyle and social supports

Health care providers, family and volunteers can provide psychosocial support for long-term care residents. Psychosocial support refers to the creation of a supportive environment where practical and emotional support is offered. This type of support can improve the older adult's mood and behaviour.

The chart below shows different types of support that some long-term care residents have found useful. It is important to remember that not all activities will be effective or welcomed by all residents. Support should be tailored to the needs and wishes of the individual resident.

Goal of care	Activities to consider
Reduce symptoms of depression	**Opportunities to meet, talk and socialize with others** • Weekly visits from family or a volunteer • Spiritual care from a minister, rabbi or other faith leader • Supportive therapy
Engage resident	**Structured, meaningful recreational activities** • Recreation based on the resident's interests and abilities (like baking, music and discussing current events) • Appropriate exercise

Counselling and therapy can also reduce the symptoms of depression and increase a person's sense of self-worth and overall well-being. Therapy should always be provided by a trained specialist.

Each resident is unique. It's important to offer support in a spirit of collaboration and respect.

What about residents who have depression and dementia?

It is common for residents who have dementia to also show symptoms of depression, and vice versa. When treatment strategies are being considered, it is important to think about the resident's ability to understand and their willingness to engage in activities. This will help avoid unintended agitation and distress.

Since dementia worsens over time, it's important to be flexible. An activity that reduced the symptoms of depression in the past may no longer work. Various strategies may be used for residents with both dementia and depression. Most are one-on-one activities. Some examples include:

- Supportive therapy
- Playing a recording (for example, a CD or DVD) of positive experiences from the resident's life and shared memories involving family and friends
- Physical activity
- Prompting personal memories about relationships, family, work and life accomplishments (this might happen during meal times)

Medication

An older adult and health care provider may decide on medication as a way of treating depression. For older adults with depression who live in long-term care homes, antidepressants are the medication of choice. It is often best if antidepressants are used along with a combination of lifestyle improvements and social supports. More information on the different types of medications used to treat depression in older adults can be found in the CCSMH depression guidelines.

Treating behavioural symptoms in older long-term care residents

Treating the behavioral and psychological symptoms of dementia is an ongoing challenge, but research is showing that certain things can be done to improve these symptoms.

Behaviours that are inappropriate and disturbing, disruptive or potentially harmful to the resident or others require attention. Most often these behaviours are a result of a decline in the person's cognitive abilities. These behaviours can be addressed by improving the person's lifestyle and social supports and, if necessary, by taking medication. Before deciding if the behaviour is due to dementia, it is important for the health care provider to find out if any medical causes (like an infection, new medication and/or depression) are the main reason for the change in mood or behaviour.

Improving lifestyle and social supports

The chart shows different types of support that some long-term care residents have found useful. It is important to remember the general principles for individualized care planning in long-term care homes. Not all activities will be effective or welcomed by all residents.

Goals of care	Activities to consider
Minimize sensory deprivation and social isolation Provide distraction and physical contact Promote relaxation	**Social contact** • One-to-one activities like talking and singing • Watching family videos • Companion animals
Reduce behavioural symptoms Stimulate the senses Enhance relaxation	**Sensory stimulation / relaxation** • Music • Snoezelen (a sensory room) • Aromatherapy • Bright light therapy • White noise • Massage and touch
Engage the resident	**Structured, meaningful recreational activities** • Sewing • Sorting and folding laundry • Cooking • Setting the table • Outdoor gardening • Walking programs • Physical group activities
Manage behaviours that may be disturbing, disruptive or potentially harmful	• Reinforcing quiet behaviours • Compliments, soothing speech, praise and food, which may serve as rewards • Distraction techniques • Individualized behaviour therapy (with a trained specialist)

Medication

Psychosocial support should be considered the first approach to relieving behavioural symptoms. There may be some cases, however, where medications will be used in combination with some of the strategies listed in the chart on pages 15 and 16.

Whenever a new medication is started, it is important to carefully examine the risks. When appropriate, some residents may be prescribed an antipsychotic medication to help reduce severe behavioural symptoms. There are some risks associated with antipsychotic use by people with dementia so an antipsychotic should be used sparingly and the health care team should monitor its effects. Other types of medication can also be used to reduce behavioural symptoms.

Some behaviours are unlikely to change as a result of medication. These include:

- Unsafe wandering
- Exit-seeking behaviours (trying to leave the facility)
- Excessive noisiness

These behaviours are best addressed through psychosocial supports.

What role can family members play in long-term care?

Family members should be **partners in care** for residents in long-term care.

If you are the family member of a long-term care resident, **share information with staff about your relative's past routines and preferences when your relative is admitted** (the form on page 8 might help). This can help promote their mental health and improve their quality of life.

It might be difficult for an older adult who doesn't speak English as a first language to communicate with a health care provider about their symptoms and treatment options. Cultural or religious beliefs may also make it difficult to talk openly about mental health issues. Family members can **help bridge the communication gap between their relative and the health care provider**.

When your relative moves into a long-term care home, **learn as much as possible about the facility and the care your relative will receive**. Ask for a copy of their Resident Handbook. It will describe the home's policies about daily care and activities. Ask about orientation meetings or additional educational materials.

Be an advocate for your family member. Don't be afraid to ask questions about the care that is being provided.

Visit your older relative frequently. Socializing is very important and staff often can't find the time to sit and talk with each resident. Encourage other family members and friends to visit too. It might be best to have one-on-one visits instead of everybody coming at once (which can be overwhelming for an older adult). Even a 15-minute visit can be beneficial.

If you want to help care for your family member once they've moved into the long-term care home, discuss your interest with the Director of Care or the recreational therapist. You can **learn how to provide safe, effective care in the new environment,** like helping at mealtimes. You can also get involved with some of the social activities, where appropriate.

Build relationships with the staff who are caring for your older relative. Seek out the nurse on duty and take five minutes to get to know him or her as well as other members of the team. You'll likely see the same people each time you visit. Let them know that you've spent time with your family member so they can include it in their notes. If you notice any changes in your relative, let the staff know. This two-way communication can be helpful for both you and the staff team.

Most long-term care homes have **Family Councils** which are venues for family members to meet with staff to discuss the daily operations and programming for residents. The councils give family members the chance to work with staff. This is one way family members can bring forward comments, complaints and compliments.

Long-term care homes are also required to hold **yearly interdisciplinary care reviews**. Family attendance is encouraged.

If you have concerns about the mental health care that is being provided at a long-term care home, you can also **speak with the Director of Care**. You may find it helpful to refer to the information in this guide.

A final note about living well & aging well

Health and well-being is a journey from birth, through childhood and into old age. Many different things impact our mental and physical health – our age, genetics, lifestyle and access to health services – and that's just for starters. We can't control everything, but we can make choices at every stage of our lives to protect and improve our mental and physical health.

Here's a list of things you can do at any age to live well:

- Eat healthy foods in healthy amounts
- Be physically and mentally active
- Get rest
- Manage your stress
- Don't smoke
- If you drink alcohol, drink only in moderation
- Get involved with things that interest you
- Spend time with people – family, friends, members of your community
- Follow the advice of your health care team
- Ask for help when you need it

If you are a family caregiver, caring for yourself is one of the most important things you can do. When your needs are taken care of, the person you care for will benefit too.

Additional resources

In addition to this family guide, the **Canadian Coalition for Seniors' Mental Health (CCSMH)** has produced three other booklets for seniors and their family members on the topics of depression, delirium, and suicide prevention. These booklets were based on the CCSMH national guidelines for seniors' mental health that were created for health professionals.
Phone: 416-785-2500 ext. 6331
Website: www.ccsmh.ca

The **Alzheimer Society of Canada** provides support, information and education to people with Alzheimer's disease, families, physicians and health care providers.
Phone: 1-800-616-8816 (toll free) or 416-488-8772
Website: www.alzheimer.ca

The **Canadian Mental Health Association (CMHA)** is a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. To locate a CMHA office near you, contact the head office in Ottawa or visit the CMHA website.
Phone: 613-745-7750
Website: www.cmha.ca

Certain long-term care homes may have access to geriatric mental health outreach teams, psychiatrists and/or psychogeriatric resource consultants. Your local Director of Care will also be able to tell you about additional resources.

The way long-term care is delivered in Canada varies from province-to-province. Call your local long-term care association or provincial/territorial ministry of health to find out what other resources are available in your area.

Provincial Long-Term Care Associations

Alberta Continuing Care Association
Phone: 780-435-0699
Website: www.ab-cca.ca

BC Care Providers Association
Phone: 604-736-4233
Website: www.bccare.ca

Long Term Care Association of Manitoba
Phone: 204-477-9888
Website: www.ltcam.mb.ca

The New Brunswick Association of Nursing Homes
Phone: 506-460-6262
Website: www.nbanh.com

Nova Scotia Association of Health Organizations
(has a continuing care section that represents long-term care homes and complex care)
Phone: 902-832-8500
Website: www.nsaho.ns.ca

Ontario Association of Non-Profit Homes and Services for Seniors
Phone: 905-851-8821
Website: www.oanhss.org

Ontario Long Term Care Association
Phone: 905-470-8995
Website: www.oltca.com

Provincial and Territorial Ministries of Health

Alberta Health and Wellness
Phone: 310-0000 (toll-free in Alberta)
then dial 780-644-8428 for Continuing Care
Website: www.health.alberta.ca

British Columbia Ministry of Health Services
Phone: 250-387-6121 (in Victoria)
604-660-2421 (in Vancouver)
1-800-663-7867 (toll-free elsewhere in BC)
604-660-2421 (from outside BC)
Website: www.gov.bc.ca/health

Manitoba Health
Phone: 1-888-315-9257 (toll-free) or
204-788-8200 (in Winnipeg)
Website: www.gov.mb.ca/health

New Brunswick Department of Health
Phone: 506-457-4800
Website: www.gnb.ca/0051/index-e.asp

Newfoundland and Labrador Department of Health and Community Services
Phone: 709-729-4984
Website: www.health.gov.nl.ca/health

Northwest Territories Department of Health and Social Services
Phone: 1-800-661-0830
Website: www.hlthss.gov.nt.ca

Nova Scotia Department of Health
Phone: 1-800-387-6665 (toll-free in Nova Scotia) or
902-424-5818
Website: www.gov.ns.ca/health

Nunavut Department of Health and Social Services
Phone: 867-975-5708
Website: www.gov.nu.ca/health

Ontario Ministry of Health and Long-Term Care
Phone: 1-800-268-1153 (toll-free) or 416-327-4327
Website: www.health.gov.on.ca

Prince Edward Island Department of Health
Phone: 902-368-6130 (general inquiries)
Website: www.gov.pe.ca/health

Quebec Ministry of Health and Social Services
Phone: 418-644-4545 (Quebec City area)
514-644-4545 (Montreal area)
1-877-644-4545 (toll-free elsewhere in Quebec)
Website: www.msss.gouv.qc.ca/en

Saskatchewan Ministry of Health
Phone: 1-800-667-7766 (toll-free in Saskatchewan) or
306-787-0146
Website: www.health.gov.sk.ca

Yukon Health and Social Services
Phone: 1-800-661-0408 (toll-free in Yukon)
Website: www.hss.gov.yk.ca

(information accurate at time of printing)

Local resources

Use this area to record contact information for organizations and support services in your region.

Local resources

Local resources

The CCSMH would like to acknowledge the continued dedication of its Steering Committee members:

Canadian Academy of Geriatric Psychiatry (chair)

Alzheimer Society of Canada

Canadian Association of Social Workers

Canadian Caregiver Coalition

Canadian Geriatrics Society

Canadian Healthcare Association

Canadian Mental Health Association

Canadian Nurses Association

Canadian Pensioners Concerned

Canadian Psychological Association

Canadian Society of Consultant Pharmacists

College of Family Physicians of Canada

Public Health Agency of Canada (advisory)

BRING SOLUTIONS TO LIGHT

METTRE EN LUMIÈRE LES SOLUTIONS

Canadian Coalition for Seniors' Mental Health

The mission of the **Canadian Coalition for Seniors' Mental Health** is to promote the mental health of seniors by connecting people, ideas and resources.

To find out more about the CCSMH, visit **www.ccsmh.ca** or call 416-785-2500 ext. 6331.

Production of this guide has been made possible through a financial contribution from the Public Health Agency of Canada.

BRING SOLUTIONS TO LIGHT

METTRE EN LUMIÈRE LES SOLUTIONS

Canadian Coalition for Seniors' Mental Health

Suicide Prevention among Older Adults:

a guide for family members

This guide complements the Canadian Coalition for Seniors' Mental Health (CCSMH) *National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide.*

Production of this guide has been made possible through a financial contribution from the
PUBLIC HEALTH AGENCY OF CANADA.

Disclaimer: This guide is intended for information purposes only and is not intended to be interpreted or used as a standard of medical practice.

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Web: www.ccsmh.ca

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Table of Contents

A full list of references is available at www.ccsmh.ca

Introduction

This guide was designed for family members and other people who provide social support to older adults, including friends, neighbours and community members. The purpose of this guide is to help you to recognize suicide risk factors and warning signs, and to know what you can do if an older adult in your life is at risk for suicide.

What is the Canadian Coalition for Seniors' Mental Health?

The Canadian Coalition for Seniors' Mental Health (CCSMH) was formed in 2002 **to promote the mental health of seniors by connecting people, ideas and resources**. Members of the CCSMH are organizations and individuals representing older adults, their family members and informal caregivers, health care professionals, researchers and policy makers.

In 2006, the CCSMH created the first set of Canadian national guidelines on seniors' mental health based on the most current available research. These guidelines were written for health care professionals who work with older adults. They recommend ways to improve the assessment, prevention, treatment and management of key mental health problems for older adults: mental health issues in long-term care homes, delirium, depression and risk for suicide. This guide is part of a series that covers the same topics for seniors, their family members and others who care about them.

The CCSMH will happily provide these resources on request. Call 416-785-2500, ext. 6331, or visit www.ccsmh.ca to download them at no cost.

Mental health problems are NOT an inevitable part of aging

Many people think that mental health problems are an inevitable part of growing older. This simply isn't true. People can have mental health problems at any age. Many, if not most, older adults experience emotional well-being. However, older adults may have unique stresses that impact their mental health and well-being. Dealing with illnesses, losing loved ones, and adjusting to new living arrangements are just some of the pressures older adults might face. Such problems can become so intensely painful that some older adults contemplate suicide. Suicide can result from hopelessness, extreme despair and intense emotional pain.

Older adults may be ashamed of their feelings of sadness, hopelessness and despair and try to hide them. Sometimes family and friends notice mental health problems, but are not sure what to do or how to help. Sometimes it's hard to know how serious the problems may be. Many mental health problems can be alleviated or treated successfully, but stigma and feelings of shame can get in the way. Ageism can also limit opportunities for older adults to get the help they need and deserve. Sadly, some people are dismissive of older adults and their problems, which can interfere with an older person's ability to get the help they need.

Many deaths by suicide can be prevented. Understanding the risk factors and warning signs associated with suicide among older adults is an important first step, which must be followed by quickly seeking appropriate professional help.

Definitions

Ageism is a way of thinking about older people based on negative attitudes and stereotypes about aging. Ageism can lead to age discrimination – treating people in an unequal fashion because of their age. Age discrimination can negatively affect older adults in all aspects of life.

Depression can cause people to feel persistently low in spirits and lose interest in things that used to give them pleasure. This is sometimes triggered by stressful events in a person's life that impact their state of mind, their health, or their ability to connect with other people. However, sometimes it can happen for no apparent reason. When a person is severely (i.e. clinically) depressed, the chemicals in his or her brain may be out of balance. Other symptoms often include sleep and appetite changes and anxiety (see page 20 for more information).

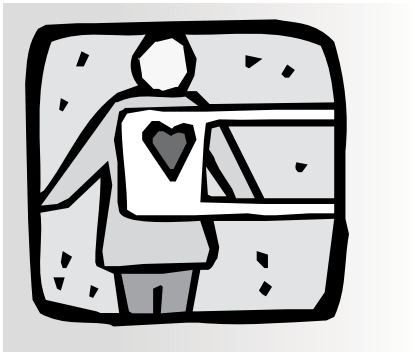
Mental health is the capacity of each person to feel, think and act in ways that allow them to enjoy life and deal with the challenges they face. The World Health Organization defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community."

Self-injury or **self-harm** is the injuring or harming of one's body. Self harm can take many forms. It can be motivated by emotional distress and unbearable inner turmoil. It may or may not result in death. People who injure themselves may or may not have a clear intent to die.

The terms **"seniors"** and **"older adults"** are used in this guide to refer to individuals over the age of 65, an admittedly arbitary cut-off. Adults under 65 can experience a lot of the same life stressors and be at risk for suicide.

Stigma is defined as a mark of shame or disgrace. It often involves stereotypes, hurtful words and discrimination. Stigma around mental health is often based on society's misunderstanding and lack of knowledge about mental health problems. Many people living with mental health problems say that society's negative reactions to them can be worse than the illness itself. Because of stigma, many people don't seek – or receive – the health care they need.

Suicide is a self-inflicted death involving at least a partial intent to die.



Key messages about suicide in later life

1. **Older adults have high rates of suicide**. If someone you know expresses the wish to die or to kill himself/herself, take it seriously.

2. Suicide typically results from overwhelming emotional pain. With appropriate help, **many suicides can be prevented**.

3. By learning about **suicide warning signs**, you can learn to recognize when an older adult may be at risk for suicide and in need of help.

4. **When you talk with someone about suicide, you WILL NOT make that person suicidal**. Don't be afraid to ask questions. If you are worried that your family member is thinking about suicide, seek immediate help from a health care professional or a mental health counsellor.

5. Depression can lead to suicide in later life. **If an older adult in your life is depressed, seek professional care**. Depression can be treated.

6. **A person who is suicidal can get better, with the appropriate help and support**. Being suicidal is not a life sentence. No one is fated or doomed to die by suicide.

7. **Suicide prevention is everyone's business – learn to do your part**. You are not alone. Develop relationships with health care providers and learn about the resources and supports in your community.

What can I do to help prevent suicide?

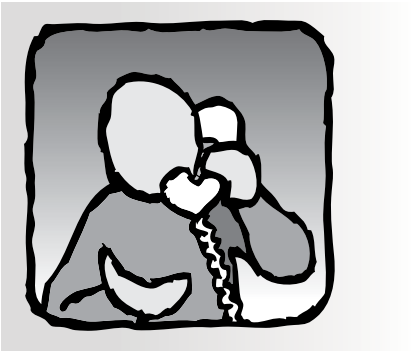
Suicide prevention is everybody's business. We each have a role to play. It is important to know what your role is, as a family member, friend, colleague, neighbour or concerned community member.

If you are not a mental health professional, nobody expects you to become one. Your primary role is to be aware of warning signs that an older adult might be at risk for suicide, and to intervene in an appropriate way.

Things you can do to help reduce a person's risk for suicide:

Get help immediately if you hear or see an older adult:

- Threatening or saying that they want to hurt or kill themselves
- Looking for ways to kill themselves (collecting lethal implements)
- Talking or writing about death, dying or suicide



Never leave a suicidal person alone. Stay with them until care providers are on the scene. If necessary, the police can be very helpful in these circumstances.

Learn the warning signs that an older adult may be at risk for suicide (IS PATH WARM – see page 22). Watch for these signs and be prepared to intervene quickly by contacting a doctor, mental health professional, crisis service or emergency medical service.

Ask if the older adult is feeling like giving up, wanting to die or thinking about suicide.

Ask questions directly but gently. Try not to overwhelm the person, but be aware that asking about thoughts of suicide will not plant the idea in the mind of someone who is not already thinking about it. The burden of wanting to die is never so great that it cannot be alleviated, at least in part, by sharing it with another.

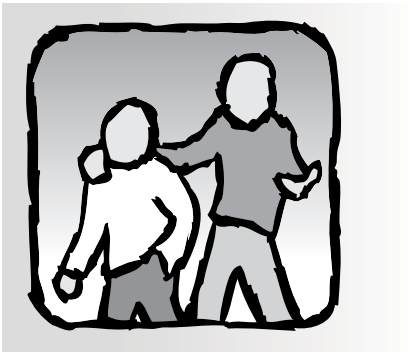
Ask about their feelings.

- *Do you feel tired of living?*
- *Have you ever felt that life isn't worth living?*
- *Do you ever wish you would die in your sleep?*
- *Have you been thinking about harming yourself?*
- *Have you been thinking about ending your life?*

If they acknowledge any of these feelings or thoughts, ask if they have a plan in mind for how they might go about hurting themselves, killing themselves, or hastening death. Then get help (see page 27).

Ask about and remind them of their reasons for living.

- *What has kept you from harming yourself?*
- *Who or what makes life so worth living that you would not harm or kill yourself?*
- *What makes it possible for you to endure your current difficulties?*
- *What makes you feel even a little bit better?*



Listen in a supportive and non-judgmental way.

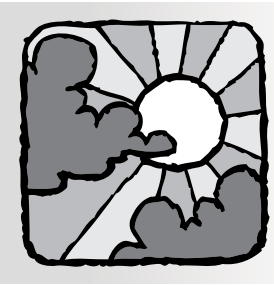
Give the person your full attention and listen to them in a calm and accepting way. Avoid the urge to problem-solve or give advice. Try not to judge or argue. Try not to push too hard. Offering support or gently expressing concern and then letting them respond can lead to a more fruitful discussion than trying to force the point.

Show your concern. You might ask, "Is everything alright?" or share that "I'm worried about you" or "You don't seem yourself lately."

Express empathy by saying things like, "I realize that things have been difficult lately" or "I can appreciate that things have not turned out the way you hoped they would and that's been hard on you."

Let them know you're glad they opened up with you. For example, you might say "I really appreciate your sharing the way you feel with me" or "I know how hard it can be to talk about these things – I really admire you for doing so."

Acknowledge their pain. Let them know that help is available, and that you are going to help connect them with appropriate care providers.

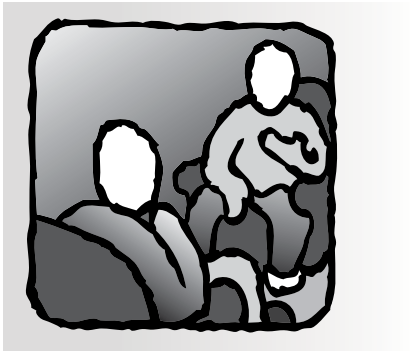


Talk about hope.

Some older adults feel that their life has lost meaning and purpose. Encourage your relative to talk about the things or people that make them feel hopeful. Take the time to talk about what makes their life worth living and explore why they feel that their life has lost its value. Provide reassurance and offer practical help and support whenever you can, but never try to take on the role of therapist. Mental health professionals who have been trained to work with suicidal people are available.

Don't be discouraged if they don't want to talk.

It can be extremely upsetting to offer hope to a family member who doesn't appear to want it, who might be in denial, or worse yet, who might resent your involvement. Try not to take these reactions personally. Try to remember that people sometimes say things that they don't fully mean when in intense emotional pain. It may be helpful to involve another person in these discussions (such as another family member, a friend, an acquaintance or a health care professional), especially if you fear that your concerns won't be listened to or if you are worried about jeopardizing your relationship with your family member. Alternatively, you can share information with your relative's health care professional, and suggest that the professional discuss sensitive topics with him or her.



Confidentiality and family members: don't keep secrets.

Never promise to keep thoughts or plans for suicide secret. If necessary, tell someone, "I need to hear what you have to say before I can promise to keep it secret." Never promise secrecy if there's a risk of suicide. If someone will only tell you what is on his or her mind if you promise to keep it a secret, you still must not make this promise. If they indicate that they're considering suicide, you must get them the professional help they need. It is better to potentially risk losing a friendship than to lose a family member or friend to suicide. Never accept or assume complete responsibility for the individual at risk for suicide. Don't assume that risk will decrease on its own over time – get help!

Urge the older adult to seek appropriate professional help or accompany them to health care services.
(see pages 27-32).

Limit or remove access to lethal means, if safe to do so.

Don't put yourself at risk of being harmed trying to protect a family member, friend or acquaintance. If a weapon is involved and you are worried about your health and well-being, as well as that of the older person, contact the police and let them know the specifics of the emergency. Make sure to mention your concern about "suicide risk."

Take care of yourself.

If you are caring for a family member, it is important to take care of yourself too. Caregivers run the risk of burnout.

Helping a suicidal person is stressful. Providing care and support for someone at risk for suicide can feel overwhelming and depressing. Don't take on too great a load, and make sure to get the support that you need for yourself. Seek help from family and friends, your physician or other health care provider and/or clergy. Family members can also call a distress line to get support for themselves and information about services in the community.

How do I know if someone is at risk for suicide?

Suicide is frightening and painful. Many of us fear losing a loved one, friend or community member to suicide. News of a death by suicide can bring about a range of feelings: sadness, loss, grief, pain, confusion, anger and guilt. Losing someone to suicide can make us feel helpless. It can make us wonder, "Did I miss something?" or "Did I contribute to the problem?" or "Could I have helped prevent this tragedy?" Most people at risk for suicide communicate their intense emotional pain either directly or through clues and cues. We can each learn how to identify someone who might be at risk for suicide.

Factors that can increase a person's risk for suicide in later life include:

- Thoughts of suicide, a plan for suicide or a desire for death
- Personal history of suicidal thoughts or actions
- Having lost someone to suicide
- Mental disorders
- Psychological factors
- Emotional pain
- Medical illnesses and chronic conditions that limit a person's ability to perform everyday activities
- Difficult life events
- Social factors
- Demographic risk factors
- Lack of resiliency

If you believe that an older adult may be at risk for suicide and are looking for information on what to do next, go to page 27.

Thoughts of suicide, a plan for suicide or a desire for death

It is not uncommon to think about death as we get older. However, wanting to die or thinking about suicide is not the same as contemplating one's mortality. Rather, these are signs of emotional pain that require immediate professional help.

What to look for

- Direct statements of suicidal intent, such as "I wish I were dead" or "I'd be better off dead" or "I'm going to kill myself."
- More indirect statements of a wish to die, such as "I feel like a burden on others" or "I won't be around much longer" or "I will soon see (someone who has died) again" or "I can't keep doing this – it's getting too hard" or "No one will miss me."
- Stockpiling or acquiring potentially lethal implements.
- Writing a suicide note, writing a "good-bye letter," making a suicide plan or pact, taking out life insurance, making funeral arrangements or writing a will.
- Giving away prized possessions, discarding or shredding photographs, letters or documents, giving away or putting down pets may be a sign of risk. (Note: older adults who are moving from a house into an apartment, condominium, retirement residence or nursing home may be required to give away some possessions)
- Preparing as if going away on a long trip when a trip has not been planned (for example, paying off bills, cancelling the newspaper, telephone or mail service).

Personal history of suicidal thoughts or actions

Suicide risk may be higher for people with:

- A history of suicidal thoughts or self-harm
- A family history of suicide or self-harm

Note: Knowing someone who died by suicide may potentially increase one's risk for suicide. However, no one is fated or doomed to die by suicide.

Mental disorders

Research suggests that as many as 80–90% of older adults who died by suicide were suffering from a diagnosable mental disorder. Having a mental disorder or a family history of mental disorders can increase a person's risk for suicide. People who have required treatment or been hospitalized for mental health problems have a higher lifetime risk for suicide.

Research has indicated that the mental disorders most commonly associated with risk for suicide are:

- Depression and mood disorders (including bipolar affective disorder or "manic-depression")
- Substance/chemical misuse (including misuse of alcohol, drugs or medications)
- Psychotic disorders (including schizophrenia and delusional disorders)
- Personality disorders

Any mental disorder can increase a person's risk for suicide. The risk is higher for people who have more than one mental disorder. The risk may be higher still for people who have a mental disorder and medical illness, especially if they are also experiencing other stressors, a sense of loss or other difficult life events.

Psychological factors

Suicide rarely occurs "out of the blue," although it may appear that way. Most older adults who die by suicide had been suffering intense psychological pain. Hopelessness, or the belief that life will not improve, has been shown to increase a person's risk for suicide at all ages. Mental suffering, feelings of loneliness, isolation, emptiness, of being a burden on others, and the perception that everything is meaningless can dramatically increase a person's risk for suicide.

People with certain personality traits or behaviours also tend to be at higher risk for suicide in later life. These include emotional instability, being introverted or avoiding social interactions, being rigid or being emotionally closed. Others who may be at higher risk for suicide include people who have unrealistic expectations of themselves, difficulty connecting with others or sustaining meaningful relationships, and those who are highly impulsive and/or aggressive.

Emotional pain

The experience of intense emotional pain can be a suicide risk factor.

What to look for

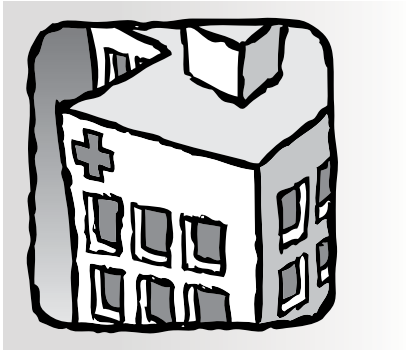
- Agitation or being easily upset
- Angry outbursts or blaming others
- Extreme frustration or irritability
- Thoughts of hurting or killing themselves and/or others
- Being anxious, fearful or stressed
- Being withdrawn, sullen or moody
- Crying or being tearful
- Mood swings
- Feeling or acting guilty
- Being emotionally flat or blunted
- Acting strangely – for example:
  - being paranoid (thinking that others are out to get them or hurt them)
  - hallucinating (thinking they see, hear, smell or feel things that others don't experience)
  - dissociating ("zoning out" or looking "spacey")
  - saying things like "I don't feel human anymore" or "I feel strangely cut off from the world"
- Seek help if someone who has been very depressed suddenly looks calm or at ease. This can be a sign that this person has made the decision to kill him or herself.

Medical illness and chronic conditions that limit a person's ability to perform everyday activities

Certain illnesses and conditions are associated with an increased risk for suicide. These include:

- Neurological disorders
- Cancer
- Respiratory diseases
- Sensory loss (for example, loss of vision or hearing)

An older adult's risk for suicide may increase as a result of having a medical illness, experiencing intense physical pain, fearing that they might have or might develop a serious or life-threatening illness (such as cancer or dementia, including Alzheimer's disease), or might become functionally impaired or dependent upon others for activities of daily living. Although terminal illness can raise thoughts of death and even thoughts of suicide, most older adults who have died by suicide were not terminally ill.

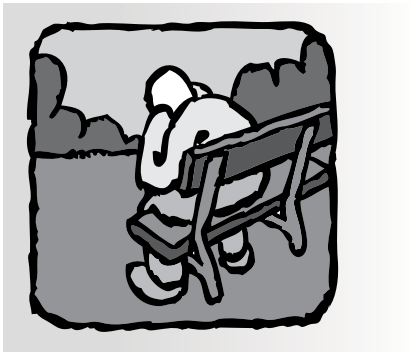


Difficult life events

Later life has been described as a "season of losses." Although all older adults deal with various life transitions and losses as they grow older, those who feel overwhelmed by them may be at risk for suicide.

Examples of such difficult life events include:

- Retirement or unemployment
- Financial difficulties
- Widowhood, loss of friends and family to illness or death
- Living far from or moving away from family and friends
- Loss of independence (for example, moving in with one's children, losing a driver's license, decrease in socioeconomic status)
- Change in residence (leaving the family home for financial or health reasons or due to bereavement, moving into a residential care facility, moving in with children or other family members)
- Medical problems or loss of functioning



Social factors

Social isolation can increase an older adult's risk for suicide. For example, older adults who tend to have interpersonal conflict, who have suffered the loss of social relationships, who are not in close contact with family members or friends and/or live far from others may be at increased risk. An older adult may also be at higher risk if he or she:

- Lacks a confidant and adequate social supports
- Feels like a burden on others
- Has poor access to care providers

Demographic risk factors

Suicide rates tend to be higher among:

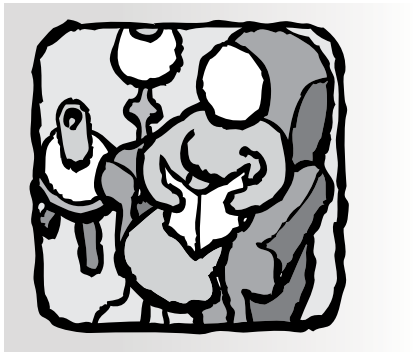
- Older adults
- Men
- Caucasians (whites)
- Some research also suggests that older Asian adults have high suicide rates.
- Although many people think that First Nations/Inuit/Metis people are at high risk for suicide, this is primarily the case for youth and not for older adults, who tend to have lower rates of suicide than Caucasians.

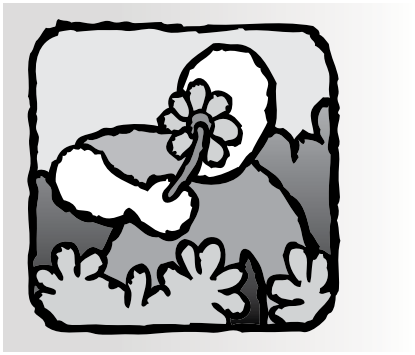
Note: Demographics suggest that some groups might be at higher risk for suicide. However, individuals from any cultural, ethnic and age group may be at risk. Most people who belong to an at-risk group never become suicidal.

Lack of resiliency

A certain resiliency – or ability to recover from illness, depression or adversity – can help protect people against suicidal thoughts and behaviours. Older adults who lack resiliency may be at higher risk for suicide. Among older adults, suicide risk may be lessened by:

- Being engaged in social activities and relationships
- Being active in community, religious, spiritual or social groups
- Pursuing a hobby or interests
- Engaging in a healthy lifestyle (including exercise, proper diet and sleep regimens, and little if any alcohol consumption)
- Experiencing and/or seeking a sense of meaning or purpose in life
- Seeking appropriate mental health care





Depression and older adults

Depression is the most common mental health problem associated with suicide in later life. However, not all suicidal older adults are depressed, and not all depressed older adults are suicidal. Nevertheless, detecting and treating depression can help reduce a person's risk for suicide.

Major Depressive Disorder (also sometimes referred to as "clinical depression") is a mental disorder involving five or more symptoms that occur simultaneously for at least two weeks in duration. These symptoms must include:

- ***Either*** intense sadness ***or*** a profound lack of interest or lack of enjoyment of activities that the individual has typically enjoyed, or both, and four of the following symptoms (three if both sadness and lack of interest are present):
- Sleeping problems
- Significant appetite or weight change
- Feeling chronically tired or lethargic
- Feeling slowed down or very agitated
- Feeling guilty or worthless
- Feeling confused or having difficulty making decisions
- Thinking of suicide or engaging in self-harm

Not all depressed older adults appear sad. The experience of depression can vary among different people and across different cultural groups. Some older adults tend to experience depression through physical symptoms (like aches and pains), rather than emotional ones (like feeling sad, empty, hopeless or guilty). Some older adults will deny feeling depressed, although they might feel that way, because

they were raised not to "air one's dirty laundry," because they do not want to "be a burden on others," or simply because they do not recognize that they are depressed. If you notice that your family member is behaving differently, this could be a sign that he or she is depressed.

Depression is not an inevitable part of aging; it is a mental health problem that can be detected and treated, very often with good results. Research findings generally support treating depression with a combination of psychotherapy and antidepressant medications. Appropriate treatment is critical, because depression can increase a person's risk of developing medical problems and of dying as a result of those medical problems. Failing to treat depression can also dramatically increase an older adult's risk for death by suicide. If you suspect that an older adult may be depressed, get him or her to a doctor or mental health provider as soon as possible. A health care provider will be able to assess whether he or she is depressed and, if needed, offer treatment.

More information on depression is available in the CCSMH **Depression in Older Adults: a guide for seniors and their families**. Visit www.ccsmh.ca or call 416-785-2500, ext. 6331, to get a copy.

Suicide warning signs

The American Association of Suicidology recently created a list of common suicide warning signs. The mnemonic **IS PATH WARM** may help you remember these warning signs. Take the time to learn these signs and make sure to get professional care for an older adult exhibiting any of them. See the next page for more details about each of these warning signs.

Is this warning sign present?		**Yes**
I	Ideation	
S	Substance abuse	
P	Purposelessness	
A	Anxiety / agitation	
T	Trapped	
H	Hopelessness / helplessness	
W	Withdrawal	
A	Anger	
R	Recklessness	
M	Mood changes	

Important! An older adult who has **any** of these warning signs may be at risk for suicide. If an older adult displays any of these warning signs, seek immediate medical, mental health or emergency treatment.

Ideation

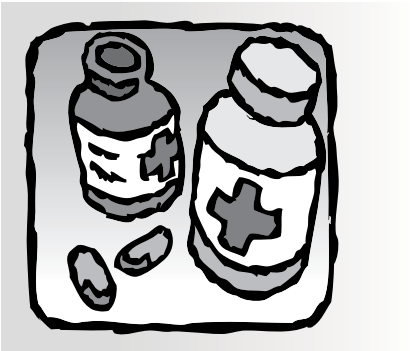
Thinking of death or wanting to die, or thinking of suicide or of engaging in self-harm may indicate that a person is at risk for suicide. Does your relative or an older adult you know communicate such thoughts or wishes? For example, have you heard them say things such as:

- *I might as well kill myself.*
- *I'd be better off dead.*
- *It's just getting to be too much for me – there's no use anymore.*
- *I've been collecting pills, just in case things get much worse some day.*

Has the person injured him or herself, either with or without the stated intention of dying? Each of these is a warning sign that should be taken seriously.

Substance abuse

Alcohol or drug abuse or the inappropriate use of medications or other substances can reduce a person's inhibitions and may make the person impulsive. This may increase their risk for suicide. People sometimes use substances like alcohol or drugs to try to feel better. This typically only makes things worse. Does an older adult you know use excessive amounts of alcohol, drugs and other substances, or misuse prescription medications?



Purposelessness

Lack of meaning or purpose in life can increase a person's feelings of hopelessness and worthlessness, and sometimes lead to thoughts of suicide. Does an older adult you know indicate or give the impression that he or she has nothing to live for?

Anxiety / agitation

People who are extremely anxious or worried may feel like everything is falling apart, may think of suicide as a way out, and may use that energy to engage in self-harm behaviour. Does an older adult you know show signs of severe anxiety, agitation, irritability or frustration?

Trapped

Many older adults thinking of suicide indicate that they want a way out of a painful emotional state or what may feel like a hopeless set of circumstances. Does an older adult you know appear to feel trapped, feel unable to get help or not know where to go for help, or say things like "There's no way out" or "I'd just like to get away from everything"?

Hopelessness / helplessness

Feeling that there is no hope for the future, and feeling helpless to do anything to change one's circumstances or to do the things that one was once able to do without difficulty, can tremendously increase a person's risk for suicide. Does your relative report feeling helpless because he or she can no longer do even simple things anymore? Does he or she report feeling pessimistic or hopeless about the future?

Withdrawal

When we experience emotional pain, we may turn inward to take care of ourselves, or cut ourselves off from those around us. Emotional pain needs to be shared with others (including close supportive family or friends, and ideally a mental health professional) to make it bearable. Does an older adult you know appear to be isolating him or herself from others? Has he or she stopped seeing friends, stopped taking part in hobbies or activities, or stopped going for medical appointments? Social withdrawal can be a warning sign that someone is at risk for suicide.

Anger

Not all depressed older adults appear sad. Many appear angry, irritable or frustrated. Anger can lead to aggressive or violent behaviour, either towards other people or towards oneself, and can, in some cases, lead to suicide. Does an older adult you know appear increasingly angry, frustrated or irritated? Has he or she always reacted to stress by becoming angry or violent? Aggressiveness can be a warning sign that an older adult is at risk for suicide.

Recklessness

As we get older, we tend to become more cautious and take fewer risks. Some older adults have always been risk-takers, and may have always been very impulsive, perhaps with negative social or personal consequences. Others, who had been very careful, may start showing a reckless abandon and take part in risky activities, or may not seem to care about the consequences of their actions. For example, an older adult who can no longer drive safely may put off going to the doctor for fear of losing his or her license, and may continue driving with an expired or revoked driver's license.

Such recklessness can increase the risk for harm, whether intentional or otherwise. Does an older adult you know appear reckless or unconcerned whether his or her actions might hurt or kill him or herself or others? In a similar way, be aware that a car accident can indicate that an older adult is overwhelmed by his or her emotional pain and unable to concentrate. A car accident may also be an example of suicidal behaviour.

Mood changes

Dramatic changes in mood can be a sign of intense emotional difficulty, a medical problem or a mental disorder. Mood changes can make a person's behaviour unpredictable. Depression and agitation can be warning signs of suicide risk. Older adults who had been depressed, but suddenly appear much happier and energetic, may be at high risk for suicide. Does an older adult you know exhibit fluctuating or rapidly changing moods? Does his or her energy level change quickly with changing circumstances? Does their mood change suddenly over the course of a conversation, for no apparent reason?

What help can I get from health care providers?

It's critically important to seek help from a health care provider when someone is at risk for suicide. Help can range from having a health care provider talk to and support an older adult who is feeling lonely and isolated to seeking immediate emergency medical intervention for someone at imminent risk for suicide.

Family doctor, walk-in clinic or urgent care clinic

When a person is feeling low or depressed but does not acknowledge suicidal thoughts or plans, it may be appropriate to accompany him or her to a family doctor, walk-in clinic or urgent care clinic for an assessment. The doctor can then refer him or her to a mental health professional who has expertise in working with people who have mental health difficulties or are at risk for suicide, if deemed necessary.

Mental health care provider

You might also consider contacting a registered mental health care provider directly (for example, a psychologist, psychiatrist, psychiatric nurse or social worker – see page 31 for more details). These professionals have distinct approaches and provide unique services, which can include assessing and diagnosing mental health problems, providing psychotherapy or counselling, and prescribing medication and other treatments. People at risk for suicide can benefit from psychotherapy and possibly antidepressant medication. You can find phone numbers for these professionals in the phone book or by contacting their professional associations or an online referral service.

If an older person's initial experience with a mental health care provider is not satisfying, he or she might want to try contacting a different provider. It can sometimes take several tries before finding the right professional who connects well with that individual. You might advise him or her not to be discouraged if the first (or second or third) mental health professional doesn't "feel right" – perhaps the next one will. If the person's risk for suicide is high, encourage him or her to continue working with a mental health care provider, even if he or she doesn't like that professional much. It's better to have a professional who doesn't "feel right" than to have none at all. People living in small or remote communities may have fewer providers to choose from and less opportunity to be selective.

Emergency room / 911

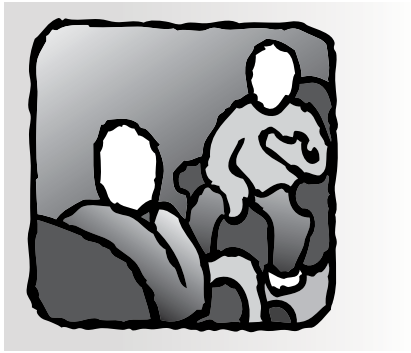
When a person's risk for suicide is high (for example, if the person reports having thoughts of suicide or intends to kill him or herself, especially if the person has a history of suicidal thoughts or self-injury) or if you don't know how high the risk for suicide might be, take the person to the local hospital emergency department or contact emergency services (for example, dial 911 if available in your area). If you do not know the older adult and you think they might be at risk, don't spend a lot of time trying to gauge their level of risk. It is better to call a professional immediately.

If the person has already injured him or herself, whether or not he or she intended to die, call 911 or the emergency number for your area. If you are very concerned that a family member is at serious risk for suicide and you can't convince them to go for help or accompany you to the hospital, you may need to call the police for assistance. The police may be able to help get the person to a hospital for an emergency assessment.

When you contact a health care provider, the police or emergency medical services, it is critical that you state clearly that you are concerned about "suicide risk." This language requires that they take you seriously and intervene. Being indirect or using euphemisms might lead them to miss the potential danger. By being clear, your message can be taken seriously and acted upon quickly. When someone is at risk for suicide, do not be shy or quiet. Speak up, speak clearly and make sure that they hear you. If the first person doesn't seem to hear you or doesn't seem to be taking your concerns seriously, keep trying! A life might be at stake.

Confidentiality and health care professionals

Health care professionals will not necessarily contact family members or other social support providers of an older adult who is at risk for suicide. Bound by confidentiality, they are not at liberty to share information regarding their clients or patients unless risk for suicide is judged to be imminent. The law requires professionals who are worried about a client's suicide risk to strive to ensure the client's safety. This may involve referring the client for emergency medical or mental health care (possibly including a hospital stay), and/or involving the police (or Justice of the Peace) and may involve discussions with family members if the client refuses to comply with recommended life saving care. This is done to ensure the person's safety, not to arbitrarily restrict their freedoms. The law requires professionals to extend confidentiality to emergency medical service providers, other mental health care providers and/or the police when the individual's risk for suicide is judged to be imminent.



It is possible for a concerned family member to take an older relative to the hospital emergency department and for the health care providers at the hospital to not share the results of their assessment with them, because they are obligated to keep information about their patient confidential. Understandably, this can be extremely frustrating for family members, but don't let this stop you from seeking appropriate help for an older adult who may be at risk for suicide. And remember, even if the professional cannot share any information with you, he or she can still listen. If you are concerned, share your concerns with the health care professional, and ask him or her to follow up with your family member and/or other appropriate professionals.

Different health care providers have different levels of knowledge, experience and skill in working with older adults at risk for suicide. Education is a two-way street. You can use this guide to help start a conversation – and share facts about – late life suicide with your health care provider.

Types of mental health care providers

Psychologists are mental health professionals who apply knowledge about how we think, feel and behave to help people understand, explain and change their behaviour. They can assess and diagnose mental disorders. Many psychologists also provide psychotherapy or counseling: one-on-one, couples, family and/or group therapy. Psychologists cannot prescribe medications unless they have pursued additional training in medicine or in pharmacology and are certified to do so. Unlike psychiatrists, the services of a psychologist are typically not covered by provincial and territorial health insurance plans; however, psychologists working in hospitals or medical clinics may have their services covered by provincial plans. Some extended, or work-based health insurance plans cover the services of psychologists. Psychologists often accept self-referrals although some request a referral from a doctor or other health care provider.

Psychiatrists are medical doctors who specialize in diagnosing, treating and preventing mental disorders. To make an appointment with a psychiatrist, you need to get a referral from a physician. Psychiatrists prescribe medications as well as other medical treatments and some provide psychotherapy.

In Canada, both psychiatrists and psychologists can assess, diagnose and treat depression and mental disorders.

Psychiatric nurses provide care in hospitals, facilities and communities. They are skilled in patient assessments, planning programs for their clients, and implementing and evaluating the effectiveness of the plans with clients. Many provide crisis and treatment intervention.

Social workers work in hospitals, community mental health centres, community agencies or private practices. They can help build partnerships between caregivers and families and work with various community services to help create supportive environments for clients. They can also educate and advocate for access to appropriate support services. Some social workers specialize in mental health issues and offer counselling and therapy services.

Psychotherapy (sometimes called "talk therapy") is a form of mental health care that involves talking about and exploring one's difficulties and discussing potential solutions or changes that can be made to help improve them. There are hundreds of different therapeutic approaches, and each involves a different philosophy and specific techniques. Clinical psychologists and psychiatrists are typically trained in the delivery of psychotherapy. Others who may be trained to provide psychotherapy include physicians, social workers, counsellors, psychiatric nurses, occupational therapists and members of the clergy.

Until recently, in certain parts of Canada anyone, regardless of training, could call him or herself a psychotherapist and provide psychotherapy without legal penalty. That is in the process of changing, as professional bodies are being established to regulate the practice of psychotherapy in various parts of the country. In the meantime, it is better to be safe than sorry. Ask about the professional training and credentials of someone you are considering meeting with for psychotherapy. Ask whether he or she is a member of a professional association or college. Health care professionals should not be offended by such a question. Discussing their professional credentials with prospective clients or patients should be a standard part of their job.

Summary: important facts about suicide in later life

- Older adults have among the highest rates of suicide of any age group in most countries worldwide.
- In Canada, the risk for suicide tends to increase with age, especially for men.
- The suicide rate of older Canadian men is roughly double that of the nation as a whole.
- Suicide is typically not about "dying with dignity," but is rather a sign of deep emotional despair that can be addressed with treatment.
- If a person starts talking about a wish to die or expresses an interest in hastening their death (i.e. physician-assisted suicide, stopping their medications), this might be a sign that they're suicidal or depressed.
- Signs of suicide risk must be taken seriously and acted upon quickly. Suicidal older adults typically use highly lethal methods when engaging in suicidal behaviour.
- Help is available. Treatment can reduce a person's risk for suicide and enhance their sense of well-being.
- **Suicide prevention is everybody's business. We each have a role to play – know yours!**

Crisis support in my community

In times of crisis, it can be difficult to respond quickly. Take a moment now to look for resources in the community and write them down.

911: Call for immediate assistance. Be prepared to give your street address and specific information about what is happening. You will also be asked if you need the police, ambulance or fire department.

Crisis Centre / Distress Line

Phone: _____

You can typically find this information in the front page of your local phone book or online. Crisis centres and distress lines can also refer you to other helpful resources in your area.

Hospital

Phone: _____

Address: _____

Family doctor: _____

Phone: _____

Mental health care provider: _____

Phone: _____

Clergy: _____

Phone: _____

Additional resources

In addition to this guide, the **Canadian Coalition for Seniors' Mental Health (CCSMH)** has produced three other booklets for seniors and their family members on the topics of delirium, depression and mental health issues in long-term care homes. These booklets were based on the CCSMH national guidelines for seniors' mental health that were created for health professionals.
Phone: 416-785-2500 ext. 6331
Website: www.ccsmh.ca

ASIST: Applied Suicide Intervention Training is a workshop for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Created by an organization called LivingWorks, its website lists two-day workshops that are offered through a variety of organizations across Canada.
Phone: 403-209-0242
Website: www.livingworks.net

The **Canadian Association for Suicide Prevention (CASP)** is a non-profit organization that works to reduce the suicide rate and minimize the harmful consequences of suicidal behaviour. CASP has developed a blueprint for a Canadian suicide prevention strategy. **It is not a crisis centre**, but its website offers links to crisis centres and survivor support groups across Canada.
Phone: 204-784-4073
Website: www.casp-acps.ca or **www.suicideprevention.ca**

The **Canadian Mental Health Association (CMHA)** is a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness. To locate a CMHA office near you, contact the head office in Ottawa or visit the CMHA website.
Phone: 613-745-7750
Website: www.cmha.ca

The **Canadian Psychological Association** is a national association that aims to promote the health and welfare of all Canadians through psychological research, education and practice. Its website offers helpful information on how to choose a psychologist, fact sheets, and listings of associations and regulatory bodies across the country.
Phone: 1-888-472-0657 (toll-free) or 613-237-2144
Website: www.cpa.ca/public

The **Centre for Suicide Prevention** is a non-profit information, education and research centre. It has a library with 39,000 documents on suicide and offers specialized training courses in suicide prevention and intervention. It is affiliated with the Canadian Mental Health Association.
Phone: 403-245-3900
Website: www.suicideinfo.ca

Centre for Research and Intervention on Suicide and Euthanasia (CRISE) is an interdisciplinary research centre affiliated with the Université du Québec à Montréal. Their objective is to reduce suicide and suicidal behaviours and to reduce the negative consequences of suicide.
Phone: 514-987-4832
Website: www.crise.ca/index_eng.asp

The **Mood Disorders Society of Canada** is a national, not-for-profit organization that is dedicated to improving the quality of life of people affected by depression, bipolar disorder and other related disorders.
Phone: 519-824-5565
Website: www.mooddisorderscanada.ca

The **Mood Disorders Association of Ontario** created a website called Check Up from the Neck Up to raise awareness about mood disorders and connect people with resources, so they can get help if they need it.
Phone: 1-888-486-8236 (toll-free) or 416-486-8046
Website: www.checkupfromtheneckup.ca

American Resources

The **American Association of Suicidology** is an organization dedicated to understanding and preventing suicide through education, research and resources. Their website features statistics and tools, current research, and information for people who have lost a loved one to suicide and for people who have survived suicidal behaviour.
Phone: 202-237-2280
Website: www.suicidology.org

American Foundation for Suicide Prevention (AFSP) is the leading American not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide.
Phone: 1-888-333-AFSP (2377) (toll free)
Website: www.afsp.org

Suicide Prevention Resource Center (SPRC) provides prevention support, training, and resources to assist organizations and individuals to develop suicide prevention programs, interventions and policies, and to advance the American National Strategy for Suicide Prevention.
Phone: 877-GET-SPRC (877-438-7772)
Website: www.sprc.org

QPR Institute was founded by Dr. Paul Quinnett, a clinical psychologist and trainer for more than 35 years. QPR offers suicide prevention training programs, educational and clinical materials for the general public, professionals and institutions (QPR stands for Question, Persuade Refer).
Phone: 1-888-726-7926
Website: www.qprinstitute.com

International Resources

International Association for Suicide Prevention (IASP) provides a forum for national and local suicide prevention organizations, researchers, volunteers, clinicians and professionals to share knowledge, provide support and collaborate in suicide prevention around the world.
Website: www.iasp.info

(information accurate at time of printing)

Local resources

Use this area to record contact information for organizations and other support services in your region.

The CCSMH would like to acknowledge the continued dedication of its Steering Committee members:

Canadian Academy of Geriatric Psychiatry (chair)

Alzheimer Society of Canada

Canadian Association of Social Workers

Canadian Caregiver Coalition

Canadian Geriatrics Society

Canadian Healthcare Association

Canadian Mental Health Association

Canadian Nurses Association

Canadian Pensioners Concerned

Canadian Psychological Association

Canadian Society of Consultant Pharmacists

College of Family Physicians of Canada

Public Health Agency of Canada (advisory)

BRING SOLUTIONS TO LIGHT

METTRE EN LUMIÈRE LES SOLUTIONS

Canadian Coalition for Seniors' Mental Health

The mission of the **Canadian Coalition for Seniors' Mental Health** is to promote the mental health of seniors by connecting people, ideas and resources.

To find out more about the CCSMH, visit **www.ccsmh.ca** or call 416-785-2500 ext. 6331.

Production of this guide has been made possible through a financial contribution from the Public Health Agency of Canada.

Cannabis & Older Adults

A Candid Conversation

Learn More +
Take Action

CCSMH
Canadian Coalition for Seniors' Mental Health
Connecting People, Ideas and Resources

What is cannabis?

Cannabis, also known as marijuana, weed, or pot, is a product that is made from the cannabis plant.

It comes in many forms, including dried leaves, extracts, topicals gels or lotions, and edible products like gummy candies, cookies, or soda drinks.

The two main chemical compounds in cannabis are THC and CBD.

- THC causes the intoxicating effect or 'high'.
- CBD does not cause intoxicating effects and may lessen some of the effects of THC.

Every cannabis product has different levels of THC and CBD. It's important to understand how much of both compounds are in cannabis products. ***Higher levels of THC can be unsafe and are not suitable for everyone.***

Why is cannabis used?

Cannabis is used for recreational, wellness, and medicinal purposes.

Recreationally, cannabis is used because of the intoxicating effect or the 'high' it produces, which is a result of the THC.

Cannabis can also be used for its **potentially therapeutic effects** both with and without a prescription. Some people use it to help manage nausea, loss of appetite, chronic pain, insomnia, or other conditions.

Medicinal cannabis has proven benefits for specific health conditions and is only obtained through a prescription from your health care provider. Cannabis used for wellness purposes does not have the same research evidence to support potential health claims.

What does cannabis do?

Using cannabis can have a range of effects.

The type of experience you have can vary from one drug-taking episode to another and will depend on the amount taken, the THC and CBD concentration in your cannabis product, frequency of use, and the method used to consume cannabis.

Some of the more desirable effects of using cannabis may include:

- Elevated mood
- Relaxation
- Heightened sensory experiences
- Increased appetite

While cannabis can temporarily elevate your mood and make you feel relaxed, ***you can also experience unpleasant effects such as:***

- Increased heart rate
- Nausea and vomiting
- Drowsiness
- Confusion
- Balance and coordination issues
- Anxiety, fear, or panic

The effects of cannabis can be felt within seconds or up to a few hours and can last up to 24 hours depending on the dosage and method used to consume cannabis.

Do not take more of the product if you do not feel the effects right away, or you may risk taking too much.

Aging and cannabis

The effects of cannabis can increase as you get older. Normal changes in body fat and muscle mass as you age can slow down your body's ability to process cannabis. This means that the effects can be more intense and last longer.

These changes can also make you more sensitive to possible negative effects, such as:

- Impaired motor skills and balance that can increase your risk of falls and injuries
- Poor concentration and memory
- Negative interactions with your other medications
- Increased risk of developing mental health problems

Thinking about using cannabis?

If you are thinking about using cannabis, consider some of the safer use tips below:

Talk to your health provider

Before your appointment, write down questions you want to ask:

- ☐ Can cannabis help my particular condition?
- ☐ Will it interact with any of my medications?
- ☐ Are there any risks or side effects I should be aware of?
- ☐ How much will it cost and will my insurance cover it?
- ☐ Are there activities I should avoid while taking cannabis?
- ☐ What type and amount of cannabis would be best for me?

Thinking about using cannabis?

Buy legal

- Purchase cannabis from a licensed source.
- Look for products with low THC concentration *(ideally less than 10%)*.

Start low and go slow

- Start by taking a very small amount and slowly increase the dose next time until the desired effect is reached.
- Allow some time for the effects to start *(it can take minutes to hours)*; do not take more too soon!

Don't mix

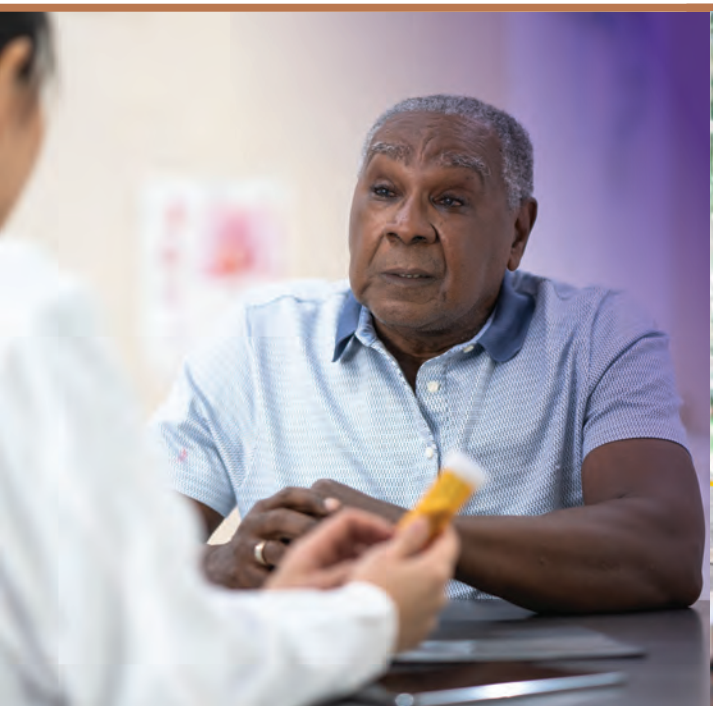
- Never take cannabis with other drugs or alcohol.

Don't drive

- Cannabis may impair your ability to drive and increase your risk of having an accident. If you have used cannabis, wait at least 24 hours before driving.

Have more cannabis free days if using recreationally

- Limiting your use to occasional use, such as once a week, can reduce health risks.



When to call for help

Taking too much cannabis at once or taking cannabis with higher levels of THC can lead to side effects that require medical attention.

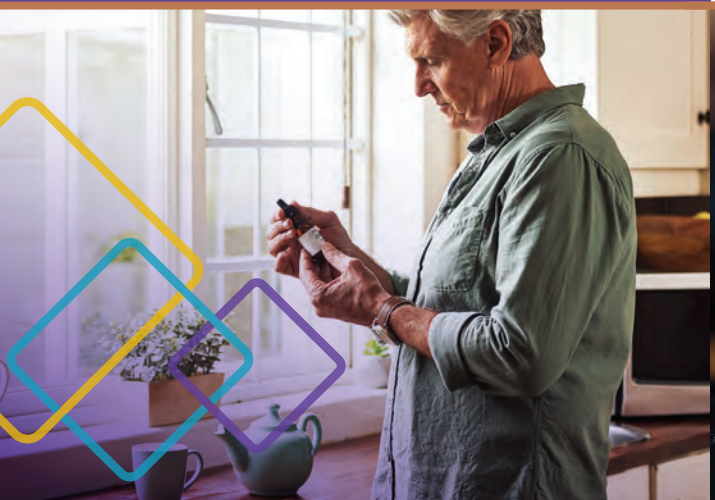
Signs to watch out for include:

- Anxiety
- Panic
- Elevated heart rate
- Shortness of breath
- Nausea and vomiting
- Paranoia and psychosis
  (i.e.; hallucinations and delusions)

If you or someone you know has taken too much cannabis and is not feeling well, seek medical attention right away.

For more information, visit the Canadian Coalition for Seniors' Mental Health (CCSMH) website.

ccsmh.ca



CCSMH
Canadian Coalition for Seniors' Mental Health

This brochure is adapted from the Canadian Coalition for Seniors' Mental Health (CCSMH) Canadian Guideline on Cannabis Use Disorder Among Older Adults.

Disclaimer: The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada. This brochure is intended for information purposes only. It is not intended to be interpreted or used as a standard of medical practice.

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Mental Health and Seniors

General Information and Resources

Resources

Bridge the Gapp NB: https://nb.bridgethegapp.ca/adult/

Canadian Coalition for Seniors Mental Health (CCSMH): https://ccsmh.ca

Canadian Mental Health Association: cmhanb.ca/506-455-5231

NB Addiction and Mental Health Helpline: 1-866-355-5550

Call to Action

If you start to notice any of the following in your loved one, have a talk with them or reach out to one of the resources listed.

- Noticeable changes in mood, energy level or appetite
- trouble feeling positive emotions; difficulty regulating sleep
- difficulty concentrating; feeling restless
- increased worry/stress
- anger or irritability
- aggressiveness
- ongoing headaches
- digestive issues
- substance misuse
- sadness/hopelessness
- suicidal thoughts or thoughts of death
- engaging in behaviour and thinking that is concerning to others
- seeing or hearing or feeling things that other people do not see, hear or feel.

General Facts

- 1/3 of adults, aged 45 and over, feel lonely; 15-30% feeling chronically lonely
- Social isolation, which can affect 1/4 of older adults, is a risk factor for mental health issues in seniors.
- There is a link between chronic illness in later life and mental health issues.
- An older adult's mental health is shaped by their physical and social environments, the cumulative impacts of earlier life experiences and specific age-related stressors (decline in function, repeated exposure to adversity).
- Around 1/4 of deaths from suicide (27.2%) are from people 60 and older.

Common signs of depression, anxiety and loneliness

These are common signs of depression, anxiety and loneliness that is often seen in seniors.

Common signs: Withdrawal from normal activities, feeling lonely, having poor quality sleep, having a poor diet, not having an interest in normal activities, feeling negative.

For more specific signs and symptoms for depression, anxiety and loneliness,
please reach out to your family doctor,
local counselling agency or one of the resources listed.

Prevention

Can help promote and prevent mental health issues in seniors through the following ways:

- focus on supporting healthy aging by reducing financial insecurity and income inequality
- creating more safe and accessible housing, public buildings and transportation
- ensuring more social support for older adults and their caretakers
- supporting healthy behaviours; be on the lookout for signs and symptoms of mental health issues.
- encourage health and social programs targeted at vulnerable groups, such as living alone, in remote areas and for those with chronic health concerns.

Information provided by the WHO.

SENIOR MENTAL HEALTH: GENERAL FACTS

Most common mental illnesses after the age of 65 are mood and anxiety disorders, cognitive and mental disorders due to medical conditions, substance misuse and psychotic disorders

Approx. 14% of adults age 60 and older live with a mental disorder; the most common is depression and anxiety

Around 1/4 of deaths from suicide, which is 27.2%, are among people 60 and older.

A key risk factor for the development of mental health issues in older adults is social isolation and loneliness.

Mental health in older adults is often over looked due to health scenarios that complicate prevention, detection, diagnosis, treatment and management.

SENIOR MENTAL HEALTH: GENERAL FACTS

Those that are socially isolated are more likely to suffer from anxiety, depression, stroke, heart disease, type 2 diabetes, cognitive issues, increased risk of dementia and other ailments.

Co-morbidities (having more than one illness) makes accurately diagnosing mental health issues more challenging.

1/3 of adults over 45 feel lonely, with some 15-30% feeling chronically lonely.

Seniors are more likely to experience adverse events such as bereavement, a drop in income and a reduced sense of purpose with retirement.

On the Mental Health Commission of Canada's website, there is a list of guidelines and tools to better support seniors with their mental health. mentalhealthcommission.ca

UNDERSTANDING GRIEF

WHAT IS GRIEF?

Grief is a natural response to a significant loss. This loss is not just a death, this can be a loss of a relationship, financial stability, retirement, learning about a serious health issue, change in ones life circumstances.

HOW DOES IT SHOW UP?

Grief can present in a number of ways. Many experience it as difficult and unexpected emotions, such as sadness, shock, anger, disbelief, fear, guilt.
For some they also experience it as physical symptoms, such as fatigue, nausea, lowered immunity, weight loss or gain, aches and pain, insomnia.

WHAT TO DO?

It is important to remember that you never feel ashamed to grieve. It is a normal. There is no right or wrong way to grief, it is based on the individual and it takes time. This process cannot be forced. The first step is acknowledging this.
Grief is not a linear process, it is like riding a roller coaster, some days are better than others.

REACH OUT

Remember, that there are healthy ways to cope with grief. If you find yourself struggling with your feelings around grief, please reach out for help.

Online resource: https://mygrief.ca/

LEGAL CONFIDENCE

LEGAL MATTERS

Covers key legal issues like powers of attorney, advance healthcare directives, and legal resources for seniors to make informed decisions.

Enduring Powers of Attorney

A guide to help you prepare for a possible loss of decision-making ability

Planning AHEAD

Public Legal Education and Information Service of New Brunswick

This guide is produced by Public Legal Education and Information Service of New Brunswick (PLEIS-NB). PLEIS-NB is a non-profit charitable organization. Its goal is to provide the public with information about the law. PLEIS-NB receives funding and in-kind support from the Department of Justice Canada, the New Brunswick Law Foundation, and the New Brunswick Department of Justice and Public Safety. We wish to acknowledge the valuable contribution of those who reviewed this guide and provided insights on how to make it accessible to the public.

This guide provides information about enduring powers of attorney (EPAs). The legislation governing EPAs in New Brunswick is called the *Enduring Powers of Attorney Act*. It came into effect on July 1, 2020. Before that, EPAs were governed by the *Property Act* and the *Infirm Persons Act*. The *Enduring Powers of Attorney Act* also governs health care directives. Information about health care directives is provided in a separate publication.

This guide addresses the commonly asked questions about EPAs. It does not contain a complete statement of the law in this area. Anyone needing specific advice on their situation should consult a lawyer.

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A. Introduction

What is the purpose of this guide?

The purpose of this guide is to provide information about *enduring powers of attorney* (EPAs). An EPA is a legal document that you can use to prepare for the possibility that you may lose your *capacity* (your ability to make your own decisions) in the future. It allows you to appoint a person or persons (known as your *attorney(s)*) to make decisions and act on your behalf.

An EPA is an important part of planning for the future. It can help you protect your personal and financial wellbeing in the event that you lose your capacity, whether due to an accident, an illness, dementia or another cause. It can also give you and your loved ones peace of mind.

It's never too early to plan ahead by making an EPA. A loss of capacity can happen at any time and without warning.

Most of the information in this guide is aimed at people who would like to know about what an EPA is and how you make one. The guide also includes information for people who made an EPA under the old legislation or in another province or country (see *Validity of existing EPAs*, page 22).

Form for making an EPA for personal care

At the end of this guide there is an optional form you can use to make an EPA for personal care in New Brunswick. Before you fill out the form, you should read the guide. You can find a fillable and printable version of the form on the PLEIS-NB website:

Enduring Power of Attorney for Personal Care

Note: Forms for the other two types of EPA (EPA for property and EPA for property and personal care) are not provided because the legislation requires that you get help from a lawyer to make those documents (see *Making an EPA*, page 17).

Are there other legal tools I can use to prepare for a possible loss of capacity?

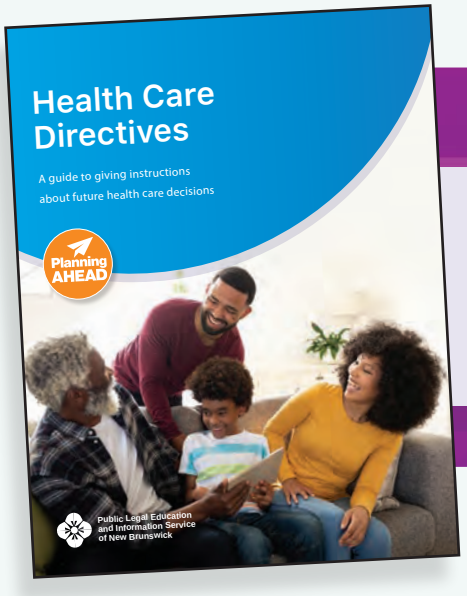
Along with an EPA, another legal tool you can use is a *health care directive*. A health care directive allows you to give instructions about future health care decisions. Unlike an EPA, a health care directive does not allow you to appoint someone to make decisions on your behalf.

In New Brunswick, EPAs and health care directives are both governed by the same legislation, which is called the *Enduring Powers of Attorney Act*.

Know your options

This guide and the guide on health care directives are intended to help you become familiar with the legal tools you can use to plan for a time when you may no longer be able to make your own decisions.

You have a number of options. If you wish, you can make both an EPA and a health care directive. Or you can make only an EPA or only a health care directive. Or you may decide not to make either document. The decision is up to you.



Guide on health care directives

You can find more information about health care directives in the PLEIS-NB guide called *Health Care Directives*.

What is capacity?

Throughout this guide, there are references to *capacity*. For example, the guide explains that you need capacity in order to make or revoke (cancel) an EPA, and that your attorney can act on your behalf when you lack capacity.

Capacity is the ability to make your own decisions. You have capacity if, when you are making decisions, you are able to understand the relevant information and appreciate the consequences that may arise as a result of the decisions (the "reasonably foreseeable" consequences).

In other words, you have capacity if you can **understand and weigh the options** when you are making decisions. If you cannot do this, you lack capacity.

It's important to keep in mind that capacity is not "all or nothing". You can have the capacity to make some kinds of decisions but not others.

For example, you could have the capacity to make decisions about personal matters but not finances.

Also, capacity can change over time. You could lose the capacity to make decisions about something and then regain that capacity at a later point.

The legislation on EPAs says that everyone is presumed to have capacity unless it is determined otherwise. This means that you can continue making your own decisions until someone determines that you lack capacity.

B. Enduring Powers of Attorney

1. General information

What is an enduring power of attorney (EPA)?

An *enduring power of attorney* (EPA) is a legal document that allows you to give another person or persons, known as your *attorney(s)*, the authority to make decisions and act on your behalf when you lack capacity.

- When you make an EPA, you are known as the **grantor**.
- The person you appoint is known as your **attorney**.

Note: Your attorney does **not** have to be a lawyer.

You can give your attorney(s) authority over your property/finances, your personal care, or both. EPAs are governed by legislation called the *Enduring Powers of Attorney Act*.

Why are they called "enduring"?

They are called "enduring" powers of attorney because the authority you give to your attorney(s) continues or endures if you lose your capacity. For other types of powers of attorney, the attorney's authority ends when the grantor loses capacity. These other types of powers of attorney are not governed by the *Enduring Powers of Attorney Act* and are not covered in this guide. If you wish to make one, you should consult a lawyer.

Who can make an EPA?

Anyone who has the capacity to make decisions about an EPA can make one. In other words, you can make an EPA if you can understand and weigh the options for the decisions involved, such as who to appoint as an attorney and what authority to give them.

What are the benefits of making an EPA?

An EPA allows you to choose who will make important decisions about your life if you lose your capacity. These decisions include how your money will be spent, where you will live, the kinds of health care treatments you will receive, and so on.

If you don't make an EPA, the court may need to appoint someone as your legal guardian. If this happens, you won't get to choose who your legal guardian will be. Someone, such as a family member or friend, will apply to the court, and the court will decide whether that person may act as your legal guardian. This can be a time-consuming and expensive process. If no one you know is able and willing to apply to the court to be appointed as your legal guardian, the Public Trustee may be asked to step in.

Who should I appoint as an attorney?

For information about what to consider when choosing an attorney, see *Choosing someone to act as an attorney,* page 7.

What are the different options for EPAs?

When you make an EPA, you have options regarding the type of attorney to appoint and the type of EPA to use. Your choices will depend on your needs and preferences.

There are two types of attorneys you can appoint:

- **Attorney for property** – This is someone who makes decisions and acts on your behalf in relation to your finances and property (house, land, vehicles, etc.). Depending on what you decide, your attorney for property can start acting either as soon as your EPA is complete or only when you lack capacity (see *When can my attorney start acting?*, page 13).
- **Attorney for personal care** – This is someone who makes decisions and acts on your behalf in relation to your health care and other personal care matters. Your attorney for personal care cannot start acting until you lack capacity.

The type of EPA you will use depends on which type(s) of attorney you are appointing:

- If you are appointing an attorney for property, you use a document known as an **EPA for property**.
- If you are appointing an attorney for personal care, you use a document known as an **EPA for personal care**.
- If you are appointing both an attorney for property and an attorney for personal care, you can either use a combined document known as an **EPA for property and personal care** or you can use two separate EPAs (an EPA for property and an EPA for personal care).

You also have options regarding the number of attorneys you appoint. You can appoint one person as both your attorney for property and your attorney for personal care or you can appoint two different people – or you can appoint two or more people to act together as attorneys for property, attorneys for personal care, or both (see *Consider whether to appoint more than one attorney*, page 7).

If I make an EPA, when would I lose the power to make my own decisions?

If you make an EPA, you do not immediately lose the power to make your own decisions.

Use of the term **attorney**

Sometimes the rules are the same for attorneys for property and attorneys for personal care. But sometimes they are different.

When the rules are the same, this guide uses the term **attorney**.

When the rules are different, this guide uses the more specific terms – **attorney for property** and **attorney for personal care**.

As long as you have capacity, you can continue to make your own decisions and you can revoke (cancel) your EPA if you wish. If you lose your capacity, your attorney(s) will be able to make decisions on your behalf (see *When can my attorney start acting?*, page 13).

Depending on your EPA, your attorney for property may be able to act on your behalf *before* you lose capacity. However, as long as you have capacity they will have to follow your instructions (see *How will my attorney make decisions on my behalf?*, page 10). In other words, they will be able to do things for you, but they won't be able to make decisions on your behalf (unless you ask them to).

2. Choosing someone to act as an attorney

What to consider when appointing an attorney

☐ Appoint someone you know and trust

The skills and attributes you are looking for in an attorney may vary depending on whether you are appointing an attorney for property or an attorney for personal care, or both. In any case, you should consider appointing:

- someone you know well and trust – for example, your spouse or partner, another family member or a close friend;
- someone who has the necessary skills – for example, your attorney for property should be someone who has experience handling money;
- someone who will be available when called on to act on your behalf.

☐ Consider whether to appoint more than one attorney

You can appoint more than one attorney if you wish. You can do this by appointing two or more people who would act together as your attorneys for property or your attorneys for personal care (or both). You can also do this by appointing different people to act as your attorney for property and your attorney for personal care.

☐ Decide how your attorneys will make decisions

If you appoint two or more attorneys, you can say in your EPA how they will make decisions. For example, if you appoint two or more attorneys for personal care, you can say that they must make decisions together (by *unanimous agreement*) or that they can make decisions separately.

What happens if my EPA doesn't say how my attorneys will make decisions?

If you appoint two or more people as the same type of attorney and you don't say how they will make decisions, they will have to make all decisions by unanimous agreement.

If you appoint different people as your attorney(s) for property and your attorney(s) for personal care and you don't say how they will make decisions that affect both property/finances and personal care, your attorney(s) for personal care will have the final say.

☐ Appoint alternate attorney(s)

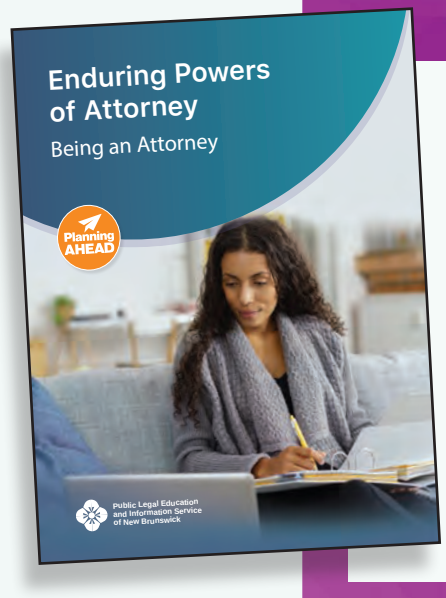
Whether you appoint one attorney or more than one, you can also appoint one or more alternate or "back-up" attorneys. An alternate attorney replaces an attorney who has resigned or has stopped acting for any reason. It is a good idea to appoint at least one alternate attorney. This will ensure that if your attorney can no longer act on your behalf and you don't have the capacity to make a new EPA, an alternate attorney of your choosing can take their place.

☐ Determine if the person you want as your attorney is willing to act

Before you appoint someone, you should talk to them and make sure they are willing and able to take on the responsibility of acting as your attorney. If you appoint them in your EPA and they refuse to act as your attorney after you have lost the capacity to make a new EPA, a family member or friend may have to apply to the court to become your legal guardian.

Look for team players

If you appoint more than one attorney, make sure they are team players. Even if they are responsible for different areas, they will have to cooperate with each other.



Guide for attorneys

You should make sure that the person you are hoping to appoint understands the role and duties of an attorney and is willing to accept the responsibility. To help you do this, PLEIS-NB has created a separate guide called ***Enduring Powers of Attorney: Being an Attorney***. It is a good idea to give a copy of that guide to the person. It has more detailed information on this topic, and includes forms that an attorney can use to keep records.

☐ Consider your options if you have no family or friends to appoint

If you don't have a family member or trusted friend, you may be able to appoint the Public Trustee as your attorney. You must apply to do this, by completing a **form** that is available on the Public Trustee Services webpage of the New Brunswick Legal Aid Services **website**. The Public Trustee charges a fee for this service.

Another option is to appoint a financial institution, such as a trust company, as your attorney for property. You should consult a lawyer before doing this, and you should also consult a lawyer if a financial institution asks you to use their form to make an EPA.

☐ Know the rules about who you can appoint

When you are deciding who to appoint as an attorney, keep these rules in mind:

- You cannot appoint someone who has been convicted of an offence that involves dishonesty, such as fraud or theft, unless you state in your EPA that you are aware of the conviction.
- You cannot appoint someone who is paid to provide health care services or support services to you unless the person is your spouse, common-law partner or relative.
- If you appoint someone who is not yet 19 years old, they will not be able to act as your attorney until they turn 19.
- If you appoint your spouse or common-law partner and you later separate from them, they will not be able to act as your attorney unless your EPA says that they can do so even if you separate.
- You cannot appoint someone as your *attorney for property* if they have filed for bankruptcy and have not finished going through the bankruptcy process (in other words, they are an "undischarged bankrupt").

3. Role of an attorney

This section provides information for people who are considering whether to make an EPA. Information for people who have been appointed as an attorney in an EPA can be found in another PLEIS-NB publication: *Enduring Powers of Attorney: Being an Attorney.*

What is my attorney required to do?

Your attorney is required to:

- act honestly and in good faith;
- act with reasonable care;
- do only what you have authorized them to in your EPA;
- give notice when they start to act (if your EPA requires them to do so);
- keep records of their actions.

How will my attorney make decisions on my behalf?

If you lack capacity and your attorney is making a decision on your behalf, your attorney is required to consult with you, if it is reasonable to do so. They must then use the following decision-making process:

1. If you gave your attorney instructions when you had capacity and the instructions are relevant to the decision, your attorney must follow the instructions. This includes instructions in the EPA or in a health care directive.
2. If you did not give your attorney any relevant instructions, your attorney must make the decision that reflects your current wishes, as long as they are reasonable.
3. If your attorney cannot determine what your current wishes are, or your current wishes are unreasonable, your attorney must make the decision that you would make if you had capacity. Your attorney must consider your values and beliefs when they do this.
4. If your attorney doesn't know what decision you would make, your attorney must make the decision that they believe is in your best interests.

Your attorney for property should not use this decision-making process if you still have the capacity to make decisions about your property and finances. In that situation, your attorney for property should consult with you and follow your instructions.

What kinds of authority can I give my attorney?

You can state in your EPA what you want your attorney to do on your behalf – in other words, what their *authority* will be. You can give them *general* authority (authority over all areas) or *limited* authority (authority only over certain areas). Your attorney can only do what you have given them authority to do.

If you give your **attorney for property** general authority, they will have authority over all areas of your property and finances.

For example, they will be able to do the following on your behalf:

- pay your bills;
- manage your banking and investments;
- do your taxes;
- buy and sell property.

If you give your **attorney for personal care** general authority, they will have authority over all areas of your personal care. This includes:

- health care;
- diet;
- clothing;
- accommodation;
- support services;
- education;
- employment;
- recreation;
- social activities.

When you are deciding what authority to give your attorney, keep in mind that if you give them limited authority, there will be things they cannot do for you and it may become necessary for a family member or friend to apply to the court to become your legal guardian.

For example, if you do not give your attorney for property the authority to sell your business assets and it becomes necessary to do so, someone may have to become your legal guardian.

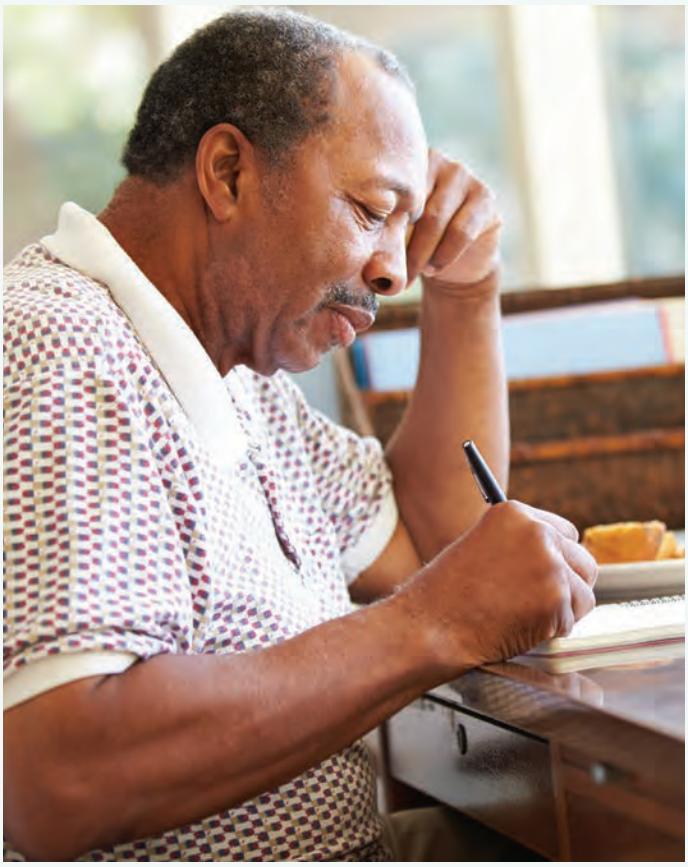
What will my attorney not be allowed to do?

Your attorney will not be allowed to:

- make, change or revoke (cancel) a will on your behalf;
- do something that is against the law or fail to do something that is required by law.

Also, your attorney will not be allowed to do the following things unless your EPA specifically gives them authority:

- give gifts on your behalf;
- delegate their authority as an attorney to another person.



Can I give my attorney instructions?

Your EPA can include general or specific instructions for your attorney, and conditions and restrictions on their authority.

For example, you could say that they must not do a certain thing or that they must consult with a certain person when making a certain kind of decision.

If you are appointing an attorney for personal care, your EPA can include instructions about the health care decisions they may make on your behalf. However, you may wish to consider making a separate health care directive instead. Health care directives are easier to re-do if you change your mind about something.

Your instructions to your attorney do not have to be in your EPA or your health care directive. You can also give instructions in a separate document or orally. However, it is a good idea to put all of your instructions in your EPA or health care directive, so it is easy for your attorney to keep track of them.

Do I have to compensate (pay) my attorney?

You do not have to compensate your attorney. However, acting as an attorney can be a time-consuming responsibility, and you can choose to compensate your attorney if you wish. If you choose to do this, you must state in your EPA that your attorney is entitled to compensation. If you don't, they will not be allowed to receive any. You should also state the rate of compensation.

Be sure to discuss the compensation and your expectations when you are asking someone if they would be willing to act as your attorney (see *Determine if the person you want as your attorney is willing to act*, page 8). This can prevent future conflict.

Can I reimburse my attorney for expenses?

Your attorney will be allowed to be reimbursed for reasonable expenses they incur while carrying out their duties, unless your EPA says otherwise.

When can my attorney start acting?

The rules about when an attorney can start acting (in other words, *exercising their authority*) are different depending on whether they are acting as an attorney for property or an attorney for personal care.

Your **attorney for property** can start acting as soon as your EPA is completed, unless your EPA says otherwise. For example, your EPA could say that your attorney for property can act only when you lack the capacity to make decisions about property and finances. In that case, your attorney will not be able to act until someone has assessed your capacity and determined that you lack the capacity to make those decisions.

Your **attorney for personal care** can start acting only when someone has assessed your capacity and determined that you lack the capacity to make decisions about personal care.

Who will assess my capacity?

In your EPA, you can name the person who will assess your capacity to make decisions about property/finances or personal care. If you don't name anyone, or if the person you name is unable or unwilling to do the assessment, any doctor or nurse practitioner can do it.

However, it is important to note that when a health care decision needs to be made and a health care provider is involved, that person will assess your capacity to make the decision, even if you named someone else in your EPA. This is the case even if someone has already assessed your capacity to make health care and other personal care decisions.

How will my capacity be assessed?

The way your capacity will be assessed depends on the situation:

- If your capacity is being assessed to determine whether your attorney can start acting on your behalf, the person you named in your EPA (or a doctor or nurse practitioner) will assess your capacity. They will determine which matters (if any) you lack the capacity to make decisions about. Your attorney will then be able to act on your behalf in relation to those matters.
- If your capacity is being assessed because a decision needs to be made about health care, the health care provider will assess your capacity. They will determine whether you have the capacity to make the decision. If you don't, your attorney for personal care will be able to make the decision on your behalf.

When does my attorney stop acting?

Your attorney stops acting on your behalf when you die, unless their authority has ended before then. For example, your attorney's authority will end if you revoke your EPA or if your attorney resigns. Their authority will also end if they are no longer eligible to be appointed as an attorney (see *Know the rules about who you can appoint,* page 9).

Choosing who will assess your capacity

It is a good idea to name someone who knows you well as the person who will assess your capacity. If you wish, you can name your attorney.

4. Monitors and misuse of EPAs

What is a monitor?

A monitor is a person you appoint in your EPA to provide oversight of the conduct of your attorney(s). Your monitor may:

- visit and communicate with you at any reasonable time;
- request records from your attorney;
- apply for a court order, such as an order requiring your attorney to provide records or an order terminating (ending) your attorney's authority.

If your monitor has reason to believe that your attorney is taking advantage of you or is otherwise misusing their authority, your monitor must tell you and the other attorneys appointed in your EPA (if any).

Do I have to compensate my monitor?

You do not have to compensate the person you name as your monitor, but you can if you wish. If you choose to do this, you must state in your EPA that your monitor is entitled to compensation, and you should also state the rate of compensation.

What can I do if I am concerned my attorney might be misusing their authority?

If you think your attorney might be taking advantage of you or otherwise misusing their authority, you can:

- ask the attorney to give you the records they have kept, and review them or ask someone else to review them;
- ask your monitor or other attorneys (if any) to get the records and review them;
- revoke the EPA (see *Revoking and changing an EPA*, page 21);
- consult a lawyer.

You can also contact the Adult Protection Program, which is run by the Department of Social Development. You can reach them by calling the 24-hour toll-free line: 1-833-733-7835. Depending on the circumstances, they may be able to help.

If you lack capacity, you may not be aware that your attorney is misusing their authority. That's why it is important to appoint someone as a monitor. If you do not have a monitor and you lack capacity, a family member or friend can apply to the court to have the conduct of your attorney reviewed.

Can my financial institution do anything if they suspect my attorney is misusing their authority?

Yes, your financial institution may:

- refuse to follow instructions given by the attorney;
- suspend or limit the withdrawal and transfer of funds from your accounts.

If your financial institution takes these actions they must notify you and your monitor and other attorneys (if any).

Why have a monitor?

A monitor can help to safeguard your well-being in the event that your attorney is misusing their authority.

What are the consequences if my attorney is misusing their authority?

The consequences for your attorney misusing their authority may range from termination of their authority to criminal prosecution.

A **financial institution** is a bank, credit union, loan or trust company, securities adviser or dealer, insurer, or insurance agent or broker.

5. Making an EPA

Can I make an EPA on my own or do I need help from a lawyer?

Many people wonder whether they can make an EPA on their own, without help from a lawyer. Whether or not you can do so depends on what kind of EPA you wish to make. The chart below explains the differences.

As the chart shows, you need help from a lawyer to make an EPA for property or an EPA for property and personal care. This is because the legislation says that an EPA that appoints an attorney for property (or both types of attorney) must include a lawyer's statement – a statement from a practising New Brunswick lawyer confirming that certain requirements have been met.

On the other hand, you do not need help from a lawyer to make an EPA for personal care. This document can be signed by two non-lawyer witnesses instead of including a lawyer's statement. However, it is still a good idea to consult a lawyer even if you only want an EPA for personal care.

Type of EPA	Requires help from a lawyer?	Explanation
EPA for property	Yes	EPA must include a lawyer's statement
EPA for property **and** personal care	Yes	EPA must include a lawyer's statement
EPA for personal care	No (but recommended)	EPA can either include a lawyer's statement or be signed by two witnesses

Note: If you make two separate EPAs, you can make your EPA for personal care without a lawyer. But if you combine them in one document, you will need help from a lawyer.

What are the requirements for a valid EPA?

To be valid, your EPA must:

- be a written document;
- be signed and dated by you or by another person on your behalf;
- be signed by two witnesses (or include a lawyer's statement) if it is an EPA for personal care;
- include a lawyers' statement if it is an EPA for property or an EPA for property and personal care.

In addition, you must have the *capacity* to make the EPA – in other words, the ability to understand and weigh the options (see *What is capacity?*, page 3).

If a lawyer is helping you with your EPA, the lawyer will make sure that you have capacity. If you are making an EPA for personal care without help from a lawyer, you should make sure that your witnesses can confirm that you have capacity.

What if I have capacity but I'm unable to sign my EPA?

If you have capacity but are unable to sign and date your EPA, you can have someone else do so on your behalf. The person:

- must be at least 19 years old;
- cannot be your attorney;
- cannot be the spouse, common-law partner or child of your attorney.

Who can witness an EPA for personal care?

If you are making an EPA for personal care without help from a lawyer, two people must witness your signature and sign the EPA. The two witnesses:

- must be at least 19 years old;
- cannot be your attorney for personal care;
- cannot be the spouse, common-law partner or child of your attorney for personal care.

How do I make an EPA for personal care on my own?

If you want to make an EPA for personal care without help from a lawyer, you can do so by creating a document that appoints your attorney(s) for personal care, describes what authority they will have, and sets out any instructions you wish to provide (see *Can I give my attorney instructions?*, page 12).

Note: You are under no obligation to use any particular form to make an EPA for personal care. You can use the form in this guide or another form, as long as it meets the requirements of the New Brunswick *Enduring Powers of Attorney Act*.

Usually people who make an EPA for personal care without help from a lawyer use a form. There is a form at the end of this guide that you can use if you wish. A fillable and printable version of that form is available on the PLEIS-NB website.

You can also use a form from the internet or another source. However, you should be aware that such forms may reflect the law of another province or country and may not meet the requirements of the New Brunswick legislation.

Whichever form you use, remember that your EPA for personal care is not complete until you have signed and dated it (or another person has done so on your behalf) and two witnesses have signed it.

Does this guide include a form for making an EPA for property?

No, this guide does not include a form for making an EPA for property. That's because you need help from a lawyer to make this document, and lawyers make customized EPAs rather than using a form like the one in this guide. For the same reason, this guide does not include a form for a combined EPA for property and personal care.

Can I use a form provided by my bank to make an EPA?

Sometimes banks ask their clients to use a form from the bank to make an EPA. You should consult a lawyer before doing this. The form may not be suitable for your needs. And if you already have an EPA for property (or an EPA for property and personal care), making a second EPA with a bank form will likely affect your existing EPA. This is because when someone has two or more EPAs that are inconsistent with each other, the most recent one has priority.

What should I do with my completed EPA?

When you have completed your EPA, you should keep it somewhere safe and make sure your attorney can access it when they need it. For example, you could:

- keep it in a secure place and tell your attorney where it is;
- give it to your attorney and ask them to keep it in a secure place;
- give it to another person you trust, ask them to keep it in a secure place, and give them instructions about when they should give it to your attorney.

You should make a copy of your EPA and put it somewhere where you can easily find it. Also, if it is an EPA for personal care (or an EPA for property and personal care) you should:

- give a copy to your doctor or nurse practitioner;
- take a copy with you if you go to the hospital.

If it is an EPA for property (or an EPA for property and personal care) you should ask your financial institutions, such as your bank and investment advisor, about their process for recognizing EPAs.

6. Revoking and changing an EPA

Can I revoke my EPA?

Yes, you can revoke (cancel) your EPA, as long as you have the capacity to do so. There are two ways to do this:

- You can state in writing that you are revoking it, either in a new EPA or in a separate document.
- You can destroy it, or get someone else to destroy it, with the intention of revoking it.

Who should I notify if I revoke my EPA?

If you revoke your EPA, you should notify your attorney and anyone who has dealt with them, such as your bank.

If I make a new EPA should I revoke my old one?

If you make an EPA and you already have an EPA of the same type, you should revoke the old one. If you don't, both EPAs will be in effect at the same time. Your attorney will have to figure out which parts of the two EPAs are different from each other and follow the new one on those parts. This will likely be difficult to do.

Can I change my EPA?

Yes, you can change your EPA, as long as you have the capacity to do so. However, it's a good idea to replace your EPA rather than changing it. An EPA that has been changed can create confusion, and it is just as easy to make a new one because the requirements for a valid change are the same as the requirements for a valid EPA (see *What are the requirements for a valid EPA?*, page 18). If you do change your EPA, you should notify your attorney and anyone who has dealt with them.

Can signing a hospital form change my EPA?

Some hospital forms may have instructions regarding health care that are different from the instructions you provided in your EPA (if any). If you sign a form like this, the instructions in it become your most recent instructions, and your attorney for personal care will have to follow them. As a result, you should be cautious about signing hospital forms. Before you do so, be sure to thoroughly read the documents you are asked to sign.

7. Validity of existing EPAs

I made a power of attorney before July 1, 2020. Do I need to replace it?

The legislation in New Brunswick on EPAs changed on July 1, 2020, when the *Enduring Powers of Attorney Act* came into effect. If you made a valid power of attorney before that date and it is "enduring" (your attorney is authorized to act when you lack capacity or are "mentally incompetent"), it remains valid and is considered an EPA under the new legislation. You don't need to make a new EPA.

If you aren't sure whether your power of attorney is an EPA, consult the lawyer who helped you make it. And even if you're sure it is an EPA, it's a good idea to ask the lawyer whether they recommend making a new one.

Do I need a New Brunswick EPA if I have one from somewhere else?

If you have an EPA (or similar document) from another province or country and it was valid in that place, it is considered a valid EPA in New Brunswick. You don't need to make a New Brunswick EPA.

However, if you have questions about your situation, it is a good idea to consult a lawyer. For example, you may wish to reconsider who you appointed to act as your attorney. Individuals that you named in another province or country may not be able to make timely decisions on your behalf in New Brunswick.

Changes in terminology

If you made an EPA before July 1, 2020, it will likely be titled "power of attorney" rather than "enduring power of attorney". Also, it might use terminology from the old legislation, such as "mental incompetence" (rather than "lack of capacity") and "donor" or "principal" (rather than "grantor").

C. Helpful Resources and Websites

Public Legal Education and Information Service of New Brunswick (PLEIS-NB)

Review the resources in the "Planning Ahead" section of the website.

www.legal-info-legale.nb.ca

Financial and Consumer Services Commission (FCNB)

Review the information on preventing fraud and read the fact sheet *Understanding the Power of Attorney*.

www.fcnb.ca

New Brunswick Legal Aid Services Commission: Public Trustee

Check out the services offered by the Public Trustee, including acting as an attorney in cases where the grantor has no one willing and able to act for them. Application forms are on the Public Trustee Services **webpage**.

www.legalaid-aidejuridique-nb.ca

Forum of Federal, Provincial and Territorial Ministers Responsible for Seniors

Review the information in the booklet *What every older Canadian should know about powers of attorney (for financial matters and property) and joint bank accounts*.

www.canada.ca

New Brunswick Seniors' Advocate

Review the information in the "What We Do" section of the website (under "About").

Toll Free: 1-888-465-1100

www.nbseniorsadvocate.ca

New Brunswick Adult Protection Program

Toll Free: 1-833-733-7835

www.socialsupportsnb.ca

Enduring Power of Attorney for Personal Care

This is a form for making an enduring power of attorney for personal care in accordance with the Enduring Powers of Attorney Act in New Brunswick. You cannot use this form to appoint an attorney for property. If you would like to make an enduring power of attorney that appoints an attorney for property, you will need help from a lawyer. Before you fill out this form, you should read the PLEIS-NB guide called ***Enduring Powers of Attorney****.*

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

A. Appointment of attorney

If you would like to appoint one person as your attorney for personal care, check the first box. If you would like to appoint two or more persons as your attorneys for personal care, check the second box.

☐ I appoint the following person to act as my attorney for personal care in accordance with the *Enduring Powers of Attorney Act*:

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

☐ I appoint the following persons to act as my attorneys for personal care in accordance with the *Enduring Powers of Attorney Act*:

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

A. Appointment of attorney *(continued)*

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

B. Appointment of alternate attorney *(optional)*

☐ I appoint the following person to act in place of the attorney for personal care (or one of the attorneys for personal care) I appointed above if the attorney for personal care resigns or the authority of the attorney for personal care is terminated:

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

C. Authority of attorney

Scope of authority *(check one)*

☐ I give my attorney(s) for personal care authority to act on my behalf in relation to all personal care matters, including health care.

☐ I give my attorney(s) for personal care authority to act on my behalf in relation to the following personal care matters:

_____

_____

_____

_____

_____

_____

C. Authority of attorney *(continued)*

Conditions, restrictions and instructions *(optional)*

The authority of my attorney(s) for personal care is subject to the following conditions, restrictions and instructions:

When my attorney may exercise authority

My attorney(s) for personal care may make a decision on my behalf in relation to health care provided by a health care provider only if the health care provider assesses my capacity and determines that I lack the capacity to make the decision.

My attorney(s) for personal care may make decisions and otherwise exercise authority on my behalf in relation to any other personal care matter only if the following person assesses my capacity and determines that I lack capacity with respect to the matter:

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

D. Decisions by attorneys

If you appointed one attorney for personal care in section A, skip to section E. If you appointed two or more attorneys for personal care in section A, check one of the following boxes.

☐ My attorneys for personal care must make decisions by unanimous agreement.

☐ My attorneys for personal care may make decisions as follows:

_____

_____

_____

E. Notice *(optional)*

My attorney(s) for personal care must make reasonable efforts to give notice to the following person(s) when my attorney(s) for personal care begin(s) to act:

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

F. Appointment of monitor *(optional)*

I appoint the following person as my monitor:

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

G. Revocation *(optional)*

☐ I revoke all of my previous enduring powers of attorney for personal care.

H. Signatures

Sign and date the form in the presence of two witnesses. If you are unable to sign and date the form, someone else can do so on your behalf. They must do this at your direction, in your presence and in the presence of two witnesses.

The following people cannot sign on your behalf and cannot act as a witness: a person who is under the age of 19; a person you appointed as an attorney for personal care; the spouse, common-law partner or child of a person you appointed as an attorney for personal care.

Name *(grantor or person signing on grantor's behalf)*

Signature Date

Name *(witness 1)*

Address

Signature Date

Name *(witness 2)*

Address

Signature Date

Advance Health Care Directives

A NEW BRUNSWICK GUIDE

The guide was produced by Public Legal Education and Information Service of New Brunswick (PLEIS-NB). PLEIS-NB is a non-profit charitable organization. Its goal is to provide the public with information about the law. PLEIS-NB receives funding and in-kind support from the Department of Justice Canada, the New Brunswick Law Foundation, and the New Brunswick Office of the Attorney General.

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- New Brunswick Medical Society
- NB Department of Health
- Horizon Health Network
- Vitalité Health Network
- University of New Brunswick, Faculty of Law

This guide does not contain a complete statement of the law on the topic of advance health care directives. Anyone needing specific advice on their situation should consult a lawyer.

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Table of Contents

1 BACKGROUND
Information

In December 2016, a law was introduced in New Brunswick called the *Advance Health Care Directives Act*.

It is intended to help simplify the process for individuals who wish to set out their health care wishes and ensure they are known and respected by health care professionals, especially if a time comes when a person is unable to communicate those wishes themselves.

This guide explains who can create a health care directive, how to create it, where to keep it, how to update it or revoke it and so on. It briefly describes how a health care directive relates to other legal tools for planning for the future, such as a power of attorney for personal care.

Throughout this guide, when referring to advance health care directives, we will simply use the term **health care directive**.

2 WHAT YOU SHOULD KNOW ABOUT *Health Care Directives*

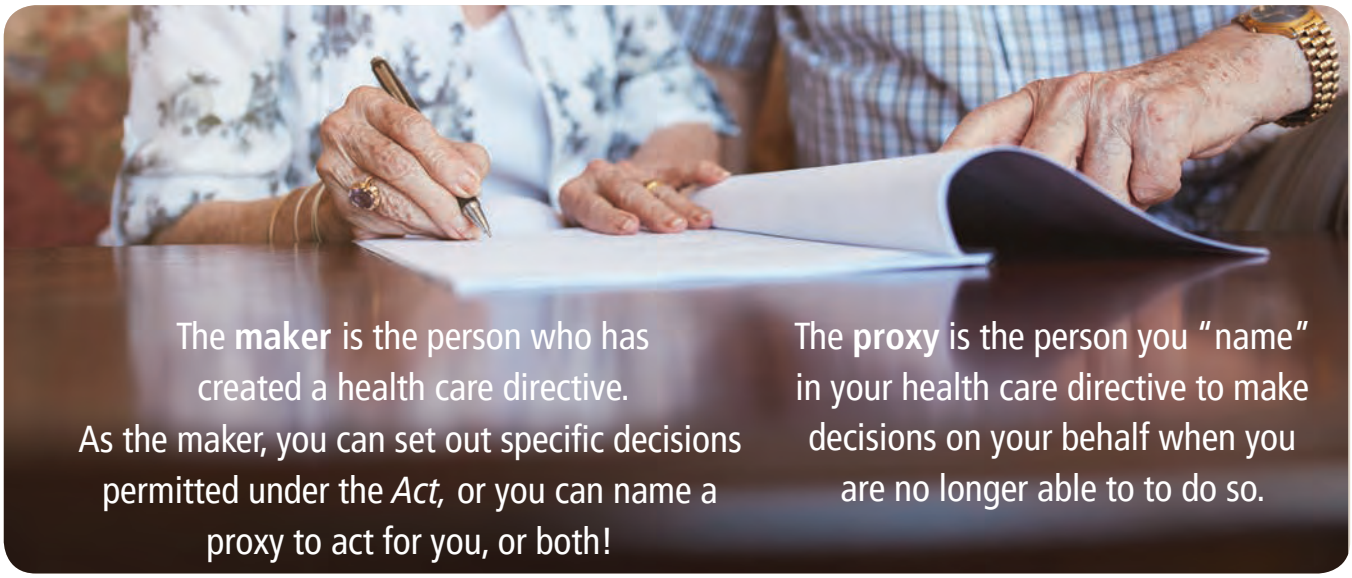
What is a health care directive?

A health care directive is a legal tool that allows you, the maker, to:

- Name a person or persons (called the proxy) to make health care decisions on your behalf when you are no longer able;
- Set out your specific instructions for your future health care;
- Include a general statement about your values, beliefs and wishes; and
- Identify persons to be notified when your directive comes into effect.

What kinds of health care decisions can I make?

You can set out your decisions and instructions for a time when you may be unable to make your own health care decisions or communicate them. You can include detailed information about your instructions such as consent, refusal or withdrawal of consent to treatment, services or procedures.



The **maker** is the person who has created a health care directive. As the maker, you can set out specific decisions permitted under the *Act,* or you can name a proxy to act for you, or both!

The **proxy** is the person you "name" in your health care directive to make decisions on your behalf when you are no longer able to to do so.

How will I know what kinds of treatments to expect?

It can be difficult to anticipate the various treatments that you might need. It may depend on your health conditions. You should talk to your doctor about the options. Be sure to ask questions about conditions, treatments and possible outcomes. This may help you decide how detailed or general you wish to be in your instructions.

What are some reasons to have a health care directive?

- You are concerned about future illness, disease or advanced age and the treatments you might receive when you are unable to express your wishes. The directive lets you state your wishes for health care when you are not able to do so;
- The directive may give your family or caregivers peace of mind knowing they are being guided by your wishes when asked to make difficult health care decisions;
- The directive may give you peace of mind knowing that health care professionals must respect your wishes;
- Health care directives can be easy to make and easily revised or updated;
- You do not need a lawyer to make the directive;
- Once signed and witnessed, they are a legally binding document;
- You may create your own health care directive or use a form available online. If you wish, you can use the form at the end of this guide.

Will health care professionals respect the content of my health care directive?

A properly created health care directive is a legally-binding document. With certain exceptions, health care professionals must respect the contents of your directive. Health care professionals under the *Act* include medical practitioners or registered nurse practitioners.

Do I need a lawyer to prepare my health care directive?

Not necessarily. The law permits individuals to set out their health care instructions with or without a lawyer. However, if you have created other legal documents, such as a **power of attorney for personal care**, you should consult your lawyer to find out if there are any potential conflicts in roles and duties.

According to the *Advance Health Care Directives Act* if a person makes a health care directive and a power of attorney for personal care and there is a conflict between provisions in one or more of the documents, health care professionals must follow the most recent document.

In light of this, if you, the maker, decide to appoint different people, you may wish not to include health care provisions in your power of attorney for personal care. It's a good idea to make your attorney and proxy aware of your plans. See page 14 for more information.

3 MAKING A *Health Care Directive*

Who can make a health care directive?

Anyone who has capacity, as defined in the *Act*, is able to make a health care directive.

What does it mean to have capacity?

The *Act* defines a person with capacity as one who is able to make decisions about their health care treatment and appreciate the reasonable consequences of their decisions or lack of decision. The *Act* presumes that individuals have capacity. [See the PLEIS-NB booklet on ***Mental Competence***].

How do I create a health care directive?

You can create a health care directive by obtaining and completing a form for that purpose, or creating one yourself. Under the *Advance Health Care Directives Act* you can create a valid directive if you follow these formal requirements:

- You (the maker) must sign and date the directive
- You must have an independent witness who watches you sign and date the directive

- The witness must be at least 19 years of age
- The witness cannot be the person you appoint as your proxy or their spouse
- The witness cannot be your spouse or common law partner (**Note:** Under this *Act*, a common-law partner is someone you have been in a conjugal relationship with for at least two years).

What if I am unable to sign the directive?

You can direct someone else to do this for you. The person who signs and dates a health care directive on your behalf cannot be your spouse or common-law partner. As well, it cannot be a proxy appointed by you in the directive or your proxy's spouse. You must document in your directive who you named to sign the directive for you.

Where can I find a form for making a directive?

You can find forms in many places. Your doctor may have them. They may be available on the government of New Brunswick website and other places on the Internet, at the hospital or at your lawyer's office. You can use whichever form you like. However, if you are using forms that were not specifically created for people in New Brunswick, they may not follow the rules and requirements of legislation in this province.

At the end of this guide is a **New Brunswick specific form**.

A fillable, printable version is available at: **www.legal-info-legale.nb.ca** (search - health care directives)

When does a health care directive take effect?

Your health care directive comes into effect when you no longer have the capacity to make treatment decisions for yourself or to communicate such decisions. Before a directive comes into effect, two health care professionals must decide and document that a maker ceases to have capacity and one of them must inform the maker of their finding, if possible.

A directive is only in effect for the period in which you do not have capacity or can't communicate. If you become capable again, the proxy's decision-making authority ceases.

Where should I keep my health care directive? Who should get a copy?

You should keep the original somewhere that is easy to find. Since there is no registry for directives in New Brunswick, it is important that you give a copy of your directive to interested parties. This could include your doctor, your proxy, and family members or friends. As well, give a copy to the Health Records Department of the hospital that you go to.

Consider keeping a copy of your directive on your refrigerator or at your bedside table so that it can be shared with health care professionals in an emergency situation.

Some people register their health care directive with Medic Alert and wear a bracelet stating this. This may be another way people in New Brunswick can inform health care professionals, especially in an emergency situation.

4 CHOOSING A *Proxy*

What is a proxy?

A proxy is a person appointed in a health care directive by the maker to make health care decisions on their behalf when they may be unable to make their own decisions or communicate them.

Do I have to name a proxy?

It's your decision. You can include detailed instructions in your directive to inform health care professionals of your wishes. However, you can also choose a proxy to carry out the instructions in your health care directive.

Without a proxy, a health care professional will implement your written instructions when the directive becomes effective. Unfortunately, written instructions can sometimes be insufficient to determine your preference. Health care professionals will do their best to follow your wishes. However, having a proxy may be beneficial as you can choose someone whose judgment you trust to advocate for the wishes you previously expressed and act in your best interests.

Who could be my proxy?

A proxy should be someone you trust and you know will make decisions in your best interest and in keeping with your wishes and values. A proxy has a very important role. He or she has the authority to make life-altering decisions on your behalf. Proxies are often a family member, a spouse, or a friend. It's good to choose someone who can be available to act on your behalf.

A proxy must be at least 19 years of age unless the proxy is your spouse or common-law partner.

Can I name more than one proxy?

Yes, you can name more than one person as a proxy. However, only one person at a time can act as your proxy. If you are unable to make or communicate your own health care decisions, then health care professionals must start by contacting the first person named on your health care directive. If that person is unable or unwilling to act at that time, the second person on your list of proxies will be contacted to act on your behalf, and so on.

It's a good idea to name alternate proxies just to be sure someone is available when called on to make decisions on your behalf.

What powers can I give a proxy?

You can give your proxy the power to advocate on your behalf in keeping with the health care values, beliefs and wishes that you expressed in your health care directive. Where decisions are not explicit in the directive, the proxy must act in accordance with any wishes they know the maker expressed when they had capacity or would express were they still capable. A proxy is not permitted to delegate their authority.

In order to make decisions about your care, your proxy has the right to be provided by health care professionals with all the information necessary to make an informed decision. This would be subject to any limitations on accessing information that you might include in your health care directive.

You should know that...

your proxy does not have the authority to make decisions outside the scope of health care decisions. They are not authorized to deal with financial or property matters or personal care directly – only as they relate to health care decisions.

This is why it is important to have other documents such as **power of attorney for financial matters** and/or **personal care.**

Should I talk to the proxy before I create my directive?

Yes. It is very important that you talk to the individual or individuals you want to act as proxies. A proxy has the right to refuse their appointment. Discuss your future health care wishes to ensure that the person you choose understands your values and wishes and would be willing to act on your behalf if it becomes necessary.

Can I give the proxy specific instructions about my care?

Yes. A health care directive may give the proxy the right to act on your specific instructions regarding your health care decisions. Remember, a general statement of wishes and desires without reference to medical conditions or treatments may be too vague and might not be helpful to health care professionals.

Do I have to pay my proxy?

There is no obligation to pay your proxy.

If you do wish to compensate your proxy for acting in this role, you must specifically indicate that in your directive.

What if I have no one to be my proxy?

Under the *Advance Health Care Directives Act* it is not required that you appoint a proxy. A maker may include specific instructions in their directive to be applied by the health care professional. However, if you do not have anyone you can appoint as your proxy, you may be able to apply to the **Public Trustee** to act on your behalf.

Contact the **Public Trustee** for more information on their services.

5 REVOKING OR CHANGING A *Health Care Directive*

Health problems and treatments change over time. Think about reviewing and updating your health care directive on a regular basis. Be sure to replace all outdated copies with the new version.

Can I change my health care directive?

Yes. A health care directive may be changed at any time. This is done by creating a new document stating your intention to revoke all prior directives.

When creating a new directive it is important that you inform all parties who received a copy of the previous directive. You must provide them with an updated version or they may follow instructions in the previous document. This will ensure compliance with your instructions.

How do I revoke a health care directive?

You can revoke an existing directive by making a new one that includes a written statement declaring your intention to revoke the previous directive. The destruction of an existing directive and all original signed copies with the intention of making it inoperative is another way you can revoke a directive. Only you or someone you authorize can revoke a health care directive. You must have the capacity to do this and the revocation must be properly signed and witnessed.

What if I become incapacitated and my proxy is making decisions that are not in my best interest?

If a health care professional believes your proxy is making decisions that are not in your best interest, they may take steps to revoke your proxy's status.

An application can be made to the Court of Queen's Bench asking that the proxy be removed. The court has the authority to do that if they find the proxy to have behaved in bad faith or contrary to their obligations.

Divorce or separation

If you split up with your spouse or common-law partner, it automatically revokes their right to act as your proxy unless you have stated otherwise in your directive.

6 HEALTH CARE DIRECTIVES AND *Other Legal Tools*

Living Wills

What if I already have a "living will"?

A living will is similar in concept to a health care directive. Living wills are documents that are intended to set out the wishes and desires of an individual for their health care, particularly at end of life when they can no longer communicate those wishes themselves.

However, living wills have no legislative authority in New Brunswick and they do not include a substitute decision-maker or proxy. Rather they spell out the wishes and desires of the maker with regard to treatment. Under the *Advance Health Care Directives Act*, a previously existing living will that is mostly consistent with the *Act* will be enforced as a health care directive.

What if I have a health care directive that I made in another province?

As with living wills, directives created in another province that express your decisions, instructions or wishes for health care treatment would be considered valid if they are mostly consistent with the provisions for making a health care directive in New Brunswick.

Powers of Attorney

If I create a health care directive, does that mean I don't need to have a power of attorney?

Having a health care directive does not replace the need for other legal tools such as a power of attorney for financial matters or a power of attorney for personal care. Your health care directive is specific to your health care treatment decisions. You cannot delegate power to allow your proxy to deal with financial or personal care or property matters.

A health care directive allows you to dictate specific directions to the proxy or health care professional. This distinguishes the health care directive from a power of attorney for personal care, in which you would typically give your attorney general decision-making powers on personal care and health decisions. When you create a power of attorney, you must name the person who will act as your attorney. When you create a health care directive, you are not required to appoint a proxy. Your written instructions are sufficient.

Typically there is no need for two doctors to agree about a person's capacity for a power of attorney for personal care to come into effect. Generally speaking, a power of attorney for personal care is deemed to be enduring – which means it remains in effect even if the person who made it becomes incompetent.

How do personal care decisions differ from health care decisions?

A power of attorney for personal care can allow your attorney to make decisions about things like your nutrition, where you will live, clothing and personal safety. Your health care directive can allow your proxy to make decisions on your behalf regarding consent, refusal or withdrawal of consent to health care treatment, services or procedures.

A power of attorney for personal care is enforceable under the *Infirm Persons Act* and usually is prepared with the assistance of a lawyer. A health care directive, on the other hand, operates under the *Advance Health Care Directives Act* and has less demanding requirements for signing.

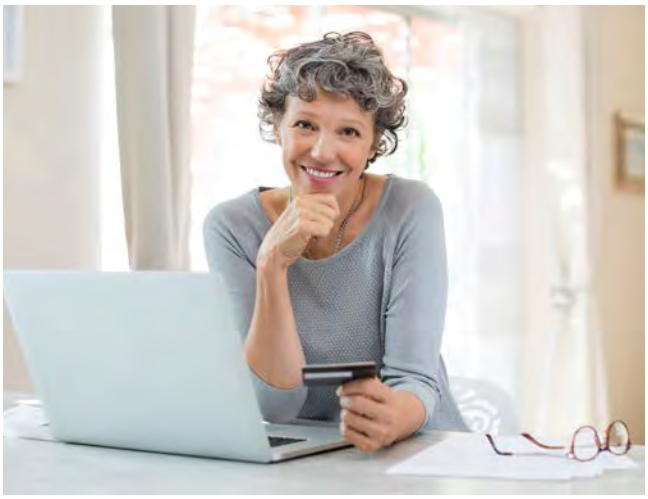
If you already have a power of attorney for personal care, discuss this question with your lawyer. The powers of your attorney may overlap somewhat with the powers of your proxy regarding personal care decisions.

Where these two documents exist and do not conflict, they will operate simultaneously. However, these documents are different legal instruments with different legal requirements.

What if my attorney and my proxy disagree about my care?

Under the *Advance Health Care Directives Act*, if you have more than one health care directive or you have a power of attorney for personal care and there are conflicts between the provisions of these documents, the document that you made most recently will prevail.

For that reason, you should be careful not to inadvertently create a new health care directive that might revoke your previous directive. For example, you should carefully read hospital admission forms. They may contain provisions for your future health care treatment. If you are not sure what you are signing, ask a nurse or administrator for clarification. If you sign this without carefully reading it, you may revoke a more thorough directive without realizing it.



Does my proxy have authority to handle my financial matters?

It is important to distinguish between the roles and powers of an attorney for financial matters, an attorney for personal care, and proxies named in a health care directive.

A proxy can only make decisions within the scope of health care matters found in the *Advance Health Care Directives Act*. This means your attorney has to make any decisions about your financial or property matters or personal care.

If you wish someone to have the authority to handle your financial and property matters, you must appoint one or more persons as your attorney under a power of attorney for financial matters. This person cannot make decisions on your behalf about your personal or health care. If you also create a power of attorney for personal care, that attorney can only make decisions about your personal care, not financial decisions.

Can my attorney and proxy be the same person(s)?

If you wish, you can appoint the same person to be your proxy and your attorney. You can appoint your attorney for financial matters, and/or your attorney for personal care, in a single document, or in two separate documents. See the PLEIS-NB publication called ***Powers of Attorney***. However, your health care directive would have to be created in a separate document since the rules for making it are different. You should talk to your lawyer about this in order to explore your options. Having the same person responsible for all of these duties may be useful in certain circumstances, such as requesting the Public Trustee to take responsibility for your overall affairs should you become incapacitated.

Can I simply create a power of attorney for personal care and give my attorney the powers of a proxy?

The *Advance Health Care Directives Act* specifically says that a power of attorney for personal care is **NOT** a health care directive. The directive is intended to be a document that lets you, the maker, easily change and update as your health conditions change over time. Having it in a separate document may help to facilitate these updates. As well, it is important to realize that the obligations and protections given to health care professionals under the *Advance Health Care Directives Act* may not be applicable under the *Infirm Persons Act*.

Medical Assistance in Dying

Can I include a request for medical assistance in dying in a health care directive?

No, you cannot.

Your health care directive only comes into effect when you are no longer able to consent to treatment. That means you cannot give advance instructions about medical assistance in dying, nor can you give your proxy the authority to ask for medical assistance in dying on your behalf.

You must be able to make this request yourself to your doctor or nurse practitioner when you are at the end of life and suffering from an incurable disease or condition.

Medical assistance in dying refers to the situation where a physician or nurse practitioner prescribes or administers medication to a competent and consenting adult to intentionally bring about their death.

See the PLEIS-NB booklet called ***Patients' Rights***.

7 *Advance Health Care Directive Form*

Date _____

Date of birth _____

Medicare# _____

This is my Health Care Directive:

Name _____

Address _____ City _____

Province _____ Postal Code _____

Tel. _____ Cell _____

❑ **I revoke any previous health care directives**

Part 1 – Appointment of a Health Care Proxy (optional)

I appoint the following person to act as my proxy to make health care decisions if I am not capable:

Proxy

Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

If my proxy is unable, unwilling or unavailable to make a health care decision, I appoint the following persons to act as as my alternate proxy:

Alternate Proxy

Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

Alternate Proxy

Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

OR ❑ **No Proxy Appointed**

I do not wish to appoint a proxy but have provided instructions for treatment decisions in Part 2.

A Health Care Directive is equally valid whether or not you use this form.

Part 2 – Treatment instructions (optional: skip this part if you do not wish to provide treatment instructions)

I give the following instructions to health care professionals and/or my proxies regarding the health care treatment I do or do not want to receive and the circumstance in which I want or do not want to receive it.

My proxy may make health care decisions on my behalf when I am unable to do so for myself:

❑ with no restrictions ❑ with restrictions as follows:

Part 3 – Values and beliefs

I provide the following statement of my values, beliefs and wishes in general terms to guide decision-making by health care providers and my proxy (if I chose to appoint a proxy).

Notification (optional) [Attach additional page if desirable]

If it is determined that I lack capacity to make a health care decision, and this health care directive comes into effect, I wish the following persons to be notified:

Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

Part 4 – Signature and date

Your advance health care directive is complete once you sign it in the presence of your witness. If you are unable to sign, a substitute may sign on your behalf. The substitute must sign in your presence and in the presence of a witness. The proxy or the proxy's spouse or common-law partner cannot be the substitute or witness.

Maker's Signature _____ Date _____

Name of substitute _____

Address _____

Tel. _____ Cell _____

Witness

The directive must be signed by a witness who is at least 19 years of age.

Name of witness _____

Address _____

Tel. _____ Cell _____

Witness Signature _____ Date _____

Health Care Directive

This is a form for making a health care directive in accordance with the Enduring Powers of Attorney Act in New Brunswick. Before you fill out this form, you should read the PLEIS-NB guide called ***Health Care Directives***.

Name _____

Address _____ City/Prov. _____

Postal Code _____ Tel. _____ Email _____

Health care instructions

The following are my instructions with respect to health care decisions that may be made on my behalf in the event that I lack the capacity to make them:

Health care instructions *(continued)*

Revocation *(optional)*

☐ I revoke all of my previous health care directives.

Signature _____ Date _____

ADVANCED HEALTH CARE DIRECTIVES

Advanced health care directives help simplify the process for individuals wishing to set out their health care wishes and ensure they are known and respected by health care professionals, especially when they cannot communicate this for themselves. (Advanced Health Care Act Law, 2016).

This is a legal tool that allows a person to name a proxy, it can be more than one person, to make health care decisions on their behalf when they are not able to.

Specific instructions can be set out for your future health care. These can be as detailed as you like. They can include a general statement about your beliefs, values and wishes and who to notify when your directive comes into effect.

When thinking of setting up an advanced health care directive, it is a good idea to have a conversation with your doctor about your options.

An advanced health care directive is easy to create, doesn't require a lawyer and once it is signed and witness is legally binding.

For more information regarding advance health care directives, contact the Public Legal Education and Information Service of New Brunswick P.O. Box 6000 Fredericton, NB E3B 5H1 Tel.: 506-453-5369 Fax: 506-462-5193 Email: pleisnb@web.ca www.legal-info-legale.nb.ca www.familylawnb.ca

LEGAL MATTERS

There many legal matters that need to be taken care of as we age.Terms such as wills, enduring power of attorney (POA) and advanced health care directive are usually thrown about. To ensure you have the correct documents in place and what information you need to gather, please contact:
NB law society: 1-506-458-8540/ **Public Legal Education and Information Service of NB**: 1-506-453-5369 or https://www.legal-info-legale.nb.ca/en/you_and_your_lawyer

WILL

A will names an excuator to your estate, gives property to people you chose to when you die and names any beneficiaries. The executor ensures that any debts against your name are paid prior to any monies being given to any one else.

ENDURING POA

There are 2 types of POA: financial and personal care. Financial is in charge only of a person's finances and personal care is in charge only of a persons care (medical care decisions, where they live, etc.). You can have one person be both but should discuss this with your lawyer and th person.
If you have no one to appoint, a trustee can be appointed through the Public Trustee of NB (1-888-336-8383)

ADVANCED HEALTH CARE DIRECTIVES

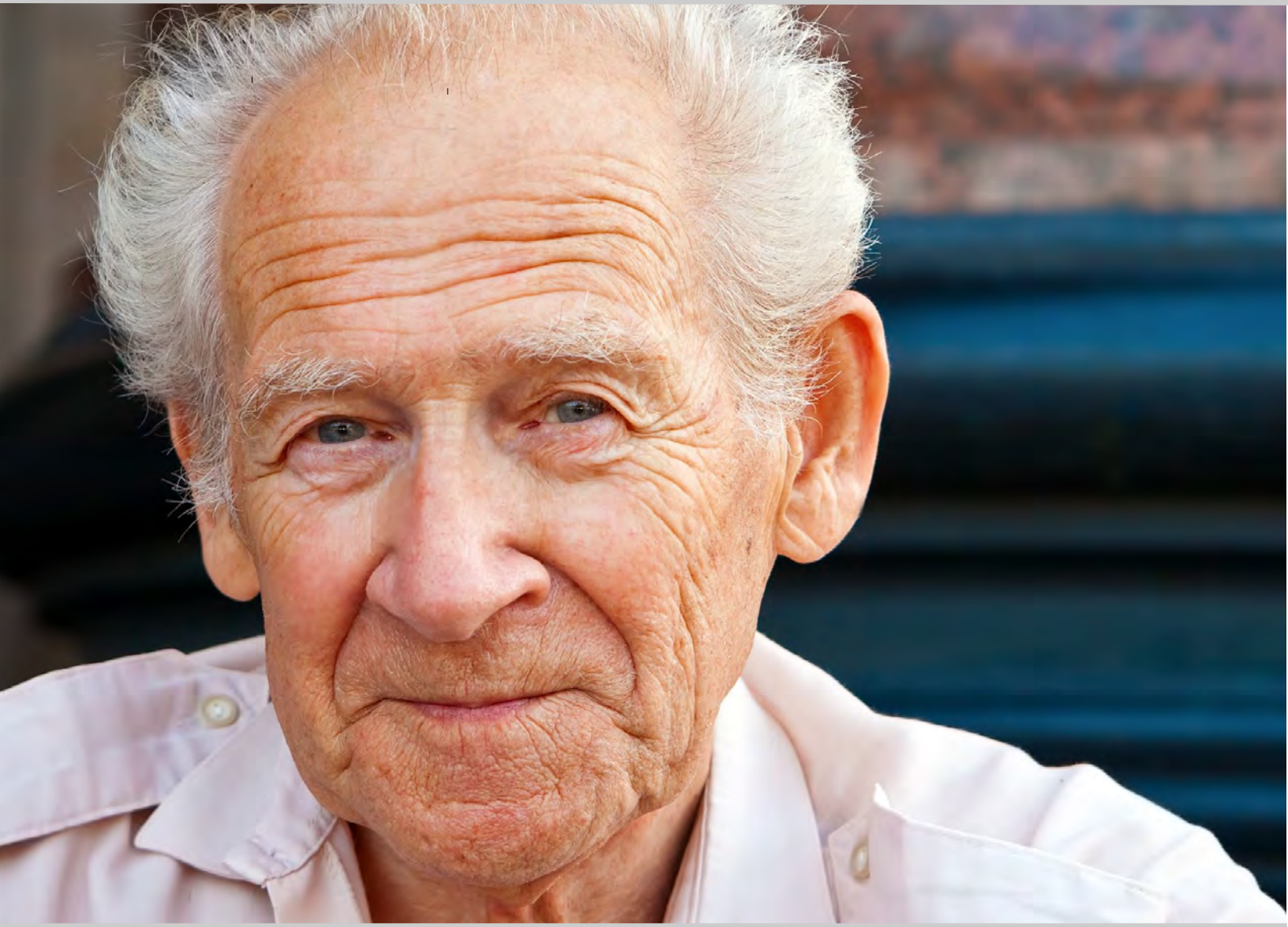
This document is used to state your wishes for your future medical care and treatment when you are not able to. You do not require a lawyer to create this document; can be found on the Public Legal Education and Information Service of NB's website. You can be as detailed as you want.

NAVIGATING DEMENTIA

LIVING WITH DEMENTIA

Shares strategies, tools, and resources for navigating life with dementia, focusing on safety, communication, and caregiver support.

ebook compliments of mmLearn.org



Activities for Dementia Patients

Purposeful Activities for All Stages

Contents

This ebook is based on a presentation by Maria Wellisch, R.N., L.N.F.A. Wellisch is a nurse, licensed nursing facility administrator and the vice president of corporate education at mmLearn.org. The experience of caring for her own mother, along with her professional background in nursing and long-term care, drives Wellisch's vision and passion for providing quality caregiver training. Her initial project to provide online training for Morningside Ministries staff has grown into an international enterprise that reaches caregivers around the globe.

Introduction

Why Do Dementia Patients Need Purposeful Activities?

Caring for someone with dementia comes with many challenges, not the least of which is how to keep the person occupied on a daily basis. Whether you provide care in a professional, family or another setting, you likely face the ongoing challenge of coming up with activities that are both engaging and meaningful. You want the person or people you care for to feel they are still making contributions to the world and doing something that's worthwhile, despite their dementia diagnosis. You may also need activities that keep them occupied in order to give yourself time to get other important things done.

Dementia is a condition that involves an impairment of a person's mental abilities that is significant enough to disrupt their daily life. It's a collection of symptoms that affect a person's memory and potentially other faculties, such as reasoning and judgment. That can make it difficult to find activities that are satisfying, enriching and safe for a dementia patient.

Purposeful activities help improve the day-to-day experience of those with dementia and other memory care conditions. So, how do you know what activities offer purpose and meaning? We have 12 ideas that are inexpensive and easy to execute. They can help occupy a dementia patient for hours and make your experience as a caregiver more manageable and meaningful as well.

Activity 1: Shoe Shine Box

When I came across an old shoe shine kit, it triggered a memory of how important shining shoes was in my father's life. Every Sunday morning before church, my dad would shine his shoes. It was a habit as routine as getting in the car to actually drive to church. Shining shoes is also a great activity for men or women with dementia.

What you need

It may not be possible to find an old-fashioned shoe shine box like the one my father had, but today you can go to a dollar store and buy an inexpensive shoe shine kit. Those kits usually come with a brush, a little sponge, a chamois cloth for buffing and shoe shine polish.

Shoe shine polish is often black, which can be messy, and it's toxic, which could pose a danger if eaten. Find a product that is nontoxic. Companies now offer a polish that is clear and nontoxic — like a furniture polish — that would be great for this activity. You can also present the brushing and buffing portion of the activity without polish at all.

The activity

Offer the dementia patient a pair of shoes, preferably their own, and allow them to buff and brush the leather. If your patient has lost some hand dexterity, give them a cloth instead of a brush, which can be easier to handle. For higher functioning patients, lacing shoes may still be an option. You can allow them to fully or partially lace the shoes, depending on their level of cognitive and motor function.

Shoe shining and lacing is an activity that is purposeful, meaningful and age-appropriate. It allows the dementia patient dignity, especially when in the company of other people, and the feeling that they still have something to offer themselves and others, just as they did in their younger years. It could engage them for a significant amount of time, and the end result is nice and shiny shoes.

View the video demonstrating the shoe shine box activity here.

Activity 2: Pocketbook

A pocketbook can be very entertaining for dementia patients if you provide one that is filled with items that have significance to the person. Consider offering a pocketbook, bag or purse that is full but not overstuffed, because you want to keep things simple. Place things inside the bag that the patient can sort through, remove and look at.

Objects to include

Choose items that will give the patient a sense of peace. Some objects that you might place inside a pocketbook are:

- Rosary beads
- Holy cards
- A hymnal
- A small picture or spiritual book
- Packages of tissues
- Keys
- A wallet
- An emery board
- Pictures of loved ones

Items that work well fit easily in a patient's hand. Select objects that are easy to use and that your patient or loved one would like. Think about what you or someone you know would put in their own purse.

Beware of including any items that might trigger negative feelings. If the person doesn't drive any longer, or if they're exit-seeking and still trying to drive, don't include keys, for example. But for many dementia patients, keys can be reassuring and comforting to handle. You might also avoid items that could make a mess, such as lipstick.

Make the pocketbook activity a tactile experience

Another significant component is the feel or texture of the pocketbook. Remember that patients can enjoy feeling things. You can find bags that are soft, leather or cloth. Especially if the patient is a woman, a pocketbook may be a reminder of experiences that they had earlier in life, as a mother or a professional. My own mother loved putting things in and outside of her wallet or a little storage box.

Instead of a pocketbook, you can also substitute something similar that is easy to open, close and handle. Use the variation that works for you.

Pocketbooks can be very positive in that they provide an entertaining activity for the dementia patient, who will enjoy taking the items out and putting them back inside.

On the other hand, be aware that a pocketbook can be a signal to the patient that they're going somewhere or that the caregiver is leaving. If a patient observes you putting a pocketbook over your shoulder, it could make them want to follow you and leave. Avoid putting the pocketbook over your shoulder when you're preparing to leave and store it out of sight of the patient.

View the video demonstrating the pocketbook activity here.

Activity 3: Silverware

Another simple activity for dementia patients is handling silverware. Sets of forks, knives and spoons are used multiple times a day in homes and memory care settings alike, and utensils go in and out of a drawer, the dishwasher or the sink.

A wonderful activity that can make a dementia patient feel that they are meaningfully participating in daily life starts with a regular tray of silverware. You can either remove all of the silverware or leave one utensil in each section of the tray. The fewer items there are in the silverware tray to start, the easier it will be for the person to be able to sort and put things back. You can determine where your patient feels comfortable by first removing all of the pieces, and then seeing if they do better if you leave some pieces in the tray. Once you find out the person's level of comfort, you can let them try to refill the tray.

It doesn't matter if they put a spoon with a fork or a knife, or if they move things around and put them in different orders. It does not have to be perfect. We're not seeking perfection, we're just looking for a meaningful activity. Once the person has finished and has put everything back into the tray, you can remove the utensils and ask them to help you again. Or you can put the items in the dishwasher. If the person is high-functioning enough, you can have them set the table for you.

Just be aware of good hygiene, and wash items as needed after this activity. View the video demonstrating the silverware activity here.

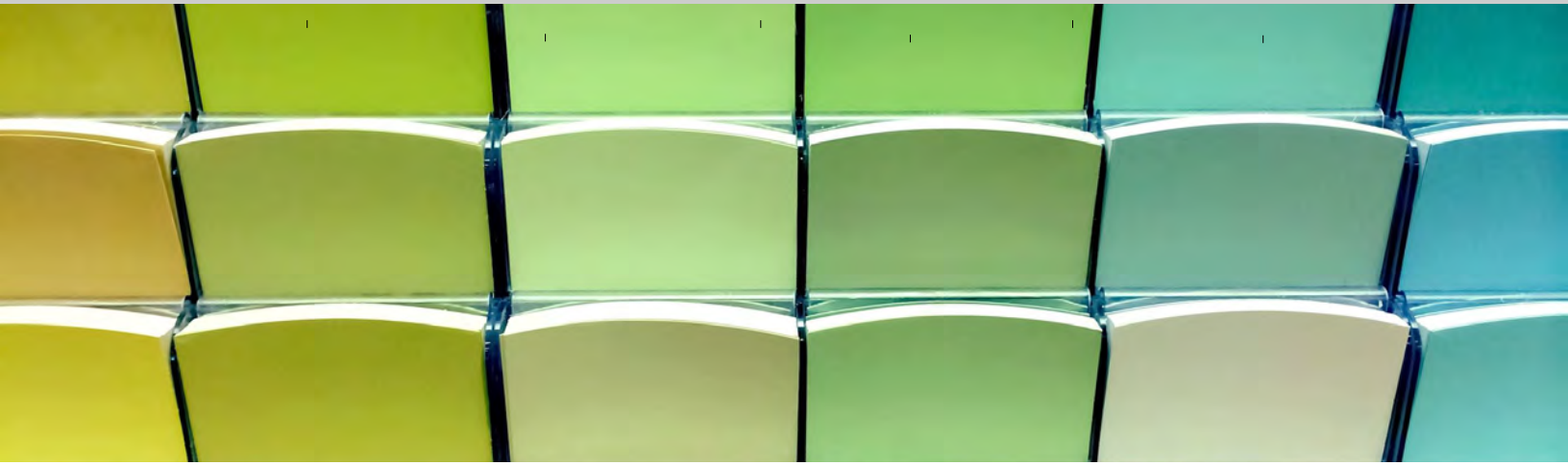
Activity 4: PVC Pipe Fittings

We all love toys, even adults. Another activity you can offer to occupy dementia patients involves what I consider adult toys. If you go to a big box home improvement store, you can purchase pieces of PVC piping for as little as 25 cents. Look for piping that screws together.

Allow the person you care for to put the pipe fittings together and take them apart like puzzle pieces. Even if they can't put them together, they can take them out of the storage bag or container and put them back inside. This is an activity that can keep someone occupied for a period of time then be neatly put away.

Imagine you're trying to cook dinner, repair something or help a child with homework. Or maybe you work in a facility and need to focus your attention on caring for another resident. These PVC pipe fittings provide an inexpensive, enjoyable way to occupy a person's time and attention.

View the video demonstrating the PVC pipe fitting activity here.



Activity 5: Paint Swatches

Another activity inspired by a trip to the home improvement store involves paint swatches. Obviously, these cards come in many colors, but their textures vary as well. Feeling different textures — from slick, high gloss to coarse — can be satisfying for a dementia patient. You can also use these swatches in a variety of other ways.

You can create something like a puzzle for matching colors. For example, get three or four of the same swatches and have the person match them by color or by size. You can also ask them to help you determine which color to paint a wall. That option could require more involvement in the activity on your part, but perhaps not. Be creative! When collecting paint swatches, you can also let the employees at the store know what you're doing, and they're likely to be very helpful.

An important part of working with senior citizens is coming up with activities that are age appropriate. Ideally, you want to find alternatives for activities using puzzles their grandchildren might be playing with, for example. That's why paint swatches are a great option to offer as part of an activity.

View the video demonstrating the paint swatches activity here.

Activity 6: Feather Dusters

In addition to caring for someone with dementia, you probably always have other daily tasks to complete as well. Those tasks can include household chores like vacuuming and cleaning. Often with housecleaning, the person we care for wants to be involved and helping. Unfortunately, though, sometimes that means they get in the way instead of being helpful.

For a low cost, you can purchase an old-fashioned feather duster from a big box or dollar store. The great thing about dusting is that cleaning is a normal part of everyday life in many households and it does more than just entertain or occupy someone.

Enlisting a dementia patient to help with cleaning using a feather duster provides a meaningful activity that also helps with a person's range of motion. Dusting can help loosen a person's joints as they reach, twist and turn. This activity provides a bit of exercise along with a feeling that they're providing you valuable assistance.

View the video demonstrating the feather duster activity here.

Activity 7: Coupons

Coupon clipping is an activity that will be meaningful to many — either they have done it in the past or remember their folks having done so when they were a child. Save the free coupons you receive in the mail and purchase an inexpensive pair of safety scissors. If the dementia patient you care for has the ability to cut — using safety scissors — they might even clip a coupon that's useful for you.

Just remember: Someone may be able to cut, but they might not cut along the borders of the coupon correctly. They might cut right across the coupon. It doesn't matter — that is not what is important.

Coupon clipping gives a dementia patient a purpose through an adult activity instead of one that's suitable for children, like cutting out paper dolls or coloring with crayons. There's nothing wrong with those activities, but it's ideal to give dementia patients the feeling that what they're doing is helping you. At the same time, it's keeping them occupied so that you can do something else. Of course if you have time, you can sit down and engage with them over the coupons.

View the video demonstrating the coupons activity here.

Activity 8: Stuffed Animals That 'Breathe'

Almost everyone loves animals. For about $20 to $40 online, you can order a plush cat or dog that appears to breathe or snore. These stuffed animals are powered by batteries, and you can watch and feel the subtle up-and-down motion of their "breath." Some arrive in a box with a little soft bed, and others also come with a brush.

Whenever you're caring for people who have dementia, especially in the later stages of the disorder, texture and feel is important. Letting them hold a plush puppy or kitty in their laps gives them something soft and soothing to stroke or brush. It's another activity that makes them feel involved and like they have a purpose. They feel as if they're soothing and comforting the animal and, at the same time, it's providing a similar effect for them!

Obviously, with this activity, the animal cannot be hurt. However, if the person with dementia expresses any concern about dropping or hurting the animal, then you can just gently move it out of their lap and place it beside them. They can stroke the animal in that position.

These stuffed creatures make a great gift. Many people with dementia want to keep their pets when they move to a facility. Sometimes those wishes can be accommodated, and other times not. There also can come a time when a person has to give up a pet because they cannot handle the responsibilities, and the pet may not be safe. So this makes a great activity for someone who has enjoyed having pets in the past, or anyone who might like the feeling of connecting with an animal.

View the video demonstrating the breathing pets activity here.

Activity 9: Jewelry Box

Another affordable and easy activity involves a jewelry box. This activity is appropriate for men and women, though it may feel more natural to present it to women. You can purchase a jewelry box and jewelry at a flea market or garage sale for not much money if you don't already have these items around the house.

Fill each compartment with a few pieces of jewelry and similar items, such as bracelets, rosary beads and the like. Allow the person or people you care for to go through the items and help them try on the pieces of jewelry if they express an interest. Simplify the items, depending on what the person can handle. Even if the pieces are of modest value, they will give you and the person something to talk about and may trigger reminiscences. Reminiscence therapy, which involves talking about past events or experiences with tangible prompts, can be very beneficial for dementia patients.

Let the person you are caring for bring out each of the items, talk about them or try them on, and then eventually return them to the box. This simple activity is age appropriate, keeping the person engaged while maintaining a sense of dignity.

View the video demonstrating the jewelry box activity here.

Activity 10: Dolls

You always want to offer people with dementia activities that are age appropriate, and interacting with dolls may initially seem like it doesn't meet that criteria. However, sometimes as people grow older, their memories reach back in time, including a time when they may have had babies themselves.

Those who are experiencing anxiety with their dementia often relax when you give them a baby doll that they can hold, rock, cuddle and swaddle in a soft, warm blanket. This can be a meaningful activity that gives someone a feeling of purpose, in addition to calming feelings of anxiety. It may remind them of their own children or grandchildren.

Even if you are on a budget, you can find simple and affordable dolls at your local drugstore that are soft and easy to hold. You don't have to settle for a hard or rigid doll. Also, the cover that you put around the doll may be as meaningful as the doll itself — offering items with a pleasing texture is so important when caring for dementia patients. If at any point during the activity they begin to get agitated or want to get rid of the doll or throw the doll, just gently take it away.

Additional baby carriage activity

Sometimes people will want to push the baby in a carriage. Unfortunately, most real or toy carriages will not be stable enough, and you should discourage the use of those. However, some walkers or rollators have baskets that make for great simulated baby carriages. You can fit the baby and its blanket inside the basket and allow the person to walk the doll that way. It's a win-win situation because the person is also getting exercise, which helps with mobility. Some people may become so attached to a doll that they wish to keep it with them at all times. This activity is a wonderful tool for anxiety.

View the video demonstrating the dolls activity here.

Activity 11: Kitchen Storage Containers

These days, you can buy kitchen storage containers with lids in all different sizes for very little money. These work something like blocks in that someone can stack them and match the lids to the containers. However, unlike the blocks you might give a child, kitchen storage containers are age appropriate. Depending on a person's level of function, they may just be able to hold the pieces and take them in and out of a box. Regardless of the stage of dementia, so many activities can be created using these simple pieces.

Another affordable purchase is a set of measuring cups, which also can be fit inside one another and stacked. Measuring spoons provide a similar function. Handling these items will spur thoughts and conversations about cooking and planning meals, which can be engaging. It also offers the person with dementia the feeling that they're helping someone by organizing everyday kitchen items.

View the video demonstrating the storage containers activity here.

Activity 12: Toolbox

This final idea works much like the pocketbook and jewelry box activities. A toolbox is another inexpensive container to purchase and fill with interesting items for a meaningful and engaging activity. This activity is not gender specific but may especially appeal to men.

A toolbox has a handle, so someone can carry it around with them, giving them a sense of purpose. Opening and closing boxes is interesting for people at any age — it offers that element of surprise. Obviously, you want to be very careful to put items in the toolbox that will be safe for the individual. That means having an understanding of the person's level of dementia and how they behave. Don't put a hammer in a toolbox with somebody that could hurt someone else or themselves with it.

Choose items that the person can safely handle and might evoke reminiscences. Some things you can put in the toolbox include: PVC piping, pieces of locks, soft paintbrushes, a lightweight tape measure. A level is another item that holds great intrigue. The person may not remember how to use it, but they often enjoy looking at the bubble inside. It's an item you can demonstrate and talk about. Keys are another great item to include, unless they will trigger someone into wanting to get in a car and drive. Anything that someone can safely take out, look at, sort and put away works for this simple toolbox activity.

View the video demonstrating the toolbox activity here.

Conclusion

Even with a dementia diagnosis, people still want to feel they are involved with their household or community. That's what most people want, regardless of age. It's a wonderful gift to be able to give someone a meaningful activity to do. When you're caring for someone with dementia, it can be hard to come up with ideas on your own to keep that person active and feeling that their life still has purpose. Hopefully these simple, inexpensive suggestions prove helpful in your caregiving. Some dementia patients may only enjoy some of these activities, while others may find hours of meaningful engagement with all of them, time and again. Find what works best for you.

Additional Resources

Watch free caregiver training videos on dementia activities by clicking here.

Get updates about new mmlearn.org videos by clicking below:

About mmLearn.org

mmLearn.org was created as a web-based program of the Elizabeth McGown Training Institute to provide quality, consistent caregiver training for Morningside Ministries employees and staff as well as residents and family members. Since its inception in 2007, mmLearn.org has produced more than 1,000 web-based caregiver training videos and has grown from a local service for Morningside employees to providing much needed training to caregivers around the world.

mmLearn.org offers real-life, quality caregiver training to anyone seeking practical ways to meet the physical, emotional and spiritual needs of older adults in their care. Whether you're a healthcare professional, a family caregiver, or seeking guidance as a pastoral or spiritual caregiver — we know that you'll find mmLearn.org an essential learning tool in caring for older adults.

mmlearn.org

All about me

This is a booklet about a person living with Alzheimer's disease or other dementia.

Name:_____

Alzheimer Society

The Alzheimer Society is the leading nationwide health charity for people living with Alzheimer's disease and other dementias. Active in communities across Canada, the Society:

- Offers information, support and education programs for people with dementia, their families and caregivers
- Funds research to find a cure and improve the care of people with dementia
- Promotes public education and awareness of Alzheimer's disease and other dementias to ensure people know where to turn for help
- Influences policy and decision-making to address the needs of people with dementia and their caregivers.

For more information, contact your local Alzheimer Society or visit our website at alzheimer.ca.

Table of contents

Introduction

This booklet is all about you, a person living with Alzheimer's disease or other dementia.

Although you have a form of dementia, you are still the same person you have always been. This booklet is designed to focus on the positive: what you are good at rather than what is no longer possible.

You and your primary caregiver* know what makes you feel comfortable better than anyone. By answering the questions in this booklet, you will have a record of what makes you content and at ease that can be used when your primary caregiver cannot be with you and others need to provide care and support. Anyone can use this booklet to give you the best day possible now and as the disease progresses.

The first section of this booklet is designed to help someone new to supporting you get to know you better. It will also suggest conversation topics that may make you feel more at ease and contribute to more enjoyable times together.

Other sections of this booklet allow you and your caregiver to outline your usual habits: your daily routines, your likes and dislikes and what makes you enjoy each day. This information will help new caregivers maintain the routines that give you a sense of security, comfort and pleasure.

When completing this booklet, always keep in mind the main purpose: to give as clear a picture as possible of you to help others provide care when the person who usually supports you is unavailable.

To help others provide effective care, keep this book in an easy-to-find location. You and your caregivers can review it from time to time to note changes and plan for the future. There are replacement pages at the back that you can use to make any updates or changes.

*The term "caregiver" is used throughout this booklet to mean anyone who supports you.

Contact information

This booklet contains information about: _____

Some of the information is provided by: _____

Names, phone numbers, email addresses of significant people in my life (family, friends, neighbours):

Name: _____

Relationship: _____

Phone number: _____

Email address: _____

Name: _____

Relationship: _____

Phone number: _____

Email address: _____

Name: _____

Relationship: _____

Phone number: _____

Email address: _____

Name: _____

Relationship: _____

Phone number: _____

Email address: _____

Date: _____

Other important numbers

Family doctor (name, phone number, address): _____

_____

Ambulance: _____

Police: _____

Fire: _____

Poison Control: _____

Local Alzheimer Society: _____

Home-care services: _____

Spiritual or faith leader: _____

Other: _____

Medical information

Other than having dementia, are there other medical issues that the caregiver should know about?

Please provide any important information on:

Allergies:

Hearing:

Vision:

Medications (attach list, if necessary) – include dosage and frequency:

Date: _____

This section is like a photograph. Try to use as much detail as you can to give readers a real sense of your personality.

My personal life

How do you like to be addressed? (e.g. nickname, Mr., Mrs., Miss, first name)

_____

When were you born? _____

Where? _____

Single/married/partner/longstanding relationship(s) with _____

Name: _____

We've been together since _____(year)

Where have you lived?

Describe this relationship (e.g. loving, difficult, supportive)

Children (names and where they are now living)

Are they involved in your life now? If so, how?

Do you have any pets? If so, what are their names?

Date: _____

In the past

What kind of jobs did you have? (e.g. homemaker, lawyer, nurse, electrician, teacher)

How do you feel about the job(s) you have done? (e.g. proud, satisfied, indifferent)

If you were asked about the major milestones in your life, what would you likely talk about? (e.g. major life events, favourite places visited)

Likes and dislikes

What makes you physically more comfortable? (e.g. always have glasses on, have a hearing aid in, daily lotion to prevent dry skin, toe spacers)

What makes you happy? (e.g. conversation topics, activities, sports, music performances, being around children/animals)

What do you dislike? (e.g. foods, activities, topics of conversation, music, smells)

What comforts you when you're upset?

What frightens you?

Date: _____

Life story (Please describe any other details of your life that would help create a full picture of you as a "whole person." What would you want others to know about you?)

Date: _____

A typical day

Routine is important for all of us, but can be especially helpful for a person with dementia.

Writing down your daily routine will help you see how you spend your time and help others who might be providing care.

Try to look at your care through the eyes of someone who has never met you before. Do you like to sleep in, have a bath in the evening, or go for a daily walk?

Use this section to describe regular daytime activities. Include activities you are involved in as well as your caregiver. Include anything that provides pleasure, comfort, or something you particularly don't like.

Morning (usual wake up time _____). How do you start your day?

Afternoon

Evening

Night (usual bedtime _____)

Date: _____

Enjoying each day

A person living with dementia is just like everyone else, a whole person with likes and dislikes, opinions, values and experience. Though some skills are lost as the disease progresses, many remain. Here are some activities that may bring you pleasure and will help you continue to live a full life while adding enjoyment to time spent with others.

Music

Do you like to listen to music? ☐ Yes ☐ No

If yes, what kind? (e.g. classical, jazz, folk, blues, or all kinds of music)

What effect does it have on you?

Do you play an instrument? ☐ Yes ☐ No

If yes, what kind of instrument do you play? (e.g. guitar, violin, clarinet)

Do you enjoy singing? ☐ Yes ☐ No

What effect does it have on you?

Reading

Do you like to read? ☐ Yes ☐ No

If yes, what do you like to read? (e.g. classics, science fiction, romance, adventure, fantasy, news, short stories)

Do you like to be read to? ☐ Yes ☐ No

Date: _____

Television

Do you like watching TV? ☐ Yes ☐ No

If yes, what are your favourite shows?

Games

Do you like to play games? ☐ Yes ☐ No

If yes, what kind of games do you like? (e.g. cards, crosswords, puzzles, Sudoku)

Sports

Are you interested in sports? ☐ Yes ☐ No

If yes, what sports do you like to play or follow? (e.g. golf, hockey, tennis, skating)

Hobbies

Do you have hobbies that you enjoy? ☐ Yes ☐ No

If yes, what kind of hobbies? (e.g. scrapbooking, crafts, photography)

Do you do household chores? (e.g. meal preparation, dusting, sweeping) ☐ Yes ☐ No

If yes, is there any household chore you particularly enjoy?

What other activities do you enjoy? (e.g. car rides, attending community programs, sitting by the window)

Date: _____

Help with daily living

How much help, if any, do you need with routine daily activities such as dressing, bathing or getting in and out of bed?

The chart on the next page lists typical routine daily activities. Feel free to change the chart to include activities that apply to you.

Where you are able to be completely independent, write "no help needed." When you need help, note how much help you need.

The "Useful tips" section is a good place for caregivers to note the degree of stress the activity creates and what special approaches might be helpful.

Here is a sample chart to guide you.

Activity	Useful tips	Is help needed?
Tub/shower Usual time: 8:00 a.m. Twice a week	• Prefer shower, don't like bath • Enjoy music or conversation during bath time • Give lots of time • Respect privacy • Be patient	• Need help in and out
Dressing	• Can button shirt, put on underwear and socks • Need to take dirty clothes away immediately • Can dress independently if clothes put on bed in right order • Offer help tying shoe laces	• May need help from time to time

Activity	Useful tips	Is help needed?
Tub/shower		
Dressing		
Dental care/dentures		
Eye care/glasses		
Hearing aid		
Hair care • Professional style/cut		
Makeup/shave		
In/out of chair		
In/out of bed		

Date: _____

Activity	Useful tips	Is help needed?
On stairs		
Use of toilet		
Use of appliances • e.g. kettle, stove, electric shaver		
Household tasks • e.g. sweeping, dusting, vacuuming, meal preparation, garden work		
Financial • Responsibility with money		
Walking • Habits, usual routes, ability to be independent		
Preparing for bed		

Date: _____

Meal time

An enjoyable breakfast:

Lunch:

Dinner:

Snacks:

Any particular likes or dislikes?

What assistance, if any, is required?

Cutting:

Use of cutlery:

Hot and cold liquids:

To learn more about how to make meal times more enjoyable, read the Alzheimer Society's information sheet on the topic, available at alzheimer.ca/mealtimes.

Date: _____

Regular weekly activities calendar

Use this calendar to show regular outings or appointments. You can use pencil so changes can be made every month, or a make a copy for each month.

Month:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Date: _____

Note: The questions in this section are designed to be answered by your primary caregiver. Your input will be valuable to give the best information possible.

Alzheimer's disease and other dementias progress over time. As the disease progresses, your abilities will change.

The information in this section will help anyone supporting you know what these changes are and how they affect your mood, behaviour and abilities. Your caregiver can suggest ways that help you feel content, engaged and secure. For example – is there a special approach that helps? Does your behaviour change only at certain times? Are there warning signs?

Below are examples of common situations.

The term "family member" is used to mean anyone with dementia whom you support.

Unsafe walking (e.g. "wandering")

Does your family member walk outside in ways that are unsafe? (e.g. will go out in winter wearing only a dressing gown) ☐ Yes ☐ No

If yes, what safety precautions do you use? (e.g. camouflaged doors, ID bracelet, regular walks with a neighbour)

Do they become upset when returned home? ☐ Yes ☐ No

If yes, is there a special approach to use to help them feel calm?

Night time restlessness

Does this occur? ☐ Yes ☐ No

If "yes," what safety precautions do you use? (e.g. nightlight, disconnecting stove or turning off water valves before retiring at night, locking closet door to prevent dressing at odd hours)

What helps to re-settle the person?

Date: _____

Restlessness

Does this occur at certain times of the day?

What helps to settle the person? (e.g. a walk or a distracting activity)

Anger or agitation

Does this occur at certain times? (e.g. bathing, meal time)

What usually triggers this? (e.g. rushing the person, too many instructions given at once)

When anger occurs, what responses tend to be helpful?

Does your family member suspect people of stealing from them? How do you deal with this?

Repetition

When they repeat themselves over and over, what responses are helpful?

Hiding or hoarding articles

Are there particular places to check where your family member "stores" specific things?

Date: _____

Does anything need to be kept out of reach? (e.g. knives, tools such as electronic drills)

Safety precautions

List any additional information that is important for other caregivers. (e.g. doors or cupboards to be kept locked, such as where toxic cleaning fluids are stored)

Are any other safety measures being used? (e.g. alarms, GPS locating devices)

Communication

If your family member has difficulty understanding and following instructions, what do you do? Is there anything that helps?

To learn more about Communication, please read the Alzheimer Society's information sheet on the topic, available at alzheimer.ca/communication.

Are there any other areas of concern and/or tips for care that comfort, reassure, support the person?

Date: _____

Alzheimer's disease follows a number of stages. While these stages can be somewhat predictable, the course of the disease will vary from person to person. Changes in physical condition, such as flu, pneumonia, infection or constipation can often result in changes in mood and behaviour. By noting changes, the person who supports you may be able to determine a pattern and prevent a situation from getting worse. It is particularly important to keep a record when medications are used. Recording these items in a journal will help caregivers when they are talking with your doctor. Caregivers should take this "All about me" booklet to your appointments.

Anyone providing care can use these pages to record all the events in a particular day.

Here is a sample journal.

Date	Comments
Mar. 30/12	To bed 8:30 p.m. -- up again 2:00 a.m. Wandered through house, could not settle down. Did not recognize me.
Mar. 31/12	Another night with no sleep!
Apr. 1/12	Still won't sleep. Now dozing all day. Doctor's appointment April 4/12.
Apr. 5/12	On new medication for an infection. Slept till 6:00 a.m. I'm trying to keep her awake during the day. I think things are getting better.

Photocopy this page to create your own journal.

Date	Comments

Journal

Date: _____

This page outlines things that have changed since I first filled out this booklet.

Date	Changes

Date: _____

This page outlines things that have changed since I first filled out this booklet.

Date	Changes

Date: _____

This page outlines things that have changed since I first filled out this booklet.

Date	Changes

Date: _____

This page outlines things that have changed since I first filled out this booklet.

Date	Changes

Date: _____

Alzheimer *Society*

Alzheimer Society of Canada
20 Eglinton Avenue West, 16th Floor, Toronto, Ontario, M4R 1K8
National office: 1-800-616-8816 Information and Referrals: 1-855-705-4636 (INFO)
Email: info@alzheimer.ca Website: alzheimer.ca
Facebook: facebook.com/AlzheimerCanada Twitter: twitter.com/AlzCanada

Charitable registration number: 11878 4925 RR0001

Alzheimer Society

AMBIGUOUS LOSS AND GRIEF IN DEMENTIA

A resource for individuals and families

"The word 'ambiguous' helped me understand what was going on. I'm still married to my wife. I love her, but I don't live with her. I've always been crazy about her and still am. She's looked after, but it is a huge loss for me. The ambiguity is exactly how I feel."

The Alzheimer Society is the leading nationwide health charity for people living with Alzheimer's disease and other dementias. Active in communities right across Canada, the Society:

- Offers information, support and education programs for people with dementia, their families and caregivers;
- Funds research to find a cure and improve the care of people with dementia;
- Promotes public education and awareness of Alzheimer's disease and other dementias to ensure people know where to turn for help;
- Influences policy and decision-making to address the needs of people with dementia and their caregivers.

For more information, contact your local Alzheimer Society or visit our website at www.alzheimer.ca

Help for Today. *Hope for Tomorrow…*®

Alzheimer *Society*

Ambiguous loss and grief in dementia: A resource for individuals and families

This resource is meant primarily to help you, as a caregiver, gain a better understanding of how loss and grief can affect you and the person with dementia. It also provides valuable information to help people with dementia deal with their own losses and grief, and live as well as possible with the disease. In addition, you will find useful strategies and tips to:

- Help you cope with multiple losses and grief
- Stay connected to the person with dementia
- Remain healthy and resilient through the progression of the disease

Loss and grief are among the most significant and challenging issues you will face as a caregiver when supporting a person with dementia. Dementia is a fatal, progressive and degenerative disease that destroys brain cells. Whether you are caring for your spouse, your parent or a friend with dementia, you may experience losses and grief in different ways at all stages in the dementia caregiving journey.

As a caregiver, you may grieve:

- The loss of your dreams and plans for the future
- The loss of a confidant and partner
- The loss of shared roles and responsibilities
- The progressive losses in the life of the person with dementia

The ambiguous loss that you may feel caring for a person with dementia can make the caregiving experience even harder. Fortunately, understanding loss and grief can help to ease the effects of the disease.

Acknowledgement: A sincere "thank you" goes to the caregivers and people with dementia whose lived experience is reflected in the stories and quotes used throughout this booklet. Please note that the names included in the stories have been changed.

Ambiguous loss & grief in dementia

What is ambiguous loss? Why is it important?

Ambiguous loss is a type of loss you feel when a person with dementia is physically here, but may not be mentally or emotionally present in the same way as before.

This is very different from the loss and grief of sudden death, as an example, where you clearly know that the person is gone. With a death, you are more likely to get support from family and friends, and may eventually find closure through traditional mourning rituals and the natural grieving process.

Ambiguous loss complicates grief. It may be hard for you to recognize this grief or know how to grieve when the abilities of the person with dementia have changed.

Grief can be frozen and it can put your life on hold. If you don't allow yourself to grieve or resume some of your regular activities, coping may be harder as the disease progresses.

Ambiguous loss also confuses relationships and can prevent moving on. For example, you may feel as if you are no longer in a marital relationship if your spouse no longer knows who you are. Yet your spouse, regardless of their abilities, is still a whole person who can be reached at all stages of the disease.

Recognizing these feelings and understanding the concept of ambiguous loss can help to ease the effects. With guidance and support, you can work through these feelings, begin to grieve the losses and stay connected to the person with dementia while also building your own strength and resilience.

Normalizing and acceptance

Whether you are caring for your spouse, your parent or a friend with dementia, the unique kinds of losses and grief you may feel are often not recognized, acknowledged or understood by the people around you. If your grief isn't acknowledged or understood by others, it only adds to your grief and you can feel more alone.

Naming your feelings and talking about them with healthcare providers, Alzheimer Society staff or other caregivers can help you understand your losses and grief, and see that this is a normal and valid response to a disease that changes the person over a period of time.

You may no longer feel so alone knowing someone is truly listening to and acknowledging your concerns. Talking with knowledgeable professionals, or peers in a support group going through a similar experience, gives you opportunities to learn strategies for coping and living with the losses.

Reaching out for support in these ways can also help both the caregiver and the person with dementia to grieve. Adjusting to loss and accepting the disease can help both of you move forward to make the changes needed to live as well as possible with dementia.

"My husband has been open about his disease all along, so everybody knows. Because he's open about it, I tell people too and that helps me. If you think about Alzheimer's like any other disease, there shouldn't be a stigma. I had breast cancer. He has Alzheimer's disease and we're dealing with it. He decided he could either accept it or get in a funk."

"Baring my soul in front of strangers felt right. It was absolutely incredible. All the other people in the support group were going through exactly the same emotions as I was. I could see the grief in their faces and it was just like me."

*André's story

Living with losses: sharing makes it easier for a person with dementia

André felt as if his world had ended when he was first diagnosed with dementia. "In one hour, you can go from being independent to feeling very dependent," he says. But his conversations with a supportive geriatric nurse helped André to see the future more positively.

"A diagnosis is not the end of things. I didn't like the idea of giving up and I decided that wasn't going to happen. There is life after dementia and I'm living as productive a life as possible. I enjoy gardening and taking the dog for long walks alone, which was a concern for my family," says André, who now carries a phone with a GPS tracker so he can continue one of his favourite activities independently and safely.

Joining an Alzheimer Society support group also helped André to cope with his feelings of loss and grief. "You have to adapt and accept the changes in your life, which is hard. Those group meetings helped me through some rough patches. We need one another for support. Sharing with other people makes it easier and we can build on each other's knowledge," he says.

It is normal to feel a sense of loss and grief when you are diagnosed with dementia. There is also ambiguity and uncertainty about how the disease will progress, whether slowly or quickly, and how it will affect your relationships with family and friends, your daily life and plans for the future.

Talking openly with family, friends, healthcare providers, Alzheimer Society staff or peers in a support group about your fears, feelings and concerns is a useful first step that can help to normalize the feelings people have about the disease.

**The names in this story have been changed*

Helping the person with dementia live with losses and grief

A person in the early stages of dementia will likely experience their own range of emotions, including grief over the diagnosis and the losses associated with their symptoms. The person may grieve the anticipated:

- Losses in memory
- Problems with thinking
- Changes in their ability to do things
- Loss of personal independence
- Changes in their relationships with others

In the early stages, encourage the person to talk openly about their fears and express their wishes about how they would like to live well with dementia. Planning for the future, while the person is still able to express their wishes and desires, gives the person with dementia some control over their life at a time when they might be feeling helpless.

Knowing the person's wishes will also help you later to make decisions on their behalf that reflect their values, beliefs and preferences. For more information about how to support the person with dementia in decision-making, refer to the Alzheimer Society's information sheet *Decision-Making: Respecting Individual Choice*, available at www.alzheimer.ca/brochures.

Strategies to help the person with dementia live with losses and grief

As the disease progresses, the person with dementia may not be able to understand or express the losses and grief they are experiencing but still may have a general feeling that something is wrong. Their grief may be expressed through feelings of being anxious or agitated.

You can support the person with dementia in dealing with these losses in many different ways:

Focus on what the person can do at each stage of the disease, rather than the abilities that have been lost.

Acknowledge their grief. Listen with empathy and offer comfort and reassurance without denying or discounting their expressed feelings.

Look for ways to make meaningful connections with the person each day. For tips on connecting with the person at every stage of the disease, see the Alzheimer Society's information sheet on *Communication*, available at www.alzheimer.ca/communication.

Share your intimate knowledge of the person with dementia – personality, needs, interests, likes, dislikes, favourite activities and life history – with any staff providing care so they are better able to support and connect with that person as a unique individual. The Alzheimer Society's *All About Me* booklet, available at www.alzheimer.ca/allaboutme, is a helpful resource for recording this information.

Ambiguous loss & grief in dementia

"I miss my best friend. My wife has always been my best friend. We used to be able to share our joys, our concerns, our hopes and our dreams with each other. We were great sounding boards for each other as we dealt with our jobs, our children and our lives. Now I have no one with whom to share my concerns – yes, I can talk to the children, and some of my friends, but it's not the same as talking something over with someone you know as intimately as your spouse."

Grieving the losses along the way

Grieving is a normal and healing response to loss.

The loss and grief you experience caring for a person with dementia is ongoing: not a one-time trauma, like the sudden death of a family member or friend. As changes occur, it can be helpful to identify and acknowledge the losses, and turn to your circle of support to talk about your grief in response to these events. Some changes that may lead to feelings of grief might include:

- Losses in memory and cognitive function
- Loss of a driver's license
- The loss of being able to travel together
- The need for outside help in the home
- The move to a long-term care home
- Palliative care, dying process and death
- Adjustment to the loss of the caregiving role

Healing happens when you allow yourself to feel the pain and grieve the losses along the way, rather than avoiding or denying your grief. You can then move on and adapt to these losses by making positive changes to enhance the quality of life for the person with dementia while taking care of your own needs too.

*Satya's story:

When Satya began attending a grief support group in her community, she didn't understand that her way of dealing with her mother's dementia was a grief reaction. "I kept thinking I could fix my mother and make her better. I was losing her and trying to find her. I experienced a lot of depression and didn't know why. I had no idea it was grief," she says.

Listening to others in the group, Satya realized she was grieving and came to accept that she could not bring her mother back. "I understood it all a little better. Physically she was my mother, but mentally she was gone. I learned you have to grieve each one of the losses, feel the loss and move on. I decided to let it go and just be with my mother," she says.

**The names in this story have been changed*

Grieving styles

Each person grieves losses in their own way. Some caregivers are more likely to experience and express their grief through feelings like:

- Sadness
- Hopelessness
- Loneliness
- Anger
- Guilt

If your style of grieving is "**feeling**" it may help to:

- Share your feelings with a supportive audience
- Join a peer support group

Other caregivers are more likely to experience and express grief through their thoughts and actions. If your style of grieving is "**doing**" it may help to:

- Get practical information
- Find solutions to problems
- Do things for yourself and the person with dementia

Many caregivers blend these "feeling" and "doing" grieving styles, and can benefit from any or all of these strategies for coping and adapting to losses.

"What grieving people need most is permission to grieve in their own style and their own time without being fixed or 'hurried' along. They need access to support and honest, accurate information about healthy grief so that they can seek help if they become stuck or overwhelmed."

*Kurt and *June's story:

Making changes and adapting to the losses

When Kurt was diagnosed with young onset Alzheimer's disease, he and his wife June talked about the changes they should be making in their lives. Although Kurt was still able to drive, they decided to sell their house and move to a condominium in the city before he had to give up his license. "Even though I do drive, I don't like to and I'm also aging. We moved before he started to decline and now live in an area where we can walk almost anywhere. It's been a godsend," she says.

June and Kurt fulfilled their retirement dream of travelling to Europe, even though it was a different kind of trip than she had envisioned. "Travelling wasn't easy. We would have split the responsibilities in the past. I had to take care of everything and keep track of him. But we did it," she says.

They still exercise together, go to social groups with old friends, and host a drop-in brunch every week for their children and grandchildren. "I keep as much of the old relationship alive as I can by doing some of the things we always did. The connection between us is changed, but I keep it going," says June.

She also recognizes the importance of balancing care for her husband and herself. "I try to keep a life for myself. I go curling one day a week in the winter. I sing in a choir and I go to lunch with friends," says June. "We have had some wonderful years since Kurt's been diagnosed and we're living our lives as fully with Alzheimer's as we can."

**The names in this story have been changed*

Reaching out to your circle of support

Seeking out support is one of the most positive and powerful ways of dealing with the feelings of ambiguous loss and grief that come with caring for your spouse, your parent or a friend with dementia. There are many ways to do this.

Many families are able to help and offer meaningful support to one another to cope with their losses and share their grief. Sometimes, however, they are going through their own grief and loss reactions and are not able to provide support to others.

Your circle of support may go beyond your biological family. It's important to reach out to individuals in your life who are your "psychological family," a term that means the people you naturally turn to in times of crisis and celebration.

Identify the people in your life who are there for you in good times and bad. These are the individuals who may be able to understand the losses and grief you are experiencing, acknowledge your remarkable efforts and successes, and give vital support.

Your psychological family can be a diverse group. It might include:

- Friends
- Neighbours
- Co-workers
- Faith leaders
- Family members who "get it"
- Staff at an adult day program, long-term care home or your local Alzheimer Society
- A geriatrician, family doctor or other healthcare provider

Joining a peer support group gives you a unique opportunity to talk about feelings of ambiguous loss and grief, and share lessons learned with people going through many of the same experiences as you.

Getting one-on-one counselling and support from Alzheimer Society staff or healthcare providers can also help you understand and grieve the losses, and learn how to ease their effects.

"My husband and I go regularly to a young onset support group. The huge benefit is you make connections with other people like you. We've made friends in the group and we get together with them socially. That's the best support."

Try thinking about your losses differently

With ambiguous loss, it is common to have what may seem like contradictory thoughts about the losses you are experiencing. This can be stressful because these thoughts often stir up mixed feelings and highlight the many uncertainties that surround dementia. Fortunately, to help cope with ambiguous loss, you can learn how to handle thoughts about loss that seem contradictory.

Try this tip

Recognize that what may at first seem like contradictory thoughts about loss are not necessarily contradictory. Do this by shifting the way you think about ambiguous loss.

Instead of believing that your thoughts about loss are either correct or incorrect, accept that many differing thoughts can occur at the same time and still accurately reflect the losses you are feeling. This shift in thinking can help you continue to connect to the person with dementia in a meaningful way.

To make this mindshift, practice changing how you view the losses you are experiencing by replacing "either/or" thoughts with "both/and" thoughts (this is sometimes referred to as "paradoxical thinking"). For example:

Instead of "either/or"…	Try "both/and"…
I can either take care of the person with dementia or myself.	I can take care of both myself and the person with dementia.
I am either the person with dementia's daughter or their caregiver.	I am both the person with dementia's daughter and their caregiver.
I either love the person with dementia exactly as they are now or I miss how they used to be.	I both love the person with dementia exactly as they are now and miss how they used to be.

Check out this tip in action

Here's how a daughter taking care of her mom started to look at ambiguous loss differently:

"Something is lost, but something is not lost. So I started to look for things that were still part of my mom. She still has a sense of humour and I can still share a laugh with her. She still has an emotional part of her, so I zero in on the emotion of the event because it's on a level where she gets it."

Next steps

Work with Alzheimer Society staff, healthcare providers or others in your support network to practice this shift in thinking.

Building resilience and planning for the future

Resilience is the remarkable quality that helps an individual to adapt positively to challenges and changes in life, and the losses and grief experienced in caring for a person with dementia.

There are many things you can do to boost your resilience:

- Reach out for support and work with your doctor to treat conditions such as depression.
- Stay physically active and eat a healthy diet.
- Remain mentally active and socially involved.
- Try stress management and relaxation activities like yoga, meditation or Tai Chi.
- Take regular breaks from caregiving responsibilities.
- Listen to positive feedback on your personal strengths from supportive friends and family, healthcare providers, Alzheimer Society staff or peers in a support group.
- Find ways to stay connected to the person with dementia as they are today.
- Maintain and nurture meaningful relationships with friends and family, and make new friends too.
- Though it is difficult, it is also important to be realistic about how the disease will affect the person over time. You need to plan for a life on your own after the person with dementia is gone.

"I knew this was happening and I knew it wasn't going to change. You have to figure out what you need and what gets you through things. I'll go to the market and have tea with a friend.

Other people have lost friends through this process. I know how much I will need friends later."

Strategies for living positively with ambiguous loss and grief

There are many steps you can take to live positively with your losses and grief while caring for someone with dementia:

- ☑ **Reflect** on the losses that occur in the life of the person with dementia and your own life too. Acknowledge, express and share the grief you feel in response to those losses with a person or people whom you know will understand and be supportive.
- ☑ **Normalize** and begin to accept your feelings of ambiguous loss and grief by talking to other caregivers who feel the same emotions and go through a similar experience, as well as Alzheimer Society staff who support people with dementia and their caregivers.
- ☑ **Stay connected** to family and friends. Strengthen existing relationships, and be open to building new relationships with others who can be supportive and enhance your life amid the loss and grief.
- ☑ **Look after your own needs.** Stay physically active, eat as well as possible, and do what you need to relieve stress. Take breaks from care. These things will boost your health and morale, and help you to make better decisions and be more effective as a caregiver.
- ☑ **Let your family and friends know how they can help**, rather than assuming people know what you need.
- ☑ **Seek out information about dementia** and what to expect. Talk to others who are caregivers at different stages of the journey. This knowledge gives you more ideas and information about how best to cope with the disease and plan for the future.
- ☑ **Seek out support** from family and friends, professional organizations such as the Alzheimer Society, a professional counsellor, and/or participate in support groups.
- ☑ **Share** your own experience and contribute by helping others in a similar situation.
- ☑ **Get involved and volunteer** with your local Alzheimer Society. Learn how to advocate for your own needs and the needs of your family member or friend with the disease.
- ☑ **Express grief in creative ways** through writing, painting, photography or other art forms.
- ☑ **Recognize and value your growth as a person**, which resulted from caring for a family member with dementia. You may have learned new skills, such as handling finances, become more compassionate, or developed an inner strength and resilience you didn't realize you had.

"My way of dealing with the disease is looking at the cup half full rather than half empty. I look at what my mother can do, instead of what she can't do. I focus on the skills she still has and accept whatever she is able to do."

Resources

1. Alzheimer Society of Canada, *Grieving*. Available at www.alzheimer.ca/grief
2. Alzheimer Society, *Ambiguous Loss and Grief: A resource for healthcare providers.* Available at www.alzheimer.ca/brochures
3. Boss, Pauline, *Ambiguous Loss: Learning to live with unresolved grief.* Harvard University Press, 2000. Book.
4. Boss, Pauline, *Loving Someone Who Has Dementia: How to find hope while coping with stress and grief.* John Wiley & Sons, 2011. Book.
5. Boss, Pauline, *The Ambiguous Loss of Dementia: Finding meaning and hope.* 2009. DVD.
6. Murray Alzheimer Research and Education Program, *Living and Transforming with Loss & Grief: An inspirational guide for persons with early-stage memory loss and their partners in care.* A By Us For Us Guide. Available at www.the-ria.ca/by-us-for-us-guides
7. Horst, Glen. *Grief in times of celebration: The empty spot.* 2017. Available at www.virtualhospice.ca/griefintimesofcelebration
8. Vancouver Island Health Authority, *Grief, Loss and Dementia: Caregivers share their journeys.* DVD, 2011 and supporting documents CD (Workbook for Dementia Caregivers, A Quick Guide for Family Caregivers, and A Quick Guide for Professional Caregivers).
9. www.mygrief.ca - a website developed by grief experts designed to help users understand and work through their grief.

Where can I get further information?

Please refer to the following resources available from your local Alzheimer Society and also at www.alzheimer.ca.

Progression series:

Overview
Early stage
Middle stage
Late stage
End of life

Day-to-day series:

Communication
Personal care
Meal times
Moving to long-term care series

Conversations About:

Decision-making
Living alone
Intimacy and sexuality
Driving

Other helpful resources:

All about me
All about me: A conversation starter

Note: This publication provides guidance but is not intended to replace the advice of a healthcare professional. Consult your healthcare provider about changes in the person's condition, or if you have questions or concerns.

Alzheimer *Society*

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LIVING WITH ALZHEIMER'S DISEASE

balancing act

Alzheimer's disease is a degenerative, progressive type of dementia that causes problems with memory, thinking and behaviour. Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks.

Discovering a loved one has Alzheimer's disease can be devastating. We explore what it's like caring for someone with Alzheimer's by walking a mile in Trish T.'s shoes. Trish's mom was diagnosed five years ago and she has learned a lot since—about the system, the challenges of being a "sandwicher" and how to celebrate the little things.

Tell me about your mom. How old was she when she was diagnosed?
My mom was social. She kept a meticulous home and there was always something cooking in the oven in case of visitors — she was social and had an open door policy. She was diagnosed with Alzheimer's-related dementia five years ago at the age of 70.

Looking back, what were the signs and symptoms of Alzheimer's your mom experienced?
Before her Alzheimer's diagnosis, my mom experienced dramatic hearing loss so in hindsight, there were many signs but they went unnoticed because we thought they were due to this. She became less vocal and didn't contribute to conversations much. Also, her kitchen cupboards suddenly became incredibly packed and unorganized. Normally, her cupboards we highly organized and anything less than that would cause her anxiety, but she seemed unaffected. And then there was *the* incident the made us realize something was terribly wrong; she went to go to a doctor's appointment ended up 40 kilometers away after boarding the wrong train. We got a call from the police who told us that staff at the train station found my mother wandering, disoriented and confused. At this point, we knew it had nothing to do with her hearing loss.

What are the challenges of caring for someone with Alzheimer's?
At first we thought, "How are we going to deal with this? What should we expect?" Ultimately, we made the decision that it was best to keep her at home and do anything we could to accommodate her there. Some of the biggest challenges were removed when we made my parents' home accessible. Before this it was hard, for example, to guide her into the tub because she couldn't hear or follow instructions. She is no longer as mobile as she was and so there is no risk of her wandering. Personally, my biggest challenge is juggling two homes ("sandwich generation"). I'm constantly coordinating care for my parents and taking care of my own family – especially my 13-year old son who demands a great deal of my time.

Tell me about some of the tasks you do to help on a regular basis?
My 84-year old father cares for my mom at home and has committed to doing so as long as he can. I'm currently the main contact and family "coordinator" for all her care including her visits to her day program, visits by her home care providers (for personal care, help with feeding and caregiver relief). I am constantly trying to find ways to make life easier for my father to care for her in their home.

What are some tips you can provide some who has just learned a parent has Alzheimer's?
The best advice I was given, is to contact the local Regional Geriatric Program as soon as a loved one is diagnosed. Nothing compares to dealing with geriatric professionals who really "get" this disease. Prior to this, we felt lost in the system. Also, contact your local community care

network–they are a wealth of information and the best navigators through the system.

What's your biggest concern about caring for your mom?
I worry that the time will come when we can't care for her at home. And, of course, ultimately, my concern is for my dad. He is 84 years old and, thankfully, is in great shape. However, I do worry about caregiver burnout. I fear my dad will get exhausted caring for her so it's important to me that he gets enough time to rest and get away from the stresses of caring for someone with Alzheimer's. This is why I advocate for him to get caregiver relief – this gives him the chance to get out and meet with friends, go for walks and also volunteer his time at church.

How do you stay positive?
It can be difficult — there isn't really a bright side to Alzheimer's. But with the modifications to my mom's home and home care in place, I'm relieved knowing that my mom will be able to stay at home for awhile to come and there's some comfort in that.

Top Signs of Alzheimer's

Forgetting entire events, not just details. It's not uncommon to forget or confuse smaller details of an event, but if the person doesn't remember ever meeting a friend for coffee or making the doctor's appointment in the first place, a flag should go up.

Putting objects in odd spots. If you're mystified as to why the keys are in the toaster oven or why the remote is in the fridge, you're right to be concerned.

Trouble with simple directions or problems. Being unable to follow a recipe is a classic sign of Alzheimer's as is trouble balancing a cheque book.

Forgetting common names of people and objects as well as everyday routines. A father forgetting his daughter's name or replacing the word "friend" with an unrelated word like "shoe" are common signs of trouble. Getting lost going to a familiar place like the grocery store or the doctor's office is also an indicator.

Personality, behaviour and mood changes. Someone with Alzheimer's may experience emotional mood swings—laughing one minute and weeping the next. Withdrawing socially—cancelling appointments or remaining silent during family conversations— is another important warning sign to look out for.

Hearing loss. Recent studies show a link between moderate to serious hearing loss and Alzheimer's. In fact, for every 10 decibels of hearing ability lost, the risk for Alzheimer's increased by 20 per cent. There are a number of theories about why this is, but it's definitely something to watch for and a challenge that can delay diagnosis.

Remember, every person is unique and so is each individual's experience with Alzheimer's. But there are some common threads in most cases. If any of these signs seem familiar, seek help from a doctor immediately for a diagnosis.

Alzheimer's Alert

One in 11 Canadians over 65 has Alzheimer's or a related dementia.

Women account for 72% of all Alzheimer's cases.

Alzheimer's cases are expected to more than double by 2036.

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Ways That Work: *Bathing* Without a Battle

By Joanne Rader, MN, RN, FAAN, and Ann Louise Barrick, PhD

Bath time is often extremely distressing to persons with dementia. This distress often results in the person feeling attacked and responding defensively with verbal and physical resistance. This article describes approaches and methods used in a study to increase the comfort of both the caregiver and care recipient during bathing.

Key words: *activities of daily living care, aggression, bathing, combativeness, dementia, problem behaviors, resistance to care*

Every day in health care settings across the United States and Canada, thousands of people with dementia are being bathed against their will. Their polite refusals of the offer to bathe are ignored, and they are removed without permission from their beds and wheelchairs and taken to an often cold, impersonal, frightening shower or tub room to be scrubbed down. As a result, the refusals escalate to verbal and physical resistance and finally to combativeness. Behavioral symptoms associated with bathing include screaming, crying, swearing, hitting, biting, pinching, and grabbing.

Although research clearly indicates that bathing can be extremely stressful to both the caregiver and the care recipient,[1–5] the standard of care in most nursing homes is that most, if not all, persons receive a shower or bath at least once or twice per week. Control of infection, skin breakdown, odor, and appearance are the main reasons for bathing persons. In addition, family members, supervisors, and sometimes external regulatory agencies seem to think that cleanliness can be accomplished only with showering or bathing. These tasks are scheduled routinely regardless of the discomfort experienced by all involved. Thus, the task becomes the focus.

It does not have to be this way. In the past, these behaviors have been viewed mainly from the perspective of the caregiver, and the person with dementia is labeled as aggressive. This article explores care recipients' behavior from their perspective and offers suggestions for creating a more pleasurable experience for them and the caregivers through individualizing care. To create a better bathing experience, caregivers are required to use a thoughtful process. This process involves no longer viewing behaviors as "problems" to be controlled but as "symptoms" of unmet or unidentified needs[6] or need-driven, dementia-compromised behaviors,[7] a form of communication,[7] or a characteristic of the person.[8] This way of thinking makes possible a more positive and hopeful approach to caring for persons with dementia and leads caregivers to more useful solutions.

The approaches and methods described in this article are designed to help make the bath and shower a more pleasant experience for persons being bathed by others. These interventions were used in a series of studies[3–5] designed to reduce behaviors related to bathing in persons

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with dementia who were labeled as aggressive or agitated. In a study just completed, "Clinical Trial of Two Bathing Interventions in Dementia," two methods of bathing, the shower and an in-bed towel bath method, were used along with other more pleasurable, comfortable ways to maintain cleanliness for persons with dementia who resist bathing. This article is based on the clinical observations of the interventionists and direct caregivers (certified nursing assistants) who participated in the study.

The approach to bathing described is based also on the emerging philosophy of dementia care in which the relationship between the caregiver and care recipient is the central determinant of quality of life and quality of care.[6,8–12] The importance of this relationship is a central tenet of the work presented in this article. A basic principle is that it is the caregiver's responsibility to make bathing as pleasurable as possible for the person with dementia. When asked to remember a particularly pleasurable bath or shower and give descriptors, caregivers list words such as relaxing, invigorating, warm, private, and soothing. Rarely is washing or getting clean mentioned. Often a major reason people choose to bathe or shower is because they find it pleasurable; if it were not, they would find other means of getting clean or defer. For example, if the shower were cold and uncomfortable, it is doubtful that people would routinely use this method of keeping clean. When asked about the experience with bathing persons in a care setting, caregivers note that it is usually an unpleasant, uncomfortable event.

Another principle considered important in bathing is that a person should not be bathed against his or her will unless there is a compelling health reason. What constitutes a compelling health reason? Caregivers identify few. Perhaps if the person has had a serious bout of diarrhea, is soiled from head to foot, and there is fear of infection and contamination, the expedient thing to do is give a quick shower. However, even then, less invasive means should be tried first. When a person is forced to bathe after verbal refusals and requests to stop, the person may perceive the continuation to be a physical or perhaps sexual assault. How else could persons with dementia interpret the lack of response to their requests and to their verbal and physical resistance? From their perspective, "combativeness" is actually a self-protective response to a real physical threat.[13]

To be bathed against one's will is a major affront and violation of a trusting relationship. When a caregiver is put in the position of having to bathe someone against his or her will, it does great damage to the caregiving relationship and destroys the trust that takes time and energy to develop. Trust is a real commodity in the caregiving relationship. If trust is destroyed over an unnecessary bath or shower, it is a loss for all. Sensitive caregivers describe the high emotional cost of bathing people against their will as heartbreaking. When caregivers are forced to do this, they often "harden their hearts." They turn the experience into merely a task to be done, because it is too painful to continually do something that they know is perceived as assaultive, particularly when no compelling reason for it exists.

FRAMEWORK FOR BATHING PERSONS WITH DEMENTIA

Being nice is not enough! A caregiver needs to know how to strengthen the relationship with the person being bathed and individualize care. Rader[6] suggested that caregivers take on a series of roles: magician, detective, carpenter, and jester. These roles are used to identify the person's unmet needs, choose interventions, and evaluate the response to the interventions (see Figure 1).

Magician role

The magician's job is to step into the other person's shoes and change the ways that problem behaviors are viewed and labeled. The magician views behaviors as a form of communication related to an unidentified or unmet need or as a characteristic. Fazio et al[8] suggested that reframing behavior in dementia provides families and other caregivers with a way of looking at the situation that leads to more positive and creative approaches. For example, instead of seeing agitation as a behavioral problem, it is reframed as a characteristic of energy.

To understand what the person is trying to communicate verbally and nonverbally, the magician must try to view the world through the eyes, ears, and feelings of that person. For example, during in-service training for caregivers, when it is suggested that they might want to arrange to be bathed by another in a care setting as a way to learn what the experience is like for persons with dementia, the response is almost universally resistance and refusal. The caregivers make statements such as they can bathe themselves or that it would be too embarrassing, cold, and uncomfortable—exactly the type of response often elicited from persons with dementia. When it is pointed out that "normal" behaviors are only labeled negatively as resistive and noncompliant when they belong to someone else, caregivers begin to get the point of the magician's work. The magician's work is to figure out what made bathing unpleasant in the past and how to make it more pleasant in the future, viewing the

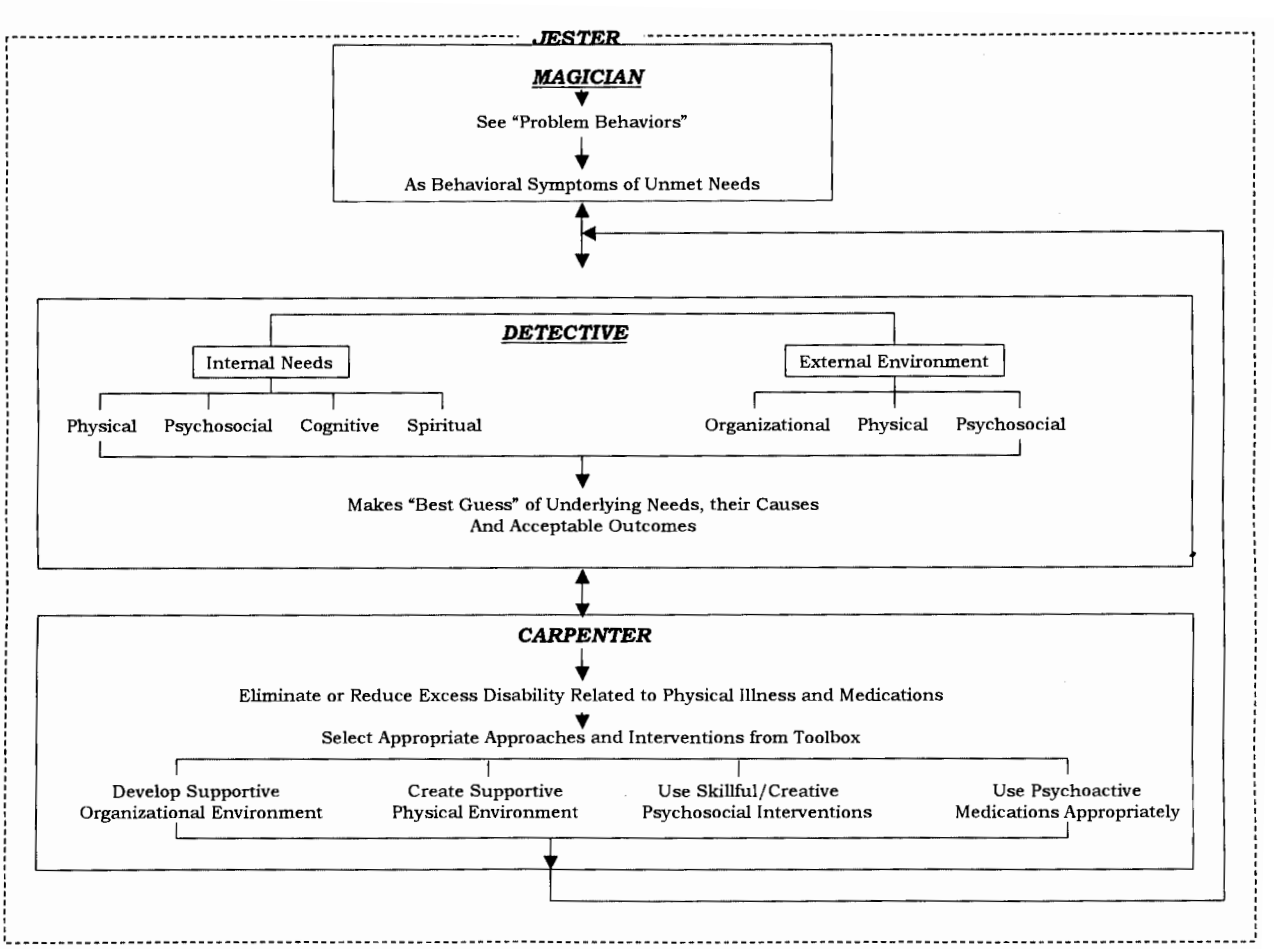

Figure 1. Framework for interventions.

Source: Reprinted with permission from Rader J. Individualized Dementia Care: Creative Compassionate Approaches. New York: Springer Publishing Company, ©1995.

experience through the mind and body of the person with dementia.

The magician's job is to step into the other person's shoes and change the ways that problem behaviors are viewed and labeled.

Detective role

Detective work is important groundwork to developing successful interventions and creating improved bathing experiences. In the past, caregivers often tried to "fix" something before they knew what was "broken." For example, a person who was yelling or resisting care was given antipsychotic medication before the reason for the behavior was identified. If the behavior is caused by pain, antipsychotic medication will not help. By carefully observing the individual and the environment, the detective can uncover cues and clues about what can be altered to improve the bathing situation.

To understand what the care recipient is trying to communicate, caregivers need to learn as much as possible about the person. The caregiver needs to know the person's physical and mental abilities and habits related to bathing, including favorite time of day, preferred method, and special tips. If the person is unable to communicate, family members and other caregivers are good sources of information. It is also helpful to know past accomplishments, topics of interest, and favorite people, songs, and foods. This search puts the caregiver in the role of the detective.

As the detective, the caregiver uncovers clues to identify factors in the internal and external environment that might be affecting the person's behaviors (see Table 1).

The internal environment

The *internal environment* refers to what is going on inside the person. A good detective uses a variety of techniques and a number of sources to identify underlying needs and strengths. First, it is important to look for sources of excess disability such as untreated or unidentified pain or chronic or acute illnesses, medication side effects, or reactions inside the individual. For example, does this person have untreated pain? In addition, it is important to identify the person's strengths and needs. For example, one woman in the study consistently refused assistance with washing, and attempts to bathe her routinely resulted in physical and verbal resistance to care. Then one direct caregiver shared that the woman loved to sing "Jesus Loves Me." When the direct caregiver started singing this song with the woman during bathing, it was possible to get her clean without a battle. Using this identified source of need and strength, the person was able to tolerate being assisted with bathing.

The detective also seeks information about the person's past to understand current behaviors. For example, one person in the study had been a prison guard. He transported prisoners and was responsible for their safety. When he was taken to the shower by two male nursing assistants, he struck out at them and responded as though he were being attacked, perhaps thinking he was at the prison. Using female assistants and reassuring him that he was just going for a shower helped calm him down.

A good detective uses a variety of techniques and a number of sources to identify underlying needs and strengths.

The detective looks at how and when the behavior occurs to understand the needs being expressed. What triggers the behavior? When does it occur? What helps? What seems to make it worse? Can the person say that a touch hurts, or does he yell when the caregiver starts to wash between his toes? What is the person doing to show that he or she is uncomfortable? Does this behavior differ from the person's usual response to situations?

As part of assessing the internal environment, the detective looks at both verbal and nonverbal behaviors to understand the message being communicated by the person being bathed. Verbal messages are expressed by such words as "No!" or through vocalizations such as mutterings. Nonverbal messages include facial expressions and body movements. In the study being reported here, persons being bathed communicated problems such as pain, fear or anxiety, cold, and the need for control. These problems were expressed by persons with dementia in many ways (see Table 2). Behaviors such as yelling can result from all of the above common problems. Caregivers are required to sort out the particular problem or underlying need that the person they are bathing is trying to communicate.

Table 1

External Environment		
Organizational	**Physical**	**Psychosocial**
Philosophy	Personalization	Communication skills
Policies and procedures	Noise level	Staff attitude
Staffing patterns	Lighting	Nurturing healthy relationships
Structure of day	Floor covering	Approaches
Staff support and education	Furniture	Activities
Equipment and supplies	Seating and mobility devices	Home-like atmosphere
	Activity or stimulation level	Family support and education
	Space for privacy	Counseling and consultation services
	Safety and security	
	Room temperature	

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The external environment

The first cue is the behavior of the care recipient. However, it is also important to look at the context in which the behavior occurs, the *external environment*, to

Table 2

Verbal and Nonverbal Expression of Needs

Problem: pain Underlying need: comfort, pain relief	Problem: feeling lack of control Underlying need: to feel sense of control	Problem: anxiety/fear Underlying need: to feel secure, safe	Problem: cold Underlying need: to be warm
Verbal/vocal	*Verbal/vocal*	*Verbal/vocal*	*Verbal/vocal*
Says: "That hurts"	Says: "No!"	Screams and yells	Says: "I'm cold"
Asks to "Stop"	Threatens, curses, and insults	Calls for help from others; a spouse, friend, the police, 911	Says: "I'm hot!"
Repeatedly asks for help	Makes demands	Calls out in pain before being touched	Yells and screams
Complains	Screams and yells	"You're going to kill me"	
Moans and groans	Says "Why are you doing this to me?"		
Screams and yells			
Mutters in a distressed tone			
Swears			
Usual noise he or she makes intensifies in volume and in pitch			
Nonverbal	*Nonverbal*	*Nonverbal*	*Nonverbal*
Winces	Pulls away	Rigidity	Shivers
Cries	Hits, bites, and grabs	Grabs	Tries to cover self
Grimaces	Scowls	Worried/fearful expression	Cold hands and feet
Flinches	Spits and snatches	Clenches fist	Trembling lips
Rubs area	Refuses to enter bathroom	Wrings hands	Cries
Guards area	Points finger at caregiver	Jittery	
Fidgets, repositions self	Attempts to leave	Shivers	
Generalized tension		Withdraws from caregiver touch	
Pulls away or other avoidance behaviors			
Extreme facial expression			
Restlessness			
Rocks			
Rigidity			
Clenches fist			
Slow movements			
Noisy breathing			
Hits			
Bites			

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better understand the need. Stressors in the external environment may be organizational, physical, or psychosocial (Table 1). Each of these aspects must be assessed to determine its effect on the bathing experience.

Organizational Environment

In the organizational environment, if the administration of a care facility has rigid policies and practices related to acceptable frequency and types of bathing, these will hamper the direct caregivers' ability to provide individualized care. For example, Patti is a 68-year-old woman with mild dementia. She refuses to shower and is able to state that she "doesn't like a shower." She cannot elaborate on her reasons but she is adamant in her refusal. The nursing home where she resides requires two showers a week. She must be forced to shower, resulting in self-protective behaviors such as hitting and kicking. Sometimes it takes four staff members to shower her. When an in-bed towel bath was tried, she responded favorably to this method. She called it her "steam bath," smiled, and was cooperative. However, the bed bath technique, considered radical by the staff, was not judged to meet the criteria for the weekly "baths," so she was forced into the shower again.

Humor is often overlooked as a source of support for persons with dementia and their caregivers.

Physical Environment

In the physical environment, there are numerous areas to explore (see Table 1). The temperature of the bathing room, the design and comfort of the shower chair, lighting, noise, and sense of privacy all affect the person's experience of bathing. By modifications to the physical environment such as warming the room prior to bringing in the person, padding the shower chair, and playing music the person enjoys, it is often possible to turn an unpleasant shower into a pleasant one.

Psychosocial Factors

What psychosocial factors in the external environment may contribute to the distress of the person being bathed? Does the caregiver ignore complaints of pain or cold or dismiss the person's concerns? How many caregivers are washing the person? Could this be overwhelming? Are the caregivers talking to each other or are they focusing on the person being bathed? When the caregiver becomes aware of the effect of his or her behaviors, attends to complaints, and apologizes for causing pain, distressed behaviors decrease. This is an example of how the caregiver assesses and modifies the psychosocial environment.

Finally, it is part of the detective's job to evaluate whether the correct underlying cause has been identified and whether the interventions selected are effective. This assessment involves collection of data on the frequency of behavioral symptoms, the potential need being addressed, and the effectiveness of the interventions tried. For example, if the behavioral symptom is striking at staff members and refusing to allow caregivers to use the water spray during the shower, the caregiver should document this behavior before intervening. The cause of this behavior may be fear of the water spray. Interventions that could be tried include using a no-rinse soap product to eliminate the need for rinsing or warning the person before using the spray. After initiating use of the no-rinse soap product, data should be collected on the frequency of the hitting behavior during two baths. If the behavior does not improve, more detective work is needed.

Carpenter role

After completing the initial detective work, the caregiver takes on the role of the carpenter. The carpenter's job is to select appropriate tools (ie, approaches and interventions) to build an individualized plan of care to keep the person clean. The caregiver often has to make a "best guess" about what the person's underlying needs are and what the behaviors are communicating because the causes may be complex. For example, behavior such as yelling may have many causes and will respond to different interventions depending on the cause. A common complaint by persons being bathed is being too cold. Showering is usually done with the person completely uncovered, beginning at the person's head and working down. In the study reported here, the caregivers were able to reduce the complaints of being cold by washing hair last and by placing towels over the person's shoulders and lap. These towels were lifted to wash the person.

After a good assessment, the caregiver is in a position to select interventions based on knowledge about who the person is, his or her preferences, possible sources of pain, and other factors. A good carpenter has a wide variety of tools to use to create an individualized plan to keep people

Table 3

Interventions for Reducing Pain during Bathing	
Action	**Explanation**
Assess need for bath. If a person is refusing the bath and there is no compelling reason to bathe, delay until a better time.	When a person is forced to bathe, it can be perceived as a threat and cause increased pain because of muscle tension.
Treat pain medically prior to the bath.	Take preventive measures.
Watch for nonverbal behaviors indicating pain.	These behaviors provide information about the discomfort of the person so that certain procedures can be avoided in the future.
Apologize at any sign of pain. Take action to correct the problem.	Validates the person. Gives information about procedures that need to be avoided.
Wash the most sensitve area last (eg, face, hair, feet).	Avoids upsetting the person.
If skin is tender:	
Wash gently using a soft touch.	Less friction reduces discomfort.
Use baby washcloths.	They are softer than most washcloths.
Pat dry instead of rub.	Avoids friction, gentler on tender skin.
Touch gently before beginning to wash.	Helps the person adjust to touch.
Tell what you are going to do before doing it.	Gives person a warning so will be prepared; avoids surprises.
Start with the least sensitive area.	Causes less distress.
Ask for feedback: "Does this feel OK?"	Lets the person know you care.
Use (warmed) wipes on rectum.	These are softer than most washcloths.
If feet are sensitive:	
Soak feet in a basin while sitting in shower chair.	Feels good and loosens dirt.
Place moist cotton balls on toes to soak prior to washing.	Helps soften dirt and dry skin for easier and less painful cleaning.
Use gloved fingers instead of a washcloth to wash feet.	Can feel more like a massage and it is easier to get to hard-to-reach places.
Place feet on a dry towel and cover with another small towel and pat dry. Wash and dry between the toes with something thin and soft (eg, dry washcloth, baby washcloth, cotton swab).	Less friction and joint pain. Allows for more gentle action than a washcloth in hard-to-reach places.
If person feels pain on movement:	
Get physical therapy consult to determine best method of transfer.	Transfers are complex and need to be individualized for the safety and comfort of both the staff and residents.
Use two to transfer.	Can move the person more gently and give needed support; reduces discomfort.
Count with the person before moving.	Helps the person prepare for move and give assistance rather than resistance; replaces fear, avoids surprises, and distracts.
Have person hold bed rail and assist with turning.	Gives the person a sense of control and makes the move easier because person can assist.
Reassure	Helps the person to feel more secure.
Distract with conversation or food.	Helps the person relax and may add something pleasant to the experience; makes it an event rather than an unpleasant task.
Use soothing tone.	Helps to relax.
Ask what will help and wait for a response if the person can talk.	Can learn what person prefers, helps feel connected to caregiver.
Move slowly.	Gives the person time to adjust, promotes a feeling of security.
When rolling over, roll the person onto the side that causes least discomfort.	Reduces discomfort.

clean. Table 3 illustrates interventions to modify the internal and external environment that can be tried when the person complains of pain. Another type of intervention is using distracters, particularly when a brief but uncomfortable procedure needs to be done. Distracters include food, conversation, and objects (see Table 4). For example, in this study, just before washing someone's sensitive rectal area, he or she would be given a favorite piece of candy to eat.

Table 4

Sample Distracters			
Food	Conversation	Objects to hold	Others
Cookies Gum Crackers Lollipop Bananas Peppermints Chocolate Coffee Tea Twinkies	About family About food About pets About past interests About past work How attractive they are Ask questions Ask opinions Give praise	A towel A wash cloth A stuffed animal Your hand A small figurine A sponge A ball A mirror A doll	Music A balloon to look at A plant to look at A mobile

The interventions selected should address internal needs and create a supportive external environment. In general, psychotropic medications should be used to modify behavior only after other interventions have been explored. The caregiver also needs to continually assess and reassess the person's response to the interventions tried and identify changing needs as the detective and carpenter roles work together.

Jester role

Humor is often overlooked as a source of support for persons with dementia and their caregivers. Those who love this work and do it well employ good doses of humor as part of the care of others as well as for self-care. One woman in the study liked to make faces and mimic the caregiver on her more energetic days. When the caregiver responded by also making funny faces, both laughed and it made the bath fun. Some weeks, the woman was quieter and then the caregiver modified her approach to be calm and reserved, and this also went well. The jester lightens the load, enhances creativity, energizes, releases tension, and promotes relationships for all. The goal is to infuse humor into all steps of assessment, care planning, and implementation.

EXPLORING THE THREE Fs OF BATHING

Even after the information gathered in the assessment process is used to intervene appropriately, the person may continue to find bathing unpleasant, still complain, or refuse or fight bathing. It is now time to explore the 3 Fs of bathing: function, form, and frequency. This is a way to assess the benefits and burdens of bathing from the perspective of the person being bathed.

Function

There are three major reasons for bathing: health reasons, social reasons, and pleasure. Health reasons are related to skin condition and infection control. Social reasons are related to how the person looks or smells. Pleasure refers to the fact that many people bathe for the enjoyment of it. If a person is resisting bathing, the caregiver first asks what must be done immediately to prevent serious health problems. If the answer is nothing and the plan is to bathe the person because it is the scheduled time or a time that fits the caregiver's schedule, the best thing to do is to come back at another time when it may be more agreeable to the person. If, however, something has to be done, for example the person has just had a bowel movement, the caregiver needs to look at the many forms that washing can take.

Form

Ask the question, "What is the easiest, most comfortable, least frightening way for me to clean the person right now?" Most caregivers tend to think of bathing as taking place in the bath or shower, but in fact, there are many ways to maintain cleanliness. Home health aides report having given satisfactory baths in a recliner chair. The whole body can be washed easily and completely in bed or at the sink in a chair or wheelchair. In-bed bathing can be done with a basin of water and washcloths. A variation of this method is to place a number of washcloths in a plastic bag and add a small amount of warm water and no-rinse soap. This way the caregiver can wash a person who is "on the move," wandering or pacing. The plastic bag will keep the cloths warm for quite a while if the bag is kept shut. If the washcloths are squeezed so they are damp but not dripping, it is often not necessary to dry the person. This method works well for

The Towel Bath: A Gentle Bed Bath Method

Equipment

- Two or more bath blankets
- One large plastic bag containing:
  - One large (5'6" x 3') lightweight towel (fan folded)
  - One standard bath towel
  - Two or more washcloths
- Two- to 3-quart plastic pitcher filled with water (approximately 105–110° Fahrenheit), to which you have added 1–1½ ounces of no-rinse soap, oil-based, (such as Septa-Soft, manufactured by Calgon-Vestal; use manufacturer's instructions for dilution).

Preparing the person

Explain the bath. Make the room quiet or play soft music. Dim the lights if this calms the person. Ensure privacy. Wash hands. If necessary, work one bath blanket under the resident, to protect the linen and provide warmth. Undress the resident, keeping him or her covered with bed linen or the second bath blanket. Consider protecting the covering linen by folding it at the end of the bed.

Preparing the bath

Pour the soapy water into the plastic bag and work the solution into the towels and washcloths until they are uniformly damp but not soggy. If necessary, wring out the excess solution through the open end of the bag into the sink. Twist the top of the bag closed to retain heat. Take the plastic bag containing the warm towels and washcloths to the bedside.

Bathing the resident

Expose the person's feet and lower legs and immediately cover the area with the warm, moist large towel. Then gently and gradually uncover the resident while simultaneously unfolding the wet towel to recover the resident. Place the covers at the end of the bed. Start washing at whatever part of the body is least distressing to the resident. For example, start at the feet and cleanse the body in an upward direction by massaging gently through the towel. You may wish to place a bath blanket over the towel to hold in the warmth. Wash the backs of the legs by bending the person's knee and going underneath. Bathe the face, neck, and ears with one of the washcloths. You may also hand a washcloth to the resident and encourage him or her to wash his or her own face. Turn the resident to one side and place the smaller warm towel from the plastic bag on the back, washing in a similar manner, while warming the resident's front with the bath blanket or warm moist towel. No rinsing or drying is required. Use a washcloth from the plastic bag to wash the genital and rectal areas. Gloves should be worn when washing these areas. Depending on the person's tolerance or preference, the damp towel can be replaced with a dry bath blanket, keeping covered as above, before or after washing the back.

After the bath

If desired, have the person remain unclothed and covered with the bath blanket and bed linen, dressing at a later time. A dry cotton bath blanket (warmed if possible) placed next to the skin and tucked close provides comfort and warmth. Place used linen back into the plastic bag; tie the bag and place in a hamper.

those persons with dementia who are often fearful of water. It is important to use clean washcloths for each area so that bacteria are not spread from one area to another.

An in-bed towel bath is another good alternative to the tub or shower. Here the person is covered with a large, warm, moist towel containing a no-rinse soap solution and is washed or massaged through the towel. The person is covered and warm throughout the bath (see the box "The Towel Bath: A Gentle Bed Bath Method"). This method of bathing was first described as the Totman Towel Bath

Technique.[14] For the study, the technique was modified to meet the needs of persons with dementia. It may be helpful to simply tell the person that he or she is going to have a nice massage to help him "get ready for the day" or "freshen up," avoiding the words "bath" or "wash." This technique is also good for a weak, fragile person who is unable to get out of bed. Most people feel clean, refreshed, and relaxed after a towel bath. This became the method of choice for maintaining hygiene for a number of persons in the study.

As with all baths, it is necessary to individualize the towel bath technique to the special needs and desires of the person being bathed (see Table 5). For example, in the study reported here, for people who were easily agitated, dimming the lights and playing a favorite type of music helped them to relax during the towel bath. Others responded negatively to the wet towel. They were covered with a dry towel and were washed with warm washcloths from a basin with no-rinse soap and kept covered and warm. Some people easily became cold so the wet towel was covered with two dry bath blankets and the wet towel was removed immediately after the front of the person was washed and replaced with dry bath blankets.

Hair can be washed in a variety of ways in addition to the shower or bathtub—at the sink, with a no-rinse shampoo, or with a comfortable, inflatable in-bed shampoo basin. Thin, short hair can be washed with wet washcloths in bed or at the sink. Often women respond well if they go to the "beauty parlor" sink for hair washing.

Frequency

How often is it necessary to wash or be washed to be healthy? Frequency is an individual thing. Persons who are incontinent, perspire heavily, or spill food need to be freshened up several times a day, because keeping "dirty" parts clean is necessary for good health and skin care. However, washing the whole body and hair may consume unnecessary time and energy for the person and the caregiver. Unless it is a pleasant experience for both, bathing should be done only as often as necessary.

GENERAL GUIDELINES FOR BATHING PERSONS WITH DEMENTIA

People bathe for many different reasons (pleasure, social acceptability, and cleanliness). When people bathe themselves, they alter the method and speed of the bath depending on the reason for the bath and the circumstances. For example, a person bathing in a cold bathroom will likely try to warm the room by running the hot water or taking a

Table 5

Individualizing the Towel Bath	
Change	Explanation
Cover the moist towel with one or two dry bath blankets.	This helps to keep the wet towel warm. For persons who are particularly sensitive to cold, two dry bath blankets increase comfort.
Remove the towel before turning the person over to do his or her back.	Some people are more sensitive to cold than others and the wet towel feels cold to them after about 5 minutes.
Do not use a moist towel. Cover the person with a large dry towel and wash under the towel with the washcloths wet with the no-rinse soap mixture.	Some people do not like the wet towel. It feels heavy or "too wet" to them.
Stand to wash back, peri area, and rectum.	Some persons feel pain when they are being rolled over. Having the person stand saves a painful extra movement. The person will be getting up to get dressed. The key here is to keep the person covered. This can be done with a dry bath blanket or towel.
Double-bag the towels with the no-rinse soap mixture.	If the plastic is thin, use two bags; this will help hold in the heat.
Moisten disposable wipes with warm water to wash rectum if it is very soiled.	Wipes tend to be softer and easier to use than a washcloth. The key is to have them warm.
Adjust the light to fit the person's preference (eg, dim or bright).	Some persons are more relaxed if the lights are low because there are less stimuli. Also, soft lighting and a quiet tone of voice can have a calming effect on the person.

quick bath, washing only the most essential areas thoroughly. When bathing a person with dementia, this individualized approach is also necessary. There are, however, some general guidelines for tailoring the bath to the person's particular needs, preferences, and abilities:

- *Focus more on the person than the task*. Reinforcing the personhood and well-being of the person is more important than providing care in an efficient manner. The "car wash approach" may get the person clean, but the costs to both the caregiver and person are high. Observe the person's feelings and reactions. (Is it fear? pain?) Always protect privacy and dignity.
- *Be flexible*. Modify the approach to meet the needs of the person. Modifying involves adapting: (1) the caregiver approach (eg, distracting the person with a cookie while bathing); (2) the environment (eg, warming the room); and (3) the procedure (eg, separating hair washing and bathing).
- *Use persuasion, not coercion*. Help the person to feel in control. Give choices and respond to individual requests. Support remaining abilities. Negotiate or find a reason for bathing that the person can accept. Use shortcuts such as no-rinse soap. Use distractions such as food or conversation to help the person feel more pleasure. Use a supportive, calm approach and praise the person often.
- *Be prepared*. Gather everything needed for the bath before approaching the person. Where will the bath take place? In the person's room? In the bathroom? What special products will be needed? Are there enough towels? Washcloths? If the person likes to be dressed in the bathroom, are the person's clothes there?
- *Stop*. When a person becomes distressed, stop and assess the situation. What is the underlying need being expressed? What can be done to prevent the person from becoming more upset?
- *Ask for help*. Talking with others about ways to meet the needs of the person gives staff members an opportunity to find different ways to make the bath more comfortable.

Bathing seems to be a particularly sensitive issue for persons with dementia. In general, agitated and aggressive behaviors occur because the individual with dementia is unable to understand environmental cues and is trying to express an unmet need. The form of expression (verbal or nonverbal) tends to vary with the stage of dementia and the sex of the person. Both the internal and external environment affect this response. If caregivers create a supportive milieu by attending to these areas, bathing will be more pleasurable for most individuals.

The following are general techniques for adapting the external, physical environment to make the bath more comfortable:

- Pad the shower chair to increase comfort. Padded shower chairs can be purchased. However, if this is not an option, use pipe insulation on the back and arms of the chair. Use of a child toilet seat insert or a purchased padded seat or washcloths around the edge of the seat can also increase comfort.
- Turn the heat on in the bathroom before giving a bath and give the room time to warm up.
- Adapt the equipment so it fits the person. For example, for a small person, use a short shower chair or a stool with a standard chair to keep the feet from dangling and to promote a feeling of security and safety.
- Use beds that can be raised or lowered as needed for health and safety, for transfers, and for giving bed baths.

Creating a supportive psychosocial environment (part of the external environment) requires adapting the caregiver's approach to match the functional abilities and preferences of the person being bathed. Methods for accomplishing this include the following:

- Use verbal and nonverbal responses that fit the person's capacities. Use verbal interventions with persons who can still talk and pay special attention to nonverbal behaviors with persons who cannot talk.
- Follow the person's lead. Talk if the person responds and is not overwhelmed. Sing if the person likes it.
- Use topics of conversation or songs that are favorites for the person. Know the names of family members, food preferences, favorite activities, and choice of music.
- Avoid the word "bath" with persons who do not like to bathe. Use an expression that is acceptable (eg, "wash up").
- Speak calmly, slowly, and simply, facing the person.
- Use the person's name.
- Tell the person what you are doing at all times and avoid surprises.
- Praise and reassure often.
- Bathe the person before he or she is dressed for the day to eliminate extra dressing.
- Wash one area at a time and then cover the area to keep the person warm.
- Wash the most sensitive area (as defined by the person being bathed) last.
- Time the bath to fit the person's history, preferences, and mood.
- Apologize any time the person expresses discomfort.

- Use distractions such as candy or other food that the person likes to help soothe the person and give him or her something else to do.

Techniques for addressing the internal environment (especially feelings of pain and cold) include these:

- Cover! Cover! Cover! Keep the person covered as much as possible or desired to keep warm and minimize muscle tension.
- Evaluate the need for medical treatments for pain.
- Start with the least sensitive area so that pain and tension do not immediately escalate.
- Move slowly and prepare the person before moving him or her by counting or giving a warning.
- Watch out for legs and other body parts that might get injured when moving.
- Minimize the number of moves during the bath.
- Ask the person who is able to talk what will help.
- Use soft cloths such as baby washcloths on sensitive skin.
- Use a gentle touch.
- Pat dry rather than rub to decrease discomfort.

CASE STUDY

The following case study illustrates how an individualized bathing care plan is developed.

> Mrs S was 93 years old and very proud of having been a preacher's wife. She also made women's hats for a living for a brief time and liked fashion. She had one son, Richard, who lived out of state but visited three or four times a year. Mrs S was born in Austria and came to the United States when she was 16 years old. She was widowed. She had been very active in the church, and her beliefs remained a source of support for her. She had done a lot of handwork such as tatting and embroidery and enjoyed cooking and baking. She entered the nursing home 2 years ago after she fell and fractured her hip. It is thought that she might have an undiagnosed illness that had created a rectal–vaginal fistula, and she often leaked fecal material. A decision was made to pursue no further diagnostic work up for this problem, however, because of her fragile emotional and physical state. She had Alzheimer's disease, along with osteoporosis, osteoarthritis, diabetes mellitus, peripheral neuropathy, and limited vision and hearing.
>
> Before the clinical nursing assistant (CNA) and one of the authors (JR) approached Mrs S for her shower, they reviewed her chart. Looking at her medical history to determine what was happening with her that would affect bathing, they discovered many potential sources for pain: arthritis, hip fracture, peripheral neuropathy, and some as yet undiagnosed illness. Mrs S had an order for acetaminophen four times a day for pain. The caregivers talked with the aides who usually cared for her. Then everyone went to her bedside to gather more information from her and try to view the bath from her perspective—all part of the magician's work. Staff members reported that she liked to get up for breakfast and ate much better when she was out of bed. She was therefore usually showered before breakfast when she was more refreshed and relaxed. However, she often said she did not want to get a shower and cried and complained of pain and being cold. She asked staff members to hurry up. She was able to express her needs and concerns verbally, but sometimes said the water was too hot when she really meant too cold. Assessing the physical environment, the caregivers noticed that transferring her with a two-person assist also seemed to be a source of pain and anxiety. The bathroom was cold and the bathing chair was a standard one, made of plastic pipe with a hard seat. After this initial assessment, the caregivers felt her major sources of distress came from her needs for comfort, warmth, and security.
>
> As the caregivers began the carpenter's work of "fixing" the bathing situation, they tried interventions to reduce pain and increase her warmth. They asked that her dose of acetaminophen be given earlier in the morning so that it would be at its peak level at the time the caregivers would be moving Mrs S for the shower. They cushioned the shower chair with a padded seat and warmed the shower room by turning on the heat lamp before bringing her to the shower room. They kept her covered with towels while showering, lifting the towels to wash small areas. They used the handheld shower to rinse, uncovering only a limited part of her body at a time. They played church music in the shower in an effort to distract and relax her, although it was difficult to communicate with her because of her hearing loss.
>
> Although Mrs S's complaints decreased, it was clear that the shower was not yet a pleasant experience for her. So, her caregivers renewed their detective efforts and tried some new carpenter tools. They tried the Arjo lift for her transfer, but she still

complained of pain. They gave her objects to hold and look at in the shower. They asked that she be given additional pain medication (a narcotic) before the shower, but this only seemed to make her lethargic. Her pain complaints, mostly related to being moved, did not change. Looking again at the physical environment, they decided to no longer use the handheld shower to rinse her, because the water spray seemed to increase her discomfort and her lower extremity leg pain. The cues they used to determine this included her facial expressions and verbal complaints. They washed her with gentle baby washcloths, using a no-rinse soap solution in a basin, and kept her covered and warm the entire time, lifting the towels to wash.

Focusing on adapting the psychosocial environment, the CNA tried several techniques for distraction (see Table 4) when Mrs S appeared to be getting anxious in the shower. They sang hymns together ("The Old Rugged Cross" was a favorite); she gave Mrs S small plastic figurines to hold and comment on or talked about her son or her work in the church. This worked well when used just before the CNA began a procedure she knew was difficult for Mrs S, such as washing her rectum. Before the CNA touched an area she knew could be painful, she also told Mrs S she was going to touch her, would touch the area gently, and would be careful. If Mrs S complained of pain or being cold, the CNA would apologize and take some action to address her need, such as covering an area or readjusting her in the shower chair. The caregivers soaked her feet in a basin of water while they washed her in the shower and she found this soothing.

To help determine why the Arjo lift was a source of distress, both caregivers tried being transferred in it. They found some points of pressure that could be relieved by straightening the fabric on the sling around the leg and placing a small towel there for padding. This modification seemed to decrease Mrs S's complaints only slightly. The caregivers' "best guess" was that fear and anxiety were playing a major role, so they tried a new "tool." They asked Mrs S to count with them before they started the transfer; this also yielded mild improvement.

The best intervention during the shower was to give Mrs S a mirror to hold. She liked to look at herself very much. The CNA thought of this idea, remembering that Mrs S always looked in the hall mirror when she was going down the hall. She would comment on her hair and her face.

Because Mrs S disliked having her hair washed, this was done last, assuring that she was warm and well covered. Her head was wet with washcloths, using minimal shampoo, and carefully deflected water, poured from a small graduate pitcher, away from her face and ears. These techniques, along with talking with her pleasantly about topics of interest, made the hair washing more comfortable for her.

As part of the jester's role, the caregivers used humor to help them cope when some of the "good ideas" yielded few or no results. In addition, they shared simple jokes with Mrs S and they would make her laugh.

This was a trial-and-error process. It required using all the roles to create an individualized bathing care plan that worked for Mrs S (see the box "Individualized Shower Care for Mrs. S"). It took getting to know her, viewing the shower through her eyes, modifying the environment, and meeting her needs for comfort and security. The end result was a pleasurable shower that took some ongoing thinking and planning but no additional CNA time.

IMPORTANT ORGANIZATIONAL QUESTIONS RELATED TO BATHING

In the bath study, in which the authors served as interventionists, most persons were bathed (by either the towel bath or shower method) only once a week. Before the study, most had received showers twice a week. During the study, many people were bathed using a no-rinse soap solution and were not rinsed or washed with running water. There were no untoward clinical effects noted by the interventionists from either reducing the number of baths or eliminating the running water. This observation raises some fascinating questions:

- Are we using precious direct caregivers' time to do a procedure that most residents do not enjoy more often than is necessary or desired by the resident simply because it is "the way we have always done it?"
- Are we tying the direct caregiver's hands by insisting that only a shower and tub bath constitute adequate hygiene methods?

One CNA who participated in the study (Parker B. Personal communication. April 26, 2000.) suggested that caregivers reframe their thinking and language and call it a cleansing experience, rather than bathing, so that the focus is on getting the person clean, rather than on the place or the method used to do it. The insistence on

Individualized Shower Care Plan for Mrs. S

Needs identified:
For comfort—has pain particularly in her legs and feet
To be warm
To feel safe

Behavioral symptoms:
Crying, complaints of being cold, in pain
Refusing shower

Goals:
Increase comfort related to transfers and foot and leg pain
Decrease fear and anxiety and increase pleasure
Keep her warm

Equipment:
3–4 bath towels, 2–3 baby washcloths, 1–2 bath blankets, 2 basins, no-rinse soap, mirror or figurine for distraction, pitcher or graduate, baby shampoo, shower chair, child's padded potty seat insert

Suggested approaches:
To increase comfort and warmth
- give routine Tylenol one hour before shower
- shower before breakfast
- assess her level of discomfort before you begin
- turn on heat lamp in shower room to warm it
- pad shower chair with child potty seat insert
- move her carefully and slowly
- tell her before you touch her esp. her feet; touch legs gently then move legs up and down gently before begin transfer
- use touch and soothing voice to reassure her you care and understand that she hurts
- position carefully in shower chair if has skin breakdown on coccyx
- use Arjo mechanical lift for transfer; tell her before you lift her; pad the legs of lift sling to decrease pressure; give her teddy bear to hang onto or ask her to count as distraction
- keep her well covered throughout shower, lifting towel to wash areas; use basin with wash cloths and no-rinse soap solution instead of water spray
- sincerely apologize if she c/o pain, being cold
- try singing hymns with her
- distract her with objects such as a hand mirror, cute figurines, pictures, flowers

To decrease fear and anxiety
- wake her up slowly and gently—keep lights low until awake
- distract her with conversation on favorite topics—her son, her husband (he was a minister), the church, Austria, being a seamstress
- speak clearly and distinctly, making eye contact as much as possible so she can read lips
- explain any misunderstandings she has r/t being HOH (ex. she hears "watch" instead of "wash")
- respond quickly to her complaints of being cold by adding blankets etc.
- clean her up before and after shower while in bed if she is leaking BM
- soak feet in basin of water and no-rinse soap
- wash hair last—be sure she is warm and well covered with bath blanket before beginning; wet head with wash cloths; use a small amount of baby shampoo; rinse using small amount of water from small pitcher or graduate, deflecting water from face and ears

the typical "twice a week shower or bath, head to toe, rinsing with running water, for your own good, whether you like it or not" approach does not lend itself to creating individualized care. A broader focus is needed. If this were done, there would be room and time for persons who wished to be bathed more frequently.

According to this philosophy, direct caregivers need to have the autonomy, authority, and flexibility to adapt how they maintain cleanliness to the needs, wishes, and desires of the individual. Of course, accountability goes hand in hand with caregiver autonomy. Caregivers are responsible for maintaining high skills in bathing techniques and decision making. In other words, it is not enough for the caregiver to say, "I asked if she wanted a shower and she said no." The caregiver must know enough about the people he or she cares for to know how to approach them, what words to use, and how to make them comfortable. Caregivers need to try several different approaches to encourage the person to have a bath before deciding to forego it.

Hands-on caregiver time is the most precious commodity in the care environment. Facilities should be open to questioning old patterns and rituals that are of no clear benefit to the individual. Supervisors of direct caregivers must rethink their role and allow responsible caregivers the autonomy and flexibility to redefine the cleansing experience.

CONCLUSION

The care of persons with Alzheimer's disease and other dementias must focus on the person rather than the task,

maintain dignity, and respect personal rights. This article describes how this approach can be applied to bathing persons with dementia. Bathing is often a challenge and can be perceived by persons with dementia as an attack. When faced with a person who is uncomfortable during bathing, caregivers must assess the benefits and burdens associated with the bath, evaluating the function, form, and frequency of the bath. They can improve the bathing experience by understanding the person's needs, structuring the environment and approach to meet those needs, and remaining open to alternatives to provide comfort and pleasure while maintaining hygiene. Such an approach to bathing can significantly reduce stress for both the caregiver and care recipient.

Those who work in long-term care will remember that not long ago it was believed that physical restraints *had* to be used for people's own good. Now it is known that this is not the case. The screams coming out of the shower room should remind caregivers that they need to constantly hold care practices up to scrutiny, particularly when they are doing something that is clearly against the wishes of the persons for whom they are paid to care. When a person with dementia is resisting care, the message is "Please find another way to keep me clean, because the way you are doing it now is intolerable."

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behaviors

What causes dementia-related behavior like aggression, and how to respond

the compassion to care, the leadership to conquer

Alzheimer's disease and related dementias can cause a person to act in different and unpredictable ways. Some individuals with Alzheimer's become anxious or aggressive. Others repeat certain questions or gestures. Many misinterpret what they hear.

These types of reactions can lead to misunderstanding, frustration and tension, particularly between the person with dementia and the caregiver. It is important to understand that the person is not acting that way on purpose.

Behavior may be related to:

- **Physical discomfort**
  Illnesses or medication
- **Overstimulation**
  Loud noises or a busy environment
- **Unfamiliar surroundings**
  New places or the inability to recognize home
- **Complicated tasks**
  Difficulty with activities or chores
- **Frustrating interactions**
  Inability to communicate effectively

Use this three-step approach to help identify common behaviors and their causes:

1. Identify and examine the behavior

- What was the behavior? Is it harmful to the individual or others?
- What happened just before the behavior occurred? Did something trigger it?
- What happened immediately after the behavior occurred? How did you react?
- Consult a physician to identify any causes related to medications or illness.

2. Explore potential solutions

- What are the needs of the person with dementia? Are they being met?
- Can adapting the surroundings comfort the person?
- How can you change your reaction or your approach to the behavior? Are you responding in a calm and supportive way?

3. Try different responses

- Did your new response help?
- Do you need to explore other potential causes and solutions? If so, what can you do differently?

Dementia affects each person differently. Inside, the Alzheimer's Association describes five common behaviors with recommended responses:

1 Aggression

Aggressive behaviors may be verbal (shouting, name-calling) or physical (hitting, pushing). These behaviors can occur suddenly, with no apparent reason, or can result from a frustrating situation. Whatever the case, it is important to try to understand what is causing the person to become angry or upset.

How to respond:

Try to identify the immediate cause

Think about what happened right before the reaction that may have triggered the behavior.

Focus on feelings, not facts

Try not to concentrate on specific details; rather, consider the person's emotions. Look for the feelings behind the words.

Don't get angry or upset

Be positive and reassuring. Speak slowly in a soft tone.

Limit distractions

Examine the person's surroundings, and adapt them to avoid other similar situations.

Try a relaxing activity

Use music, massage or exercise to help soothe the person.

Shift the focus to another activity

The immediate situation or activity may have unintentionally caused the aggressive response. Try something different.

2 Anxiety or agitation

A person with Alzheimer's may feel anxious or agitated. He or she may become restless and need to move around or pace. Or the person may become upset in certain places or focused on specific details. He or she may also become over-reliant on a certain caregiver for attention and direction.

How to respond:

Listen to the frustration

Find out what may be causing the anxiety, and try to understand.

Provide reassurance

Use calming phrases. Let the individual know you're there for him or her.

Involve the person in activities

Try using art, music or other activities to help the person relax.

Modify the environment

Decrease noise and distractions, or move to another place.

Find outlets for the person's energy

He or she may be looking for something to do. Take a walk, or go for a car ride.

3 Confusion

The person with Alzheimer's may not recognize familiar people, places or things. He or she may forget relationships, call family members by other names or become confused about where home is. The person may also forget the purpose of common items, such as a pen or fork. These situations are extremely difficult for caregivers and require much patience and understanding.

How to respond:

Stay calm

Although being called by a different name or not being recognized can be painful, try not to make your hurt apparent.

Respond with a brief explanation

Don't overwhelm the person with lengthy statements and reasons. Instead, clarify with a simple explanation.

Show photos and other reminders

Use photographs and other thought-provoking items to remind the person of important relationships and places.

Offer corrections as suggestions

Avoid explanations that sound like scolding. Try "I thought it was a fork," or "I think he is your grandson Peter."

Try not to take it personally

Remember, Alzheimer's causes your loved one to forget, but your support and understanding will continue to be appreciated.

4 Repetition

A person with Alzheimer's may do or say something over and over again – like repeating a word, question or activity. In most cases, he or she is probably looking for comfort, security and familiarity.

The person may also pace or undo what has just been finished. These actions are rarely harmful to the person with Alzheimer's but can be stressful for the caregiver.

How to respond:

Look for a reason behind the repetition
Try to find out if there is a specific cause for the behavior.

Focus on the emotion, not the behavior
Rather than reacting to what the person is doing, think about how he or she is feeling.

Turn the action or behavior into an activity
If the person is rubbing his or her hand across the table, provide a cloth and ask for help with dusting.

Stay calm, and be patient
Reassure the person with a calm voice and gentle touch.

Provide an answer
Give the person the answer that he or she is looking for, even if you have to repeat it several times.

Engage the person in an activity

The individual may simply be bored and need something to do. Provide structure and engage the person in a pleasant activity.

Use memory aids

If the person asks the same questions over and over again, offer reminders by using notes, clocks, calendars or photographs, if these items are still meaningful to the individual.

Accept the behavior, and work with it

If it isn't harmful, let it be. Find ways to work with it.

5 Suspicion

Memory loss and confusion may cause the person with Alzheimer's to perceive things in new, unusual ways. Individuals may become suspicious of those around them, even accusing others of theft, infidelity or other improper behavior. Sometimes the person may also misinterpret what he or she sees and hears.

How to respond:

Don't take offense

Listen to what is troubling the person, and try to understand that reality. Then be reassuring, and let the person know you care.

Don't argue or try to convince

Allow the individual to express ideas. Acknowledge his or her opinions.

Offer a simple answer

Share your thoughts with the individual, but keep it simple. Don't overwhelm the person with lengthy explanations or reasons.

Switch the focus to another activity

Engage the individual in an activity, or ask for help with a chore.

Duplicate any lost items

If the person is often searching for a specific item, have several available. For example, if the individual is always looking for his or her wallet, purchase two of the same kind.

Did you know? Six out of 10 people with Alzheimer's disease will wander and become lost. The Alzheimer's Association Safe Return® program can help. To learn more, call us toll-free at 1.888.572.8566 or visit www.alz.org/safereturn

If you have questions about your loved one's changing behavior, the Alzheimer's Association is here to help. Contact your local chapter directly or call our 24/7 Nationwide Contact Center Helpline, which provides information, referral and care consultation in 140 languages:

1.800.272.3900

10 quick tips

Responding to behaviors

1. Remain flexible, patient and calm
2. Respond to the emotion, not the behavior
3. Don't argue or try to convince
4. Use memory aids
5. Acknowledge requests, and respond to them
6. Look for the reasons behind each behavior
7. Consult a physician to identify any causes related to medications or illness
8. Explore various solutions
9. Don't take the behavior personally
10. Share your experiences with others

The Alzheimer's Association, the world leader in Alzheimer research, care and support, is dedicated to finding prevention methods, treatments and an eventual cure for Alzheimer's.

For reliable information and support, contact the Alzheimer's Association:

1.800.272.3900
www.alz.org

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Dementia and Aggressive Behaviour

As a person's dementia progresses, they may sometimes behave in ways that are physically or verbally aggressive.

This can be very distressing for the person and for those around them. Looking at what causes this behaviour and being aware of the person's needs can help to reduce this behaviour or make it easier to manage.

Aggressive behaviour may be:

- Verbal – for example, swearing, screaming, shouting, or making threats.
- Physical – for example, hitting, pinching, scratching, hair-pulling, biting, or throwing things.

Some people assume that aggressive behaviour is a symptom of dementia itself. This may be true, but it is more likely that there is another cause. It is important to see beyond the behaviour and think about what may be causing it.

Reasons for the person's behaviour may include:

- brain dysfunction due to dementia, ie: memory loss, language or orientation problems.
- their mental and physical health, ie: they may have pain, infection, or discomfort that they are unable to communicate.
- their physical surroundings, ie: if the room is too dark, too cold, or too warm, the person may become distressed.
- a sense of being out of control, frustration with the behaviour of others, or feeling that they're not being listened to or understood.
- frustration and confusion at not being able to do things or not being able to make sense of what is happening around them.

Knowing the person – how they react to and deal with things, their preferences, routines, and history – can help when it comes to supporting them. For example, if the person has always been impatient or anxious, they may be even more so now that they have dementia.

Our response to these behaviours is very important. Do not yell at the person or tell them that they should know better. Keep a safe distance and speak calmly. Look past the behaviour to identify the need causing their distress. Offer toileting, rest periods, pain medication, food, comforting words, hand massage, calming music.

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REDUCING RISK OF FALLS FOR PEOPLE WITH DEMENTIA

People with dementia are four to five times more likely to fall than older people who do not have cognitive impairment. For those who fall, the risk of sustaining a fracture is three times higher than for cognitively well people. Also, those who fall are five times more likely to be hospitalized or live in a long-term care setting than older adults with dementia who do not fall. People with Parkinson's disease, vascular and Lewy body dementia are more prone to mobility disturbances. (Fiona Shaw, 2003)

The person with dementia may experience changes that increase their risk of falling.

Changes may occur in:

- insight, which affects judgment and the ability to reason
- recognition of sensory input, such as sight, sound, touch
- communication: ability to understand and express needs
- coordination of movement: the brain's inability to communicate with the muscles and carry out day-to-day functions despite having the physical ability
- interpretation of their environment, causing illusions and misperceptions e.g., depth, light intensity, colour, pattern, temperature
- retention of information: loss of memory, difficulty with new learning
- initiation of tasks, leading to immobility

Things to consider when a person falls:

- Is there a reversible cause or is it related to another medical condition?
- Is the person taking multiple medications?
- Is the person experiencing medication side-effects or interactions?
- Are medications being taken as prescribed?
- Does the person have changes in vision?
- Has the person's mobility changed?
- Is the person restless?
- Is the person fatigued?
- Is the person in pain but unable to recognize or communicate their discomfort?

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Keep Pathways Clear

- declutter
- keep surfaces level, dry and non-slip

Suggestions:

Floors:

▪ Remove anything in the pathway that could cause the person to trip.	▪ Remove scatter mats or secure mats with double-sided tape.
▪ Replace uneven, damaged flooring.	▪ Replace rippled carpets.
▪ Avoid waxing floors.	▪ Ensure doorsills are no more than one inch high.
▪ Clean up spills immediately.	▪ Tie up or secure extension cords.

Furniture:

▪ Remove light, unstable or low pieces of furniture.	▪ Keep furnishings in consistent places.
▪ Use simple furniture arrangement.	

Outdoors:

▪ Keep pathways and the driveway level, in good repair, free of clutter and clear of ice and snow.	▪ Paint outside stairs with a mixture of paint and sand.
▪ Paint step edges a contrasting colour.	

Enhance Accessibility

- Keep important items in consistent, visible, easy-to-reach places.
- Use a firm mattress.
- Lower bed height.
- Use adaptive equipment.

Suggestions:

▪ Keep glasses and keys in consistent places.	▪ Label cupboards with the name of the contents.
▪ Install railings on the stairs and in hallways.	▪ Keep mobility aids close by.
▪ Place frequently used kitchen items within easy reach.	▪ Relocate the bedroom to the main floor near a bathroom.
▪ Have important items by the bedside.	▪ Have an emergency plan.
▪ Place emergency numbers by the phone.	▪ Keep a cell phone handy at all times.
▪ Consider purchasing a fall alert device e.g., Lifeline.	▪ Register with MedicAlert® Safely Home®.

Increase Bathroom Safety

Suggestions:

▪ Use a non-slip bath mat.	▪ Utilize a hand-held shower.
▪ Use a bath chair or bath bench.	▪ Install a raised toilet seat.
▪ Secure appropriately-placed grab bars by the tub and toilet.	▪ Lower water heater temperature to 48 degrees Celsius or less.
▪ Place night lights in the bathroom and the hallway to the bathroom.	▪ Have an accessible emergency system close by e.g. Lifeline, pull cord.
▪ Light the area adequately.	

Communication

How the caregiver communicates with the person they are assisting is an important factor in reducing the risk of falls for people with dementia.

Remember to:

- obtain the person's attention: reduce distractions, gain eye contact
- watch for non-verbal cues from the person to help understand their actions and reactions
- be mindful of your approach: remain calm and watch your facial expression and gestures
- give thought to how instructions are given: use short, simple sentences; suggest one step at a time; use cue; allow time; encourage the person

Protective Considerations in the External Environment

Ensure Adequate Lighting

- increase lighting
- reduce glare
- limit shadows

Suggestions:

▪ Use night lights in the bedroom and hallway.	▪ Turn lamps on in dimly lit rooms.
▪ Purchase glow-in-the dark light switches.	▪ Utilize high wattage/low energy bulbs.
▪ Install lights in dark closets.	▪ Close drapes and use additional lighting at night.
▪ Open drapes during the day.	▪ Keep entrances and outside walkways well lit.
▪ Install outdoor motion-sensor light.	

Provide Visual Contrast

- Use obvious contrast in colour to define objects from the background.
- Use solid colours with no pattern to decrease confusion.
- Avoid black surfaces, which may be misinterpreted as being a black hole.

Suggestions:

▪ Use a contrasting coloured rubber mat or decals on bottom of the tub.	▪ Place a contrasting coloured towel or apply contrasting coloured tape on the edge of the tub.
▪ Use a non-slip contrasting bath mat.	▪ Install a contrasting colour toilet seat.
▪ Install darker handrails on light coloured walls.	▪ Use a contrasting colour doorsill.
▪ Apply bright, non-slip tape on the edge of each step or on the bottom and the top stair.	▪ Paint walls a light colour and baseboards a darker tone.
▪ Have darker floors and lighter coloured furniture.	

Ensure Safe Footwear

Suggestions:

▪ Check fit regularly.	▪ Buy shoes with Velcro® closures.
▪ Check soles for wear.	▪ Avoid walking indoors in socks or slippers.
▪ Avoid extra-thick soles.	▪ Purchase shoes with a good tread.
▪ Ensure outdoor footwear is appropriate for the weather.	

Reduce Noise Level

Suggestions:

▪ Reduce busyness in the living space.	▪ Avoid sudden, loud noises.

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Reducing Risk of Falls for People With Dementia:
A Checklist

Consider the risk factors that may lead to falls and take action to increase safety.

Things to Consider	Yes	No	Action Plan
Have reversible medical causes been investigated?			
Have medications and how they are taken been reviewed?			
Has mobility been assessed?			
Is an adaptive mobility aid needed?			
Is current adaptive equipment for mobility being used?			
Has footwear been assessed and is it in good repair?			
Is the person restless?			
Is the person fatigued?			
Is the person in pain and unable to communicate their discomfort?			
Are there other unmet needs e.g., need to use bathroom, boredom, loneliness, hunger?			
Has vision been checked recently?			
Is the person wearing their glasses?			
Has hearing been checked recently?			
Are instructions given in an easy to understand way?			
Is bathroom safety equipment installed?			
Is indoor and outdoor lighting adequate?			
Are contrasting colours used to differentiate objects in their environment?			
Are patterns kept simple and black surfaces avoided?			
Are indoor and outdoor pathways free of clutter?			
Are walking surfaces level, dry and non-slip?			
Are important items kept in places that are consistent, visible and easy to reach?			
Is the living space too busy or too loud?			
Do you have a plan in case of emergency?			

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The information you provide on these forms will help those who support you to better understand what will help you during your emergency visit stay.

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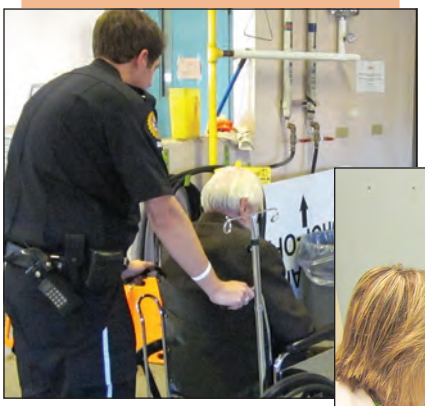
You can find the tools at:
www.alzheimer.ca

Being in a hospital can be an upsetting experience for anyone. To help make a trip to the hospital less stressful, we have created a series of handy checklists and forms for you—a person with dementia—to fill out with your family, friend, or caregiver.

coming to the hospital



being in the hospital

going home

Tools to help you

Start with the checklist on the next page.
As you do the checklist, you will use other tools in the series:

- About Me and Who Knows Me Best
- My Medications
- My Wishes
- My Ready-to-Go Bag
- Plan Ahead for Going Home

Checklist

This checklist can help you and your caregiver plan for a visit to the emergency department.

Give information about me to the doctors and nurses.

☐ **Fill out the About Me tool.**

☐ **Fill out the Who Knows Me Best tool.**

The hospital staff need information about me. It will help them give me better personal care.

✓ Keep the information up to date.

✓ Keep copies handy in a wallet or purse.
Give a copy to each contact person.
Put one copy in the ready-to-go bag.

☐ **Have a list of my medications for the hospital staff. Fill out the My Medications tool.**

My medication list will help the hospital staff give me safe care.

✓ Keep the list up to date.

✓ Keep copies handy in a purse or wallet.
Give a copy to each contact person.
Put one copy in the ready-to-go bag.

☐ **Know about my medical wishes. Use the My Wishes tool.**

In the future, I may not be able to make medical decisions for myself. I want you and others to know what I want.

We can also get information about advance care planning and advanced health directives from the Alzheimer Society in our area.

Note: Each province and territory has its own rules about advance care planning and advance health directives.

☐ **Pack a bag to take to the hospital. Use the My Ready-to-Go Bag tool.**

Pack this bag with important items and nice-to-have items for both of us. Get it ready now. In an emergency, the bag can go with us or with me in the ambulance.

✓ Put a name tag on the bag.

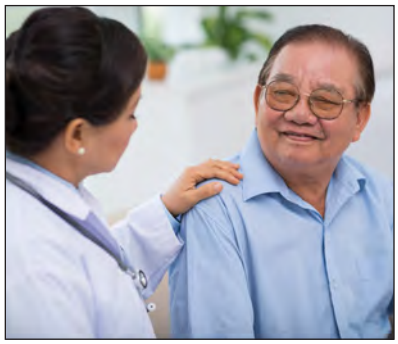
✓ Keep the bag where it is easy to see.

☐ **Plan to take my mobility aids to the hospital.**

Do I use a mobility aid? For example, a cane, walker or wheelchair. It should go to the hospital with me.

My mobility aid is the right height and size for me. I know how to use it.

☐ **Have a plan for leaving the hospital. Use the Plan Ahead for Going Home tool.**



We can plan ahead for leaving the hospital.

- ✓ How will we get home? Who can help us?
- ✓ Will I need new supports at home? For example, a walker or wheelchair, bed rails, draw sheets.
- ✓ What information will we need from the hospital staff?

☐ **Put name tags on my ready-to-go bag, mobility aids, and other personal items.**

Put a name tag on personal items so they do not get lost at the hospital. Try using luggage tags, key tabs, or sticky labels.

☐ **Plan for help. Make a list of people who can take turns with you in the hospital.**

As a caregiver, you may be at the hospital for hours. Who can help you so you can rest and eat?

More tools

You can find the tools in this series at:

www.alzheimer.ca

Where to get help and information

Active in communities right across Canada, the Alzheimer Society provides information, support and education to people living with Alzheimer's disease and other dementias, their families and caregivers.

Call 1-800-616-8816 (toll free) or go to:
www.alzheimer.ca

About this series

Funded in part by a research grant sponsored by the Alzheimer Society of Canada; Canadian Institute for Health Research: Institute on Aging; Canadian Nurse Foundation; Parkinson Society Canada.

Alzheimer Society

Online Support Services for Dementia Care Partners

Alzheimer Society Caregiver Support Network:

https://alzheimer.ca/nb/en/help-support/programs-services/caregiver-support-network

Facebook Group located in Fredericton:

https://www.facebook.com/groups/theicarecommunity/

United States (available to everyone):

https://www.caregiveraction.org/community

Canadian Newsletter:

https://canadiancaregiving.org/

Online blog and posts from caregivers:

https://www.alz.org/help-support/community/support-groups

THE USE OF RESTRAINTS WITH DEMENTIA PATIENTS

A restraint is any device or intervention that limits the freedom of a patient. The use of restraints produces a constant tension between patient rights and patient safety. The widespread use of restraints with the elderly was a major stimulus for OBRA legislation.

Research shows that increased use of restraints increases overall expense. There is no scientific evidence that restraints will reduce the likelihood of harm to elderly patients. Since the implementation of OBRA regulations, the use of restraints has declined in nursing homes. Restraints are divided into chemical and physical. A medication becomes a restraint when the effect is sufficiently severe to limit a patient's activity -- either from sedation or drug-induced motor side effects. Gait problems occur in 8% to 19% of individuals over age 65 and 38% over age 85.

Each year, between 30% and 60% of nursing home patients fall and 10% of those individuals will sustain a significant injury. Restraints were commonly used in medical settings and previous studies have shown that 30 - 50% o nursing home residents have been restrained and 8% to 17% of medical inpatients. Restraints are used for a variety of reasons including protecting the patient, protecting other patients, protecting the staff, staff convenience, family request and for no discernible reason. The degree of physical restraints can vary from bean bag chairs that use gravity to secure the frail elder in the recumbent position through 4-point leather restraints used for extremely agitated patients. Devices such as mittens, helmets and bed rails can be considered restraints. Studies show that the degree of physical or verbal aggressions and the patient's unpleasantness predict duration of restraints. There should be a comprehensive evaluation to show the need for restraints and to ensure the least restrictive restraint is used and monitored appropriately.

OBRA regulations mandate that nursing homes attempt to achieve a restraint-free environment. This goal may never be met consistently in any facility.

Restraints are divided into two categories -- medical and psychiatric. The devices used to secure the patient are the same but the purposes are different. Medical

immobilization includes restraining patients to avoid pulling endotracheal tube, IV line or falling out of bed if the patients suffer from severe dementia and gait apraxia. Psychiatric restraints include tying patients down to avoid fighting, assault or dangerous behavior. Both types of restraints require careful monitoring. Psychiatric restraints incur great scrutiny in the hospital setting. Nursing home inspectors do not always distinguish medical from psychiatric restraints.

Studies show that up to 75% of restraints are ordered by nursing staff and 15% of restraints are applied without the knowledge of responsible physicians. Nurses order restraints but physicians assume responsibility for their consequences. Nurses and physicians often disagree on the reason for restraints. The decision to restrain a patient mandates a team decision that includes opinions of the physician, the nursing staff, the patient and the patient's family based on the comprehensive evaluation.

TARGET SYMPTOMS

The use of a physical restraint is similar to that of psychotropic medications and requires a clearly defined target symptom, consideration of alternative therapies, a titrated level of restraint, assessment of side effects, consideration of restraint reduction and systematic monitoring of program effectiveness.

Target symptoms for medical immobilization include documented attempts to disrupt or remove medical devices essential to patient welfare and safety. Examples include removing endotracheal tubes, pulling PEG tubes etc., in a patient who is incapable of giving informed consent. Competent patients who demand the removal of medical devices have the right to discontinuation of therapy. Patients who engage in dangerous behavior as a result of cognitive impairment are also candidates for restraints (e.g., a gait apractic patient who attempts to walk producing falls that may fracture a hip). Psychiatric immobilization requires considerably more thought and documentation of target symptoms. Common annoying behavior such as wandering, rummaging, repetitive questions, disrobing and other non-injurious activities are poorly treated by physical restraints. Patients who manifest aggressive or hostile behaviors can be restrained as a last resort following documentation that valid attempts of less restrictive alternatives such as behavioral management and psychopharmacology have failed. The use of psychiatric restraints requires a clearly defined target symptom and documentation of less restrictive alternatives. Physical restraints can be used with dangerous patients until chemical restraints are effective. Patients who require prolonged use

of physical restraints for behavioral management should undergo inpatient geriatric psychiatric evaluation for diagnosis and pharmacological management.

Any type of restraint order must include a specific type of device. The least restrictive alternative is always chosen. Minimal research is available on the relative safety of each type of device. There are no reports of serious injuries or deaths in bean bags, geri-chairs, lap buddies and mittens. Waist and chest devices have significant potential for patient injury including patient strangulation. Staff must be trained on the appropriate application of each device and alerted to potential complications from inappropriate applications.

Nursing personnel commonly use restraints for legal, safety and financial reasons. Studies show minimal legal protection to nursing homes by restraining patients. Restraints are sometimes employed because administrators perceive that these devices reduce expenditures. Economics studies of restraints show increased long-term expenditures by nursing homes through the use of restraints unless staff ignores requirements for monitoring release and repositioning. Restrained patients require more staff time for documentation and monitoring as well as increased care and costs for the complications resulting from patient restraint. The studies clearly indicate that restraints are more expensive than behavioral management or other long-term interventions.

COMPLICATIONS AND RESTRAINTS

Patients suffer physical, physiological and psychological complications from restraints. Physical problems include decubiti, decreased range-of-motion, muscle loss and others. Physiological problems include diminished exercise tolerance, increased fluid loss, alteration of bowel function, weight loss and others. Psychological problems include humiliation, demoralization, isolation, agitation and increased confusion. The complications from restraints are divided into immediate and long-term. Immediate complications from restraints include injury, bruising, dehydration, rectal impaction, malnutrition, increased risk of falls, asphyxiation, and death. Studies indicate that one per thousand residents in nursing homes suffer from restraint-related death. Half of restraint deaths occur in bed and half in chairs. Elderly, demented females who attempt to escape restraints are most likely to die. The long-term complications of restraints include weight loss, muscle bulk loss, impaired gait, depression, isolation, loss of ADL function and increased pain.

Monitoring of side effects include assessment for complications from restraints such as circulation, impaired ventilation, dehydration, etc. The staff should identify problems rather than waiting for complications. Patients with multiple risk factors (e.g., confusion, low weight, poor nutrition, etc.) are of higher risk for complications.

APPLICATION OF RESTRAINTS

Restraints should be applied for a precise length of time and only when necessary. The symptoms of dementia often fluctuate on a daily or hourly basis. Some patients may be calm and cooperative in the morning and not require physical restraints to prevent harm but are combative in the evening (i.e., sundowning) where some restraint is indicated. Delirious patients often require some type of physical restraint. Delirium will clear within one to two weeks and restraints can be discontinued. Most behavioral problems arising from dementia are poorly treated by restraints. Restrained, demented patients generally become more agitated and more hostile as a result of the restraints. Demented patients often struggle in restraints with increased need for hydration and calories. No patient with dementia should be placed in restraints without a subsequent detailed assessment for the causes of agitation and aggressive behavior **(See Behavior Management Book).** Restraints are not an acceptable alternative for an effective fall prevention program, structured activities and staff training. Nurses restrain to prevent falls but long term studies indicate that restrained patients suffer injuries as often as non-restrained individuals. Gait impairment is usually worse following periods of restraints due to weakness, stiffness, increased confusion and muscle loss.

RESTRAINTS AT HOME

The use of restraints in the home situation is largely unstudied. Many advanced stage Alzheimer patients are restrained by family. Family members require education about application of restraints, potential complications and ways to minimize discomfort and distress for the patient. No regulations presently apply to the use of restraints at home for the elderly. The criminal justice system does not consider the good-faith application of restraints with impaired elders as a form of illegal incarceration, abuse or assault. The inappropriate use of physical restraining devices by family caregivers can be investigated as a form of abuse or neglect if it is used in a punitive manner or it exceeds the bounds of common sense. Most protective service workers and law enforcement officials are reluctant to prosecute any family member unless the judgment or behavior is clearly outrageous. Home health agencies are responsible for informing families about the

proper application, monitoring and potential side effects of physical restraints. There is no known case where a home health agency was held liable for the family restraining a patient. Home health agencies do have a responsibility to inform appropriate agencies when restraints are used in an abusive, exploitative manner.

QUALITY ASSURANCE

The Restraint Quality Assurance Program should monitor the rate, duration and types of restraints used in a facility. Large numbers of psychiatric patients in restraints suggests that the facility lack behavioral management programs. Large numbers of restrained patients also suggest under-staffing and poor patient supervision. The program should documentation of release and turning as well as staff education. Each restrained patient should have an initial note that documents target symptoms, consideration of less restrictive alterations, application protocol and long-term strategy to discontinue restraints.

EXAMPLE: Mr. Jones has dementia and frequently assaults other patients without warning in the evening. He is hallucinating and delusional. Staff will use lap restraints in afternoon and evening while doctor titrates neuroleptic. We will discontinue when he is less psychotic or refer to geropsych unit for stabilization.

ROLE OF EDUCATION

Studies show that nursing personnel identify restraints in over 80% of cases as the first option in managing behaviors that may have other solutions. Education for family and team management will increase awareness of alternative options. Administrators and facility lawyers must recognize that there are few successful lawsuits for failure to restrain but numerous suits from failure to supervise patients.

CONCLUSION:

Advanced dementia patients operate at an intellectual level of an 18-month old child. As the staff uses restraints, they should see how their 18-month old child would feel under similar circumstances.

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Dementia Navigation Resources
New Brunswick 2024

General	
Aging in NB Resource Booklet	www.stu.ca/aging-in-nb/ Printable checklists
Government NB	https://www2.gnb.ca Available services and programs for seniors
Department of Social Development	1-833-733-7835 https://socialsupportsnb.ca/en/program/long-term-care-program To open Long Term Care file for home care services, Special Care Home or Nursing Home placement. Report Adult Protection concerns- abuse, self neglect.
Dept Veteran Affairs	www.veterans.gc.ca Check eligibility for services
Government Financial Programs	Home - Benefits wayfinder Assistance with fuel costs, home improvements for seniors, etc
Power of Attorney, Wills	www.legal-info-legale.nb.ca Information on Power of Attorney, Wills, Senior Abuse
Extra Mural Program	https://extramuralnb.ca/ 1-(844)-982-7367 Wellness visits, Foot care, Blood specimen collection
Dementia resources	www.forwardwithdementia.ca Printable resources
Alzheimer Society	www.alzheimer.ca Information on Dementia, Care partner Support

Careblazer	https://www.youtube.com/c/DementiaCareblazers Videos on caring and coping with Dementia. Printable Survivors Guide in PDF Library
Home Care Agencies NB	Dial 211 to have a list sent to you. www.nb.211.ca You may pay privately or seek financial assistance from Social Development
211 Senior Services	Dial 211 to request nonmedical information. www.nb.211.ca Programs and services in your community
811 Telecare NB	Non urgent health issues. When you require non-urgent health advice or information, call Tele-Care. A registered nurse will assess your needs.
Patient Connect NB and Health Link NB	Call 811 to register for a physician or Nurse Practitioner 1-833-354-2300 from Monday to Friday, between the hours of 9 a.m. and 4 p.m. www.NBHealthLink.ca
Disability Tax Credit	https://www.canada.ca/en/revenue-agency/services/forms-publications/forms/t2201.html You may claim a person as your dependent when this form has been completed and approved. Your physician will need to complete and sign as well.
Rogers Internet packages for Low-income Seniors	https://connectedforsuccess.ca/ You may qualify if you receive Guaranteed Income Supplement or Low-Income Rental Assistance
Ability NB	https://www.abilitynb.ca/ Provide help to empower mobility and independence in NB
Equipment Loan	https://www.redcross.ca/in-your-community/new-brunswick/health-equipment-loans

Equipment loan/rent/buy	Tango Medical https://tangomedical.ca/ Orthopaedics Plus 506-633-1312 Saint John or 506-472-1312 Fredericton www.ortho Local drugstores-Lawton's, Shoppers Drug Mart
Paperback books Dementia Care Support	https://www.amazon.ca/Caregivers-Guide-Dementia-Practical-Yourself/dp/1646113926 Caregiver Guide for Dementia, The 36 Hour Day
Project Lifesaver	https://yssr.ca/project-lifesaver/ Tracking device for lost adults in New Brunswick
Medication Management	Blister Packs through your local pharmacy May be a free service but dispensing fee is every 4 week refill.
Dog Care Assistance	www.elderdog.ca 1-855-336-4226
Adopt A Grandparent Program	Fredericton 1-506-261-6551 Volunteers assist seniors with household tasks, transportation to appointments
Living My Culture	www.livingmyculture.ca
Alcoholics Anonymous	www.aa.org
Al-Anon Maritime Family Groups	www.al-anonmaritimes.ca Support for families and friends of alcoholics and addictions

Narcotics Anonymous NB	www.nanbasc.com For those with narcotic addiction. Meeting schedules
Gamblers Anonymous	www.gamblersanonymous.org For those with gambling addiction
Transportation Charlotte Co. NB	www.charlottedial-a-ride.com
Human Development Council Saint John NB	www.sjhdc.ca Exploring community resources in Saint John, NB
NB Senior Citizens Federation	www.nbscf.ca 1-800-453-4333
NB Coalition for Seniors	www.nbcoalitionforseniors.org
Emotional Support	
Virtual Hospice	www.virtualhospice.ca Provides information about end-of-life care
CHIMO Helpline NB	www.chimohelpline.ca 1-800-667-5005 Mental health supports
Bridge the Gap	www.bridgethegapp.ca 1-833-456-4566 Mental health supports
Ambiguous Loss and Grief	www.alzheimer.ca

Caregiver Support	www.caregiver.org
Canadian Mental Health Association	1-506-455-5231
Safety and Equipment	
Ability NB	https://www.abilitynb.ca/ 506-462-9555 Provide help to empower mobility and independence in NB
Project Lifesaver	https://yssr.ca/project-lifesaver/ 1-506-461-5832 Tracking device for lost adults in New Brunswick. Search and Rescue GPS
Medication Management	Blister Packs through your local pharmacy May be a free service but dispensing fee is every 4 week refill.
Lifeline	www.lifeline.ca 1-866-729-0532 Fall monitoring system, call system for help
Care-Link Advantage	www.carelinkadvantage.ca 1-866-876-7401 Medication reminders, call system for help
Senior Store Canada	www.seniorstore.ca 1-888-795-7718 Alarms, Personal aids
Alzheimer Store	www.alzstore.com 1-800-752-3238 Alarms, medication reminders and more
Safely Home Registry	www.alzheimer.ca Registry with Alzheimer Society and local RCMP. PDF in Library.

Vial of Life	www.vialoflife.com Information for health care professionals. PDF in library
Hearing Amplifying Device	www.amazon.ca Williams Sound Pocket Talker Alternative to hearing aids. Approximate price $150
Canadian Red Cross Equipment Loan Program	www.redcross.ca Short-term loans of health equipment- wheelchairs, walkers, bath seats, benches, commodes, crutches, bed handles, etc.
Lawton's Home Health Care	www.lawtons.ca Check your local store listing
Tango Medical	www.tangomedical.ca Check your local store listing
Jean Coutu Pharmacy	www.jeancoutu.com Check your local store listing
Orthopaedics Plus	www.orthopaedicsplusltd.godaddysites.com Check your local store listing
National Seating and Mobility	www.nsm-seating.ca Check your local store listing
NB Home Oxygen Program	Access through a Physician or Nurse Practitioner consult to ExtraMural Respiratory Program. (Medigas, Vitalaire)
Adaptive Clothing	www.silverts.com 1-800-387-7088

WHAT IS A

DEMENTIA PATIENT NAVIGATOR?

Patient Navigators assist persons with dementia and their care partners to navigate through the social and health care systems in New Brunswick. We also provide educational resources and connections to social programs within a person's community.

Improve access to Long Term Care Programs

Education and Support Groups

Connect to Community Programs

ROLE OF PATIENT NAVIGATOR

- Identify patient and care partner needs.
- Advocate and connect patient and care partners to programs and services.
- Support and guidance through the dementia journey.

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

UNB EST. 1785 UNIVERSITY OF NEW BRUNSWICK

If I get dementia, please embrace my reality. If I think my spouse is still alive, or if I think we are visiting my parents for dinner, let me believe those things. I will be much happier for it, and it will be easier for you.
If I get dementia, please do not treat me as if I am a child. Talk to me as the adult that I am.
If I get dementia, please let me enjoy the things that I have always enjoyed. Help me find a way to exercise, read, visit with friends, garden, and whatever else I have always enjoyed.
If I get dementia, please ask me to tell you a story from my past.
If I get dementia, and I become agitated, please take the time to understand what is bothering me, then help me solve the problem.
If I get dementia, please treat me the way that you would want to be treated.
If I get dementia, please make sure that there are plenty of snacks for me in the house. Whenever anyone fails to eat, he or she becomes angry or at least irritable, but if I have dementia, I may have trouble telling you what I need.
If I get dementia, please do not discuss me in my presence as if I am not in the room.
If I get dementia, please do not feel guilty that you cannot care for me 24 hours per day, 7 days per week. No one can do that. Instead, please find someone who can help you, including finding a great new place for me to live.
If I get dementia, please visit me often.
If I get dementia, please do not be frustrated if I mix up names, events, or places. Instead, please take a deep breath, then remember it is not my fault.
If I get dementia, please make sure I always have my favorite music playing within earshot.
If I get dementia, and I take items from where they belong then carry them around, please help me return those items to their original locations.
If I get dementia, please do not have parties and family gatherings without me.
If I get dementia, please remember that I still like receiving hugs or handshakes.
If I get dementia, please remember that I am still the person you know and love.

Hours of operation

Monday to Friday
9am to 3pm

Reopening Fall of 2022

Contact Us

Email

cpurcell@yorkcarecentre.ca

Phone

(506) 444-3880 Ext 2522

www.yorkcarecentre.ca

Adult Day Program Services

YORK CARE CENTRE
EXCELLENCE IN LONG-TERM CARE

The Adult Day Program offers a variety of social and therapeutic recreation programs and services for those living with dementia and for those who are socially isolated due to mobility issues or other ailing conditions.

The program focus' on a person centered approach. Providing stimulation in a comfortable and secure environment.

Recreation activities are semi-structured and are flexible to the clients needs.

Other Services Avaialble for ADP Clients

- Hair Care Salon
- Dental Suite
- Respite Care etc.

Upon starting a day at the Adult Day Program, the client will be welcomed by an experienced Activity Aide, kicking off the morning with a quick snack and update on current events. The Therapeutic activities will be tailored to the clients needs and interests.
Art Therapy, Music Therapy, Pet Therapy and outings are just a few examples of ways the clients will be engaged.

SENIORS OUTREACH PROGRAM

Loch Lomond Villas Seniors Outreach Program offers seniors in our community a wide-range of activities – everything from cards and bingo to gardening, crafts, bowling, walking, and exercising.

We know that many seniors want to stay in their homes as long as possible. Our Seniors Outreach Program provides caregivers some much-needed respite, delaying and even sometimes preventing hospital admissions – which, in turn, helps ensure the overall sustainability of our health-care system.

The Seniors Outreach Program is a non-profit organization, funded by the Government of New Brunswick. The team includes a co-ordinator, activity workers and volunteers.

Transportation to and from the program is the responsibility of the clients and their families. Local transportation services are available. Some assistance in arranging transportation may be available through the Department of Social Development.

For more information on our Seniors Outreach Program, contact us at 506-643-7175

COST / ELIGIBILITY

The cost of the program is $45.00 per day, including lunch and snacks. We offer a complimentary one-day trial for interested seniors (and their families), following an assessment by our Registered Nurse.

Seniors may qualify for a subsidy under the Department of Social Developments or, if a veteran, the Department of Veterans Affairs.

If a resident becomes ineligible because of increased care needs, the coordinator will contact the family / care giver.

Meaningful Connections Adult Day Centre, Oromocto, NB

Description

Adult Day Centre

- provides respite care for caregivers of persons with or without dementia provides supervised activities offered in a safe and secure environment.
- programming to improve or maintain participants' physical, social, mental, and emotional well-being.
- individual and group activities guided by participants' personal preferences.
- planned intergenerational recreation with local daycares and schools with volunteer support promote holistic care and community inclusion.
- community partnerships with local high school and college promoting co-op and clinical experiences for students while enhancing the lives of program participants.
- Meals on Wheels
- foot care
- blood pressure and blood glucose clinics

Contracted by the Department of Social Development

Eligibility

Persons with or without dementia or other related cognitive impairments who would benefit from increased social engagement and planned recreation and their caregivers

Application Process

Apply online or call apply through Social Development Long Term Care Program

Office 506-259-9420

Email:meaningfulconnectionsdaycentre@gmail.com

Mailing Address

15 Carter Crescent
Oromocto, NB, E2V 0C4
Canada

Languages English

Contact

Katharina Burns, Program Coordinator, Registered Nurse
Email: kburns4@unb.ca

CARE WITH CONFIDENCE

CAREGIVER RESOURCES

Supports caregivers with stress management tools, guides, and communication tips to help them provide compassionate and effective care.

CAREBLAZER SURVIVAL GUIDE

Careblazer™: *Noun*, a person who loves and cares for someone with dementia. Also known as a dementia care hero.

NATALI N EDMONDS, PSYD ABPP

TABLE OF CONTENTS

PREPARE FOR THE JOURNEY

Loving and caring for someone with dementia can be challenging. I'm guessing I don't need to tell you that. If you are reading this, then you've probably already had a taste of the struggles that come along with caring for someone with dementia.

No one asks for their loved one to be diagnosed with dementia. It just happens. All of a sudden, it seems like your world has turned upside down. You find yourself responsible for things you never had to do before and you are scared about what the future looks like for you and your loved one.

If you are like many other Careblazers, you may have found yourself facing struggles such as:

- Wondering how much longer you will be able to provide care
- Wondering where to turn for help and how to ask for help
- Wishing your loved one would stop saying mean things and stop accusing you of things that aren't true
- Trying to convince your loved one to shower or change clothes
- Feeling all alone with no one who understands
- Feeling guilty for losing your temper or wishing it was all over
- Noticing that your personal relationships with others have slipped away and you have stopped doing the things that you enjoy

If you have had any similar concerns, then this guide is for you. In the pages that follow, I am going to share common dementia symptoms and how to

respond to help you feel less stressed AND to improve your loved one with dementia.

We have to learn about the disease and enter their reality in order to make the biggest impact and have the most success.

Before you proceed, I have to give you my full honest warning. Even though your loved one with dementia is the one with the disease, the biggest way to help improve your loved one is to change yourself.

GASP! Yes, you have to change in order for your loved one to improve.

I know it doesn't make much sense at first, but this is reality when you love someone with dementia. It's what you have to do if you want your loved one to be as calm and happy as possible. It will make your life much easier as a result.

In order to improve ourselves AND our loved ones, we must understand some basic things about the disease. The things that your loved one with dementia does that seem to make no sense and drive you crazy will all of a sudden make more sense. When we have a good understanding of the disease, then we are able to understand how to respond.

I promise you are not alone. Many Careblazers around the world started out feeling overwhelmed, frustrated, and depressed. They felt like they were at the end of their rope and that there was no hope for their situations. Once they started changing their approach and using the information provided in this guide, their loved ones with dementia started to improve and their own health started to get better.

I encourage you to take the chance on improving your situation. If you are tired of your current situation and are ready to make a change, then continue reading. In the next chapter, I'm going to explain why your loved one with dementia seems to purposefully giving you a hard time.

UNDERSTAND

No, your loved one isn't purposefully trying to drive you crazy. I promise! Sometimes, it can feel like your loved one is literally trying to drive you crazy. Why else would they insist on not showering, insist they can continue driving, or constantly accuse you of things that aren't true? In some cases, your loved one may even blame you for their struggles!

Have you ever tried to convince your loved one to change their mind?

Have you ever tried to convince your loved one to do something they didn't want to do?

Have you ever tried to correct your loved one when they said something that wasn't true?

I'm guessing if you have ever tried to do any of the above things, it didn't go smoothly. Why do you think that happened?

Many Careblazers think that their loved one is in denial. In a minute, I'll explain why that isn't actually true and why we cannot respond to our loved ones with dementia in the same way we would respond to people without dementia.

When you understand what is happening with the disease process, then you understand that the way you have been responding to your loved one has actually been making the situation worse! You can't interact with your loved one with dementia like you interact with others. You must learn a new way to communicate. Once you learn this new way of communicating, your situation will significantly improve.

So, what is happening? Why does your loved one argue with you when you remind them they can no longer drive?

Why does your loved one refuse to do the basic things like change their clothes or take a shower?

> Why does your loved one seem to treat you worse than others when YOU are the one that does so much for them?

Let me explain. It's not denial, it's something called anosognosia. This is a process in dementia where your loved one's brain does not have the ability to understand the problems they are having. The term anosognosia means "lack of awareness." It literally means your loved one does not have the ability to be aware of their disease and all of the problems their brain is having. It's a common symptom in dementia.

Because your loved one is not capable of being aware of their problems (no matter how much you try to explain), they see YOU, as someone who is just getting in the way and preventing them from doing the things they want to do. Instead of seeing you as someone trying to help and keep them safe, they see you as someone who treats them like a baby.

Here's an example:

> Your mom with dementia is no longer able to manage her finances. She forgets to pay the bills, pays the wrong amount of money, and is sometimes even scammed out of money from people calling the home.
>
> However, your mom doesn't believe this. Even when you show her the overdraft fees, the late payments, the proof of scams, she STILL does not believe you. Instead, she makes up reasons for the things you are pointing out (i.e., someone hacked her account, you are stealing her money, the banks are corrupt, etc.).
>
> Your mom now starts to resent you. She accuses you of trying to steal her money! The more you try to explain the situation, the more she mistrusts you and argues with you. She has even started to hide money from you and make financial decisions behind your back. After all, in her mind, you are trying to take away control of her money for no reason!

Do you see how this can lead to resentment, anger, and frustration for both you and your loved one?

Anosognosia is the reason that your mom doesn't believe you. This is why no matter what you say, no matter how much evidence you have, and even if you are able to physically prove your point, your loved one does not budge in their belief.

So, what the heck are you supposed to do to avoid the arguments and frustration if your loved one will not believe the truth no matter what you tell them?

For starters, you need to learn a new way to communicate with your loved one that does not highlight their weaknesses because they are not capable of even being aware of those struggles!

You also need to stop trying to argue, correct, reason, and rationalize with your loved one with dementia. The more you try to explain, the more frustrated you and your loved one become.

You cannot make a blind person see. And many times, you can't make someone with dementia reason. The brain simply doesn't have that capability. So, stop communicating with your loved one as if their brain is working perfectly.

In the next chapter I share my top dementia survival tips that will help avoid the pitfalls of correcting, arguing, and reasoning with your loved one with dementia.

SURVIVAL TIPS

The tips below are a few of my favorite Careblazer approaches to help you interact and communicate with your loved one with dementia. These tips are designed specifically for people with dementia and are often the complete opposite thing you would naturally consider, which is precisely why these tips are really important.

If you use the approaches below, your interactions with your loved one will be more enjoyable and your relationship will improve. Less frustration, more joy. Yay!

Ready to improve your relationship with your loved one? Here we go!

Tip #1: THE COMPASSIONATE LIE

This tip really starts to get into the nitty gritty of how interacting with someone who has dementia is so much different than interacting with someone who does not have dementia. Many people feel very strongly when they think about lying to someone. They are taught that lying is wrong and should be avoided at all costs.

In dementia, “lying” is sometimes the kindest thing you can possibly do. Stick with me here.

When people think of lying, they think of the traditional reason to lie- to deceive someone, usually so they can get some type of personal gain. In dementia, a compassionate lie is not meant to deceive it is meant to **relieve**.

Let me say that one more time. Compassionate lying is not meant to deceive, it is meant to relieve.

If the truth about something is bringing your loved one with dementia significant anxiety, worry, or pain, what can you do to relieve that pain?

Example: Your dad with dementia has not worked in over 10 years. He wakes up every morning and starts to get ready for work.

Caregiver Response: “Dad, you don’t work anymore, remember? You stopped working 10 years ago.”

Careblazer Response: “Dad, the boss called, you have the day off from work today! Let’s go for a walk.”

Reminding your dad that he doesn’t work anymore is going to make him either… #1. Not believe you and continue to get ready #2. Feel anxious that he no longer works and didn’t remember that or #3. Feel sad because the thing that he did for so long no longer happens.

Instead of viewing lying as all bad, I want you to think of your reason for lying. Is it to relieve your loved one’s pain or is it for personal gain? If it’s primary cause is to relieve your loved one’s pain, then by all means, do it. This is going to save you and your loved one so much heartache.

Here’s another example of when a compassionate lie can help.

Example: Your husband has dementia and is no longer safe to drive. You are getting ready to drive to a doctor’s appointment when your husband says, I’ll drive.

Caregiver Response: “You can’t drive anymore, you have dementia and the doctor said you aren’t safe.” This is likely to lead to arguments, resentment, and frustration.

Careblazer Response: “I actually feel like driving today. Let me chauffer you around.” Smile, open the passenger door for him, and motion for him to go inside.

The Careblazer approach is much more likely to avoid arguments and does not make your loved one feel bad for reminding him of something he is no longer able to do.

Whether you have dementia or not, no one likes to be reminded of what they can’t do. Because there are many things that may pose a safety risk for people with dementia, it can feel that much of what you say to your loved one is negative or a reminder of their disease. Get creative, think of things you are able to tell your loved one that reduces the chances for anxiety, sadness, and anger.

Whatever you do, resist the urge to argue, correct, or reason with your loved one.

Tip #2: CHOOSE YOUR BATTLES

There will be MANY things that your loved one says and does that do not make sense, that are wrong, or may be completely strange.

Before you correct your loved one, ask yourself, “Is it necessary for me to correct?” (think of a Careblazer saying to use here).

There will be many struggles along your caregiving journey and it is up to you to decide which ones you want to focus on and which ones are better left alone. If your loved one insists that the chicken they are eating for dinner is pork, let it be. If your loved one insists on wearing a princess crown when they leave the house, then by all means, let them be a queen. If your loved one tells you that they were the president of the USA, nod your head and smile. Not only is this approach super helpful to you, it will be super helpful to your loved one.

There is no need to correct or challenge. Bottom line: You will need to save your energy for the more important things.

Careblazer Rule of Thumb: If what your loved one is saying or doing is not a safety risk, then let it be. This will improve your relationship with your loved one AND reduce your level of stress since you aren’t constantly correcting them.

Ask yourself, would you rather be right or would you rather be happy?

Get familiar and know what could be coming. The more you recognize the challenges as part of the disease, the easier it will be for you to deal with the challenges when they happen. Please note that I am not saying caring for someone with dementia is easy or will ever be easy. Loving someone while watching them drift away in front of your eyes is one of the hardest and most

heartbreaking things. But preparing yourself and getting informed about the disease will help you feel more in control, it will help you think of ways to respond, and it will help you realize that you are not alone.

Tip #3: JOIN THEIR WORLD

Sometimes, we try to respond to our loved ones with dementia, the way we would respond to people without dementia. Quickly you will find that this approach does not work most of the time.

IT'S NOT ABOUT MAKING SENSE IN YOUR WORLD, IT'S ABOUT MAKING SENSE IN THEIR WORLD.

As humans, we immediately jump to trying to explain or rationalize with our loved ones with dementia only to find out that it backfires on us. In order to know the best way to respond to your loved one with dementia, you have to take the time to view things from their perspective. Remember, their brains are slowly dying and they are not able to understand much of the information that we are so fortunate to understand. What seems like a completely reasonable explanation to us, may not make any sense at all to someone with dementia.

> Example: You are caring for your mom with Lewy Body dementia. She is terrified every time she wakes up and yells that there are people watching her.
>
> Caregiver Response: "Mom no one is watching you." You don't understand it and tell her everything is okay and there is no reason to be afraid. Your efforts to talk to her don't help. She continues to insist every morning that there are people watching her. You are frustrated that your mom isn't listening to you and your mom continues to be scared every morning.
>
> Careblazer Response: "It's okay, mom. I'm here. You are safe." You now take time to enter her world. You take what you know about dementia and look around the room. You notice that there is a mirror right next to her bed and realize that when she wakes up and sees her reflection, she thinks it is another person. You decide to take the

mirror out of the room and now your mom no longer yells that people are watching her when she wakes up. Success!

From your perspective, you understand that no one else is in the room. But from your mom's perspective, she cannot understand that. You can either continue to try to convince her and be frustrated every morning, or you can take the approach of joining her world and getting creative with your response.

IF YOU WANT YOUR LOVED ONE WITH DEMENTIA TO CHANGE, THEN YOU ARE THE ONE THAT HAS TO CHANGE.

Tip#4: YOUR BEHAVIOR IS MORE IMPORTANT THAN YOUR WORDS

In dementia, the ability to understand words gets harder and harder. Because of this, your nonverbal behavior becomes more important than ever. You are basically a mirror to your loved one. Whatever emotion you are showing on your face, will be the emotion your loved one with dementia shows back to you. If you look stressed, nervous or frustrated, then your loved one with dementia will likely be stressed, nervous, or frustrated.

This is good news! This means that if you look happy, calm, and peaceful, your loved one is likely to be happy, calm, and peaceful. Nonverbal behaviors are often the key to what separates a typical dementia caregiver from an excellent Careblazer.

If your non-verbals are giving messages of stress and frustration, you can pretty much forget about getting your loved one to do anything you want. Your loved one will not be able to focus on what you want them to do because they are going to be stressed.

Situation: It's bath day for your wife with dementia.

Caregiver Response: You are already nervous because this is a stressful experience. You are tense, you face is stressed, and you are talking sternly to your wife to make sure she understands that she needs to get in the bath. You start to help her undress when she hits you and refuses to get in the tub.

Careblazer Response: It's bath day but you tell her it's spa day. You know this is a stressful day for your wife so you make sure that you are in a good mood and mentally prepared for the task. You make sure the bathroom is

warm, her favorite music is playing, that the water temperature is good, and you are constantly smiling and telling your loved one they are okay. Before you start taking your wife's clothes off, you tell her what you are about to do. You move slowly and make sure to smile throughout. Your wife is able to get through the "spa" experience.

Here are non-verbal skills to practice with your loved ones. **NON-VERBAL SKILLS**

- Nod
- Smile
- Keep your posture and body open and inviting. Your body language is important.
- Look at your loved one when talking.

TRY IT OUT

Take a moment to write down your biggest current struggles and think about ways you can try to respond to them using the information you just learned. Think about joining their world, seeing things through their eyes, and researching or asking others about how they have handled similar situations. Remember: sometimes just changing your own thoughts about the situation and using coping statements can make all the difference. Give it a try.

BIGGEST CURRENT STRUGGLE:

POSSIBLE COMPASSIONATE LIE:

THINGS YOU CAN STOP CORRECTING AND JUST LET BE:

WHAT THINGS ARE YOU TRYING TO CHANGE THAT YOU DON'T NEED TO CHANGE?

NON-VERBAL BEHAVIORS TO START USING:

SEE IT FROM THEIR POINT OF VIEW: How may your loved one be viewing the situation?

WHAT OTHER POSSIBLE REASONS MAY BE CAUSING THEIR BEHAVIOR? Consider pain, hunger, boredom, anxiety, need for bathroom, etc.

GET YOUR MIND RIGHT

Sometimes it can feel like your loved one is purposefully trying to drive you crazy. We've already learned that much of your loved one's behaviors are a result of the dementia, and that anosognosia (i.e. lack of awareness), is one of the biggest reasons why your loved one might be resistant toward your attempts to help.

Even though you may know this, there will still be times when you are frustrated and feel convinced that your loved one knows what they are doing. Usually this is because your loved one may have had some similar behaviors before their dementia diagnosis.

Regardless of the reason for your loved one's difficult behaviors, thinking your loved one is purposefully trying to give you a hard time will ruin your ability to provide good care and will increase the chances that your loved one will continue to have difficult behaviors. Your loved one will pick up on your frustration, irritability, and overall negative attitude and this just makes your situation that much harder.

Let me tell you about a proven principle that psychologists world-wide use to help people improve their mood and ultimately improve their lives.

Our thoughts create our feelings, and we act and respond based on how we feel.

Most people think that situations create our feelings, but that is not true. This is why people in the same situation feel and act different ways. The thing that makes the difference? Our thoughts.

Some of you reading this may be asking, *"How on earth could changing my thoughts actually lead to any change with my loved one? I just need my loved one to change. My thoughts have nothing to do with changing them."* Let me explain with a simple example.

SITUATION: Your mom lost her purse again and is yelling that you stole her purse.

THOUGHT: “She’s such a liar! I can’t believe she has the nerve to accuse me of stealing her purse after everything I do for her!”

FEELING: Anger.

BEHAVIOR: You snap back at your mother. The rest of the day is tense with little communication. Your mother chooses not to eat dinner that night.

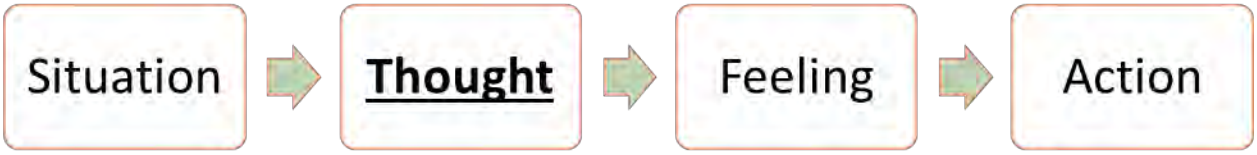
SITUATION: Your mom lost her purse again and is yelling that you stole her purse.

THOUGHT: “Her mind is trying to understand how her purse is missing again. What an awful disease.”

FEELING: Compassion and understanding.

BEHAVIOR: You tell your mother you that you love her, will help her find her purse and then you two engage in a pleasant activity together.

Do you see how the situation was the same (your mom accused you of stealing her purse), but your feeling and actions afterwards were different based on what you thought about the situation? This is a really quick example to show how our thoughts are important and to hopefully encourage you to be mindful of your thoughts.



For dementia caregiving, we can take this diagram a step further.
Because people with dementia pick up on your emotions and facial expressions more than they do your words, your actions (which are influenced by your thoughts) will start to change your loved one…either for the better or for worse.

Our thoughts become our reality so if you think to yourself, "*My dad is always doing things to drive me crazy*!" Guess what? Your dad will probably always seem to be doing things to drive you crazy because your feelings, facial expressions, and actions will trigger your dad to act in those ways.

Instead, if you think "*This disease is really hard on my dad and I know it's not his fault. I'm frustrated but I understand*." Guess what? You will be calmer and more understanding of your dad's difficult behaviors. As a result, your dad's behaviors will reduce because your feelings, facial expressions, and actions will help your dad feel more comfortable.

Now you understand your thoughts can impact your mood and behavior, AS WELL AS, your loved one's actions. Because you understand the relationship between thoughts and feelings, it doesn't mean that you aren't

going to find yourself completely frustrated and thinking negative thoughts. We are all human and those moments are completely natural.

However, it is not okay to let those negative thoughts hang out in your mind and simmer. When you notice that you are having a negative thought toward your loved one, you want to be able to replace those thoughts with something that will be more helpful- for you AND your loved one.

You know hard moments are coming, that is a reality. It's important to know how to get through those tough moments. On the next page, I've included some examples of coping statements to give you an idea of things you can say to yourself when you feel like you are about to lose all control. These simple statements take no time, and hardly any effort to do when you are feeling at your wits end. Don't mistake simple for not worthwhile. These statements can truly make a difference, but they only work of you put them to work.

Take a look at the list on the next page and see what kind of style matches your style of thinking. Then, try to create your own coping statement.

As a Careblazer, you need to be aware that your thoughts can actually influence your loved one's behavior – for better or for worse.

Your loved one is not trying to give you a hard time. They are having a hard time.

SAMPLE COPING STATEMENTS

Think matter of fact:
"Yup, here it is. I knew it was coming and I know that it is a part of the disease."

Think funny:
"Well, it's good to know mom's mouth still works, even if her brain doesn't."

Think calmly:
"Just breathe. Nice and easy breaths, I know that I will get through this moment."

Think future:
"I really don't like this, but I know one day he won't be around to say anything at all."

Think honestly:
"I am so sick of this sh*t, but I will get through it no matter how hard the days!"

Think like you: What can you picture yourself saying in your mind that would be helpful in getting you through the difficult moments? Use words that you can hear yourself saying. Remember, this is just in your mind so you can be as true to yourself as you want without fear of anyone else knowing. Write your statement below.

_____

_____

SELF-CARE EXCUSES

Let's take a moment to talk about the many reasons that make it difficult to take time to care for yourself.

I AM TOO BUSY
It's true. You probably are too busy. Loving someone with dementia takes up a lot of time and many of you are also trying to juggle caring for your loved one with dementia AND your own children, job, spouse, parent, pets, etc. **IT IS A LOT**. But taking care of yourself doesn't have to take up all your time. In fact, you can still do everything you are currently doing **AND** find little, simple ways to be kind to yourself during the day. Examples include:

- Take some deep breaths
- Enjoy a moment of peace in the shower and use a new body wash
- Pick up the phone and talk to a supportive friend while you wash the dishes or fold laundry (hands free device of course)
- Go for a short walk
- Paint your nails or get your nails done
- Journal
- Meditate
- Visualize a happy or calming scene
- Watch a funny TV show or movie
- Listen to some of your favorite music when you get ready for the day
- Take time to eat healthy food that will give you energy and make your feel good

You do not need a big chunk of time for self-care. You can take advantage of the brief moments throughout the day and enjoy the mini-breaks.

Notice how many of these activities could be done when you are physically still with your loved one (watching TV, taking deep breaths, going for a walk). Other activities, are things you are already doing during the day but you are now making more of an effort to make it a quality time for self-care (music when you get ready, using a new body wash in shower, etc.). These are things that are not going to take up any more of your time. **It's about using the time you already have in a way that supports you.** If possible, look into options for having people come to your house and give you a break so you can do even more for self-care.

I FEEL GUILTY

Many dementia caregivers struggle with taking time out for themselves. In their mind they think that taking time for themselves is selfish and makes them a bad caregiver. The complete opposite that is true. Taking time for yourself is actually one of the best things you can do for your loved one with dementia!

Be honest. Right now, stop and ask yourself what would happen to you if you were all of a sudden too sick to care for your loved one? What would happen to your loved one? If you did not change one thing about your self-care and 3 years went by, what would your life look like? Would you somehow be in a better position, the same position, or would you be worse? Sometimes, it takes getting real honest with yourself to realize that not giving yourself the care you deserve has a pretty scary future for you…and your loved one.

Self-care isn't selfish!

WHAT WILL OTHERS THINK OF ME?

One of the things I tell myself over and over is that **it is none of my business what other people think.** You may find it helpful to think the same thing. You cannot live your life worried about what other people think because that would be a pretty awful life. Besides, when it comes to the stress of loving someone with dementia, it is important to surround yourself with people who support you and want to see you take care of yourself. Loving someone with dementia is hard enough without people around you bringing you down. People who would think something bad of you for taking care of yourself are 1) not the supportive people you need in your life and 2) probably have no idea what it is like to love someone with dementia. If you really want to shut them up, offer to let them take care of your loved one for a while. Okay, I'm just joking on that last part but I bet it would work! ;)

I HAVE NO HELP

Many times, people feel all alone when caring for their loved one with dementia. There aren't too many people eager to spend their free time caring for someone who most of the time doesn't realize they need the help, or doesn't want the help, or resents you for giving the help. It can often feel like a lonely and thankless job. However, you might be surprised at the help you can get if know how to ask for help or accept help when it is offered.

Many times, when a neighbor or friend, or co-worker asks if there is anything they can do for help, the usual response is a passive, *"No thanks. I've got it handled, it's just hard."* I

It's okay to say, *"You know what, it would be really helpful to have someone sit with my mom for an hour while I _____."* You can fill in the blank with whatever you want. Or you can say, "*That is so kind of you. If you ever have any leftover dinner, it would be a big help to save me from having to cook dinner one night."* Most times, the people who care about you want to help but they just don't know what to do or what would be helpful. It's okay to give them suggestions, after all, they are asking.

If asking for help seems too uncomfortable to you, then keep this in mind the next time your birthday comes around or when the holidays come around. This is the time of year, people expect you to have some ideas for what you want/need. Consider asking for someone to give you a break for a few hours, or a gift card to a nearby restaurant so you won't have to cook dinner.

In addition to asking for help or accepting help when it's offered, you also want to get to know the resources in your community that can offer help to you. Some of the most common resources include:

Online support groups: There are many support groups online. Do a google search for online dementia support groups to see what pops us. Also, make sure to join the Dementia Careblazer Community- a closed FB group for Careblazers to support one another!

In person support groups. If you go to www.alz.org, you can search for in person support groups in your area through the Alzheimer's Association. Also, consider contacting senior community centers in your area to see if they know of any support groups near you.

Adult day health care centers: A safe place for your loved one to spend time during the day to give you a break.

Local Area Agency on Aging: Google your local area agency on aging. They often have resources in your area about

- Respite care
- Home health aide care
- Dementia caregiver websites

PRACTICE SELF-CARE

SIMPLE THINGS I CAN START DOING TO IMPROVE SELF-CARE:

WHAT WILL I TELL MYSELF WHEN I FEEL GUILTY FOR TAKING TIME FOR MYSELF?

HOW CAN I ASK FOR HELP IF I WANT A BREAK?

IF SOMEONE ASKS ME WHAT THEY CAN DO TO HELP, THIS IS WHAT I WILL SAY:

WHAT RESOURCES DID THE LOCAL AREA AGENCY ON AGING GIVE ME THAT COULD HELP?

CAREBLAZER SURVIVAL GUIDE CHECKLIST

☑ **Preparation:** I understand that the disease makes my loved one act in challenging ways and I do not take it personal. I am able to respond to them in ways that help them feel calm and safe. I don't argue or try to convince my loved one of something they don't believe.

- I am creative in how I handle challenges.
- I talk to other caregivers to see how they cope with similar challenges.
- I am aware of how my behavior, non-verbal's, and thoughts can make the situation better or worse.

☑ **Mind set**: I know there will be difficult times, but I am ready and able to face them without letting them tear me down. I also know there will be some good times and I will take time to cherish those moments.

- I am prepared with coping statements.

☑ **Refresh**: I put myself first because I know it makes me a better caregiver.

- I take time for myself. The time I take caring for myself will make the time I spend with my loved one better, easier, happier.
- I remember that I have a life to live even after my loved one is gone. What kind of life will that look like for me if I don't start taking care of myself now?

BE A PART OF CAREBLAZER NATION

HTTPS://WWW.PATREON.COM/CAREBLAZERS

Do find that Careblazers has been helpful to you? Do you want to make sure Careblazers continues to give helpful information? Please consider becoming a Careblazer supporter by clicking the above link and showing your support. Just one dollar a month makes a big difference!

WWW.CAREBLAZERS.COM

Your weekly TV show discussing all things dementia. Be sure to watch every week for new videos and leave a comment below any video with your questions for a chance for your question to be featured in a future video!

CAREBLAZERS@GMAIL.COM

Want to send an email? You can reach me here.

WWW.FACEBOOK.COM/DEMENTIACAREBLAZERS/

This is my Facebook page. Click the link above or search “DEMENTIA CAREBLAZERS” in the Facebook search bar to find the page. This page gives you more of a behind the scenes look into Careblazers, lets you know of new and exciting things happening in the world of dementia, and gives you a glimpse of my personal life.

HTTPS://WWW.FACEBOOK.COM/GROUPS/DEMENTIACAREBLAZERS/

The link above is a closed Facebook Group. Consider it a support group of types where Careblazers support one another and share tips for caring for a loved one with dementia. I personally review each request for access to the group. Click on the link above to request access and answer the required questions.

CAREBLAZERS

DEMENTIA CARE HEROES

STOP BEING A CAREGIVER AND BECOME A CAREBLAZER.

Hi, I'm Natali Edmonds! I'm a board certified Geropsychologist which basically means that I am a clinical psychologist who specializes in working with the geriatric population.

I work full time job for a major hospital and came up with the idea for Careblazers because there just isn't enough time in a day to help everyone face to face. I decided to bring my knowledge to the online world and create a weekly YouTube channel answering common questions about dementia.

When I'm not working on Careblazers TV, I'm probably running or cuddling with my 14 year old rescue pup, Guinness.

Alzheimer Society

Alzheimer's disease and other dementias

Reducing caregiver stress

Forget Me Not

Ne m'oubliez pas

Supporting a person with dementia requires time and energy. While it can be a rewarding experience, it can also be demanding and stressful. Knowing and recognizing signs of stress in yourself or someone you care about is the first step towards taking action.

If the following symptoms occur, call your doctor or contact your local Alzheimer Society for help.

10 signs of caregiver stress

Sign 1 Denial

…about the disease and its effect on the person with the disease.

"Everyone is overreacting. I know my parent will get better."

Sign 2 Anger

…at the person with dementia, yourself and others.

"If they ask me that question once more I will scream!"

Sign 3 Withdrawing socially

…you no longer want to stay in touch with friends or participate in activities you once enjoyed.

"I don't care about getting together with friends anymore."

Sign 4 Anxiety

…about facing another day and what the future holds.

"I'm worried about what will happen when I can no longer provide care."

Sign 5 Depression

…you feel sad and hopeless a lot of the time.

"I don't care anymore. What is wrong with me?"

Sign 6 Exhaustion

…you barely have the energy to complete your daily tasks.

"I don't have the energy to do anything anymore."

Sign 7 Sleeplessness

…you wake up in the middle of the night or have nightmares and stressful dreams.

"I rarely sleep through the night, and don't feel refreshed in the morning."

Sign 8 Emotional reactions

…you cry at minor upsets; you are often irritable.

"I cried when there was no milk for my coffee this morning. Then I yelled at my child."

Sign 9 Lack of concentration

…you have trouble focusing and you find it difficult completing complex tasks.

"I used to do the daily crossword. Now I am lucky if I can solve half of it."

Sign 10 Health problems

…you may lose or gain weight, get sick more often (colds, flu), or develop chronic health problems (backaches, high blood pressure).

"Since the spring, I have had either a cold or the flu. I just can't seem to shake them."

---

10 ways to reduce caregiver stress

As a caregiver, you need to take care of yourself. You may well be the most important person in the life of the person with dementia. The suggestions below will help maintain your health and well-being.

Learn about dementia

Knowing as much as you can about dementia and care strategies will prepare you for the dementia journey. Understanding how dementia affects the person will also help you comprehend and adapt to the changes.

Be realistic about dementia

It is important, though difficult, to be realistic about dementia and how it will affect the person over time. Once you are realistic, it will be easier for you to adjust your expectations.

Be realistic about yourself

You need to be realistic about how much you can do. What do you value most? A walk with the person you are caring for, time by yourself, or a tidy house? There is no "right" answer; only you know what matters most to you and how much you can do.

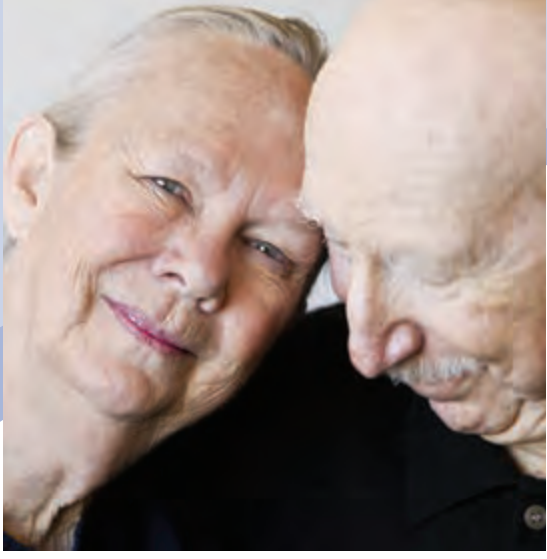
Accept your feelings

When caring for a person with dementia, you will have many mixed feelings. In a single day, you may feel content, angry, guilty, happy, sad, embarrassed, afraid and helpless. These feelings may be confusing. But they are normal. Recognize that you are doing the best you can.

Share information and feelings with others

Sharing information about dementia with family and friends will help them understand what is happening and prepare them to provide the help and support you need.

It is also important to share your feelings. Find someone you feel comfortable talking with about your feelings. This may be a close friend or family member, someone you met at a support group, a member of your faith community, or a healthcare professional.



Be positive

Your attitude can make a difference to the way you feel. Try to look at the positive side of things. Focusing on what the person can do, as opposed to the abilities lost, can make things easier. Try to make every day count. There can still be times that are special and rewarding.

Look for humour

While dementia is serious, you may find certain situations have a bright side. Maintaining a sense of humour can be a good coping strategy.

Take care of yourself

Your health is important. Do not ignore it. Eat proper meals and exercise regularly. Find ways to relax and try to get the rest you need. Make regular appointments with your doctor for check-ups. You also need to take regular breaks from caregiving. Do not wait until you are too exhausted to plan this. Take time to maintain interests

and hobbies. Keep in touch with friends and family so you will not feel lonely and isolated. These things will give you strength to continue providing care.

Get help

Support: You will need the support that comes from sharing thoughts and feelings with others. This could be individually, with a professional or as part of a dementia support group. Choose the form of support with which you are most comfortable.

Practical help: It can be hard to ask for and accept help. But asking for help is not a sign of inadequate caregiving. You cannot care for a person with dementia alone. Ask family and friends for help. Most people will be willing to assist you. Programs in your community may offer help with household chores or caregiving tasks. Your local Alzheimer Society can help you access these.

Plan for the future

Planning for the future can help relieve stress. If possible, review finances with the person with dementia and plan accordingly. Choices relating to future health and personal care decisions should be considered and recorded. Legal and estate planning should also be discussed. As well, think about an alternate caregiving plan in the event that you are unable to provide care in the future.

The **Alzheimer Society** is the leading nationwide health charity for people living with Alzheimer's disease and other dementias. Active in communities across Canada, the Society:

- Offers information, support and education programs for people with dementia, their families and caregivers
- Funds research to find a cure and improve the care of people with dementia
- Promotes public education and awareness of Alzheimer's disease and other dementias to ensure people know where to turn for help
- Influences policy and decision-making to address the needs of people with dementia and their caregivers.

Contact your local Alzheimer Society for more information. Visit alzheimer.ca/helpnearyou.

Help for Today. *Hope for Tomorrow…*®

Created: 2013. Last reviewed: 2022. Next review due: 2024.

Alzheimer *Society*

Alzheimer Society of Canada
20 Eglinton Avenue West, 16th Floor, Toronto, Ontario M4R 1K8
National office: 1-800-616-8816
Information and Referrals: 1-855-705-4636 (INFO)
Email: info@alzheimer.ca Website: alzheimer.ca
Facebook: facebook.com/AlzheimerCanada
Twitter: twitter.com/AlzCanada

Charitable registration number: 11878 4925 RR0001

B300-11E 2022

Caregiver Stress and Burnout

By Melinda Smith, M.A.

What is caregiver burnout?

While caring for a loved one can be very rewarding, it also involves many stressors. And since caregiving is often a long-term challenge, the emotional impact can snowball over time. You may face years or even decades of caregiving responsibilities. It can be particularly disheartening if you feel that you're in over your head, if there's no hope that

your family member will get better, or if, despite your best efforts, their condition is gradually deteriorating.

If the stress of caregiving is left unchecked, it can take a toll on your health, relationships, and state of mind—eventually leading to burnout, a state of emotional, mental, and physical exhaustion. And when you get to that point, both you and the person you're caring for suffer.

That's why taking care of yourself isn't a luxury, it's a necessity. Cultivating your own emotional and physical well-being is just as important as making sure your family member gets to their doctor's appointment or takes their medication on time.

Signs and symptoms of caregiver stress and burnout

Learning to recognize the signs of caregiver stress and burnout is important, so you can take immediate action to prevent things from becoming worse and start improving the situation for both you and the person you're caring for.

Common signs and symptoms of caregiver stress

- Anxiety, depression, irritability.
- Feeling tired and run down.

Difficulty sleeping.

- Overreacting to minor nuisances.
- New or worsening health problems.
- Trouble concentrating.
- Feeling increasingly resentful.
- Drinking, smoking, or eating more.
- Neglecting responsibilities.
- Cutting back on leisure activities.

Common signs and symptoms of caregiver burnout

- You have much less energy than you once had.
- It seems like you catch every cold or bout of flu that's going around.
- You're constantly exhausted, even after sleeping or taking a break.
- You neglect your own needs, either because you're too busy or you don't care anymore.
- Your life revolves around caregiving, but it gives you little satisfaction.
- You have trouble relaxing, even when help is available.
- You're increasingly impatient and irritable with the person you're caring for.
- You feel helpless and hopeless.

How to cope

While caring for a loved one will never be stress-free, the following tips can help you to lighten the load, avoid the symptoms of caregiver burnout, and find more balance in your life.

Avoid caregiver burnout by feeling empowered

Feeling powerless is the number one contributor to burnout and depression. And it's an easy trap to fall into as a caregiver, especially if you feel stuck in a role you didn't expect or helpless to change things for the better. But no matter the situation, you aren't powerless. This is especially true when it comes to your state of mind. You can't always get the extra time, money, or physical assistance you'd like, but you can always get more happiness and hope.

Practice acceptance. When faced with the unfairness of a loved one's illness or the burden of caregiving, there's often a need to make sense of the situation and ask "Why?"

But you can spend a tremendous amount of energy dwelling on things you can't change and for which there are no clear answers. And at the end of the day, you won't feel any better. Try to avoid the emotional trap of feeling sorry for yourself or searching for someone to blame.

Embrace your caregiving choice. Acknowledge that, despite any resentments or burdens you feel, you have made a conscious choice to provide care. Focus on the positive reasons behind that choice. Perhaps you provide care to repay your parent for the care they gave you growing up. Or maybe it's because of your values or the example you want to set for your children. These deep, meaningful motivations can help sustain you through difficult times.

Look for the silver lining. Think about the ways caregiving has made you stronger or how it's brought you closer to the person you're taking care of or to other family members.

Don't let caregiving take over your life. Since it's easier to accept a difficult situation when there are other areas of your life that are rewarding, it's important not to let caregiving take over your whole existence. Invest in things that give you meaning and purpose whether it's your family, church, a favorite hobby, or your career.

Focus on the things you can control. You can't wish for more hours in the day or force your brother to help out more. Rather than stressing out over things you can't control, focus on how you choose to react to problems.

Celebrate the small victories. If you start to feel discouraged, remind yourself that all your efforts matter. You don't have to cure your loved one's illness to make a difference. Don't underestimate the importance of making your loved one feel more safe, comfortable, and loved!

Get the appreciation you need

Feeling appreciated can go a long way toward not only accepting a stressful situation, but enjoying life more. Studies show that caregivers who feel appreciated experience greater physical and emotional health. Caregiving actually makes them happier and healthier, despite its demands. But what can you do if the person you're caring for is no longer able to feel or show their appreciation for your time and efforts?

Imagine how your loved one would respond if they were healthy. If they weren't preoccupied with illness or pain (or disabled by dementia), how would your loved one feel about the love and care you're giving? Remind yourself that the person would express gratitude if they were able.

Applaud your own efforts. If you're not getting external validation, find ways to acknowledge and reward yourself. Remind yourself of how much you are helping. If you need something more concrete, try making a list of all the ways your caregiving is making a difference. Refer back to it when you start to feel low.

Talk to a supportive family member or friend. Positive reinforcement doesn't have to come from the person you're caring for. When you're feeling unappreciated, turn to friends and family who will listen to you and acknowledge your efforts.

Ask for caregiving help

Taking on all of the responsibilities of caregiving without regular breaks or assistance is a surefire recipe for caregiver burnout. Don't try to do it all alone.

Look into respite care. Enlist friends and family who live near you to run errands, bring a hot meal, or watch the patient so you can take a well-deserved break. Volunteers or paid help can also provide in-home services, either occasionally or on a regular basis. Or you can explore out-of-home respite programs such as adult day care centers and nursing homes.

Speak up. Don't expect friends and family members to automatically know what you need or how you're feeling. Be up front about what's going on with you and the person that you're caring for. If you have concerns or thoughts about how to improve the situation, express them, even if you're unsure of how they'll be received. Start a dialogue.

Spread the responsibility. Try to get as many family members involved as possible. Even someone who lives far away can help. You may also want to divide up caregiving tasks. One person can take care of medical responsibilities, another with finances and bills, and another with groceries and errands, for example.

Set up a regular check-in. Ask a family member, friend, or volunteer from your church or senior center to call you at a regular time (daily, weekly, or as often as you think you need it). This person can help you spread status updates and coordinate with other family members.

Say "yes" when someone offers assistance. Don't be shy about accepting help. Let people feel good about supporting you. It's smart to have a list ready of small tasks that others could easily take care of, such as picking up groceries or driving your loved one to an appointment.

Be willing to relinquish some control. Delegating is one thing, trying to control every aspect of care is another. People will be less likely to help if you micromanage, give orders, or insist on doing things your way.

Give yourself a break

As a busy caregiver, leisure time may seem like an impossible luxury. But you owe it to yourself—as well as to the person you're caring for—to carve it into your schedule. Give yourself permission to rest and to do things that you enjoy on a daily basis. You will be a better caregiver for it.

There's a difference between being busy and being productive. If you're not regularly taking time-off to de-stress and recharge your batteries, you'll end up accomplishing less in the long run. After a break, you should feel more energetic and focused, so you'll quickly make up for your relaxation time.

Maintain your personal relationships. Don't let your friendships get lost in the shuffle of caregiving. These relationships will help sustain you and keep you positive. If it's difficult to leave the house, invite friends over to visit with you over coffee, tea, or dinner.

Share your feelings. The simple act of expressing what you're going through can be very cathartic. Sharing your feelings with family or friends won't make you a burden to others. In fact, most people will be flattered that you trust them enough to confide in them, and it will only strengthen your bond.

Prioritize activities that bring you enjoyment. Make regular time for hobbies that bring you happiness, whether it's reading, working in the garden, tinkering in your workshop, knitting, playing with the dogs, or watching the game.

Find ways to pamper yourself. Small luxuries can go a long way towards relieving stress and boosting your spirits. Light candles and take a long bath. Ask your spouse for a back rub. Get a manicure. Buy fresh flowers for the house. Whatever makes you feel special.

Make yourself laugh. Laughter is an excellent antidote to stress—and a little goes a long way. Read a funny book, watch a comedy, or call a friend who makes you laugh. And whenever you can, try to find the humor in everyday situations.

Get out of the house. Seek out friends, family, and respite care providers to step in with caregiving so you can have some time away from the home.

Take care of your own health

Think of your body like a car. With the right fuel and proper maintenance, it will run reliably and well. Neglect its upkeep and it will start to give you trouble. Don't add to the stress of your caregiving situation with avoidable health woes.

Keep on top of your doctor visits. It's easy to forget about your own health when you're busy with a loved one's care. Don't skip check-ups or medical appointments. You need to be healthy in order to take good care of your family member.

Exercise. When you're stressed and tired, the last thing you feel like doing is exercising. But you'll feel better afterwards. Exercise is a powerful stress reliever and mood enhancer. Aim for a minimum of 30 minutes on most days—break it up into three 10-minute sessions if that's easier. When you exercise regularly, you'll also find it boosts your energy level and helps you fight fatigue.

Practice a relaxation technique. A daily relaxation or meditation practice can help you relieve stress and boost feelings of joy and well-being. Try yoga, deep breathing, progressive muscle relaxation, or mindfulness meditation. Even a few minutes in the middle of an overwhelming day can help you feel more centered.

Eat well. Nourish your body with fresh fruit, vegetables, lean protein, and healthy fats such as fish, nuts, and olive oil. Unlike sugar and caffeine—which provide a quick pick-me-up and an even quicker crash—these foods will fuel you with steady energy.

Don't skimp on sleep. Cutting back on time in bed is counterproductive—at least if your goal is to accomplish more. Most people need more sleep than they think (8 hours is the norm). When you get less, your mood, energy, productivity, and ability to handle stress will suffer.

Join a caregiver support group

A caregiver support group is a great way to share your troubles and find people who are going through similar experiences each day. If you can't leave the house, many online

groups are also available.

In most support groups, you'll talk about your problems and listen to others talk; you'll not only get help, but you'll also be able to help others. Most importantly, you'll find out that you're not alone. You'll feel better knowing that other people are in the same situation, and their knowledge can be invaluable, especially if they're caring for someone with the same illness as your loved one.

Local vs. Online Support Groups for Caregivers

Local support groups:	Online support groups:
People live near each other and meet in a given place each week or month.	People are from all over the world and have similar problems.
Meetings provide you with face-to-face contact and a chance to make new friends who live near you.	You meet online, through email lists, websites, message boards, or social media.
The meetings get you out of the house, get you moving, provide a social outlet, and reduce feelings of isolation.	You can get support without leaving your house, which is good for people with limited mobility or transportation problems.
Meetings are at a set time. You will need to attend them regularly to get the full benefit of the group.	You can access the group whenever it's convenient for you or when you most need help.
Since the people in the support group are from your area, they'll be more familiar with local resources and issues.	If your problem is very unusual, a rare disease, for example, there may not be enough people for a local group, but there will always be enough people online.

To find a community support group, check the yellow pages, ask your doctor or hospital, or call a local organization that deals with your loved one's health problem. To find an online support group, visit the websites of organizations dedicated to your loved one's health problem.

Find caregiver services

In the U.S.	Family Care Navigator – Including eldercare services. (Family Caregiver Alliance)
	Resources for Caregivers – Support for caregivers of adults, children, individuals with disabilities and mental disorders, veterans, and more. (American Psychological Association)
	Elder Care Services Search – Services for older adults and their carers. (The U.S. Department of Aging)
	Respite Locator – Services in both the U.S. and Canada. (Arch National Respite Network)
In the UK	Your Guide to Care and Support – NHS services, including respite care. (NHS)
Australia	Support for Families and Carers – Resources and information. (Carers Australia)
New Zealand	Carers New Zealand – Help and advice, including guidance on respite care services. (Carers NZ)
Canada	Services for Seniors (PDF) – Including in-home support. (Government of Canada)

More Information

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Caregivers' Guide

Practical information for caregivers of older adults

www.gnb.ca

New Nouveau Brunswick

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Introduction

More than eight million Canadians are family caregivers. They are individuals (family members, neighbours, friends and other significant people) who take on the caring role to support someone as he or she ages. With an aging population, it is no longer a question about if someone will assume the role of caregiving; rather it is when. Today, New Brunswickers are living longer and with fewer health issues than in the past; however, most seniors continue to be challenged by at least one chronic disease or condition.

Family caregivers play an important role in helping seniors remain at home. It is well known that seniors prefer to stay in the familiar surroundings of their home for as long as possible, but eventually, they may require help to do so. In many instances, this can be achieved with enhanced supports from the community. These, in turn, may help delay or even avoid the need for more costly forms of long-term care services, such as hospitals, special care homes or nursing homes. It may also lead to better overall health and quality of life for your loved one.

This guide provides information to individuals who are now, or anticipate becoming family caregivers. It provides advice about various aspects of caregiving as well as practical ways caregivers can adapt their lifestyles and living environments to ensure a better quality of life for themselves and the senior for whom they are caring.

Please be advised that all the information in this guide is provided for informational purposes only and is not a substitute for professional medical advice, diagnosis or treatment. It should be noted that programs can change. Details should be obtained directly from the sources mentioned.

Caregivers in the midst of their many day-to-day responsibilities often do not take care of themselves and run the risk of developing health problems and feeling stressed. To help you manage your caregiving responsibilities, we have included information about available services and programs and suggestions about self-care and the importance of building and enlisting the help of a support network.

Caregivers

Caregivers who are employed

Balancing work and caregiving responsibilities is a challenge. Many caregivers are also raising children, volunteering, working and more. Employers are recognizing that the struggle to balance work and family commitments has important implications for employee productivity. As a result, more workplaces are promoting family-friendly organizational policies such as flexible work arrangements, family leave, Employee Assistance Programs and educational opportunities. If you are experiencing difficulties balancing work and caregiving responsibilities, ask your employer about what help is available through your workplace.

Taking care of yourself

The caregiver is a very important person in the life of the care recipient. Providing support can be demanding, requiring time and energy. Many caregivers suffer health problems as a result of the intense physical and emotional demands of looking after someone. As a caregiver, it is essential to look after yourself.

The personal satisfaction of caregiving can include:

- developing a new relationship with the person for whom you are caring;
- having the opportunity to give back;
- feeling a sense of purpose, accomplishment and satisfaction;
- developing new skills and knowledge;
- increasing understanding and compassion; and
- making new friendships through your support network.

Caregivers are strong and courageous individuals who play an important and invaluable role in society.

Caregiving is rewarding, but it is normal to have emotions that challenge your effectiveness as a caregiver.

Emotions you may experience include feeling:

- frustrated at your inability to meet all of the older person's needs or to balance your caring roles and personal life;
- resentment about the changing relationship and your new role as a caregiver;

- anger and frustration about the physical/mental changes the older person is experiencing;
- guilt about not doing enough or not making the best choices; and
- grief about the loss of your loved one's abilities. You may also grieve the loss of future plans or the relationship you once had with the individual.

As a caregiver, you may feel upset about these feelings. This is a normal reaction. Taking out your frustration on others only adds to your feelings of guilt and loss of control. It also creates tension between you and others. If you find yourself reacting negatively to the person for whom you are caring, take a break and do something positive for yourself.

Tips:

- Seek options for relief services, such as day activity centres for seniors and respite beds in special care homes and nursing homes.
- Arrange for services such as Meals on Wheels, telephone reassurance calls and safety checks.
- Collaborate with employers to encourage the implementation of more flexible work policies to support family members assisting seniors.
- Help families learn how best to carry out the tasks of caregiving by making information available when needed.

Sometimes care recipients will not want to accept help and prefer to assert their need for independence. They can feel frustrated, too, and they may be grieving over their loss of independence. Respect their choices even if you do not agree with them. Be a patient listener and allow them to express their feelings. This may improve their outlook, and your understanding of the situation may help improve communication. As long as there is no risk of danger to themselves or others, it is important for them to be able to make their decisions wherever possible.

Accept that there are some things you cannot change, so focus on the things you can.

Tips:

- Help the care recipient cope with his or her feelings; his or her life is changing, too.
- Instead of focusing on what the care recipient can no longer do, choose to focus on what he or she can still do.
- If the care recipient has a medical condition, learn about it and how you can best care for him or her. This will help you to feel better equipped and allows you to be prepared for changes that may happen over time, so you can be better able to plan for future needs.
- Familiarize yourself with common behavioural changes. Knowing what to expect can help you to cope better.
- There is a difference between "helping" and "doing" – adopt an approach that promotes the care recipient's independence whenever possible.

Always make time for yourself, even if it is just an hour or two.

Take care of your health

Tips:

- Get adequate rest, good nutrition and sufficient exercise.
- Trust your abilities and talents.
- Be gentle with yourself and others.
- Take a rest and recharge.
- Try to be aware of your limitations.
- Let go of grievances and grudges.
- Maintain your hobbies and interests.
- Caregiving can be exhausting; do not feel guilty about arranging respite breaks for yourself.
- Do not be afraid to ask for help! If you are feeling overwhelmed, seek advice from a friend, a caregiver support group or a health-care professional who can offer insights, comfort and support to help you cope and get through the transition in your life.
- When friends and family members offer help, welcome their assistance and do not be afraid to be specific about what kind of help you need. It can be as simple as running an errand for you, helping with childcare or even making a casserole to help with meals.
- Community organizations may also provide some of the help you need.

Learn to recognize the signs of stress

- Denial.
- Anger.
- Social withdrawal.
- Anxiety/worry.
- Difficulty sleeping.
- Exhaustion.
- Difficulty concentrating.
- Health problems.
- Weight gain or loss.

More ways to take care of yourself

Tips:

- Be realistic about how much you can do.
- Be positive – your attitude affects how you feel and the way you approach your caregiving role.
- Accept your feelings – in a single day, you may feel content, angry, guilty, happy, sad, embarrassed, afraid and helpless. These feelings may be confusing, but they are normal.
- Remember anger and resentment are often symptoms of exhaustion. Taking time to rest and recharge is not being lazy.
- Reach out to family, friends, health-care professionals or community resources for help.
- Take advantage of relief or respite programs, which provide temporary care while you take a break from caregiving.

An honest conversation can help relieve tension, resolve problems and erase negative feelings.

Respite care options

Relief or respite care can be provided by an informal system of family members or friends.It can also be obtained through the Department of Social Development's Long-Term Care Program:

- Day activity centres for seniors provide caregiver relief, social support and meaningful social/recreational activities in a group setting. There is a daily fee for these services, but it may be subsidized for eligible clients. A small daily fee is charged to cover the cost of snacks and meals.
- Home support services help with daily activities such as personal care (examples: feeding, grooming, bathing), housekeeping and meal preparation. This service could provide you with relief care for personal time or errands or assistance with care needs that you may need support to complete (example: a safe transfer into a bathtub or into a chair). Relief care can be provided to give support to families or caregivers to keep seniors in their homes and delay or prevent placement in residential facilities or hospitals. Temporary relief can be provided in a person's home, a special care home or a nursing home.

Respite care offers you a break and time to relax. Relief staff can provide quality care in your absence. Using respite staff allows you and the care recipient to become familiar with the respite staff and be confident in the care provided.

To access these services under the Long-Term Care Program (see page 27), contact any regional office of the Department of Social Development, 8:30 a.m. – 4:30 p.m., Monday to Friday (closed on statutory holidays):

- Acadian Peninsula: 1-866-441-4149
- Chaleur: 1-866-441-4341
- Edmundston: 1-866-441-4249
- Fredericton: 1-866-444-8838
- Miramichi: 1-866-441-4246
- Moncton: 1-866-426-5191
- Restigouche: 1-866-441-4245
- Saint John: 1-866-441-4340
- For more information:
- Email: sd-ds@gnb.ca
- Web: www.gnb.ca/seniors

Some communities offer senior living facilities to individuals able to live more independently than others but do not want the concerns of maintaining a home. These rental facilities offer access to meals, social activities and events, transportation and housekeeping service. Staff are available for emergency support when required 24 hours a day.

Recognizing one's need for help is a sign of strength in itself.

Your support network

Learning to accept help is central to self-care for every caregiver. The following are examples that could be included in your support network:

- Family members – Listen to each other and come to a mutual agreement on plans for the care recipient. It may be helpful to identify the role for which each family member will take responsibility. Family members who live far away can also help. For more information, see page 8.
- A professional/community team:
    - Trained caregivers are ideal for relief care, even if only for an afternoon or evening.
    - A home support worker can help with personal care such as bathing and dressing.
    - Community groups such as the Alzheimer Society of Canada, the Canadian Cancer Society, Ability New Brunswick can provide information and services that could help you in many ways.
    - Caregiver support groups are a good way to share experiences and advice with others in a similar situation.
- The Internet is a great source of information, providing links to various organizations and available resources to help you in your caregiving role.
- Assistive devices such as walkers, wheelchairs, raised toilet seats, bedside commodes, shower chairs and grab bars can help you provide care and allow for more independence for the care recipient. See page 19.
- Technology such as Lifeline or Care Link Advantage can help the care recipient live independently and summon help in an emergency.

How family, friends and neighbours can help

Family, friends and neighbours are important sources of support for caregivers.

Tips:

- Take time to listen – let the caregiver know you are there to talk if he or she is feeling overwhelmed.
- Be specific with your offers of help. Instead of an open-ended offer such as, "Let me know if you need anything," try a more concrete offer such as, "I am going to the store. Would you like me to pick something up for you?"
- Offer to relieve the caregiver – encourage him or her to relax, spend time on a favourite activity or run some errands.
- Provide a change of scenery – suggest an outing to the park or a visit to your home that could include the care recipient.
- Choose an activity that everyone will enjoy and arrange a suitable time for the visit.
- Keep in touch – a visit, a telephone call, a card, an email or a text can mean a great deal.

- Visits should be relaxed, engaging and not rushed. Be sensitive to the health condition of the care recipient.
- Talk about things the person enjoys, or chat about everyday happenings, the weather, pets, children or grandchildren.
- Stay the course – caregiving is often a long journey. Any support you can provide along the way will be appreciated.

What you might not know about caregivers

- They often feel alone and isolated from friends and family.
- They are often reluctant to ask for help, even though they may need assistance.
- They sometimes could use help with errands or household tasks.
- They experience stress that can affect their health.
- They need regular breaks from caregiving.
- They often need someone to listen.

Contingency planning

Planning for contingencies can reduce worries by ensuring that steps are in place in case of a sudden or unexpected change in the health of the care recipient or the caregiver. All those involved will have the satisfaction of knowing that a system is in place that outlines what needs to be done and who will do it. If the care recipient is mentally competent, ask what his or her future care wishes are and make sure they are respected. Do not be afraid to talk about the what-ifs. It is better to plan ahead than react to a crisis.

Tips:

- Keep an up-to-date list of contact information of services providers and programs in the care recipient's area.
- With the consent of the care recipient, arrange for programs and services in the community, such as Meals on Wheels; Canadian Red Cross Telephone Reassurance Calls and Wellness Checks; Home Support Services; Respite Care; and day activity Centre programs for seniors.
- Learn all you can about the health condition of the care recipient.
- Keep a personal notebook or journal where information about the care recipient can be recorded and is easily accessible. It helps to keep it available in the same place, perhaps, near the telephone. This will give you peace of mind in knowing all the pertinent information you require is in one place. Remember to keep it updated. Examples of what to include:
    - Full name of the care recipient.
    - Date of birth.
    - Social Insurance Number.
    - Medicare number.
    - Health insurance information.
    - Emergency contact numbers.
    - Up-to-date list of medications – what they are for, the dosage and when and how they are to be administered.
    - Names, addresses and telephone numbers of doctors, hospital and clinics.
    - Dates and times of appointments.
    - Schedule of caregiving events (visits from home support worker, Extra Mural nurse, medical appointments, etc.).
    - Contact information of family and friends involved in your support network.

Caregiving from a distance

Caring for someone from a distance can be just as stressful as or even more stressful than being there. If you are a long-distance caregiver, you help locate and coordinate services or discuss plans with health-care providers and other family members or caregivers.

You may also delegate tasks, monitor the situation and help make decisions.

> If you are not the primary caregiver, make yourself available to the person who is.

There are a number of ways for a long distance caregiver to participate in caregiving:

- Keep regular contact with the care recipient – establish routines for telephone calls, send emails, photographs and if possible arrange for Skype or FaceTime visits.
- Visit as often as you can to provide relief to the on-site caregiver.
- Offer to help with financial matters, such as contributing to the purchase of a piece of equipment.
- The use of technologies can offer peace of mind to caregivers who live at a distance. See page 24.

Personal care

Personal care is an intimate time. The care recipient may be modest and feel uncomfortable. If you are helping someone with personal care, it is important to plan plenty of time to allow for all necessary activities while following the person's usual routine as much as possible. The most important part of a personal care routine is maintaining dignity and privacy.

Bathing

- Be familiar with the routines and preferences of the care recipient – does he or she prefer a shower, a tub bath or a sponge bath.
- Talk to the care recipient ahead of time so he or she knows when the bath is planned.
- Use a calm and gentle manner and proceed slowly. Do one step at a time, talking the care recipient through each one.
- Maintain a feeling of privacy by creating a calming and relaxing ambiance.
- Make sure the bathroom is warm and inviting.
- Test the bath with your elbow for a safe water temperature.
- To prevent burns, you may want to adjust your water heater's settings. The ideal water heater setting is 120˚F (49˚C).
- Use a bath chair in the tub or shower stall.
- A hand-held showerhead can make bathing easier.
- Collect all the necessities, including towel, soap, washcloth, razor, shaving cream and skin lotion, and place them within easy reach.
- Give the care recipient the opportunity to participate in his or her care. Hand the bath items out in order of use, if you are required to do so.

Hair care

- Encourage the care recipient to choose a cut that is attractive but easy to care for.
- Make shampoos part of the regular shower or bath routine. Dry shampoo can be used between hair washings.
- If a care recipient's movement is limited, a device such as shampoo board or a bath visor can make shampooing easier. Check with a beauty salon equipment supplier or go online to obtain one.
- A visit to or from a barber or hairdresser makes any day special.

Skin care

Attention to basic skin care is essential to good health. Neglect can lead to painful sores that may require medical attention.

- In older adults the skin is thinner, lacks elasticity and can be easily damaged.
- Prevent pressure sores by making sure the care recipient changes positions, sits or lies on a flotation cushion or sheepskin and wears soft fabrics (such as cotton) close to the skin.

- Check the care recipient's skin daily. Look for red skin over bony parts of the body and blue or dark purple patches. Look for any tenderness or broken skin. If a sore is noted, talk to your health-care provider as soon as possible about how to clean, dress or bandage the area.
- Keep skin clean and moisturized. Use body lotion on dry skin, especially on elbows, knees and soles of the feet.
- Use soaps, antiperspirants and perfumes sparingly, and keep hot baths to a minimum because they dry the skin.
- Apply sun screen when planning outdoor activities.
- Special attention is necessary in cases of incontinence. See page 13.

Foot and nail care

Foot and nail care, including regular inspections for cracks, cuts or ingrown nails are important in overall health and particularly important for people with diabetes.

- When caring for the care recipient's nails, filing is preferable to cutting.
- Keep toe and fingernails filed straight across. If nails are very thick or difficult to trim, consult a professional such as your family physician or call the Extra Mural Program.
- Watch for signs of discomfort or redness on pressure areas of the foot. Sheepskin protectors or foam can be used to take pressure off the area.
- Seek medical attention if foot sores are noted or there is drainage or an odour coming from a foot sore.

Oral hygiene

Talk to the care recipient ahead of time to let him or her know that it is time to brush his or her teeth. Encourage regular brushing and gentle flossing.

- Use a soft tooth brush with toothpaste.
- If assistance is needed, take a gentle, slow and patient approach, talking the care recipient through each step.
- If the care recipient resists tooth brushing, stop and try again later.
- Depending on the care recipient's ability, you may need to place your hand over his or hers to guide brushing, or stand behind him or her and brush the teeth.
- Dentures should be rinsed after meals and soaked in water overnight. Keeping dentures in the mouth overnight can promote infections.
- If dentures seem uncomfortable, consult a dental professional to find out if they need to be adjusted.

- Make sure that the care recipient gets regular dental check-ups, even if he or she wears complete dentures.
- If you notice any changes in the mouth, such as a broken or damaged teeth, sores, lumps or swollen gums, have them checked by a dentist or a health-care professional.

Clothing and footwear

- Choose attractive, comfortable, functional and washable clothing.
- Make sure the care recipient has the right clothes for the right activities as well as extra clothes in case something gets soiled.
- Consider buying duplicates of favourite outfits.
- Choose garments with a minimum number of buttons, fasteners and zippers, and make sure these are all easy to reach.
- Large, flat buttons are easier to manage than small round ones.
- Centre-front fasteners are easier to manage than ones on the side or back.
- Clothes with Velcro fastenings can help increase independence with dressing.
- Zippers should have pull-tabs that are easy to grip.
- Choose loose-fitting pants that can easily be pulled up or down.
- Care recipients who sit for long periods or who are confined to wheelchairs can be more comfortable in short jackets, capes and shawls.
- Long T-shirts, night shirts or night gowns may be better for bed wear.
- Choose warm, comfortable shoes with non-slip soles.
- Opt for Velcro fasteners instead of shoe laces.
- Avoid slippers that lack support or are too large – they increase the risk of falls.

Eating well

Good nutrition is important at every age. As we age, our dietary needs change. The key to healthy eating is to plan food choices and meals using *Eating Well* with *Canada's Food Guide*.

To order a free guide:

- Telephone: 1-866-225-0709
- Email: publications@hc-sc.gc.ca

A registered dietitian can provide advice tailored to the care recipient's nutritional needs. To find a qualified dietitian in your area:

- Web: www.dietitians.ca

Physical activity

Physical activity helps us remain healthy and maintain our bodily functions. When we do not use a part of our body, we risk losing its functional ability. Remember, exercise should never hurt. Ask a physiotherapist what kind of exercise is best for the care recipient. A first step would be to order the *Active NB SeniorsToolkit*.

To order this guide:

- Telephone: 1-855-550-0552
- Web: www.wellnessnb.ca/seniors

Constipation

Many things can cause constipation. These include a diet high in refined or processed foods and low in fibre. It can also be caused by a lack of physical activity as well as some prescription drugs and over-the-counter medications. Bowel movements can often be regulated by eating well, increasing dietary fibre intake, drinking at least eight glasses of water every day and exercising regularly.

If constipation remains a problem, consult a health-care professional. A limited course of laxatives may be prescribed, but over-use can sometimes worsen the situation.

Incontinence

Getting to the bathroom can be difficult for those with limited mobility, or who are confined to bed, or whose bedrooms or sitting rooms are a distance from the bathroom.

Tips:

- Place a commode beside the bed.
- Visit the bathroom regularly (perhaps every two hours).
- Place waterproof protective covers on the bed and furniture.
- Place waterproof pads and sheets in layers on the bed, so when you remove one layer there is a dry surface underneath.
- Have plenty of clean, dry underwear available.
- Check the care recipient frequently for incontinence.
- Use protective underwear liners or disposable underwear and change as required. Protect the skin from too much moisture. Soiled skin is porous to bacteria and prone to infection and breakdown.

> Incontinence is not unusual, especially for seniors and people with various health problems and conditions. The choice of absorbent adult briefs will depend on the care recipient's needs. Many are slip-on and look and feel very much like regular underwear. This can help a person maintain dignity and be comfortable during daily activities.

Medication

Make sure that the doctor and pharmacist know about all the medicines that the care recipient is taking. These include prescribed and over-the-counter drugs including vitamins and herbal dietary supplements. This is important because some medications may cause problems when used with other medications.

Be sure the doctor and pharmacist know of any allergies or adverse reactions the care recipient may have had to any medications.

Make sure you know what each medication is for, how it should be taken and what its potential side effects are. Try to use one pharmacy for all medication needs. This way the pharmacist can keep track of the medications and check for possible interactions.

The care recipient's pharmacist will provide counselling to ensure the prescriptions are appropriate and provide the greatest benefits.

Ask the pharmacist about putting medications in a blister pack to simplify their administration.

Keep medications out of sight and reach of children.

Sleep

In later life, the need for sleep decreases to about six hours on average. Less time is spent in deep sleep; sleepwaking is more frequent; and there is a tendency to nap during the day.

Many things may interfere with optimal sleep in older adults. Acute and chronic illnesses, side effects of some medications, mental health conditions, sleep disorders and abrupt uncontrollable changes in social and personal life may contribute to sleep difficulties. A first step to better sleep is to know what interferes with it.

Having a regular sleep schedule and getting enough sleep every night are especially important for older adults.

Tips:

- Good nutrition and physical activity are associated with good sleep.
- Relaxation techniques can assist with physical and mental relaxation.
- The optimal duration of a nap is 10 to 20 minutes. Otherwise, napping during the day may take away from total sleep time at night.
- Create the best possible environment for sleep: a quiet and dark room and comfortable ambient temperature.
- Avoid television and other electronic screens in the bedroom.
- Reduce the intake of stimulants such as caffeine, nicotine and alcohol as much as possible.
- Reduce stressful experiences and worries close to bedtime.
- Ask the pharmacist or doctor about the possible side effects of medications on sleep.

Visiting the doctor

As caregiver, you may need to advocate on the care recipient's behalf when visiting the doctor. This role may involve asking questions and taking notes on the doctor's instructions during appointments.

Tips:

- Remember the care recipient should be included and have a voice on making decisions for his or her treatment.
- Communicating clearly with doctors is crucial. Making regular, scheduled visits with enough time to discuss concerns will help you and the care recipient make the most of every appointment. If there are questions following a visit, contact the doctor's office.
- Bring bottles or vials of prescribed and over-the-counter medications, including dietary and herbal supplements with you to the physician's office.

- Keep a journal with notes about the health of the care recipient. Note any symptoms and changes in the care recipient's health and behaviour, include medications taken and the time at which they are taken, as well as any reactions. Bring these notes to appointments.
- You and the care recipient should keep a list of questions to ask the doctor and be prepared for a follow-up visit if time is limited.

Hospitalization

Should the care recipient require hospitalization, your involvement can facilitate care and treatment.

Tips:

- Provide as much information as possible to the doctors and nurses who will be providing care to meet the needs of the care recipient.
- Speak to the manager or primary care nurse to find out the best way to make your comments and/or concerns known.
- Care can be greatly enhanced by the presence of family and/or friends who understand the care recipient's capabilities, strengths and limitations, likes and dislikes, fears and anxieties, and who are capable of advocating on his or her behalf.
- A hospital social worker and discharge planner are available to help with questions, support and counselling.

Quality of life

Focus on what the care recipient can do and respect his or her desire to remain independent.

Even though the care recipient may have some physical or mental challenges, it is very important to recognize his or her knowledge, strengths and talents and to provide opportunities to engage him or her in meaningful activities with family friends and those around him or her. An individual still needs to feel connected.

Tips:

- Help the care recipient choose activities that are enjoyable.
- Choose flexible activities that can be adapted to suit the needs of the care recipient.
- Build on the care recipient's strengths and talents; consider activities that relate to his or her accomplishments, interests or hobbies.
- Emphasize the importance of doing things, not the result.
- Help the care recipient create his or her memoirs or story of his or her life experiences and accomplishments.
- Look for activities that make the care recipient feel valued and productive. The care recipient may prefer to only watch or help at first, and may join in later.
- Do not insist on participation. Just watching can be enjoyable for some.
- Feeling a sense of inclusion is important. Plan activities that include interactions with family and friends and where the care recipient feels support and connected to others.

Using a personal tablet can help the care recipient connect with family and friends, send or receive emails or view family photographs.

Activities that promote quality of life

- Walks or drives.
- Listening to music.
- Singing favourite songs.
- Playing an instrument.
- Dancing.
- Gardening.
- Visiting the park.
- Doing a favourite hobby or pastime (knitting, woodcarving).
- Reminiscing/story telling.
- Going through old photograph albums.
- Reading.
- Playing games (cards, board games, video games).
- Having coffee, tea and conversation.
- Visiting with a pet.
- Visiting with young children.
- Surfing the Internet.
- Watching favourite television shows, movies and videos.

Reading is a pleasant and enlightening pastime

Consider these tips to make reading more enjoyable:

- Good lighting.
- Large print.
- Illustrations.
- Reading glasses.
- Audio books and e-readers.
  A book support (for use in bed and in chairs).

Those willing to read aloud make it possible for others to enjoy the social connection and as well as the joy of reading.

Daily household activities

The importance of keeping the care recipient involved in daily household activities cannot be overemphasized. Simple but helpful tasks include:

- Setting or clearing the table.
- Helping with food preparation.
- Drying the dishes.
- Dusting.

- Organizing the recycling bins
- Watering plants or gardening.
- Helping with groceries.
- Collecting the newspaper/mail.
- Folding laundry.
- Folding grocery bags.
- Caring for a pet (brushing or feeding it).

Outings

Change is as good as a rest, and an outing is a pleasure, especially if it is well planned.

- Allow plenty of time to get ready so you do not feel rushed.
- When spending time outside on sunny days, wear sunscreen, sunglasses and a hat.
- At a restaurant, mention any special dietary requirements when you order.
- Call ahead if you are unsure about the accessibility of a building you plan to visit.
- If you would like to obtain a parking permit for persons having a disability, application forms are available from Service New Brunswick:
    - Telephone: 1-888-762-8600
    - Web: www.snb.ca

Spirituality

Many seniors draw comfort and strength from their beliefs, and it is important to support them in their convictions. For example, encourage visits from clergy or pastoral care workers if these are important to the care recipient.

For many people, spirituality fosters hope and provides a foundation for the celebration of life. It can help people find meaning in a difficult situation and achieve a sense of inner peace. Spiritual practices can provide comfort and reassurance as well as encourage acceptance of our mortality.

Physical environment of the older person

Today's advances in medicine and technology make caring for seniors easier than in the past. Contact the Extra Mural office in your area (telephone number found in the white pages of the telephone book) to talk to an occupational therapist about what home modifications, tools and devices are appropriate for the care recipient.

Many assistive devices are available, explore options online or consult a health-care professional or home health outlet.

Providing physical assistance to others may put you at risk of injury. Being familiar with techniques to prevent injury to yourself or the care recipient is important. You can prevent injuries by learning the correct way to help someone roll over in bed, get up from a chair or move from a wheelchair to a car.

Health care equipment

Seniors can borrow standard and specialized health equipment free of charge from the Canadian Red Cross Society through the Seniors' Rehabilitative Equipment Program. Available equipment includes hospital beds and mattresses, raised toilet seats, over-bed tables, canes, crutches, wheelchairs, walkers and commodes. To obtain equipment, a written referral must be completed by a New Brunswick physician, nurse, physiotherapist or occupational therapist. All equipment is returned to the Canadian Red Cross Society office when it is no longer required. For further information, contact your nearest Canadian Red Cross Society office.

Explore options online or consult home health outlets for the assistive devices available.

Options to consider for the home:

Bathroom

- Install sturdy grab bars by the toilet and in the bathtub/shower area. Grab bars should be securely attached to studs in the wall. The space between the wall and the bar should not exceed five centimetres (two inches). A space any wider could allow an arm to slip through and cause injury.
- Consider installing a raised toilet seat. You may want to consider getting one with arms to help the care recipient get up from the toilet easily.
- Place a comfortable suction bath mat on the floor of the tub.
- Place a non-skid mat beside the tub.
- Showering is often easier than taking a bath, especially when you place a bath chair in the tub or shower stall.
- A hand-held showerhead offers greater water control and is especially useful for those who sit in the shower.
- If only a bath will do but getting into the tub poses a challenge, investigate what equipment and home adaptation options are available.

Bedroom

- If the bedroom is on the second level and access is a problem, convert a downstairs room into a bedroom and bathroom or install a stair lift to access bedrooms on the second level.
- Hospital beds can be raised to make it easier for you to work with the care recipient, or lowered to make it easier to get in and out of bed. They also offer several positioning options and have side rails that can be used for support and safety.
- An adjustable-height commode is useful when the care recipient must urgently go to the bathroom, especially at night.
- A securely installed "trapeze" (suspended triangular device to be grabbed to assist in sitting up or standing) may be useful.
- An adjustable over-the-bed table can be used to hold drinks, snacks, books and crafts.

Make sure smoke detectors in the home are properly installed and working.

Entryways

- Consider installing motion detector lights to light up the path to the main door.
- Ensure there are handrails on both sides of the stairs. These should be sturdy, securely attached and in good condition.
- Replace doorknobs with levers.
- For easy access to and from the outdoors, an access ramp may be required.

Floors

- Avoid deep carpets and scatter rugs; they make walking with a cane or walker or using a wheelchair difficult and dangerous.
- Take care that floors are not slippery.
- Remember a shiny floor can cause confusing reflections.
- Keep floors free of clutter to prevent falls.

Furniture

- Arrange furniture for ease of movement when using a cane, walker or wheelchair.
- Make sure furniture is sturdy and steady enough that it will not tip if someone leans on it while sitting or standing.
- Avoid chairs with deep seats.
- Choose synthetic fabrics that can be easily wiped clean.
- Upholstered furniture can be treated with protective spray against spills and stains.
- Place contrasting fabrics on the backs and arms of sofas and chairs to help care recipients with visual impairments.
- Consider replacing lamps that have hard-to-reach switches.
- Use footstools with caution because they can become a fall hazard.

Kitchen

- If necessary, adjust the stove by removing knobs or installing dial guards so it cannot be used without supervision. Many ovens are equipped with a self-locking feature – if yours does not have this feature, a lock can be purchased separately.
- Keep sharp utensils and small electrical appliances out of sight.
- Use safety latches on cupboard doors if necessary.
- Keep all cleaning products and detergents locked up and out of reach.
- An electric, whistling kettle with an automatic shut-off system can be a safe choice.
- Purchase a fire extinguisher and place it in a visible area of the kitchen.

Fall prevention

- Call the Extra Mural Program for a safety assessment.
- Plan for regular vision and hearing tests.
- Install proper lighting throughout the home.
- Check that stairs are in good condition and are slip resistant. Take the same precautions for outdoor steps.
- Arrange to have leaves, snow and ice removed regularly.
- Use salt or sand throughout the winter. Keep a supply handy near the door.
- Choose proper footwear. See page 12.
- Use walking aids and other safety devices for extra safety.
- Make sure that area rugs are non-slip. If needed, secure them with double-sided carpet tape.

You can learn how to react in an emergency by taking a First Aid and Cardiopulmonary Resuscitation (CPR) and automated external defibrillator (AED) course.

For course offerings in New Brunswick:

St. John Ambulance:
- Telephone: 1-800-563-9998
- Web: www.sja.ca/newbrunswick

Canadian Red Cross Society:
- Telephone: 506-674-6200
- Web: www.redcross.ca/atlantic

For more information about adapting your physical environment, order a free copy of *The Safe Living Guide*, published by the Public Health Agency of Canada:

- Telephone: 613-952-7606
- Email: seniorspubs@phac-aspc.gc.ca

Some homeowner households may be eligible for a forgivable loan for both disabled accessible modifications and other major repair items (i.e., structural, electrical) to a maximum of $20,000.

Seniors are eligible for a forgivable loan for minor adaptations to facilitate independent living to a maximum of $3,500. For more information:

- Telephone: Any Department of Social Development regional office (see page 5)
- Web: www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/Housing/fedprovrepairprog-e.pdf

It's not just about conversation. A touch on the hand, stroking of the hair, a kiss on the cheek, a hug … says a lot!

Communication

Staying connected

Continued participation in familiar activities and regular contact with family and friends are extremely important because they provide stimulation and can help maintain independence. Some family members or friends may be reluctant to visit because they no longer know how to communicate with the care recipient. The opportunity for conversations may be limited when the care recipient's ability to express himself or herself becomes compromised. Even though the care recipient may have difficulty communicating, he or she is still aware of his or her surroundings and can still sense the emotional state of others. Even sitting quietly together conveys you care and provides comfort and companionship.

Conversation

- Listen attentively and try to sense the feelings the care recipient is expressing. You can then respond to the emotional tone of what is being said. For example, "You seem to be upset" or "You look happy today."
- Body language is a useful communication tool. Pay attention to pauses, tone and volume of the voice, gestures, posture and facial expressions.
- Reflect on how you are presenting yourself. Are you tense and frowning, impatient, or calm and reassuring?
- A slow and calm encouraging approach promotes reassurance.
- Use a gentle touch to help convey your message.
- Maintain a normal, adult conversational structure – do not use "baby talk" or patronizing language.
- Speak slowly and clearly and allow plenty of time for a response.
- Do not converse with others in front of the care recipient as if he or she is not present. When others are present, remember to always include the care recipient in the conversation.

Communication devices

Communication devices, both simple and sophisticated, can simplify daily activities and are essential in emergencies.

Consider the following suggestions:

- Invest in a telephone with large numbers and a memory dial feature. A cordless telephone

or cell telephone may be handy for those unable to get to the telephone easily.
- Post large-print emergency and back-up caregiver telephone numbers near the telephone.
- Adjust the telephone volume to an appropriate level.
- A cordless or cell telephone put in a carrying case can be attached to a walker or wheelchair.
- Consider a medical alert or remote monitoring system such as Lifeline or Carelink for a care recipient living alone.
- Talk to your police department if the care recipient might wander away from home. The police can put a plan in place and can react more quickly when they know about the situation.
- The Alzheimer Society has the Medic Alert Safety Home Program that offers an effective way to identify the care recipient who is lost and bring the family back together. Contact your local Alzheimer Society office for more information and to register the care recipient.

Independent living with the use of technology

Several technologies are available to help care recipients live independently while providing peace of mind to family members. These are ideal for care recipients who live alone or are alone for long periods, have a medical condition or are at risk of falling. The availability of assistive technology for care recipients is advancing quickly; check online for devices available.

Medical alert services allow care recipients to call for help at the touch of a button, ensuring that emergencies are responded to quickly and efficiently. In the event of an emergency, a family member or emergency services are contacted, depending on the care recipient's need. Some medical alert systems can detect falls automatically and activate a call to the proper emergency response system if the care recipient is unable to activate a call for help.

Monitoring systems using motion sensors and discrete cameras (optional) allow caregivers to monitor a care recipient's daily activities from a distance to ensure he or she is safe and well. This service can also provide caregivers with instant notifications on selected areas of concern, such as:

- wandering;
- forgetting to take medications;
- sleeping and eating habits;
- absence of activity;
- injuries and other health issues.

Legal concerns

Plan ahead: help the care recipient settle legal and end-of-life matters ahead of time. Although everyone should plan ahead, the care recipient and his or her caregivers may have particular concerns about what might happen if he or she loses their ability to make decisions. The Canadian Hospice Palliative Care Association has resources that may help start the delicate conversation on advance care planning and informs the caregiver and the care recipient on a variety of topics that should be considered.

- Web: www.advancecareplanning.ca

Have a full discussion to seek advice from a trusted financial or legal advisor about the care recipient's personal situation and assets.

Things to consider when planning:

- Making a will.
- Making funeral arrangements that respect the care recipient's wishes.
- Considering a pre-arranged funeral.
- Creating a power of attorney for financial matters in which the care recipient (as the donor) gives another person (the donee) the authority to handle his or her financial and property matters. (It needs to be an "enduring" power of attorney for the power to continue if the care recipient becomes mentally incompetent.)
- Creating a power of attorney for personal care in which the care recipient, as the donor, gives another person the authority to make his or her personal and health-care decisions when he or she is unable to do so. This other person should be aware of any advance medical directives, health-care treatment or end-of-life decisions that the care recipient has.
- The care recipient can choose as many donees as he or she wants. The care recipient can require donees act together or as alternates. If the care recipient wishes, he or she may choose the same person or persons to act on his or her behalf for financial matters and personal care decisions. Or, the care recipient may choose a different person or persons to handle each of these matters.

Do not delay. Having a power of attorney can give the care recipient peace of mind knowing that if he or she becomes physically disabled or mentally incompetent, he or she has chosen someone able to act on his or her behalf. If the care recipient delays in giving the power, he or she may be unable to do so when he or she needs it.

Important documents should be kept in a safe place but where you can easily access them.

For more information and educational pamphlets on legal topics, contact the Public Legal Education and Information Service of New Brunswick (PLEIS-NB). PLEIS-NB is a provincial non-profit organization and a registered charity. Its mandate is to provide the public with information about the law.

PLEIS-NB does not provide individual legal advice, only general information. A range of educational booklets are available, many dealing with topics of particular interest to seniors, such as wills and estate planning, powers of attorney, abuse and neglect, going to a nursing home, and investment fraud. Anyone requiring specific legal advice should consult a lawyer.

- Telephone: 506-453-5369
- Email: pleisnb@web.ca
- Web: www.legal-info-legale.nb.ca

Services available under the Long-Term Care Program

Care recipients who need help with daily activities (e.g., mobility, bathing, preparing meals) on a long-term basis may be eligible for subsidized services under the Long-Term Care program. These services may be provided in the home, in an adult residential facility or nursing home. All Long-Term Care services are voluntary, and care recipients need to consent to being referred. Referrals to the Department of Social Development can be made by calling the regional office where the care recipient lives.

In-home services overview

Home support services can help a care recipient with his or her daily activities such as personal care (e.g., feeding, grooming, bathing), housekeeping and meal preparation in the comfort of his or her home. This service can also be used to offer relief to caregivers. Additional services that have been detailed in this document such as the monitoring system, Meals on Wheels and adult day programs can be subsidized to eligible care recipients as well.

Eligibility

A care recipient's eligibility is based on his or her will to be assessed for services that will address his or her unmet needs with respect to personal care, daily activities such as housekeeping and meal preparation as well as various cognitive and behavioural factors.

Cost

Eligibility for a financial subsidy for any of the in-home support services is determined through a financial assessment.

Adult residential facilities (special care homes and memory care homes)

Overview

Special care homes and memory care homes provide supervision and assistance with daily living for people with limitations who can no longer remain in their home. Some special care homes also offer enhanced services to individuals with dementia or a physical frailty and who require help with all aspects of daily life. The Department of Social Development has a complete provincial list of licensed facilities:

- Web: www.gnb.ca/seniors

Eligibility

Care recipients are assessed through the Department of Social Development's Long-Term Care Program for eligibility into adult residential facilities.

Cost

Care recipients may apply for a subsidy that will aid in the cost of the placement in a residential facility by undergoing a financial assessment. Care recipients will be able to retain a monthly comfort and clothing allowance that they can use to cover expenses associated with clothing, personal items, co-pay for prescription drugs and haircuts.

Nursing home services

Overview

Nursing home services are intended for individuals who are medically stable and who need access to 24- hour nursing care. Services in nursing homes emphasize the resident's physical, social and psychological independence. These services include resident care, resident support, plant and maintenance and general administration. Nursing homes are staffed with registered nurses, licensed practical nurses, resident attendants, dietitians and personnel in laundry, kitchen, activation, rehabilitation, maintenance and administration.

> Moving to a long-term care facility can be made easier if the care recipient is included in the decision. You and the care recipient should plan ahead and understand when and why a move to a nursing home is required.

Eligibility

The Department of Social Development must approve all admissions to nursing homes. The department will determine the care recipient's eligibility by looking at his or her long-term health care and social needs. Going into a nursing home is voluntary.

Costs

If a care recipient can afford to pay his or her nursing home costs (which cover staff room and board), he or she must do so. If a care recipient feels he or she cannot afford the costs, he or she can apply to the Department of Social Development for a subsidy. A care recipient's ability to pay is assessed based on net income. Assets are not included in the calculation of a care recipient's financial contribution. The maximum amount to be paid by nursing home residents may be adjusted from time to time. For up-to-date information about daily costs and nursing home services:

- Web: www.gnb.ca/seniors

Most nursing home residents are entitled to receive medications approved under the New Brunswick Prescription Drug Program at no cost. Residents in receipt of assistance from the Department of Social Development are entitled to retain a personal comfort and clothing allowance. This allowance covers expenses associated with personal items, clothing and medications not covered by the New Brunswick Prescription Drug Program and over-the-counter medications not routinely supplied by the nursing home. Residents who are subsidized are also entitled to a health card providing such benefits as eye glasses, hearing aid and other specific health supplies. They are also eligible to access the HST rebate.

Preparing for the move to a long-term care facility

A difficult decision

A long-term care placement such as a special care home, memory care home or a nursing home is a very difficult decision for families.

Emotions that may arise for family members include the following:

- Guilt, often leading to second thoughts about the decision.
- Relief that the responsibility of providing care is no longer solely on your shoulders.
- Grief, often based on a fear of the unknown.
- Loss of control over decisions about the care recipient's daily care.
- Anxiety about handing over the responsibilities of caregiving to others.
- Concern about the quality of care provided.
- Worry that the care recipient will have difficulty adapting to his or her new home.

While daily care shifts to the long-term care facility, caregiving does not end. Family members will still play an important role by providing emotional support and becoming advocates for the care recipient.

Tips:

- Get to know facility staff and the director of nursing.
- Develop a positive relationship with staff at the home.
- Determine what role you may share in the delivery of care.
- Find out whether there is a family council or advocacy group.
- Join a family caregivers' support group.
- Familiarize yourself with the home's policies and activities.

Adjusting to the new situation

It will take time for you and the care recipient to adjust. Keep in mind that there is no "ideal" number of times to visit during this period. For some, the strain of caregiving has been such that he or she needs a rest during the first few weeks after the move. Other care givers may want to visit as often as possible.

Stay connected; visit as often as you want and stay for as long as you feel comfortable. The important thing is to make each visit – no matter the length or the frequency – as full and rewarding as possible for the both of you.

The care recipient will also need some time to adjust to his or her new environment. Be patient as he or she settles in. For some, this may take weeks or months; for others, it may be less. Do not hesitate to communicate closely with the staff during this period.

Sometimes, the care recipient adjusts quite well to his or her new surroundings. This may leave you with mixed emotions – while you feel happy that the care recipient is doing so well, you may also feel slightly rejected if he or she seems more content in the facility than at home. These feelings are perfectly natural.

You have not lost your role as caregiver. You are now sharing the responsibility of care with others. An advantage of having outside care is that you can focus your time and energy on providing the care recipient with a sense of love and belonging that no one else can give.

End of life care

End of life or palliative care is health care for people (of any age) and their families who are living with a life-limiting illness, usually at an advanced stage. The goal of palliative care is to manage physical symptoms and provide social, emotional and spiritual support for patients and their families throughout the illness. In some cases, a physician may suggest the option of palliative care either in hospital or at home delivered by the Extra Mural Program.

While providing comfort and dignity is important at all times and is especially important during end-of-life care. Decisions will need to be made throughout the late stage of life. These decisions may be difficult, and you may feel uncomfortable making them.

Some care recipients may have set out advance medical directives to help family members carry out his or her wishes in terms treatment and end-of-life decisions. If these wishes have not been communicated and are not in place through a power of attorney for personal care, respecting the expressed wishes of the care recipient should guide all end-of-life care decisions. If these wishes have not been communicated, knowing the care recipient's values and beliefs can help you make a decision that would most closely resemble one that the person would make if capable of doing so. A guiding principle is to uphold the dignity, privacy and safety of the care recipient.

If plans have not been made, or if there are disagreements among family members, you may want to consider asking a third party – such as a member of the health-care team, counsellor or clergy.

Financial assistance for caregivers

Although some employers offer flexible work arrangements, the responsibilities of caregiving can still disrupt a caregiver's work life. In addition, many caregivers are paying out-of-pocket expenses to care for the care recipient.

As a caregiver, you may be eligible for assistance from the Government of Canada. Service Canada has prepared a list to help you prepare for this role.

1. **Apply for Employment Insurance Compassionate Care Benefits**
   Employment Insurance (EI) provides Compassionate Care Benefits to persons who have to be away from work temporarily to provide care or support to a family member who is gravely ill with a significant risk of death. You can apply for EI online or in person at a Service Canada Centre. You should apply as soon as you stop working, even if you receive or will receive money when you become unemployed.

   Self-employed persons who register for EI may also be eligible to receive Compassionate Care Benefits.

2. **Claim the caregiver amount on your income tax return**
   You can claim the caregiver amount tax credit if you lived with a dependant who was one of the following individuals:

   - you or your spouse or common-law partner's child or grandchild; or
   - you or your spouse or common-law partner's brother, sister, niece, nephew, aunt, uncle, parent or grandparent living in Canada;
   - other criteria may apply.

3. **Take care of yourself while taking care of others**
   The *Self-Care for Caregivers Guide* from the Public Health Agency of Canada provides information about taking care of yourself in demanding times.

   - Web: www.phac-aspc.gc.ca

4. **Explore live-in caregiver options**
   The Live-in Caregiver Program for employers and caregivers abroad allows professional caregivers to work in Canada. Caregivers are individuals who are qualified to work without supervision in a private household providing care for children, elderly persons or persons with disabilities. Live-in caregivers must live in the private home where they work in Canada.

   Application information for the program is available from the federal Department of Immigration, Refugees and Citizenship (formerly known as Citizenship and Immigration Canada):

   - Web: www.cic.gc.ca

Conclusion

With the growing emphasis on independent living, caregivers will continue to play a critical role in helping care recipients remain in their homes for as long as possible. In many cases, a little help from family and neighbours is all that is needed for a care recipient to continue living independently in his or her community. It can be as simple as providing transportation to and from an appointment, shovelling snow, mowing the lawn or running an errand.

We hope the information and suggestions in this guide are useful to you and your family in providing care for a loved one. For information about services and programs available for seniors in New Brunswick and how to access them, contact the Seniors Information Line, 8:30 a.m. – 4:30 p.m., Monday through Friday:

- Telephone: 1-855-550-0552

As helpful as it may be, written material is no substitute for an understanding listener, so remember to reach out to family, friends, professionals and support groups for help. Remember that you are not alone; you have the right to ask questions and to ask for help.

Additional resources

Websites and contacts that provide information and helpful tips for informal caregivers include:

Department of Social Development
- Telephone:
  - Acadian Peninsula: 1-866-441-4149
  - Chaleur: 1-866-441-4341
  - Edmundston: 1-866-441-4249
  - Fredericton: 1-866-444-8838
  - Saint John: 1-866-441-4340
  - Miramichi: 1-866-441-4246
  - Moncton: 1-866-426-5191
  - Restigouche: 1-866-441-4245
- Web: www.gnb.ca/seniors

Government of Canada – Information for Caregivers:
- Telephone: 1-800-622-6232
- Web: www.seniors.gc.ca

Alzheimer Society New Brunswick:
- Telephone: 1-800-664-8411
- Web: www.alzheimer.ca/en/nb

Elizz – Online caregiver resource centre:
- Telephone: 1-855-275-3549
- Web: www.elizz.com

Canadian Red Cross Society:
- Telephone: 1-800-588-4881
- Email: az-communityhealth@redcross.ca

COMMUNICATION TIPS FOR CAREGIVERS

- ☑ **Reduce distractions:** Communicating is always easier if other things are not happening at the same time. For example, if the TV or radio is distracting the person, turn it off.
- ☑ **Gain attention:** Face the person. Making eye contact with the person will help focus their attention. Get close enough so they can see your facial expressions and any gestures you may use. As some people have problems recognizing family and friends, you might want to introduce yourself and remind them who you are.
- ☑ **Be aware of your tone and body language:** Remain calm and still and speak in a relaxed tone of voice to put them at ease. Brusque or hurried movement as well as a sharp tone or raised voice may cause distress.
- ☑ **Be clear and concise:** Talk slowly and clearly, using short and simple sentences. Use closed-ended questions which are focused and answered using a simple "yes" or "no" instead of open-ended questions, which are time-consuming, may result in unnecessary information, and may require more effort on the part of the person with dementia. Avoid phrases that can be interpreted literally, such as “it’s the cat’s pyjamas” or “up to my eyeballs” which might be confusing.
- ☑ **Be respectful:** Use the person’s name when addressing them to help them retain a sense of identity. Do not patronise or speak down to the person. Avoid using childish or “elder” talk or any demeaning language. Avoid talking about the person as if they aren’t present. Do not talk over the person. They may still understand what is being said even though they have lost the ability to form the words that are in their mind.
- ☑ **Listen carefully:** Listen carefully to what the person is saying and observe both verbal and non-verbal communications. Try not to interrupt the person even if you think you know what they are saying. If the person is having difficulty finding the right words, you can offer a guess as long as they appear to want some help.
- ☑ **Be patient:** The person may need more time to process the information so be patient. Provide reassurance. If they are having trouble communicating, tell them that it's fine and encourage them to keep trying to put their thoughts into words. If they sense you are impatient or agitated, they may feel stressed or frustrated.
- ☑ **Encourage exchange:** Make your communication a two-way process that engages the person with dementia. Involve them in the conversation. If you don’t understand what is said, avoid making assumptions. Check back with them to see if you have understood is what they mean.
- ☑ **Show and talk:** Use actions as well as words. For example, if it is time to go for a walk, point to the door or bring the person's coat or sweater to illustrate what you mean. Use body movements such as pointing or demonstrating an action to help the person understand what you are saying. Of course, this should be done tactfully so the person does not feel you are treating them as a child.
- ☑ **Encourage humour and laughter, respect sadness:** Humour can bring you closer, can release tension, and is good therapy. Laughing together over mistakes or misunderstandings can help. If the person seems sad, encourage them to express their feelings, and show you understand.
- ☑ **Don’t forget to account for hearing or vision problems!** Make sure that the person is wearing a working hearing aid and/or clean glasses, if prescribed. Schedule regular checkups are done and listen for cues to health problems.

SAFE & MOBILE

DRIVING SAFETY & AGING

Provides tips and resources for safe driving as seniors age, ensuring mobility while prioritizing safety.

National Blueprint for Injury Prevention in Older Drivers

Keeping on the go: Driving safely as you age

Driving & Alzheimer's disease

Meet Jean-Louis...

Jean-Louis is 75 years old and has recently been diagnosed with Alzheimer's disease. Jean-Louis is the main driver for himself and his wife. He has been asking:

Should I continue driving?

A diagnosis of Alzheimer's disease does not automatically mean that you can not drive. However, at some point in time, the effects of Alzheimer's disease will make you unsafe to drive.

How might Alzheimer's disease affect safe driving?

The effects of Alzheimer's disease are different for each person. Some of the effects of this disease may interfere with your ability to drive. For example:

Memory: You may have difficulty remembering things and familiar places.
Decision making: You may find it more difficult to make decisions.
Attention: You may have difficulty doing more than one thing at a time or you may be easily distracted.
Reaction time: Your reaction time may be slowed.
Judgement: You may not recognize when you can no longer do tasks safely.
Impulsiveness: You may act quickly without always thinking about your actions.

Warning signs of unsafe driving

- You lose your way.
- You have less confidence in your driving skills.
- You notice other drivers honk at you.
- You miss stop signs or traffic lights.
- You mix up gas and brake pedals.
- You have problems with lane changes or merging.
- You have minor accidents or traffic tickets.
- Your passenger needs to help you.
- Family and friends refuse to get in the car with you.

If these warning signs reflect your situation, maybe it is time to make some changes to your driving strategies or have your driving evaluated.

Safe driving strategies

All drivers find themselves in driving situations that are risky. Here are some strategies that can be used to reduce the risk:

Strategies to reduce the effects of Alzheimer's disease on driving

- have regular medical checkups and ask your medical doctor about your ability to drive
- have a formal driving assessment
- recognize what is stressful for you while driving(e.g. busy traffic)
- plan your trips so that you avoid stressful situations when possible
- limit distractions when you drive (e.g. turn off the radio)

General strategies

- choose a vehicle that is easier to drive, such as one with an automatic transmission or power options like adjustable seats
- make sure your vehicle is in good working condition
- make sure your seat, steering wheel and mirror are properly adjusted
- limit driving at night, in bad weather, during rush hour or on limited access highways
- be careful when changing lanes, making a left-hand turn or merging into traffic
- maintain a safe following distance
- take breaks if you are driving a long distance
- have regular medical checkups
- make sure you know how your medications might affect your ability to drive safely

Strategies for family

When a person is unable to recognize or admit that his or her driving abilities are no longer safe, as family members and caregivers, you often have to take this issue into your hands. This can be a difficult task and you should prepare yourself ahead of time.

- seek support and information from others – family members, medical doctors, occupational therapists, certified driver rehabilitation specialists
- start the discussion when everyone is relaxed and there is enough time to talk
- observe your family member while driving
- keep a written record of unsafe driving behaviours over time
- don't leave your family member feeling abandoned
- offer alternatives and support
- you may need to take the keys if necessary

Getting help

- an occupational therapist or a certified driver rehabilitation specialist can evaluate driving, develop programs to improve safe driving, or help find alternative transportation
- a driver information session or refresher course may be useful

Driving retirement

There may come a time when you no longer feel that you are safe to drive or you have been told that you can no longer drive. Here are some strategies to help:

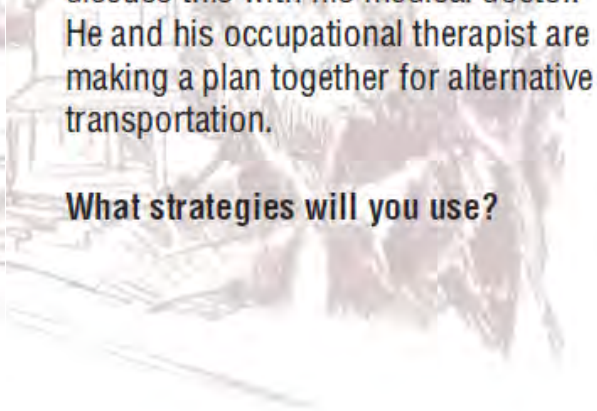
- plan ahead: planning for driving retirement should begin before you stop driving
- make a personal transportation plan:
  - collect information on local transportation options
  - check the blue pages or the Internet for local or regional transportation service providers and for government or community services for older adults that may offer transportation services
- become familiar and comfortable with alternative transportation options

Remember: Never be afraid to ask for help from other family or friends.

Jean-Louis' decision

Jean-Louis understands that he will have to give up driving eventually, but until then, he and his wife are going to monitor his driving ability and will discuss this with his medical doctor. He and his occupational therapist are making a plan together for alternative transportation.

What strategies will you use?



RESOURCES

For more information
www.olderdriversafety.ca

Canadian Association of Occupational Therapists: www.caot.ca

Alzheimer Society of Canada: www.alzheimer.ca

American Occupational Therapy Association: www.aota.org

Association for Driver Rehabilitation Specialists: www.aded.net

Canadian Automobile Association: www.caa.ca

Hartford Group: www.thehartford.com

Public Health Agency of Canada: www.publichealth.gc.ca/seniors

Seniors Canada: www.seniors.gc.ca

CAOT • ACE

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CONTACTS	COORDONNÉES
Acadian Peninsula Déplacement Péninsule (506) 727-2012	**Péninsule acadienne** Déplacement Péninsule (506) 727-2012
McAdam McAdam Transportation (506) 784-7044	**McAdam** McAdam Transportation (506) 784-7044
Restigouche RESTIGOUCHE Community Transportation (506) 759-8448	**Restigouche** Transport communautaire RESTIGOUCHE (506) 759-8448
Kent County KENT Community Transportation (506) 523-1239	**Comté de Kent** Transport communautaire KENT (506) 523-1239
Chaleur Community Transportation Chaleur (506) 547-2975	**Chaleur** Transport communautaire Chaleur (506) 547-2975
Miramichi/Northumberland Northumberland Community Transportation (506) 251-7334	**Miramichi/Northumberland** Transport communautaire Northumberland (506) 251-7334
Charlotte County Charlotte Dial A Ride (506) 466-4414	**Comté de Charlotte** Charlotte Dial A Ride (506) 466-4414
Sussex and region Sussex Dial A Ride (506) 433-4453	**Sussex et région** Sussex Dial A Ride (506) 433-4453
Fundy Dial A Ride Fundy Regional (506) 609-RIDE (7433)	**Fundy** Dial A Ride Fundy Regional (506) 609-RIDE (7433)
Westmorland – Albert Urban/Rural Rides (506) 962-3073	**Westmorland – Albert** Transport Urbain/Rural (506) 962-3073
Harvey Harvey Regional Dial-A-Ride (506) 366-3344	**Harvey** Harvey Regional Dial-A-Ride (506) 366-3344
York County – Coming Soon Hanwell, Oromocto, Cambridge Narrows (506) 999-2102	**Comté de York – Bientôt** Hanwell, Oromocto, Cambridge Narrows (506) 999-2102

STRENGTH IN PLANNING

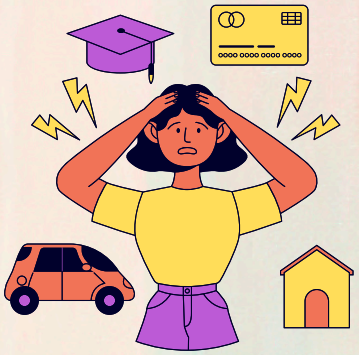
FINANCIAL MATTERS

Highlights financial programs and benefits, including tax credits and income supplements, to support senior financial health.

FINANCIAL MATTERS

Long Term Care and Taxes: You can claim the whole amount **you** paid for care in nursing home care on your taxes. Need form **T2201**; Disability tax credit certificate). Call the CRA at 1-800-959-8281 for more information.

Disability Tax Credit: For more information about if you qualify for the disability tax credit, contact the CRA at 1-800-959-8281.
You will need a Dr. or Nurse Practitioner to provide a note indicating the medical reason you require care.



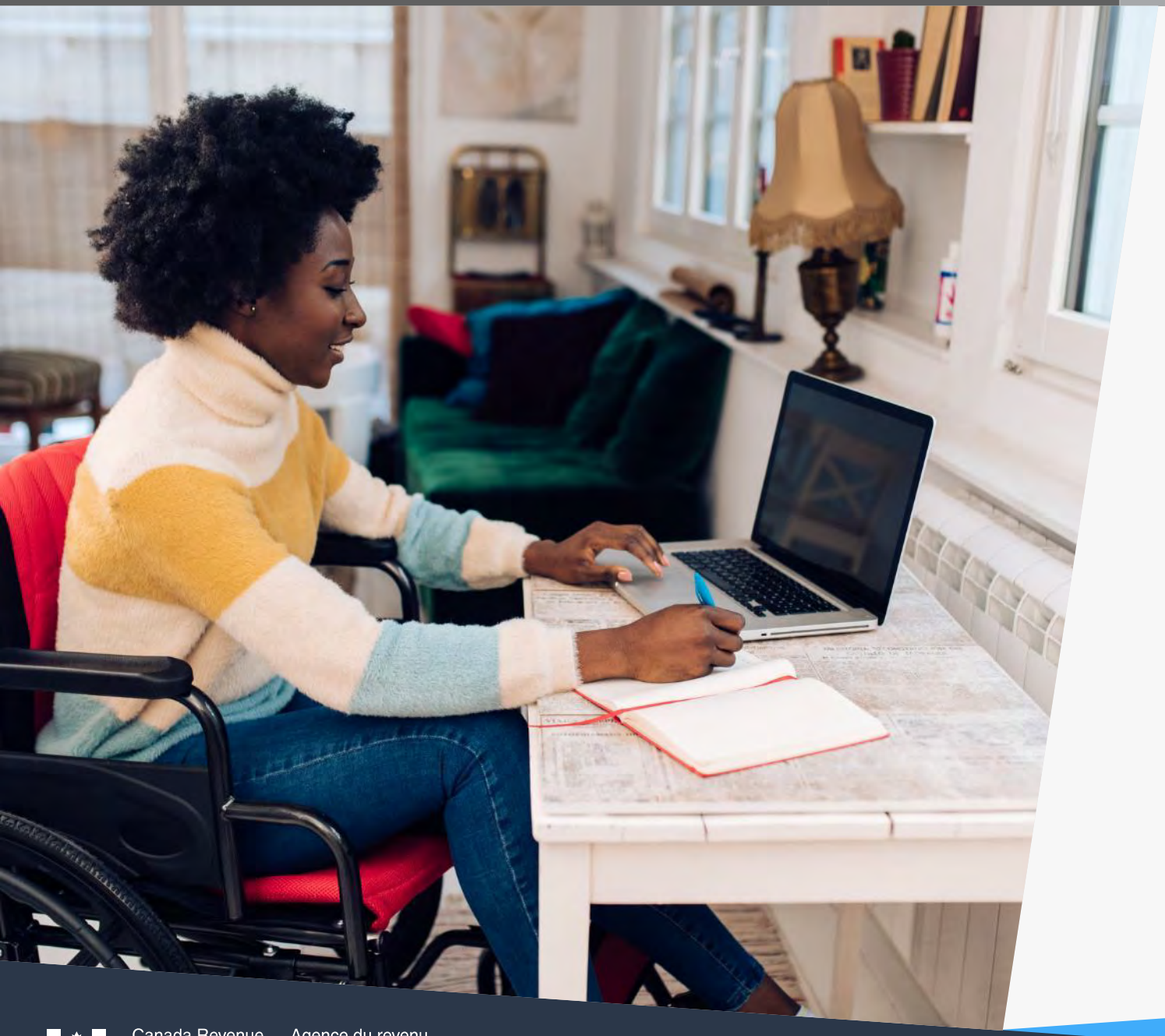
Bills: As we age, it is important to create a list of accounts and their passwords, in case you require someone you trust to access them on your behalf. Regardless if you have a partner, it is a good idea to discuss having an enduring power of attorney for your finances, someone who can take care of bill payments when you are not able to.

Old Age Security/CPP: If you need to give someone else permission to access information regarding these, you need to complete a form called consent to communicate information to an authorized person. Service Canada can provide one or it can be found on their website. Once complete mail to: Service Canada, P.O. Box 250 Station A, Fredericton, NB, E3B-4Z6.

FINANCIAL ABUSE IS REAL! DISCUSS THIS WITH SOMEONE YOU TRUST.

Special Care Homes and Taxes: You CAN'T claim the whole amount you paid in care for special care home or rent in retirement home on your taxes.
You can claim some if you qualify for the disability tax credit. The special care home can give you a detailed receipt that tells you what you can claim.

Numbers: Other important numbers to get more information.
Caregiver Credit: 1-800-959-8281
Home Reno Tax Credit: 1-800-669-7070
Registered Disability Savings Plan: 1-800-959-8281
Rent Supplement programs and Emergency Fuel Benefit: 1-833-733-7835



Persons with disabilities

Related benefits and credits

Topics we will cover

- Disability tax credit
- Child disability benefit
- Canada workers benefit disability supplement
- Canada caregiver credit
- Medical expenses
- Home accessibility tax credit
- The GST/HST credit
- Scams
- Useful info and tools to help you do your taxes

What is the Disability tax credit?

- Non-refundable tax credit that helps persons with disabilities offset disability-related costs
- Family members who support the basic necessities of life for another member, may claim the disability amount on their tax return
- Opens the door for other disability-related benefits

Child disability benefit

A tax-free payment for families who care for a child under the age of 18 who is eligible for the DTC.

- Up to $2,985 annually.
- Paid monthly along with the Canada child benefit.

Canada workers benefit (CWB) disability supplement

- The CWB is a refundable tax credit of up to $2,403 for low income workers and their families.
- Provides up to an extra $720 for eligible low-income workers who are also eligible for the DTC.
- Advance payments are available.

Canada caregiver credit (CCC)

A non-refundable tax credit you can claim for the following people with impairments who depend on you for support:

- Your spouse or common-law partner.
- Your or your spouse or common-law partner's child, grandchild, parent, grandparent, sibling, uncle, aunt, niece or nephew.

canada.ca/caregiver-credit

Medical expenses

Claim eligible medical expenses that you or your spouse or common-law partner paid for:

- Yourselves and your children under 18 years of age.
- Certain family members who depended on you for support and were residents of Canada at any time in the year.

Note: you can only claim the part of an eligible expense for which you have not been or will not be reimbursed

canada.ca/taxes-medical-expenses

Home accessibility tax credit

Claim up to $10k in renovation expenses you paid to make your home more accessible for yourself or another eligible individual.

A qualifying individual can be either:

- 65 years of age or older.
- Eligible for the DTC.

GST/HST credit

Tax-free payment of up to

- $467 if you are single
- $612 if you are married or have a common-law partner
- $161 for each child under the age of 19

Paid over 4 installments.

canada.ca/gst-hst-credit

Be scam smart

Listen to your voice of reason before you act!

Did we really text or email you?

Signs of a fraudulent email or text message:

- Email that gives or asks for personal or financial information
- Text message or email with a link for a refund
- Email or text message asking to fill out a form
- Email or text message demanding immediate payment by gift card, pre-paid credit card or e-transfer

CRA will not ask for your:

Credit card number

Bank account number

Passport number

Here's what you can do to be scam smart!

- Take a minute and question why the CRA needs your personal information
- Check if you have new mail or any amount owing in My Account
- Learn what to expect if the CRA contacts you
- When in doubt – delete, delete, delete!

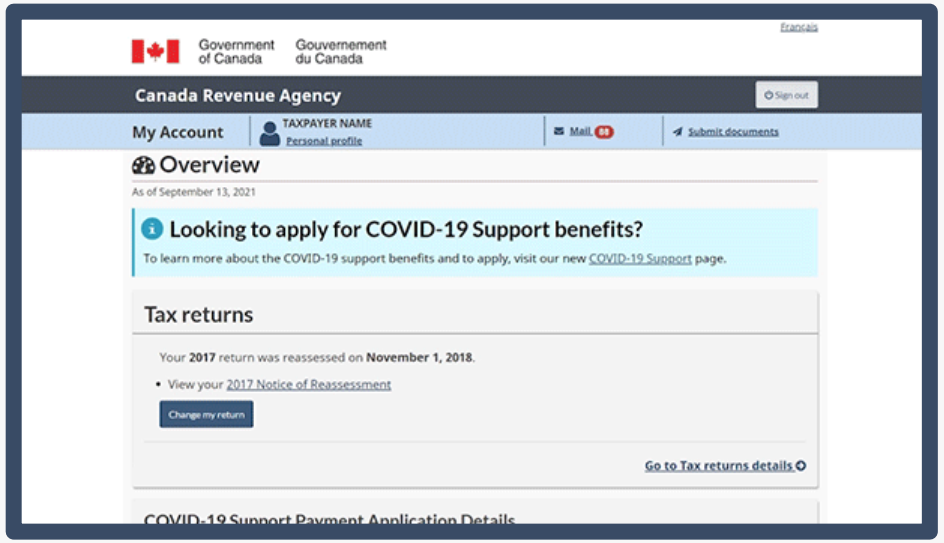
canada.ca/be-scam-smart

Report a scam!

Report a scam to the Canadian Anti-Fraud Centre at antifraudcentre.ca or by calling 1-888-495-8501.

My Account for individuals

Manage your tax and benefit affairs quickly, conveniently, and securely online at canada.ca/my-cra-account



Need help?

You can give permission to another person to deal with the CRA for you.

Your representative can be a:

- family member
- friend
- lawyer
- accountant

Form AUT-01, Authorize a Representative for Offline Access

Do your taxes on time

- Information from your tax return is used to calculate your benefit and credit payments (such as the child disability benefit).
- Avoid payment delays by doing your taxes on time.

Ways to do your taxes

Online

- Use tax software (some are free): canada.ca/netfile

On paper

- Download a tax package at canada.ca/taxes-general-package or call 1-800-959-8281

Free tax clinic (CVITP)

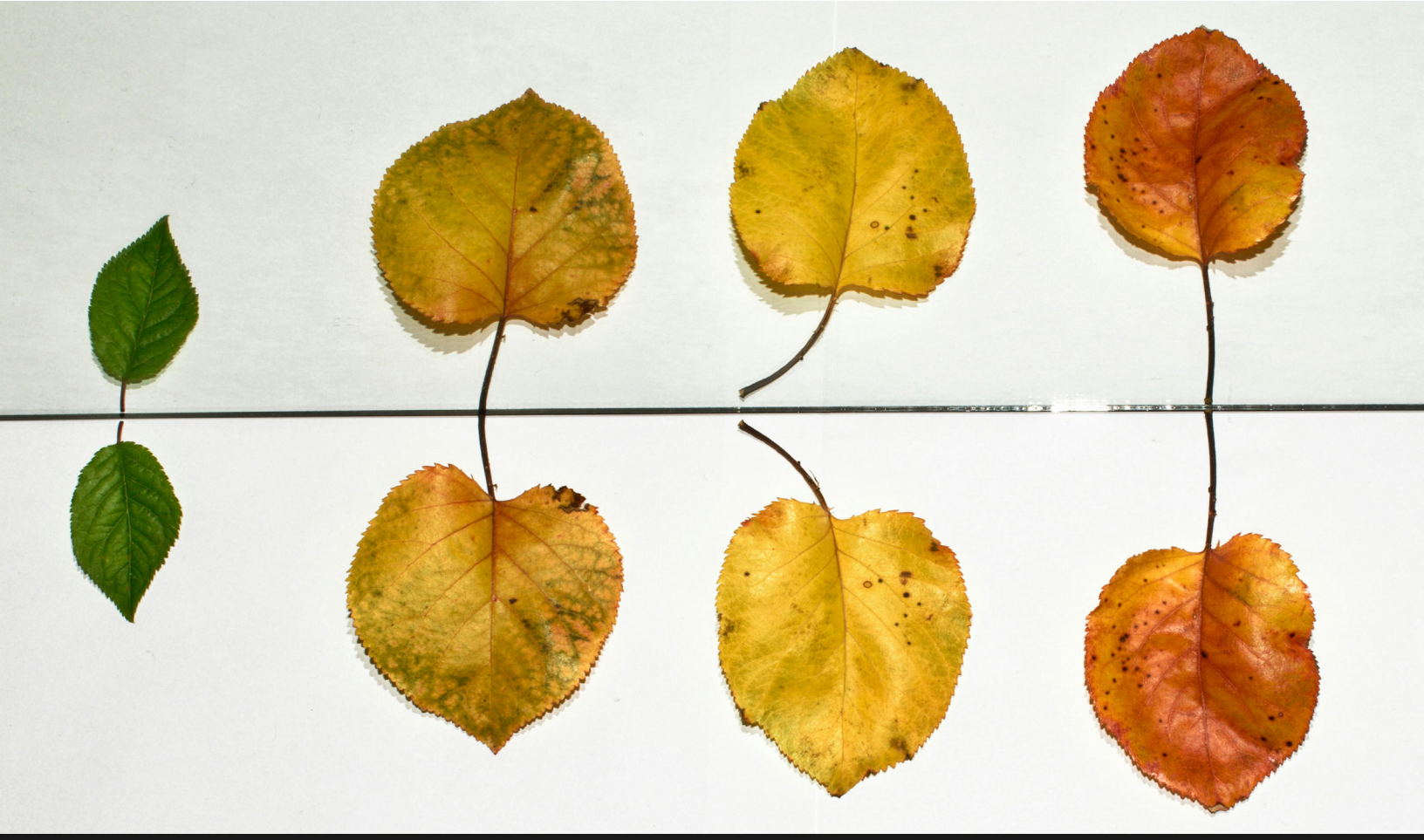
- Get a volunteer to do your taxes for free!

Free tax help

Volunteers prepare income tax and benefit returns for those who are eligible, for free!

canada.ca/en/revenue-agency/campaigns/free-tax-help

Thank you



COMPASSIONATE CHOICES

END OF LIFE

Discusses palliative care, planning, and end-of-life decisions to provide peace of mind for seniors and their families.

Barriers to Access to Palliative Care

Pippa Hawley

Pain & Symptom Management/Palliative Care Program, BC Cancer Agency, Vancouver, BC, Canada.

Palliative Care: Research and Treatment
1–6

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SAGE

ABSTRACT: Despite significant advances in understanding the benefits of early integration of palliative care with disease management, many people living with a chronic life-threatening illness either do not receive any palliative care service or receive services only in the last phase of their illness. In this article, I explore some of the reasons for failure to provide palliative care services and recommend some strategies to overcome these barriers, emphasizing the importance of describing palliative care accurately. I provide language which I hope will help health care professionals of all disciplines explain what palliative care has to offer and ensure wider access to palliative care, early in the course of their illness.

KEYWORDS: palliative care, health service delivery, models of care, barriers to care

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Introduction

Understanding how palliative care adds to a traditional medical model of disease management has advanced significantly in recent years. In 2014, the World Health Assembly Resolution on Palliative Care[1] called for all countries to incorporate palliative care provision into their health care systems—an initiative that was intended to ensure access to palliative care for all patients in need. Its desired outcomes have not yet been realized.

Why not? What can we do to make it happen?

First, we need to clarify what modern palliative care actually is.

Palliative care can be described briefly as a way of caring for people with life-threatening illnesses which focuses on quality of life. The full World Health Organization (WHO) definition[2] includes much more detail, but in summary palliative care addresses patient needs in the physical, social, psychological, and spiritual domains via 3 main components:

1. Meticulous prevention and management of symptoms, including pain;
2. Excellence in communication, in discussion of goals of care and advance care planning;
3. An extra layer of support for practical needs, particularly with respect to care provided at the patient's home.

There is now an overwhelming body of evidence that for patients with serious illness, receipt of palliative care is better in all respects than no access and that early access is better than late.[3] Multiple studies of palliative care programs in different countries and health care systems show they can improve patient outcomes, including symptom control and quality of life, and caregiver outcomes, such as reduced stress and dysfunctional grief. In addition, most studies show at least cost neutrality, with many showing substantial cost avoidance by transfer of care from acute care settings to patients' preferred locations—at home or in residential hospice.[4] Palliative care is intended to prevent and relieve suffering; however, studies also show that patients who receive concurrent palliative care tend to live at least as long as those whose care is directed at disease management alone.[5,6] Although life prolongation should not be a reason to refer, there should at least be no fear of shortening of life by making (or accepting) a referral to specialist palliative care services.

Contrary to what many people believe, modern palliative care can be provided alongside treatments targeting the underlying disease and may be needed from the time of diagnosis. Similarly, treatments targeting control of disease may be required alongside palliative care, right up to the time of death. Both approaches are necessary and should have equal value, whether in a high-resource health care system with many treatment options or in a developing setting where patients are diagnosed late in the course of illness and few curative treatments are available.

This concept of simultaneous disease-targeting and palliative approaches to care has taken a long time to become established, especially in areas other than cancer care. The needs of people with other life-threatening chronic conditions, such as heart or kidney failure, chronic lung disease, and neurodegenerative diseases, are only relatively recently becoming recognized by specialist palliative care programs.

Current Reach of Palliative Care

Palliative care services are not yet available to all patients with serious chronic illness, even in a high-resource system such as

in the United States. Nearly one-third of US hospitals with more than 50 beds do not have any palliative care service.[7] A recent article described care patterns in the single largest US health care system (the Veterans Health Administration) in 2012. They found that patients received a palliative consultation care on average 38 days before death and received hospice care (at home or in a residential facility) only 20 days before death.[8] Yet, in an accompanying editorial, these are described as "remarkable improvements" as compared with 2004-2006 data from a similar US health care network, and the achievements of the Veterans Affairs are quite justifiably described as "striking progress."[9] The potential benefits of early integrated palliative care have yet to be fully realized, and many heath care networks and institutions have a very long way to go for services to be able to even be described as adequate.

Even where integrated programs have been developed, trends in timeliness of referral are not always going in the direction which would maximize the benefits. For example, British Columbia's Fraser Health Palliative Care Program cares for a population experiencing about 10 000 deaths a year, with more than 5000 referrals per year in a variety of settings. The average length of stay of patients on the program has dropped from 108 days in 2007 to 68.5 days in 2016, with a median length of stay of just 22.5 days (Personal communication, N. Hilliard, Medical Director of the Fraser Health Palliative Care Program, September 2016). Personal communication with palliative care specialists from Australia, New Zealand, and the United Kingdom, and some published data,[10] suggests that this backward trend is being noted consistently around the world as palliative care services become progressively more stretched.

This is just not enough time to deliver the full potential of palliative care; either from a patient and family perspective or from an economic perspective.

So, why aren't all patients diagnosed with a life-threatening chronic illness clamoring for referral? Why aren't health care organizations pouring resources into development of integrated palliative care services, especially now that the "baby-boomer" generation is entering their senior years.

Some previously well-described[11–13] reasons are listed below:

- Lack of resources to refer to;
- Not knowing that resources exist;
- Ignorance regarding what palliative care is;
- Reluctance to refer;
- Reluctance of patient and/or family to be referred;
- Restrictive specialist palliative care service program eligibility criteria.

Resource Availability

In developed countries, cancer patients are relatively well provided for, with good access to palliative care units and hospices, at least in urban centers. Community hospitals and rural areas are, however, less well served, and people living with chronic noncancer diagnoses have much poorer access to specialist palliative care programs. Health care professionals in these fields tend to have less training in the skills necessary to deliver at least basic palliative care than those in oncology. Home hospice is inconsistently available, and very few countries have enough palliative care specialists to meet their current workforce needs, let alone meet anticipated future needs.

In less developed health care systems, there may be additional administrative barriers to delivery of palliative care, particularly around access to opioids. Opioids are an essential tool for delivering adequate pain management, and all countries should ensure access to more than one opioid and appropriate adjuvant analgesics. There should be preparations available that can be delivered by oral and parenteral routes. Although often more expensive, transdermal, transmucosal, and rectally administered opioids should also be considered, especially where there is a paucity of nursing staff and/or sterile equipment for administering medicines by injection.

Ignorance and Lack of Awareness of Resources

The trend for residential hospices to be freestanding buildings in pleasant locations away from urban hospitals can lead to lack of awareness of their existence. Students and residents infrequently have access to palliative care rotations, and the paucity of palliative care teaching in many medical school and residency programs makes it difficult for physicians to understand what happens in a specialist palliative care setting. It is therefore important for palliative care teams to interact with their colleagues in other specialties on a regular basis, attending rounds, teaching, and participating in committee work. This can be challenging when added to the responsibilities of professionals who are already overloaded with clinical work and needs to be taken into consideration in workforce planning and staffing models.

Referrer Reluctance

There are many well-documented reasons for referrer reluctance, including the following:

- Fear of upsetting patients;
- Not wanting to abandon them;
- Seeing referral as an admission of failure;
- Not understanding the benefits of referral.

Many still do not understand that palliative care can be provided concurrently with disease-directed therapy, although there has been some progress with this in oncology, as shown in the Veterans Administration study[7] and directives from a leading oncology society.[14,15]

Integration is not easily defined or measured as a basic level of palliative care can often be provided by family doctors/general practitioners, nurse practitioners, or specialists in other areas of medicine and may entirely meet the patient's and family's needs. Integration of a palliative approach may therefore be difficult to identify when that care is delivered by

professionals who do not have a specialist designation, when care is delivered in community hospitals without designated palliative care beds, or when care is delivered in residential care homes that do not have designated hospice beds.

Specialist palliative care consultation should be considered either when the patient's or family's needs exceed the competence and confidence of the primary team or when it is required to access certain services. The proportion of patients and families needing specialist palliative care will vary from place to place depending on the skills and resources available through primary care. In an ideal world, all health care professionals' training would include basic palliative care competencies, but in reality this has yet to happen, so the threshold for specialist referral is appropriately quite variable. Recognition of when the point of unmet need occurs can be difficult, especially where there is no routine screening for unmet needs. Discretionary referral alone cannot be relied on to provide a timely and appropriate referral practice.

Triggers to refer can be activated automatically when transitions in care are documented (eg, on detection of metastases in cancer care) or by expression of distress recognized through use of screening tools. As distress can occur any time in the course of illness, screening should occur regularly from the time of diagnosis. Prompt referral for specialist palliative care support should be made at any time when physical, social, psychological, or spiritual unmet needs are not able to be satisfactorily resolved by the primary caring team (which may include a variety of specialists as well as family medicine/general practice), including when the goal of disease management is curative in intent.

Although this integrated model may appear to be new in some specialties, there are already examples of where it has been successfully implemented. The emergence of new disease-modifying modalities in many diseases has created prognostic uncertainty and a challenging environment for palliative care integration. For example, some children are living for many years with the possibility of imminent death at the same time as promising new treatments emerge. Specialized palliative care services are needed to collaborate closely with the teams providing disease management over often very extended periods. Some cancer patients have amazing responses to new targeted cancer treatments, even with very advanced disease, and are discharged from hospice services. People with human immunodeficiency virus whose disease used to be inevitably fatal are now living for a long time if they have access to highly active antiretroviral treatment (HAART). Access to HAART may be insecure; hence, prognosis can be unpredictable.

Patient and Family Reluctance

Reluctance to accept a referral for specialist palliative care on the part of the patient and family can vary from one culture to another, but there are common threads to this hesitation, namely, the association of palliative care with dying. "Magical thinking" is the idea that avoidance of talking about death will allow avoidance of death itself or that discussing death may bring "bad karma." Patients may also not want to upset their regular doctor, thinking that their doctor will see them as giving up or worry that they may have disease-controlling treatment withdrawn. There may also be separation anxiety, with reluctance to lose a valued relationship with their familiar team.

The language used in health care is also very important. It is still thought by many that palliative care and hospice mean the same thing: "somewhere to go to die."[16] The term "palliative care" (in French: *Soin Palliatif*) was coined by Canadian urologist Dr Balfour Mount in the 1970s because of the historical association in the Canadian francophone community of the term "hospice" with the destitute.[17] This renaming facilitated the spread of palliative care programs in the latter part of the 20th century and the term served its purpose well. Originally intended to be a more socially acceptable term, the word "palliative" has unfortunately been misused as a euphemism for dying. Thus, palliative care has now become the new negatively associated term, equivalent to how hospice was originally perceived. As the benefits of early palliative care have been increasingly recognized, there is a need to reframe the language of palliative care.

The term "hospice" is still in use and over the last 40 years has usefully evolved to mean something a little different to "palliative care." In some settings, hospice refers to a freestanding residential care facility for people in the last weeks of life, whereas in other settings the word is used to describe end-of-life care delivered anywhere, especially in the home (home hospice). The consistent feature that now differentiates hospice from modern palliative care is that hospice care is understood to be for patients who are at end of life and have discontinued attempts to cure or control the illness. Hospice care is the last part of an integrated palliative approach to care, and transition from integrated palliative care to hospice may involve a new set of care providers.

To complicate the terminology further, in the United States, hospice usually refers to being on the hospice benefit, which is a financial program allowing care to be delivered in either a residential hospice or at the patients' home, but is quite restrictive. For example, to qualify for Medicare (Part A—Hospital Insurance), a person must[18]

- Be aged 65 years and above, or
- Be totally disabled for at least 2 years, or
- Have end-stage disease (eg, complete kidney failure).

To be eligible for Medicare Hospice Benefit, a person must

- Be enrolled in the Medicare Part A (see above);
- Have a doctor and the hospice medical director certify that they are terminally ill and probably have less than 6 months to live;
- Sign a statement choosing hospice care instead of routine Medicare-covered benefits for their terminal illness;

- Receive care from a Medicare-approved hospice program.

Once a person signs up for the Medicare Hospice Benefit, Medicare will not pay for treatments and medications intended to control the disease. Medicare will also not pay for medical care or services that are not arranged by the hospice. Even though there has been progress in US patients receiving concurrent palliative cancer treatments in recent years,[6] and even if the hospice benefit will disappear tomorrow, it will take a long time for public perception of the role of hospice in the United States to change.

The patient characteristics used to ration scarce palliative care resources also perpetuate misperception of palliative care as being appropriate only at end of life when all efforts to cure or control have failed. Examples of language focusing on dying copied from the websites of typical large programs in Canada, Australia, and the United States include the following:

> A seamless system of care for the dying." Eligible patients require "Significantly decreased functional abilities (Palliative Performance Scale (PPS) score of 50% or less)" and "Are in the final stages of a life threatening illness (e.g.- metastatic cancer, end-stage cardiac or lung diseases, end-stage neurological disorders, end-stage organ failure, end-stage HIV/AIDS, etc.).

> Palliative Care xxxx actively raises awareness and builds capacity for the community to address life limiting conditions, death and dying, grief and loss.

> Palliative Care Program resources and services support and enhance the ability of the patient's primary care team to continue to care for them at the end-of-life. Specialized units exist for patients whose needs cannot be met in other settings.

We give our patients and colleagues mixed messages:

- Refer early . . . but only when you are 100% sure your patient is dying;
- Refer early . . . but we don't have room for any but the sickest;
- Palliative care will make you feel better . . . but you can only have it when there's nothing else left to offer;
- Palliative care is better at home . . . but you will have to do a lot of all the work and shoulder much of the costs.

Restrictive Program Eligibility

Rationing of services according to patient characteristics is seen as an unfortunate necessity for palliative care and hospice programs; however, assumption of all aspects of care by specialist palliative care programs propagates an inefficient model of service delivery that is neither sustainable nor patient centered. Family doctors and referring specialists tend to drift away from providing care once a palliative care program becomes involved, either because of a perception that their skills are no longer relevant or that their involvement is not welcome.

Patients do best by having access to both disease-modifying treatments and palliative care simultaneously, so it makes no sense to hand over all aspects of care to a service with limited resources when a referral is made. The most efficient model of care is to have the right people delivering the care at the right time that most suits the circumstances. Who is "right" may change a number of times over the course of a long illness, and palliative care professionals can most efficiently and cost-effectively share their expertise at multiple points in the illness trajectory, stepping back when not needed, ensuring ongoing care is provided by the referring team.

Costs avoided by patients receiving palliative care are rarely redeployed to support the programs that create those savings, and palliative care specialists' ability to assist those patients with long or indeterminate life expectancies will be severely constrained if a take-over model of care is practiced. This is going to become even more important as patients with increasingly unpredictable prognoses are included in specialist palliative care programs' mandate.

So How Can We Overcome These Barriers?

Some suggestions have already been presented in discussing the barriers above, but I believe that lack of awareness of the role for modern palliative care is a key obstacle to patients receiving appropriate care. We need to "rebrand" palliative care and hospice.

Rebranding should focus on the benefits of early integration of palliative care into chronic disease management, emphasizing quality care for people living with serious chronic illness, and to use our dwindling public funds in the most responsible and cost-effective manner possible. This rebranding needs to include administrators and politicians. Too many people with the power to make a positive impact do not understand what modern palliative care is, and opportunities to cost-effectively relieve suffering are being lost.

Complex constructs are sometimes extremely difficult to convey in words, and pictorial representations can sometimes convey the necessary nuances of the issue more effectively than long explanations. New visual models of palliative care are emerging, including the bow tie model[19] which emphasizes the inclusion of survivorship as a possible outcome (Figure 1).

This model illustrates the concurrent care of the patient alongside treatment of the disease. It provides a visual map of their potential course of illness and illustrates the dual reality of "hoping for the best, but planning for the worst." Survivorship is a visibly possible outcome, but the reality of mortality is still present.

The words in the model can be adjusted to different cultures as an understanding of the wider applications of palliative care develops. For example, the term "palliative approach to care" has recently emerged and could potentially describe the middle diamond of the model. "Supportive care" might have previously been understood by some to be an appropriate term for that diamond, but the term has already been adopted

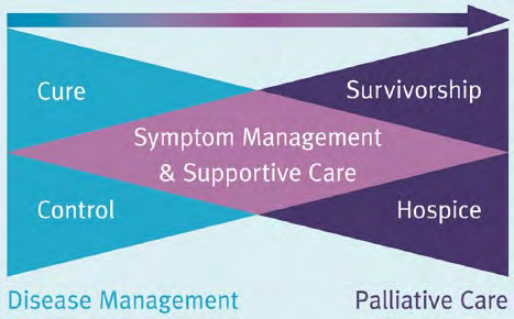

Figure 1. The bow tie model of 21st century palliative care.[19]

by the oncology world to mean the medical interventions (eg, transfusions and antiemetics) required to allow for delivery of toxic treatments aiming to cure cancer. It is therefore probably too late now to use it in a wider sense. Combining "supportive care" or "a palliative approach" with additional terms such as "pain and symptom management" not only makes the language unwieldy but also risks diminishing the role of palliative care specialists to being just symptomatologists and does not acknowledge the multidisciplinary teams' important contributions to meeting patients' needs. Hospice could be extended to "hospice care" in places where hospice is used to indicate a freestanding building, thereby emphasizing that end of life care can be delivered in patients' homes, residential care facilities, freestanding residential hospices or even in hospital.

A suggested lexicon for programs to draw from for their mission and value statements, leaflets, Web sites, posters, presentations, and verbal communication includes the following terms.

A Palliative Approach to Care

Palliative care knowledge and expertise can be embedded upstream into the delivery of care across different health care sectors and professions by health care professionals who do not specialize in palliative care. A palliative approach to care is particularly important when the prognosis of the patient is uncertain, and survivorship is a possibility.

Hospice Care

Hospice care is care that focuses on relieving symptoms and supporting patients with incurable illnesses who have a life expectancy of weeks to months. In most cases, hospice care is provided to a patient in his or her own home. It also can be provided in freestanding hospices, hospitals, nursing homes, and other long-term care facilities.

Survivorship

Survivorship refers to a distinct phase in the illness trajectory between cessation of attempts to cure the disease and transition back to normal life or as near to the person's normal as possible. Learning to live with stable illness may be one state of survivorship, and cure is not necessarily required. People who have been cured of a serious illness may be irreversibly damaged by the disease or its treatment and may require significant multidisciplinary care to achieve their full subsequent potential.

An additional definition which may be helpful in describing what programs provide is that of a palliative care specialist, adapted from the WHO definition of palliative care.

Specialist Palliative Care

Specialist palliative care is provided by a specially trained team of doctors, nurse practitioners, nurses, social workers, and other health care professionals, who work together with a patient's primary care team to provide an extra layer of support for people with serious illness. It focuses on providing relief from the symptoms and improving the quality of life of both the patient and the family. It is appropriate at any age and at any stage of a life-threatening illness and can be provided along with curative-intent treatment.

Recommendations

The time has come for modern health care systems to expand the reach of palliative care professional expertise outside of end-of-life care. Health care professionals should no longer use the term palliative as a euphemism for dying. Hospice care describes the part of palliative care that targets truly end of life and the term hospice should be used with pride and specific intent. The suffering of patients who enter the "limbo" of survivorship should be acknowledged and palliative care specialists have the skills to be able to contribute enormously to the care of these patients. Use of the visual bow tie model can help understand this new way of meeting patient needs.

Patients receiving curative and palliative disease-modifying treatments are generally ambulatory, and the most cost-effective way of meeting their needs will be in the outpatient clinic setting, either independently or in conjunction with other specialist visits such as oncologists. Administrators and funding agencies need to be made aware that these ambulatory and integrated services will need considerable expansion. The value of their investment will be seen in costs avoided as illness progresses.

The basic skills required to deliver a palliative approach to care need to be provided for all staff in health care settings where people with chronic illnesses may reside, particularly residential care homes and general hospitals. A palliative approach to care needs to be widely introduced into the training of all health care professionals involved with patients who have serious illnesses. This means that the small cadre of trained palliative care specialists already in practice will need to increase the proportion of their time spent teaching and mentoring. In-hospital consultation services need to be substantially expanded until other disciplines have acquired the knowledge and skills to deliver the palliative approach to care themselves when universal access to this kind of care can become the normal standard of care.

If the best time to start accessing palliative care is as soon as possible after diagnosis, palliative care programs have to start helping patients who may not die of their illness, certainly not in any predictable time frame—"dipping" in and out of their

care when needed. A Do Not Resuscitate order should be a goal for specialist palliative care program eligibility, not a prerequisite. When specialist palliative care programs can respond to need for their skillset on an as-needed basis, independent of prognosis, they can avoid being overwhelmed by the need to assume responsibility for all their needs until time of death.

With a consistent message, given the demographics that we are facing and the widely acknowledged stresses on public funding of health care, the time is right for a substantial shift in the way health care is delivered. In fact, it would be irresponsible not to change!

Author Contributions

PH reviewed and approved the final manuscript.

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Les soins palliatifs peuvent être prodigués par de nombreux professionnels de la santé, selon vos besoins tout au long de votre maladie.

Nous travaillons en équipe pour assurer votre confort, pour répondre à vos besoins, et pour préparer vos soins futurs.

N'hésitez pas à nous poser des questions et à nous dire ce que vous ressentez.
Nous sommes là pour vous.

Votre médecin de famille dirige vos soins médicaux en collaboration avec vous, votre famille et divers autres professionnels de la santé.

Le personnel infirmier vous aide et vous appuie tout au long de votre maladie en vous offrant des soins sur les plans physique et émotionnel. N'hésitez pas à leur dire ce que vous ressentez.

Les pharmaciens peuvent réviser vos médicaments et vous proposer des façons d'en réduire les effets secondaires. Vous n'avez qu'à le leur demander!

Les thérapeutes respiratoires peuvent vous aider à résoudre vos troubles respiratoires, le cas échéant.

Les ergothérapeutes peuvent vous offrir des conseils sur la façon de ménager vos efforts, de conserver votre énergie et d'assurer votre sécurité et votre confort.

Les physiothérapeutes peuvent vous suggérer des moyens pour vous permettre de vous déplacer plus aisément et de façon plus sûre.

Les orthophonistes peuvent aider à soulager vos craintes concernant la déglutition et la communication.

Les diététistes peuvent offrir des conseils utiles si votre appétit, votre goût ou vos habitudes alimentaires ont changé.

Les travailleurs sociaux offrent un soutien en vue de répondre aux préoccupations d'ordre affectif et pratique. Ils aident les gens à affronter les sentiments de perte et de chagrin, à régler les problèmes qui entourent le décès et à résoudre les conflits familiaux. Ils peuvent également vous diriger, vous et votre famille, vers les ressources appropriées pour régler toute question courante, comme le coût des médicaments et l'assurance invalidité, entre autres.

Les psychologues peuvent vous aider à soulager vos symptômes de dépression ou d'anxiété et à mieux comprendre vos émotions, y compris le désespoir, la peur et la culpabilité.

Les fournisseurs de soins spirituels sont là pour vous encourager et vous soutenir dans vos démarches pour développer vos sources de force intérieure, de paix, d'espoir et de joie, et pour vous aider à donner un sens et une raison à votre expérience.

L'infirmière ressource en soins palliatifs est une infirmière qui a reçu une formation spécialisée dans le domaine des soins palliatifs. Elle offre un appui au personnel infirmier de première ligne ainsi qu'aux autres membres de votre équipe de soins en ce qui a trait à vos besoins thérapeutiques plus complexes.

Les médecins en soins palliatifs sont des médecins qui ont reçu une formation spécialisée dans le domaine des soins palliatifs. Ils offrent un soutien à votre médecin de famille afin de trouver les meilleures options de traitement médical possible pour la gestion efficace de vos symptômes les plus complexes. Bien que les médecins de famille soient en mesure de gérer un bon nombre de symptômes, les médecins en soins palliatifs sont là pour leur offrir un appui, le cas échéant.

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Palliative Care

Patient Guide

- Palliative Care is a way to care for patients with life- threatening illnesses.
- Palliative care focuses on quality-of-life, including physical, social, emotional, and spiritual needs.
- Palliative care is patient and family centered care based on your goals.
- Palliative Care supports you and your family or loved ones through this period of illness.
- Palliative Care can include end-of-life care but that is not the main focus.

HHN-0794 (12/17)

Many health professionals can be involved in providing palliative care, depending on your needs at different times throughout your illness.

We work together as a team to meet your comfort and care needs and help plan for your future care needs.

Ask us questions and tell us how you feel. We are here for you.

Your Family Doctor coordinates with you, your family, and other health care professionals to guide your medical care.

Nurses help and support you throughout your illness with physical care but also emotional care. Please let the nurses know how you are feeling.

Pharmacists can help review medications and may suggest ways around any difficulties with them. Just ask!

Respiratory Therapists can help if you have trouble breathing.

Occupational Therapists can help you save energy, pace yourself, be safe and comfortable.

Physiotherapists can help with suggestions to move more safely and easily.

Speech Language Pathologists can help with worries about swallowing or communicating.

Dieticians can give helpful tips when faced with changing appetite, taste or eating habits.

Social Workers provide support with both emotional and practical concerns. They assist with feelings of grief and loss, issues related to death, family conflict, questions about day-to-day matters such as medication costs or disability insurance, and identifying resources that may help you and your family.

Psychologists listen and help you deal with symptoms of depression/anxiety and help understand emotions such as hopelessness, fear or guilt.

Spiritual Care Providers encourage and support you in developing your sources of inner strength, peace, hope, joy, meaning and purpose.

A Palliative Care Resource Nurse is a nurse with specialized training in palliative care who supports your main nurses and the rest of your team with more difficult care needs.

Palliative Medicine Doctors are physicians with specialized training in palliative care who support your family doctor to find the best medical options to manage more complex symptoms. Family physicians can manage many symptoms but a Palliative Medicine Doctor is available if needed.

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

Soins Palliatifs

Guide Du Patient

- Les soins palliatifs sont des soins destinés aux patients qui sont aux prises avec une maladie mettant leur vie en danger.
- Les soins palliatifs visent la qualité de vie et sont conçus pour répondre aux besoins physiques, sociaux, émotionnels et spirituels.
- Les soins palliatifs favorisent une approche fondée sur le patient et la famille en fonction des résultats souhaités.
- Les soins palliatifs sont là pour vous aider, vous et votre famille ou vos proches, à surmonter cette période de maladie.
- Les soins palliatifs peuvent comprendre les soins de fin de vie, quoiqu'ils n'en soient pas le principal objectif.

HHN-0794 (12/17)

AGING WELL IN NB

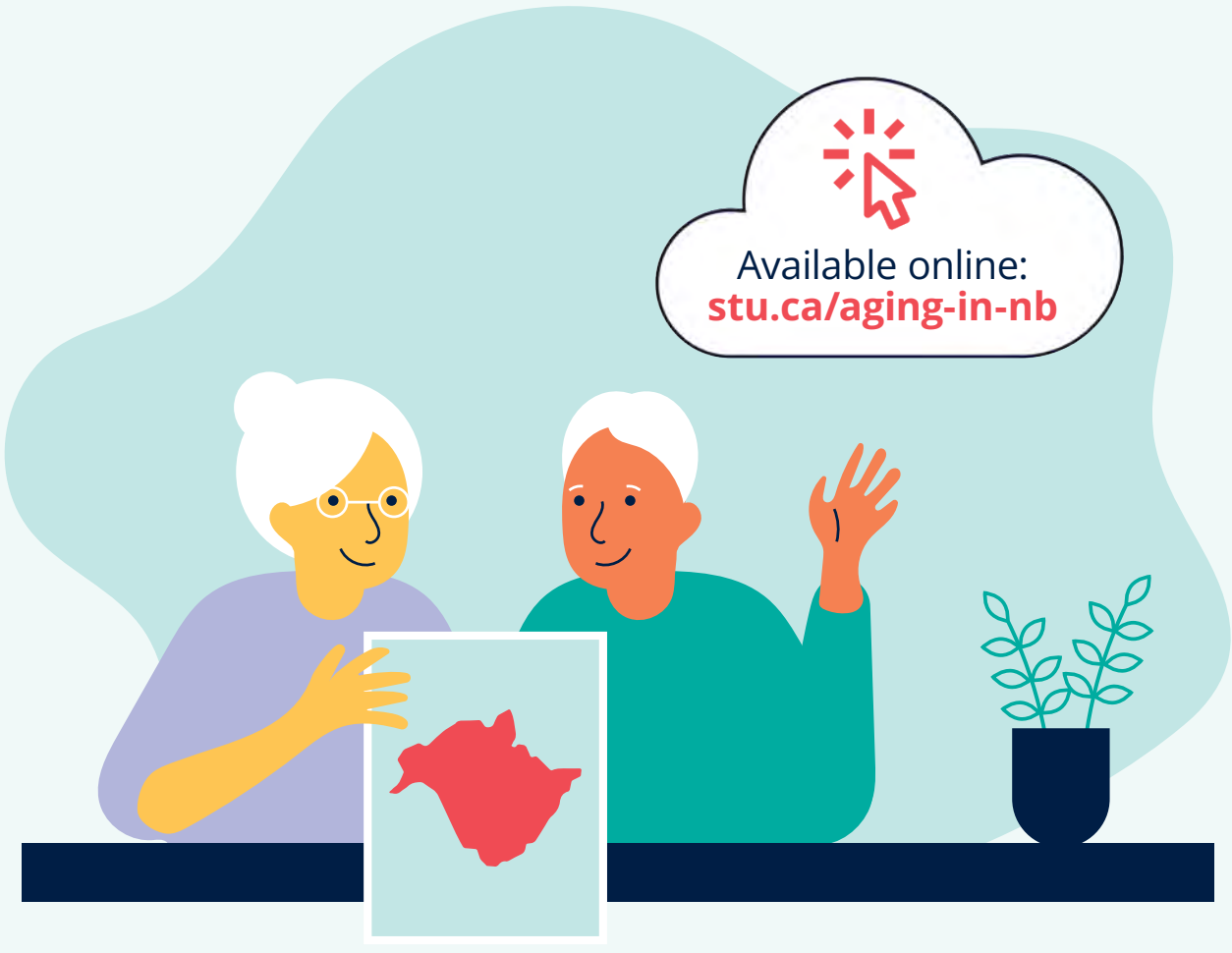
STU AGING IN NB: A USER'S GUIDE

Offers an in-depth exploration of aging in New Brunswick, serving as a comprehensive guide to resources and services available to seniors.

Aging in New Brunswick:

A User's Guide

Fourth Edition



These materials were put together by a group of researchers and practitioners in New Brunswick who work with older adults. Our aim was to help older adults in New Brunswick navigate the complex landscape of information, services, forms, and resources. We hope that you will find this helpful. This guide was last updated in June 2024.

www.stu.ca/aging-in-nb/

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SSHRC CRSH

New Brunswick Health Research Foundation / Fondation de la recherche en santé du Nouveau-Brunswick

St. Thomas University

Table of Contents

This guide is intended to be shared. Please feel free to print and distribute.

This guide is for informational purposes only and is not a substitute for professional medical, legal, or financial advice. Programs and information can change over time, so please check details with the services and agencies mentioned in this document.
[Last update, June 2024]

My Record of Important Information

Preparing for illness, disability, or death is something many people put off. But taking care of these things now can be a great help to you and those you care for. It's never too early.
Start today!

TO DO CHECKLIST	CHECK WHEN DONE
Hire a lawyer to make your Will and Enduring Powers of Attorney (see chapter on "Legal Matters") • Think about who you want to name in your Will (as Executor) and in your Enduring Powers of Attorney documents and ask them if they are willing to take on these roles. Keep them updated on all your important information, including where to find your legal documents. • For more information, see the chapter on "Legal Matters."	☐
Make a Health Care Directive • Make sure that the people you have named in your Health Care Directive have agreed to take on this role and know where to find your Health Care Directives. • Post your Health Care Directives in a place that is easy to find them, like on your fridge at home. Paramedics will sometimes check the fridge to see if they are posted there. • For more information, see the chapter on "Legal Matters."	☐
Review the beneficiaries listed on all your policies and accounts and make sure they are up to date. Here are some examples: • RRSPs, RRIFs and TFSAs • Pension • Life insurance policies	☐

TO DO CHECKLIST	CHECK WHEN DONE

Make a back-up plan to pay all your bills if you are unable to.

Option 1

- If you have a joint bank account with another person, like a spouse, they can continue to make your payments. There are risks in having joint accounts with another person, but it is common for spouses and common-law partners who share income and expenses. To learn the pros and cons of joint accounts, visit: https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/power-attorney-financial.html

☐

Option 2

- If you are the only person named on your accounts as responsible for paying your bills, make an Enduring Power of Attorney for financial matters. You have to hire a New Brunswick lawyer to do this. Ask a person you trust if they are willing to act as your financial Attorney. Once the Enduring Power of Attorney documents are signed, take an original copy to your bank, and have it recorded on your file. Your financial Attorney will then be able to deal with your Bank to pay your bills for you. They have to keep records of every payment they make. They will also be able to make changes to any account (e.g., phone bill, power bill). See the chapter on "Legal Matters" for more information on this.

☐

Note for Caregivers: **Financial abuse is a very real problem and banks, and other companies take confidentiality and privacy very seriously. They will require that a financial Attorney is legally appointed and is not abusing the Enduring Power of Attorney. You will be required to show legal proof that you are allowed to take care of that person's financial matters.**

MY RECORD OF IMPORTANT INFORMATION

It is helpful to have the following information on hand. Keep it in a safe place and tell people you trust where to find it in case you are no longer able to manage your affairs on your own.

PERSONAL INFORMATION:	INFORMATION OR LOCATION OF DOCUMENTS
Full name	
Address	
Telephone number	
Social Insurance Number	
Medicare Number	
Birth Certificate	
Marriage Licence	
Divorce Records	
Death Certificate (of deceased spouse)	
Military service records	
Passport/Citizenship papers	
MEDICAL INFORMATION:	
Family Doctor or Nurse Practitioner	
Pharmacy	
Health Care Directives	
Medications: Name of medication and doses	
Private insurance information (e.g., Blue Cross, Sun Life)	
• Policy number • ID number	• What kind of plan do you have? • What services are covered?

FINANCIAL:	INFORMATION OR LOCATION OF DOCUMENTS
Bank & bank accounts	
Investments	
Financial planner and advisor	
Pension(s)/benefits	
Debts (credit cards, lines of credit)	
Life insurance policy	
Safety deposit box	
Accountant or person who does your taxes	
Previous years' tax returns	
All regular bills (phone, cable, internet, insurance, Netflix, health insurance, etc.). List providers, account numbers and how bills are paid (monthly, pre-authorized, etc.)	
LEGAL:	
Lawyer	
Enduring Power of Attorney	
Will	
Executor	
Location of personal items named in the will	

HOME:	INFORMATION OR LOCATION OF DOCUMENTS
Mortgage or rental documents	
Homeowner or rental insurance	
Property tax bills	
Deeds/titles for properties	
AUTOMOBILE & RECREATIONAL VEHICLES:	
Registration (list all vehicles)	
Loans/financing	
Insurance	
OTHER:	
People who have a spare key to your house	
Pets & Veterinarian	

*The above chart has been adapted from the Financial and Consumer Services Commission and you can find their full version here https://fcnb.ca/sites/default/files/2020-06/The%20Record%20Keeper.pdf

Home Support Services:

Hiring someone to help in your home

Are you having a hard time with daily activities like bathing, cleaning, or cooking?

Would having some help make life easier and help you to stay in your home longer?

If so, Home Support Services (help in your home) may be a good option for you! Different agencies offer different services. Some of these can include:

- Cleaning
- Cooking
- Help with eating
- Supervising medication
- Laundry
- Grooming (like bathing or shaving)

How do I find Home Support Services? Which one do I choose?

Many businesses offer Home Support Services. For a list of agencies in New Brunswick that are approved by the Department of Social Development, visit: socialsupportsnb.ca/homesupport, or call **2-1-1** for more information. You can also find an agency or care worker that is not on this list by talking with friends and family members or searching online.

For more information on how to get Home Support Services, visit:
socialsupportsnb.ca/homesupport, or call or **2-1-1**.

Tip: Ask friends and family for suggestions on people or agencies they have hired.

Tip: Occupational therapists can help you find the right supports for you. You can hire one privately, go through the Extra Mural Program, or your local hospital or community health care centre. See chapter on "Walkers, wheelchairs, grab bars, raised toilet seats, etc." for more information on finding an Occupational Therapist.

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Here are some important questions to ask when you contact Home Support Service agencies:

- What types of services do they offer?
- What types of services don't they offer?
- What communities or locations do they offer services in?
- How much does each service cost per hour?
- When can the support worker come (day, evening, weekends)?
- How often do you pay for the service (daily, weekly, monthly)?
- What happens if the worker has to cancel? Will someone replace them that day?
- Can they provide you references?
- Do they have first aid training?
- Do they have a criminal record check?
- Do I feel comfortable with the person or agency?

What other types of help can you get in your home?

Foot Care:

- You can hire a foot care nurse to come to your home for things like cutting toenails and checking your feet for inflammation, bruising, cuts or blisters. This service can be very important if you have diabetes.
- To find services in your area, call **2-1-1** or search online.
- You may be able to receive these services through the Department of Social Development's Long Term Care Program. To find out if you qualify and/or to apply, visit socialsupportsnb.ca/ltc or call **1-833-733-7835**. You can also try their online Financial Help Calculator at socialsupportsnb.ca/en/calculator to see an estimate of what you would pay for services through the program.

Medical Alert Systems and Technology options:

These services offer a call button that is worn around the neck or wrist and can be activated if the person wearing it falls. This can provide peace of mind to help you remain in your home. Some examples include:

- **Lifeline:** Call **1-866-729-0532**, visit https://www.lifeline.ca/en/ or Google "lifeline medical alert Canada".
- **Caretrak:** Call **1-855-333-3381**, visit https://www.caretrak.ca/ or Google "caretrak."

- **Telus LivingWell Companion:** Call **1-855-724-0031,** visit https://www.telus.com/en/personal-health/livingwell-companion or Google "telus living well."
- **CareLink Advantage:** This service offers technology such as motion detectors, bed sensors, and medication reminders, that can be used to help people live on their own. Call **1-866-876-7401**, visit https://carelinkadvantage.ca/, or Google "carelink advantage."
- You may be able to receive these services through the Department of Social Development's Long Term Care Program. To find out if you qualify and/or to apply, visit socialsupportsnb.ca/ltc or call **1-833-733-7835**. You can also try their online Financial Help Calculator at socialsupportsnb.ca/en/calculator to see an estimate of what you would pay for services through the program.

Meals on Wheels:

- This service provides nutritious and affordable ready-made meals.
- They can provide specific meals to support dietary requirements.
- This service is not available in all communities in New Brunswick.
- To find out if there are services in your area and for more information, call **2-1-1**, visit socialsupportsnb.ca/meals-on-wheels , or Google "Meals on Wheels NB."
- You may be able to receive these services through the Department of Social Development's Long Term Care Program. To find out if you qualify and/or to apply, visit socialsupportsnb.ca/ltc or call **1-833-733-7835**. You can also try their online Financial Help Calculator at socialsupportsnb.ca/en/calculator to see an estimate of what you would pay for services through the program.

Tip: If you have care hours covered by the Department of Social Development, think about using a meal delivery service such as Meals on Wheels to cover food needs, and using your care hours for other in-home services such as help with cleaning or grooming.

What if I need financial help to pay for support services at home?

Home Support Services are not covered by the Canadian Health Care System (i.e., Medicare). Instead, people pay for these services privately ("out-of-pocket"). There are also programs to help pay for these services for people with low income or high care needs (see section below on "What if I need financial help to pay for Home Support Services?").

Private insurance: Some private health care insurance programs (e.g., Blue Cross, Sun Life) cover some Home Support Services (but, these do not cover "custodial care," which includes cleaning and laundry services). You will need a note from your doctor or nurse practitioner stating that Home Support Services are needed in order to claim these expenses on your health insurance. Doctors and nurse practitioners often charge a fee for writing that note.

What if I need financial help to pay for Home Support Services?

Veteran's Benefits – If you are a serving or former member of the Canadian Armed Forces or the RCMP, or their spouse or dependent, you may qualify for certain Home Support Services. To find out if you qualify you can contact them at:

- **1-866-522-2122** (English)
- **1-866-522-2022** (Français)

Department of Social Development – The Long Term Care Program can provide support to seniors who have unmet needs. There are two assessments that will determine your eligibility for the program:

- A financial assessment will figure out if you qualify for financial support.
- A functional assessment will figure out what type of care and how much is best for your needs.

Social workers will assist you throughout this application process.

Financial Tip: The Department of Social Development has an online calculator to help you see if you might qualify for financial help. To use it, visit https://socialsupportsnb.ca/en/calculator/ or Google "Social Supports NB calculator".

To learn more about the Home Support Services offered through the Department of Social Development, visit socialsupportsnb.ca/homesupport.

Myth buster

Myth: A common myth is that if you contact the Department of Social Development, you will be required to go into a nursing home. This is not true.

Truth: Getting help through the Department of Social Development is totally voluntary and based on an assessment completed by a Social Worker. They will discuss options that are available for you and develop a plan with you to meet your needs.

Myth: A common myth is that if you need financial help for your care, you will need to sell your home. This is not true.

Truth: When figuring out how much you will pay toward the cost of care, the government only 'counts' your income (e.g., Canada Pension Plan (CPP), Old Age Security (OAS), Guaranteed Income Supplement (GIS), private pensions, etc.). They will not 'count' things you own (e.g., the price of your house or your savings). The government will not assess your house or savings.

What you need to know before you call the Department of Social Development

Step 1

GATHER THIS INFORMATION:

- Name
- Address
- Date of Birth
- A clear idea of your needs, and if those needs are long-term. Some examples:
    - "I have been falling at home and am having trouble walking."
    - "I have no one to help me at home and have a hard time getting around."
    - "I would like to have my father assessed for Home Support Services as he is not able to care for himself at home."
    - "I am having trouble standing for long periods of time and it's getting harder to take care of myself."

Tip: Be clear about why you need help. For example, instead of saying, "I need help cleaning my house," explain why: "I can't stand for very long and I often fall." Explain if the need for help is short-term (e.g., recent accident) or long-term (e.g., dementia). Eligibility is not based on a diagnosis but rather on the need for services on a long-term basis.

Tip: If you have a spouse who also has care needs, ask that you are both assessed through the Department of Social Development. It's important to note that having two people needing care at home doesn't mean you get twice the care hours in your plan.

Tip: If you are in hospital, you can ask the Discharge Planner to help you choose what supports you will need once you leave the hospital. Other hospital staff, such as the geriatric team, resource nurses, occupational therapists, social workers, and physiotherapists are also there to help plan for Home Support Services after you get out of the hospital.

Step 2

CONTACT THE DEPARTMENT OF SOCIAL DEVELOPMENT TO APPLY FOR THE LONG TERM CARE PROGRAM. YOU CAN DO THIS IN TWO WAYS:

Option 1: Complete the application form online on the Social Supports NB Website at socialsupportsnb.ca/ltc.

- You will be asked some pre-screening questions and then be directed to the application form.
- For more information visit socialsupportsnb.ca/ltc or Google "Social Supports NB Long Term Care Program".

Option 2: Call the Department of Social Development at 1-833-733-7835 and press the number to select 'services for seniors'. You will be asked some questions, and then will be sent a form that you have to fill out. This form will be sent by mail. If you use email, you can ask for the form to be sent by email, which can make the process faster.

- **Once you have received your forms, complete them and return them to the Department of Social Development.** You can return them by bringing them in person or sending them by mail or email. You have about one month to complete the forms and return them to the Department of Social Development. This is to make sure the information is correct at the time of assessment. Filling out the forms can take time and effort.

You will need the following information to apply for the Long Term Care Program:

- Full name
- Address
- Date of birth
- Social Insurance Number
- Next of kin or emergency contact person, their relationship to you, and their phone number
- The name and date of birth of any dependents living with you.
- Proof of the following if it applies to your situation or is requested:
    - o Private insurance
    - o Other income not declared on your income tax return (e.g.: disability insurance, veteran pension, pension from out of country, current pension amounts if your situation changed since last income tax return, etc.)
    - o Copies of Power of Attorney or Trustee

- To apply for financial help to help pay for the cost of long-term care, you must provide information about your taxes for the last two years. You can do this by providing consent to the Department of Social Development to request financial information from the Canada Revenue Agency (CRA) on your behalf. If you prefer not to consent to the CRA process, there's another way to assess your finances. Please call the Department of Social Development at **1-833-733-7835** to find out more about this process and check if it's right for you.

Tip for caregivers: If you are a caregiver of an older adult and are asking for tax information on their behalf, you will need to send the Canada Revenue Agency a copy of your Enduring Power of Attorney. To contact them, call **1-800-959-8281.**

Ask a family member or friend for help! This can be a lot of work!

I need financial help to pay for support services at home and have applied to the Department of Social Development for the Long Term Care Program. What happens next?

The Department of Social Development will work with you and your family to help figure out what supports you need. Together you will work on creating a plan that meets your unmet needs.

Two things will happen after you return your completed forms to the Department of Social Development:

1) FINANCIAL ASSESSMENT FOR THE LONG TERM CARE PROGRAM

This assessment will figure out if you qualify for financial support to help pay for the kind of care that you need. It is based on your income and the type of service that you need. Keep in mind that mostly everyone pays a certain amount out-of-pocket, but the financial assessment figures out how much the government is able to pay for you.

The financial assessment only 'counts' the income of the applicant and their spouse/partner (if this applies). The most common sources of income include:

- Canadian Pension Plan (CPP)
- Old Age Security (OAS)
- Guaranteed Income Supplement (GIS)
- Employment insurance payments
- Income Tax
- Private Pensions
- Income from employment
- Interest from investments

The financial assessment does not 'count' assets (things you own). In other words, the price of your house or your savings are not used in figuring out how much money you have – only the regular income you receive. A common myth is that the government will 'take your house' if you need financial help for care. This is not true.

Financial Tip: The Department of Social Development has an online calculator to help you see if you might qualify for financial help. To use it, visit https://socialsupportsnb.ca/en/calculator/ or Google "Social Supports NB calculator".

Financial Tip: If you are struggling financially and paying your contribution towards services would stop you, your spouse, or your dependents from affording things like food, housing, heat, medication, and other required healthcare expenses, you can ask for a "temporary cost adjustment". This process requires a lot of extra work but does exist for emergency situations.

2) FUNCTIONAL ASSESSMENT FOR THE LONG TERM CARE PROGRAM

A functional assessment will be done to figure out what type of care and how much care is best for your needs.

A Social Worker will complete this assessment. You may ask to have a friend or family member be there with you when the assessment happens. The Social Worker will ask you questions about how you are doing living in your home, if you have friends or family close by who help you, and what kinds of help you might need. Your Social Worker may need more information from other professionals (such as your doctor, extra mural nurse, occupational therapist, etc.). This assessment helps the Social Worker understand what type of care you need, and how much care they can offer. Keep in mind that the Long Term Care Program may not be able to subsidize all services you ask for. The Long Term Care Program is a voluntary program.

Tip: It can be really helpful to have a family member or friend with you when the Social Worker does the assessment. If you wish, you can tell the Social Worker that you want someone to be there with you at the time of the assessment.

Hiring Home Support Services through the Department of Social Development

If you qualify for support and financial assistance through the Department of Social Development, the Social Worker will give you a list of Home Support Services to choose from. For a list of agencies that are approved by the Department of Social Development, visit: **socialsupportsnb.ca/homesupport**, or call **2-1-1** for more information. Keep in mind, you do not have to use a company on this list.

Tip: Ask friends and family for suggestions about people or agencies they have hired.

Financial Tip: If you want to hire someone to provide home support services who is not on the list of options offered by the Department of Social Development, you may do so. In those situations, you would be responsible for hiring and doing background checks. If you decide to hire someone yourself, the Department of Social Development will pay a rate equal to minimum wage. Any costs above that rate will be your responsibility to cover.

Financial Tip: If you do not qualify for financial assistance for Home Support Services through the Department of Social Development, but you have private healthcare insurance, check to see if your policy covers any Home Support Services.

Home First Program

Do you want to know about supports that can help you live at home longer? Do you want to learn how to maintain a healthy, active, and independent life?

If so, you can have a Seniors Health, Wellbeing and Home Safety Review. This free and voluntary service covers topics like:

• how to prevent falls
• getting involved in your community
• physical activity
• wellness

> **To request a Seniors Health, Wellbeing and Home Safety Review**, **register online at** socialsupportsnb.ca/homefirst. You can also call **2-1-1**.

Adult Day Centres

Are you 65 years old or older living with dementia or a related cognitive impairment? Are you looking to be a part of meaningful activities outside of the home? Are you a caregiver that works, runs errands, or would like respite care during the day?

If so, Adult Day Centres may be able to help you. Programming at each Adult Day Centre will vary. Here are some examples of what they may offer:
• Supervised individual or group activities
• Personal care (for example bathing, toileting, foot care)
• Snacks and nutritious meals

This service is not available in all communities in New Brunswick.

You can access Adult Day Centres two different ways:

1. Apply through the Long Term Care Program. They will help you assess, plan, and coordinate the services you need. You may qualify for financial help towards the cost of services. Call **1-833-733-7835**, visit socialsupportsnb.ca/LTC or Google "Social Supports NB Long Term Care Program."

2. Contact one of the Adult Day Centres located in the province. Visit socialsupportsnb.ca/day-centres for a list of Adult Day Centres. You can also call **2-1-1**.

Nursing Home Without Walls Program

Some nursing homes have started to offer services to people who live in their own homes in the community. By sharing nursing home staff, tools, and resources, this program helps older adults stay in their own homes longer. Services that might be available in your area could include:

- The use of special showers and baths that are easy to get in and out of;
- Transportation to help people get to appointments or social outings. Some have minibuses that are wheelchair accessible;
- Staff that can make friendly check-ins and social visits;
- Staff that can help you find the resources you need to stay in your home (e.g., getting meals delivered to your home or finding social groups);
- Fun social activities.

The Nursing Home Without Walls Program is offered by some nursing homes in the province. This service is free.

To find out if there is a nursing home near you that does this, call **2-1-1** or visit socialsupportsnb.ca/nhww.

Red Cross Friendly Calls Program

For some people, a little chat can make a big difference.

The Friendly Calls Program matches adults with trained Red Cross personnel who call them regularly to check in, provide emotional support, encourage healthy coping strategies, and suggest helpful services and resources in the community.

Friendly Calls is safe, accessible, free, and available nationwide.

To sign up, call **1-833-979-9779** toll-free from 9 a.m. to 5 p.m. (Monday to Friday), or visit redcross.ca/friendlycalls.

Tip: Did you know that some businesses offer "mobile services" that come to your home?

- For instance, in some parts of the province, you can find **lawyers**, **hairdressers**, and other services. Ask the people you usually hire if they could come to you. You can also call **4-1-1** or search online.
- Do you have a **dog** and need help with walking, grooming, feeding them? Do you need short-term care for your dog while you are in hospital? If so, **ElderDog** is a free service that helps older adults take care of their dogs. For more information and to see if they offer services in your area, visit http://www.elderdog.ca/, Google "Elderdog Canada," or call **1-855-336-4226**.
- Do you love to read but can't visit the library in person? The public library **"Books by mail"** program can send **books magazines, audiobooks, music, and movies** to your home by mail for free. You can also borrow **e-books** online. For more information on the range of services they offer, call your local library, or visit the New Brunswick Public Libraries page. You can also visit socialsupportsnb.ca/library or call **2-1-1**.

If the level of care you need goes up and living at home becomes too hard, the next step is to think about moving into a Long-Term Care Home (Special Care Homes or Nursing Homes).
See the chapter "Long-Term Care Homes."

Long-Term Care Homes:

Special Care Homes, Generalist Care Homes, Memory Care Homes & Nursing Homes

Is living in your own home getting too hard, even with help at home?

Is it time to think about moving into a Long-Term Care Home to have more help?

If yes, the **first step** is to contact the Department of Social Development **(1-833-733-7835)** or connect with your social worker if you are already a client of the Long Term Care Program.

Note: Even if you will be paying privately, you still have to go through the Department of Social Development to move into a Long-Term Care Home (Special Care Home or Nursing Home).

Myth buster

Myth: A common myth is that if you need to go into a Long-Term Care Home, the government will 'take your house'. This is not true.

Truth: When figuring out how much you will pay toward the cost of care, the government only 'counts' your income (e.g., Canada Pension Plan (CPP), Old Age Security (OAS), Guaranteed Income Supplement (GIS), private pensions, etc.). They will not 'count' things you own (e.g., the price of your house or your savings). The government will not assess your house or savings.

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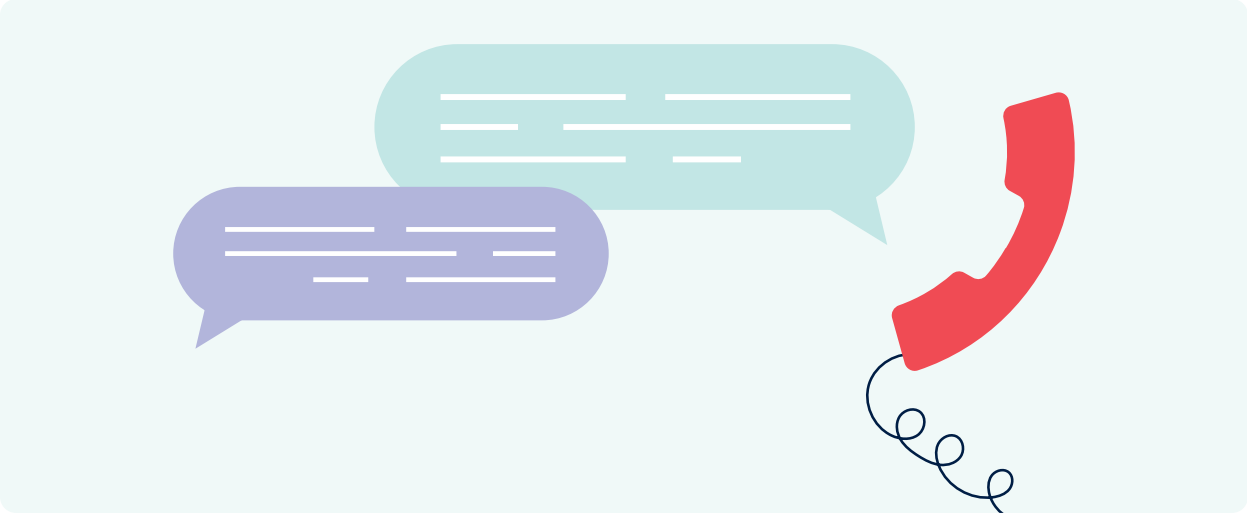


Why do you have to contact the Department of Social Development?

Long-Term Care Homes (Special Care Homes and Nursing Homes) are not covered by the Canadian Health Care System (i.e., Medicare). These services are not free. Instead, people pay for these services, with financial help available for people who can't afford them. If you are looking to move into a Special Care Home or Nursing Home, call the Department of Social Development **(1-833-733-7835)** to determine if you qualify for placement.

To learn more about special care homes, you can visit:
socialsupportsnb.ca/special-care-homes
Or Google "Social Supports NB Special Care Homes"

To learn more about nursing homes, you can visit:
socialsupportsnb.ca/nursing-homes
Or Google "Social Supports NB Nursing Homes"

What you need to know before you call the Department of Social Development (1-833-733-7835)

Step 1

GATHER THIS INFORMATION:

- Name
- Address
- Date of birth
- A clear idea of your needs. Some examples:
  - "I have dementia and my family is worried I'm not safe living alone."
  - "I would like to have my mother assessed for Long-Term Care."
  - "I am having a hard time living at home, even with a lot of home support services."

Tip: If you are in hospital, you can ask the Discharge Planner to help you set up care once you leave the hospital. Other hospital staff, such as the geriatric team, resource nurses, occupational therapists, and physiotherapists are also there to help you plan for after you get out of the hospital.

Step 2

CONTACT THE DEPARTMENT OF SOCIAL DEVELOPMENT TO APPLY. YOU CAN DO THIS IN TWO WAYS:

Option 1: Complete the application form online on the Social Supports NB Website at socialsupportsnb.ca/ltc.

- You will be asked some pre-screening questions and then be directed to the application form
- For more information visit socialsupportsnb.ca/ltc or Google "Social Supports NB Long Term Care Program"

Option 2: Call the Department of Social Development at 1-833-733-7835 and press the number to select 'services for seniors'. You will be asked some questions, and then will be sent a form that you have to fill out. This form will be sent by mail. If you use email, you can ask for the form to be sent by email, which can make the process faster.

- **Once you have received your forms: Complete any paper forms needed and return them to the Department of Social Development.** You can return them by bringing them in person or sending them by mail or email. You have about one month to complete the forms and return them to the Department of Social Development. This is to make sure the information is correct at the time of assessment. Filling out the forms can take time and effort.

You will need the following information to apply for the Long Term Care Program

- Full name
- Address
- Date of birth
- Social Insurance Number
- Next of kin or emergency contact person, their relationship to you, and their phone number
- The name and date of birth of any dependents living with you.
- Proof of the following if it applies to your situation or is requested:
    - o Private insurance
    - o Other income not declared on your income tax return (e.g.: disability insurance, veteran pension, pension from out of country, current pension amounts if your situation changed since last income tax return, etc.)
    - o Copies of Power of Attorney or Trustee
- To apply for financial help to help pay for the cost of long-term care, you must provide information about your taxes for the last two years. You can do this by providing consent to Social Development to request financial information from the Canada Revenue Agency (CRA) on your behalf. If you prefer not to consent to the CRA process, there's another way to assess your finances. Please call Social Development at **1-833-733-7835** to find out more about this process and check if it's right for you.

Tip for caregivers: If you are a caregiver of an older adult and are asking for tax information on their behalf, you will need to send the Canada Revenue Agency a copy of your Enduring Power of Attorney (financial). To contact them, call **1-800-959-8281.**

Ask a family member or friend for help! This can be a lot of work!

It can be helpful to have the following information and documents on hand through the process of applying for and moving into Long-Term Care.

- Date of Birth
- Mailing address
- Social Insurance Number
- Medicare Number
- Medication & Pharmacy: Names of medication and how to take them. Pharmacy name, address, and phone number.
- Family Doctor or Nurse Practitioner: Name & Phone number
- Lawyer: Name & Phone number

Tip: It is helpful to keep all of this information and important documents in one place (like a bag that you can easily bring with you) so you can have it on hand when you need it.

Enduring Power of Attorney and paying bills: If you have been named as a person's financial Attorney in their Enduring Power of Attorney documents and they are no longer able to pay their own bills or accounts (e.g., because they have dementia), you can get set up to pay their bills by getting your Enduring Power of Attorney on file at each company (e.g., NB Power, cable company, etc.). You may also need to provide evidence that the person is no longer able to manage their finances or bills (e.g. letter from doctor).

Tip for Caregivers: If you use email, scan a copy of your Enduring Power of Attorney so that you have this ready to send whenever you are asked for it.

I have applied to the Department of Social Development for placement in Long-Term Care. What happens next?

The Department of Social Development will work with you and your family to help figure out the level of care that you need. Two things will happen after you submit your completed forms to the Department of Social Development:

Step 1

FINANCIAL ASSESSMENT FOR THE LONG TERM CARE PROGRAM

This assessment will figure out if you qualify for financial support. It is based on your income and the type of placement that you need. Keep in mind that mostly everyone pays a certain amount out-of-pocket, but the financial assessment figures out how much the government can pay for you.

The financial assessment only 'counts' the income of the applicant and their spouse/partner (if this applies). The most common sources of income include:

- Canadian Pension Plan (CPP)
- Old Age Security (OAS)
- Guaranteed Income Supplement (GIS)
- Employment insurance payments
- Income Tax
- Private Pensions
- Income from employment
- Interest from investments

The financial assessment does not 'count' assets (things you own). In other words, the price of your house or your savings are not used in figuring out how much money you have – only the regular income you receive. A common myth is that the government will 'take your house' if you need financial help for care. This is not true.

Financial Tip: The Department of Social Development has an online calculator to help you see if you might qualify for financial help. To use it, visit socialsupportsnb.ca/en/calculator or Google "Social Supports NB Calculator."

Financial Tip: The cost of Long-Term Care depends on the "level" of care you need and on the type of Care Home you move into. So, even if you might not qualify for government financial help when first assessed, you might qualify later if you have to move to a different type of care home. It can be a good idea to complete the financial assessment even if you think you won't qualify for financial help.

> **E.g.** George did not qualify for financial assistance when he first moved into a Special Care Home. A year later, he moved to a different home that was a better fit for his care needs. After he moved, he did qualify for some financial support.

Financial Tip: If you are struggling financially and paying your contribution towards services would stop you, your spouse, or your dependents from affording things like food, housing, heat, medication, and other required healthcare expenses, you can ask for a "temporary cost adjustment". This process requires a lot of extra work but does exist for emergency situations.

Step 2

FUNCTIONAL ASSESSMENT FOR THE LONG TERM CARE PROGRAM

A functional assessment will be done to figure out what type of care home is best for your needs. A Social Worker will complete this assessment. You may ask to have a friend or family member be there with you when the assessment happens. The Social Worker will ask you questions about how you are doing living in your home, if you have friends or family close by who help you, and what kinds of help you might need. Your Social Worker may need more information from other professionals (such as your doctor, extra mural nurse, occupational therapist, etc.). This assessment helps the Social Worker make a decision on what kind of Care Home is best for you. The Long Term Care Program is a voluntary program.

As part of this assessment, you will need to have a **'Physical Examination and History'** form completed by a doctor or nurse practitioner. Some doctors or nurse practitioners will charge a fee to complete the form. Once the assessment is complete, the Department of Social Development will work with you to see if you

qualify to move to a Special Care Home, Generalist Care Home, Memory Care Home or Nursing Home. If so, the Social Worker will give you a list of options that are right for you.

Tip: It can be really helpful to have a family member or friend be with you when the Social Worker does the assessment. If you wish, you can tell the Social Worker that you want someone to be there with you at the time of the assessment.

Tip: If you can, go and visit the different homes available to see if you would like to live there. Or you can have someone you trust do that for you. See below "Choosing a Long-Term Care home – What matters to YOU?"

After the financial and functional assessments (for nursing homes only)

- You choose 2 nursing homes that you would like to live in. These two selections are treated as equal preferences.
- The nursing home will call you when a spot becomes available for you.
- If there is no vacancy in either of the 2 nursing homes you chose, you may be offered an "interim" option. An "interim placement" is another nursing home 100 kms or less from your home which offers services in your language of choice. When you accept an offer of interim placement, your name may remain on the waitlists of the 2 nursing homes you selected, upon your request. When a bed is available at one of your preferred homes you can transfer, or you may choose to stay at the "interim" nursing home.
- What happens if I refuse a spot in a preferred or interim nursing home?
  - If you live at home when awaiting placement and you decline a spot at either a preferred or interim placement, your name will be placed at the bottom of all waitlists.
  - If you are awaiting placement in hospital and have been medically discharged, you will keep your place on the waitlist. Be sure to ask about hospital policies related to medically discharged patients.
- Anyone living in a nursing home can apply for a transfer to another nursing home at any time. To do this, contact the nursing home that you would like to move into and ask to put your name on that nursing home's transfer list.

Financial Tip: Nursing Home rates are all the same, but each Special Care Home charges its own rate, and prices can be very different. Be sure to check how much each home costs. If you qualify for financial help, the Department of Social Development will pay a certain amount for you (ask your Social Worker about this). If you want to go into a home that charges more than the amount the Department of Social Development will pay, you will have to pay the difference.

Choosing a Long-Term Care Home

What matters to YOU?

These are some things to think about when looking at different homes. If you can, visit each Long-Term Care Home you are thinking about and ask questions about the things that are important to you. Or, you can have someone you trust do this for you. Some examples of questions to ask include:

- ☐ Is there a spot available? How long is the wait list?
- ☐ How much does it cost? Are there extra fees (e.g.,TV, internet)?
- ☐ Are the bedrooms shared or private? If bedrooms are shared, how many people live in the same room?
- ☐ What is the ratio of Care Staff to residents? (Be clear that Care Staff are Nurses and Resident Attendants – not cooking and cleaning staff.)
- ☐ How many Care Staff are on the floor during the day?
- ☐ How many Care Staff are on the floor overnight?
- ☐ Are the Care Staff trained to provide special medical supports if these are needed (e.g., oxygen)?
- ☐ Can I bring my own bed?
- ☐ What personal items can I bring (e.g., chair, TV)?

- ☐ How many people live in the building? (It is important to think about if you prefer a large or small home.)
- ☐ How far is the home from my friends and family?
- ☐ Am I able to see a doctor or nurse practitioner while living there? How often do they visit?
- ☐ Is there a shuttle service? If so, how can it be used? Can it take me to appointments, such as the doctor, nurse practitioner, dentist, eye doctor, etc.? Are there extra costs to use the shuttle?
- ☐ What is the food like? Can I see an example of a menu?
- ☐ Do I like the feel of the home? Can I see myself living here?
- ☐ What social and recreational activities are offered? Can I see a monthly program of activities?
- ☐ Is there an outdoor space? Do residents get outside regularly?
- ☐ What type of equipment for mobility help is available (e.g., grab bars, elevated toilet seats)?
- ☐ Is there a telephone in my room?
- ☐ Can I put a television in my room? Is there an option to pay for extra channels that I want?
- ☐ Is there air conditioning in each room? If not, can I put one in?
- ☐ What are the rules around smoking?
- ☐ What are the rules around alcohol?
- ☐ What is the business model of the home? Is it “For Profit” or “Not for Profit”?

Descriptions of the different types of Care Homes

Different Long-Term Care homes provide different types of care. Some homes are best for people who need supervision and less hands-on care, and other homes are best for those whose needs are more frequent or complex. See below for a description of each type of care home.

A Social Worker from the Department of Social Development will help you figure out the best type of care home for your needs.

Care Homes

Care Homes are for people needing hands-on care or supervision on a 24-hour basis. They may need some help or guidance with mobility, bathing, grooming or taking medications.

SPECIAL CARE HOMES (SOMETIMES CALLED "LEVEL 2")

A Special Care Home can provide support to someone who is independent in some ways. They might walk with a walker or be in a wheelchair, but they can get around on their own. The care staff can help with tasks like getting dressed, showering, taking medications, making beds and doing laundry.

Examples:

- Frank likes to do things himself but sometimes he has a hard time with tasks, like getting his socks on in the morning or getting into the tub.
- Henna enjoys living on her own but isn't able to cook for herself anymore and often skips meals. She is having trouble with her memory and forgets to turn the stove off.
- Dana moves around easily but is having trouble with memory and needs to be reminded to take medications.

GENERALIST CARE HOMES (SOMETIMES CALLED "3G")

Generalist Care Homes are for people with complex needs who need staff with more advanced skills. They may have a hard time moving around on their own and need more help with daily living activities. If they have dementia, it is mild.

Examples:

- Evelyn uses a walker, but sometimes struggles to move back and forth. Daily activities are hard for her to do on her own and she needs help with many things like dressing and bathing.
- Abdul is in a wheelchair and can move around, but he can't always get very far. He needs help with things like shaving and showering.
- Geno is not able to move himself in his wheelchair and needs help with eating his meals.

MEMORY CARE HOMES (SOMETIMES CALLED "3B")

Memory Care Homes are units specifically for people with problems with memory, such as dementia, and who need more help than a Generalist Care Home. Memory Care Homes are for people with moderate to severe dementia who need special supports.

Examples:

- Robin has dementia and often wanders off when no one is around.
- Freida has Alzheimer's Disease and can get upset in the evenings and has a hard time calming down.

Tip: Some homes offer several types of care homes in the same building, in case your care needs increase. Someone with dementia, requiring a Special Care Home type of home, may want to look for places that also have a Memory Care Home in the same building. This is helpful because if the person has to move to a higher level of care as the disease gets worse, it will be easier for them to move within the same building.

NURSING HOMES (SOMETIMES CALLED "3A")

Nursing Homes are units that are right for people who need full-time nursing care, but do not need to be in a hospital.

Examples:

- Marjorie can't get out of bed by herself. She needs a 'lift' to help her get into her wheelchair and needs a lot of help with daily activities.
- Roland has dementia and is not able to speak or move around on his own. He also has Chronic Obstructive Pulmonary Disease (COPD) and needs nursing care.
- Joseph has back pain that often stops him from being able to move on his own. He can use a walker but needs to be helped when walking from his room to the dining hall to make sure he doesn't fall. He also has dementia and needs help throughout the day.

Long-term care and doctors: Each Nursing Home has its own doctor, but Special Care Homes do not. This means that if you move into a Nursing Home you will switch to that Nursing Home's doctor. But if you move into a Special Care Home, you keep your own doctor.

If you live in a long-term care facility and feel unsatisfied with the services, there is a process to file a complaint.

If you live in a Special Care Home, Generalist Care Home, or Memory Care Home and are not satisfied with the services:

You should first bring up your issue with the management of your Care Home. If you are still not satisfied, your next step is to report your concerns to your assigned Social Worker from the Department of Social Development. If you feel your issue has still not been resolved, you can contact the New Brunswick Seniors' Advocate at **1-888-465-1100.**

If you live in a Nursing Home and are not satisfied with the services:

You should first bring up your issue with the management of your Nursing Home. All nursing homes must have a process in place for dealing with complaints. Every attempt to reach an agreement regarding a resident's care must be made. If you are still not satisfied with your concerns about the standards of care, your next step is to report your concerns to a Liaison Officer from the Department of Social Development, by calling them at **1-833-733-7835**. If you feel your issue has still not been resolved, you can contact the New Brunswick Seniors' Advocate at **1-888-465-1100.**

Financial Tips: Income Tax and Long-Term Care

Nursing Homes and Special Care Homes are dealt with differently by the Canada Revenue Agency.

Income Tax and Nursing Home Fees:

You can claim the whole amount that you paid for care in a **Nursing Home** on your income tax. You will need to file form T2201 (Disability Tax Credit Certificate) on your taxes or provide a written note from your doctor or nurse practitioner stating that you are not able to care for yourself independently and are dependent on others for your personal needs and care.

Financial Tip: Typically, you cannot claim Nursing Home fees AND a Disability Tax Credit – only one or the other. It is best to talk to an accountant about this.

Income Tax and Special Care Home Fees:

You cannot claim the whole amount that you paid for care in a **Special Care Home** or the rent you paid in a retirement home (e.g., "retirement living" apartments) on your income tax. But you can claim some expenses for care in such homes if you qualify for the Disability Tax Credit.

To apply for the Disability Tax Credit, a medical professional (e.g., your doctor or nurse practitioner) has to fill out the Form T2201 (Disability Tax Credit Certificate) and note that you have a medical reason to need care. Then, you must send that completed form to the Canada Revenue Agency to see if they approve it.

To learn more about the process of applying for the Disability Tax Credit call the Canada Revenue Agency at 1-800-959-8281, Google "Disability tax credit CRA," or visit https://www.canada.ca/en/revenue-agency/services/tax/individuals/segments/tax-credits-deductions-persons-disabilities/disability-tax-credit.html.

To learn more about claiming medical expenses, call the Canada Revenue Agency at 1-800-959-8281, Google "Medical expenses CRA," or visit https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/rc4065/medical-expenses.html.

Financial Matters:

Paying bills and filing taxes

How to make sure your bills get paid if you are no longer able to take care of it yourself

Option 1

- If you have a joint bank account with another person, like a spouse, they can continue to make your payments. There are risks in having joint accounts with another person, but it is common for spouses and common-law partners who share income and expenses. To learn the pros and cons of joint accounts, visit: https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/power-attorney-financial.html.

Option 2

- If you are the only person named on your accounts as responsible for paying your bills, make an Enduring Power of Attorney for financial matters. You have to hire a New Brunswick lawyer to do this. Ask a person you trust if they are willing to act as your financial Attorney. Once the Enduring Power of Attorney documents are signed, take an original copy to your bank, and have it recorded on your file. Your financial Attorney will then be able to deal with your Bank to pay your bills for you. They have to keep records of every payment they make. They will also be able to make changes to any account (e.g., phone bill, power bill). See the chapter on "Legal Matters" for more information on this.

Note for Caregivers: Financial abuse is a very real problem and banks, and other companies take confidentiality and privacy very seriously. They will require that a financial Attorney is legally appointed and is not abusing the Enduring Power of Attorney. You will be required to show legal proof that you are allowed to take care of that person's financial matters.

This guide is for informational purposes only and is not a substitute for professional medical, legal, or financial advice. Programs and information can change over time, so please check details with the services and agencies mentioned in this document. [Last update, June 2024]

Tip: Keep a list of all your bills, savings accounts, investments, etc. That way, if needed, the person you name in your Enduring Power of Attorney (financial) document knows what accounts you have and where they are held. See the chapter on "My Record of Important Information" for an easy way to keep track of all of this.

Tip: Having an Enduring Power of Attorney on file for your accounts (such as bills, banking, taxes, etc.). before it is needed can help the person you name in that document if they ever need to step in and act as your financial Attorney. Some companies may need you to sign a paper to allow your financial Attorney to act on your behalf.

Tips for caregivers:

- If you use email, scan a copy of your Enduring Powers of Attorney so that you have this ready to send when you are asked for it.
- Send a copy of your Enduring Power of Attorney to all businesses and agencies that you deal with often. Once your Enduring Power of Attorney is on file, you can access the accounts (e.g., phone company, private insurance, Canada Revenue Agency, etc.).

Senior Financial Abuse

Older adults can be targets of theft, fraud, and scams, including:
- being pressured to give someone control of your money
- being pressured to make an Enduring Power of Attorney
- being pressured to sell your house or possessions
- being pressured to change your will
- phone or internet scams

The effect of financial abuse can be devastating, including loss of money, loss of trust, social isolation, and health problems. To learn more about how you can protect yourself and those you love visit:

- Socialsupportsnb.ca/financial-abuse or Google "Social Supports NB senior financial abuse"
- Finances50plus.FCNB.ca or Google "Financial and Consumer Services Commission"

How to find past Tax Returns or Notice of Assessments from the Canada Revenue Agency

If you can't find them in your files, you can get past Notice of Assessments or Tax Return information from:

- The accountant who did your taxes last year
- From the Canada Revenue Agency: Call **1-800-959-8281**, or sign into your CRA account at Canada.ca/cra, or Google "NOA copy."

Tip: If you have to ask for tax information from the Canada Revenue Agency, try to do this as early as you can because it can take many weeks for this information to arrive.

Enduring Power of Attorney and Tax and Pension Accounts

If you have been named in the Enduring Power of Attorney document as the financial Attorney and are caring for a person who can no longer take care of their own taxes, you must register your Enduring Power of Attorney with the Canada Revenue Agency. You can do this in two different ways:

Option 1

- Online by visiting https://www.canada.ca/en/revenue-agency/services/tax/representative-authorization/how.html or Googling "Canada Revenue Authorize a representative for online".

Option 2

- Calling the Canada Revenue Agency (**1-800-959-8281**) and asking for:
    - The form to register your Enduring Power of Attorney
    - The mailing address or fax number where the form can be sent once it is filled out.
        - Before you call, you will need this information about the person who has appointed you as their financial Attorney in their Enduring Power of Attorney document:
        - Full name
        - Address
        - Date of Birth
        - Social Insurance Number

- Once you get the form, fill it out and write the person's Social Insurance Number on every page.
- Make a copy of this document. Keep the original. Mail the copy to the Canada Revenue Agency at the address you were given.
- After you have mailed your documents, call back in a few weeks to ensure they received your form.
- Once the Canada Revenue Agency has processed your documents, a letter will be mailed to you to confirm.
- Once your Enduring Power of Attorney is on file with the Canada Revenue Agency, you can manage the person's account online or call on their behalf. To do so, you can call at **1-800-959-8281**, visit https://www.canada.ca/en/revenue-agency/services/e-services/represent-a-client.html or Google "Represent a client CRA."

Enduring Power of Attorney and Old Age Security (OAS) and Canada Pension Plan (CPP):

If you are someone's financial Attorney and you need to access financial information about their Old Age Security or Canada Pension Plan, you will need to submit a form by mail to Service Canada. This form is called the "Consent to Communicate Information to an Authorized Person" form. You can ask for a copy from your local Service Canada office or you can download and print the form here: https://catalogue.servicecanada.gc.ca/content/EForms/en/Detail.html?Form=ISP1603OAS.

Once filled out, you must mail the form to:

Service Canada
PO Box 250 Station A
Fredericton NB E3B 4Z6
CANADA

How to claim Long-Term Care on your Income Tax

Nursing Homes and **Special Care Homes** are dealt with differently by the Canada Revenue Agency. See below for details on how to claim both on your income tax:

Income Tax and Nursing Home Fees: You **can** claim the whole amount you paid for care in a **Nursing Home** on your income tax. You will need to file form T2201 (Disability Tax Credit Certificate) on your taxes or have a written note from your doctor or nurse practitioner stating that you are not able to care for yourself on your own and must rely on others for care.

Financial Tip: Typically, you cannot claim Nursing Homes fees AND the Disability Tax Credit – only one or the other. But there may be some situations when you can. It is best to ask an accountant about this.

Income Tax and Special Care Home Fees: You **cannot** claim the whole amount you paid for care in a **Special Care Home** or the rent you paid in a retirement home (e.g., "retirement living" apartments) on your income tax. But you can claim some costs for care in such homes if you qualify for the Disability Tax Credit. The Special Care Home should give you a detailed receipt that tells you what you are able to claim on your tax return.

To apply for the Disability Tax Credit, your doctor or nurse practitioner has to fill out the Form T2201 (Disability Tax Credit Certificate) and note that you have a medical reason to need care. Then, you must send that form to the Canada Revenue Agency to see if they approve it.

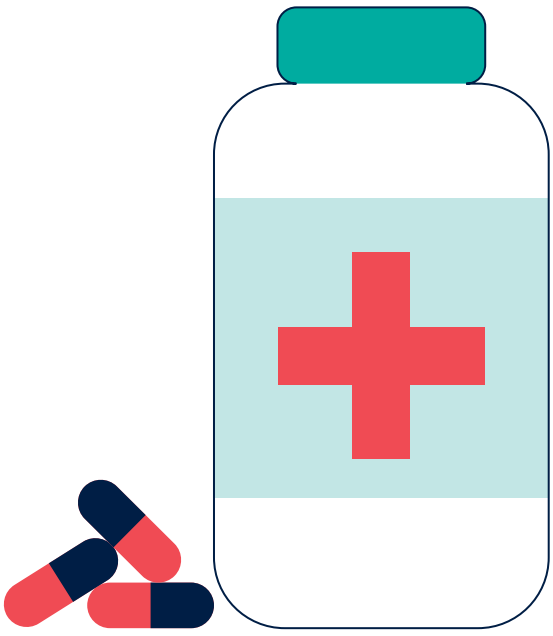
To learn more about the Disability Tax Credit or to apply call: **1-800-959-8281**, visit https://www.canada.ca/en/revenue-agency/services/tax/individuals/segments/tax-credits-deductions-persons-disabilities/disability-tax-credit.html, or Google "Disability tax credit Canada."

Medical Costs and Income Tax

You may be able to claim certain medical costs on your income tax. These can include prescription drugs, walkers, or wheelchairs. A full list of eligible medical costs and whether you need a prescription for them can be found here: https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/lines-33099-33199-eligible-medical-expenses-you-claim-on-your-tax-return.html, or Google "Medical expenses tax credit CRA."

If you have to travel to your medical appointments and these are at least 40km away (one way), you may be able to claim travel costs. It can be helpful to keep a log of all medical visits. Keep in mind you must travel the most direct route to qualify and that you will need confirmation of your appointments from your doctor or nurse practitioner.

To learn more about claiming medical costs, call: **1-800-959-8281**, visit https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/rc4065/medical-expenses.html, or Google "Medical expenses."



Do you need help getting your taxes done, but can't afford to pay for it?

Tax clinics can help people who qualify get their taxes done for free. These clinics are often held during March or April.

To qualify, you must have:

1) A simple tax situation: This means you either have no income OR you get your income through:

- Employment
- Pensions
- Benefits (like the Canada Pension Plan, Old Age Security, Disability Insurance, Employment Insurance, and Social Assistance)
- Registered Retirement Savings Plans (RRSPs)
- Support payments
- Scholarships, fellowships, bursaries, or grants
- Interest (under $1,000)

AND you have:

2) A modest income: This is based on the number of family members living in your house. Your income must be below these annual amounts:

- 1 person: $35,000
- 2 persons: $45,000
- 3 persons: $47,500
- 4 persons: $50,000
- 5 persons: $52,000
- More than 5: $52,500, plus $2,500 for each additional person

To find a tax clinic near you, call the Canada Revenue Agency at **1-800-959-8281**, visit https://www.canada.ca/en/revenue-agency/services/tax/individuals/community-volunteer-income-tax-program.html, or Google "Free tax clinic CRA."

What tax benefits or credits could I be eligible for?

Disability Tax Credit

Do you have a disability (this can include having a hard time walking around or needing care)? If so, you may be eligible for a tax credit from the Government of Canada that can help reduce the amount of income tax you have to pay.

To be eligible, **one** of these must apply:

- You are blind
- You need therapy to maintain your life (at least 14 hours a week). This can include therapies such as insulin therapy, kidney dialysis, or chest physiotherapy.
- You are markedly restricted in at least one of the basic activities of daily living (walking, speaking, dressing, bathing, feeding). This means that for one or more of these activities, you are either unable to do it or it is very difficult and takes you a very long time to do.
    - **Example:** Maria has a very hard time getting dressed in the morning and needs her husband's help to do so.
- You are significantly restricted in two or more of the basic activities of daily living (walking, speaking, dressing, bathing, feeding, or you have a vision impairment). This means that it is very difficult to do two or more of these activities and when combined they take you a very long time to do.
    - **Example:** Paul has trouble getting in and out of the shower and getting dressed for the day. He can do these on his own, but it takes him a very long time to do these tasks.

And, all of these must apply:

- the disability must be prolonged, which means it has lasted, or will last non-stop for at least 12 months
- the disability must be present all or most all the time (at least 90% of the time)

To find out if you qualify, you can answer some questions on the Government of Canada website. Visit https://www.canada.ca/en/revenue-agency/services/tax/individuals/segments/tax-credits-deductions-persons-disabilities/disability-tax-credit/eligible-dtc.html, or Google "DTC are you eligible questions." You can also call the Canada Revenue Agency (**1-800-959-8281**) and ask about your eligibility.

To apply for the tax credit, you must fill out a T2201 (Disability Tax Credit Certificate). A section of this form is filled out by you. The other section is filled out by a health care provider like your family doctor or nurse practitioner. They may charge a fee to fill this out. Once it is filled out, you can upload it to the website or return it by mail.

To download the form to print or to upload the filled out form, call **1-800-959-8281**, visit https://www.canada.ca/en/revenue-agency/services/forms-publications/forms/t2201.html or Google "T2201 form."

Canada Caregiver Credit

Are you caring for someone in your family who has a mental or physical disability? If so, you may qualify for a tax credit from the Government of Canada.

To qualify, the person you are caring for must rely on you for regular support. You must also provide them with some or all of the basic needs of life, like food, shelter and clothing.

The amount you can claim depends on:

- Your relationship to the person that you are claiming the Canada Caregiver Credit for (your spouse, common-law partner, or dependent)
- Your situation (e.g., whether you are a spouse, a dependent, have dependents, etc.)
- The net income of the person you are caring for
- Whether other credits are being claimed for that person

More details on the Canada Caregiver Credit can be found by contacting the Canada Revenue Agency. Call **1-800-959-8281**, visit https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/about-your-tax-return/tax-return/completing-a-tax-return/deductions-credits-expenses/canada-caregiver-amount.html, or Google "Canada caregiver credit.".

Home Renovation Tax Credit

Do you need to make changes to your home because you are having a harder time moving around?

With the New Brunswick Seniors' Home Renovation Tax Credit, you can claim up to $10,000 on your tax return. These must be changes to your home that will make

your home safer and more accessible. To be able to claim this on your tax return, these changes must be done by a professional.

To learn more about what is eligible under this program or to apply, call **1-800-669-7070**, visit socialsupportsnb.ca/home-renovation or Google "Social Supports NB seniors home renovation tax credit."

Multigenerational Home Renovation Tax Credit

Are you a family caregiver who wants to add an apartment to your home so you can provide care for an older family member? If so, you may be eligible for a tax credit to make these renovations.

To learn more, see https://www.canada.ca/en/revenue-agency/programs/about-canada-revenue-agency-cra/federal-government-budgets/budget-2022-plan-grow-economy-make-life-more-affordable/multigenerational-home-renovation-tax-credit.html or Google "Multigenerational Home Renovation Tax Credit".

Financial Tip: In doing your taxes, the receipts you use for home renovations can sometimes also be claimed as medical expenses. Talk to an accountant about this.

Low-Income Seniors' Benefit

Are you over the age of 60 and qualify as low income? If so, you may be eligible for the New Brunswick Low-Income Seniors' Benefit.

To be eligible you must:

- Have been a resident of New Brunswick on December 31 of last year,
- Be 60 years or older **and**
- Be getting at least one of these federal benefits:
    - Guaranteed Income Supplement (65 years or older)
    - Allowance for Survivor Program (between 60 and 64 years old)
    - Allowance Program (between 60 and 64 years old)
- Applications are available on April 1st of each year. To apply you will need this information:
    - Your name
    - Your address
    - Your Social Insurance Number
    - Which of the federal benefits you receive

For the application form and more information on the benefit, call **1-800-669-7070**, visit socialsupportsnb.ca/lisb or Google "Social Supports NB Low-Income Seniors' Benefit."

Registered Disability Savings Plan

Are you under the age of 59 and are getting the Disability Tax Credit? If so, you may qualify for a Registered Disability Savings Plan.

This is a savings program meant to help you save for retirement. The amount of money you can contribute depends on your income. The Government of Canada may match contributions made before the age of 50.

For more information, talk to your bank, call **1-800-959-8281**, or visit https://www.canada.ca/en/revenue-agency/services/tax/individuals/topics/registered-disability-savings-plan-rdsp/opening-rdsp.html, or Google "RSDP open." See also www.RDSP.com.

What financial help is available for homeowners or renters?

Rent Supplement Programs

Do you have a limited income? If so, subsidized rental programs may be able to help. They provide safe and affordable housing based on your income. Visit socialsupportsnb.ca/housing or contact **2-1-1** for more information. Call **1-833-733-7835** to apply.

Emergency Fuel Benefit

Are you unable to pay the costs of winter heating? If so, the Emergency Fuel Benefit may be able to help. This benefit provides up to $550 / year to help pay for winter heating for those who qualify. Visit socialsupportsnb.ca/emergency-fuel-benefit or contact **2-1-1** for more information. Call Social Development at **1-833-733-7835** to apply.

Enhanced Energy Savings Program

Are you a homeowner who would like to save money on heat and electricity bills? The Enhanced Energy Savings Program offers free home efficiency upgrades. If you own and live in your own home and have a low income, you may qualify. Apply online at saveenergynb.ca.

Would you like to learn about other financial supports?
Visit socialsupportsnb.ca/finances or call **2-1-1** for more information.

Legal Matters:

Wills, Enduring Powers of Attorney & Advance Care Directives

Overview

It is important to plan ahead to make sure that your needs and wishes can be taken care of by those you trust. There are 3 important documents that will help you do this:

1) A WILL
2) ENDURING POWER OF ATTORNEY
3) ADVANCE CARE DIRECTIVES

Don't wait! Talk to a lawyer today! Having these documents will give you peace of mind, knowing that someone you chose will be able to take care of you if you are no longer able to do so. If you wait to have these documents written, you may not be able to do so later, such as if you have an accident or get very sick. Not having a Will or Enduring Power of Attorney can mean months of paperwork and legal fees for those you leave behind.

To make these documents, it is best to contact a lawyer. Lawyers can be very helpful for making a Will and will ensure it is valid. To get help, look for a lawyer who does Wills and estates.

For a list of New Brunswick lawyers:

- Visit https://lsnb.alinityapp.com/client/publicdirectory, or Google "NB Lawyer directory" and enter your city and province to find a list of lawyers in your area (you do not need to enter a lawyer's name or firm)
- Call New Brunswick Law Society at **(506) 458-8540**

Tip: Lawyers don't always keep your documents on file after they are made, so make sure to keep your documents in a place that is safe from fire, water damage, loss, and theft.

This guide is for informational purposes only and is not a substitute for professional medical, legal, or financial advice. Programs and information can change over time, so please check details with the services and agencies mentioned in this document. [Last update, June 2024]

A Will

A Will is a legal document which names an Executor to pay your debts and give your property to the people you choose after you die.

Although the law does not require that you use a lawyer to create a Will, it is a good idea. Lawyers know how to properly prepare the Will to make sure it is valid.

What is an Estate?

Your estate is what you own at the time of your death. This can be anything from a car, a house, a cottage, land, furniture, money, jewelry, and even your social media accounts and email.

When making a Will, you will have to make two important decisions:

1) WHO WILL BE MY BENEFICIARIES?

Beneficiaries are the people or organizations that you name in your Will, who will get a share of your estate after your death.

Financial Tip: If you cannot afford to hire a lawyer to create a Will, some bookstores and websites have standard forms or "Will kits" you can buy. If you decide to use one, it is important to keep in mind that they may not include all information required by law in New Brunswick to be considered a valid Will. Whenever possible, hiring a lawyer is the best option to make sure the Will is valid. If you use a website or Will kit, you must follow their instructions exactly.

For more information on Wills, contact Public Legal Education and Information Service of New Brunswick (PLEIS): By phone: **(506) 453-5369**
Online: Visit http://www.legal-info-legale.nb.ca/en/index.php?page=making_a_will, or Google "PLEIS will."

2) WHO WILL BE MY EXECUTOR (AND MY ALTERNATE EXECUTOR)?

An Executor is the person you pick to take care of your Will when you die. This is a big job, so choose someone you trust and someone who is willing and able do the job.

Tip: Be sure to talk to your Executor about your wishes. See the chapter on "End of Life" for tips on pre-planning funerals. Pre-planning can make things easier for your Executor.

Executors take care of:

- Making and paying for your funeral arrangements
- Working with your lawyer and getting the original copy of your Will
- Taking control of your estate and making a list of all your assets
- Paying all of your debts from the money in your estate. This includes filing your taxes
- Distributing your assets according to your wishes
- If necessary, applying to the court for letters probate ("probating the Will" means it is approved and validated by the court. This gives the Executor the authority to deal with the Estate.)

An Executor can only do the things written in your Will and cannot do anything else or change anything.

It is a good idea to name an Alternate Executor who can step in if your Executor is not able or willing to act as Executor after you die.

Many people choose a relative or close friend as their Executor. An Executor must be 19 years of age or older. If you don't have someone you would like to name as Executor, you may want to have The Public Trustee of New Brunswick, or a licensed trust company act as your Executor. Ask your lawyer or accountant about this. Keep in mind that choosing this option can be expensive.

You can choose two or more people to act together as your Executors. If you choose to do this, it is important to include specific instructions in your Will explaining how they are to settle differences of opinion.

The Executor has the right to be paid for doing this job. Talk to your lawyer about this.

Tip: Talk to the person you want to be your Executor and make sure they are willing and understand what will be needed of them. They have the right to say no.

Tip for Caregivers: Being an Executor takes time and responsibility. Make sure you are up for it. You have the right to say no.

Planning ahead and having important documents ready before you meet with a lawyer will save you time and money. It can also help your Executor. Keep a list of everything you own (e.g., house, car, investments, pension, etc.). and all your debts (e.g., mortgage, bills). The Public Legal Education and Information Service of New Brunswick (PLEIS) has a helpful checklist for keeping track of this information and making a Will. You can request it by calling **(506) 453-5369** or downloading it at: http://www.legal-info-legale.nb.ca/en/uploads/file/pdfs/Checklist_for_Making_a_Will_EN.pdf , or by Googling "PLEIS checklist will".

Tip: Keep the original copy of the Will in a safe, fireproof place (like a safe or a safety deposit box at a bank). You can also scan all important documents and save them electronically in another place as a back-up copy.

Make sure your family and Executor know where to find your Will and any information you have about your wishes for funeral arrangements. Your Executor should also know where you keep important documents, such as life insurance policies. If these are locked up in a safe or safety deposit box, make sure they have access to the key or passcode.

Tip: Marriage, common-law partnership, separation, divorce, remarriage, and death of a spouse all have different consequences for your Will and Enduring Power of Attorney. Be sure to talk to a lawyer and update your legal documents to reflect any changes in your life.

WHAT HAPPENS IF I HAVE DEBT?

Your debts and taxes get paid first. Although Wills are instructions for what you wish to leave for your family and how to distribute your estate when you die, your beneficiaries will only get what is left over after debts and taxes are paid.

Enduring Powers of Attorney

There are two types of Enduring Powers of Attorney

1) The Enduring Power of Attorney for Property and Financial Affairs is a document that must be made with a lawyer to be legally binding. In it you give someone you trust the authority to manage your finances and property (called your "financial Attorney"). They can act for you anytime you authorize them to, or when you are not able to act or make your own decisions (e.g., if you are in a coma or if you develop advanced dementia).

Financial Attorneys can do things like:

- Deposit cheques into your bank account
- Take money out of your bank account
- Pay your bills
- Pay your taxes
- Sell your home or car
- Manage your investments

2) The Enduring Power of Attorney for Personal Care is a document that outlines your wishes for your future medical treatment and care. In it, you name a personal care Attorney who can make decisions for you if you can't (e.g., if you are in a coma, are very sick, or in an advanced stage of dementia).

Personal Care Attorneys can do things like:

- Make medical decisions for you when you are unable (e.g. what medications you get; decide if you should have a medical procedure or operation)
- Talk to your doctor or other health care providers
- Make decisions about your personal and daily care (e.g., food, shelter, and personal safety. For example, should you be allowed to walk around alone even if there is a risk you might fall? Or, should you be offered solid food if there is a risk of choking?)

For more information on **Enduring Power of Attorney**, contact the Public Legal Education and Information Service of New Brunswick (PLEIS): call **(506) 453-5369**, visit http://www.legal-info-legale.nb.ca/en/powers_of_attorney, or Google "PLEIS POA."

Options for Choosing the People you Name in your Enduring Powers of Attorney Documents

One Person for Both Forms of Enduring Powers of Attorney (Financial and Personal Care)

You can have **one person** be your Attorney for financial and personal care decisions. That person would be responsible for managing your financial and personal care decisions if you are unable to do this for yourself.

Example: Marie, your niece, is your financial and personal care Attorney.

Different People for Financial and Personal Care Enduring Powers of Attorney

You can have different people be your Attorney for financial and personal care decisions. One person would manage your financial matters and a different person would manage your personal care decisions, once you can't. There are rules to settle any disputes between your Attorneys.

Example: Marie, your niece, is your financial Attorney. Daniel, your son, is your personal care Attorney.

Multiple People for Each Kind of Enduring Powers of Attorney (Financial and Personal Care)

You can have more than one person be your Attorney for financial or personal care decisions. There are two ways to set this up:

- You can require everyone named as Attorney to agree on a decision before anything can happen.

Example: Your children, Daniel AND Linda, are your Financial Attorneys. They both need to be present to make any financial decisions. They BOTH need to agree and sign on every decision before anything can be done.

Tip: Having everyone agree can make it more complicated, especially if the different people who act as Attorneys live in other provinces or countries. Talk to your lawyer about what works best for you.

- You can arrange that any one person named as Attorney can make decisions on their own.

Example: Your children, Daniel and Linda, are your Personal Care Attorneys. Either one of them can make a personal care decision for you. If the doctor calls Daniel to ask which medicine he would rather you have, he can answer the doctor on his own, and does not need Linda to agree. If Daniel is away on vacation and the nursing home needs a decision made, they can call Linda and she can make the decision without Daniel's approval.

Tip: You can choose in advance which decisions your Attorney is able to make on your behalf.

Often spouses identify each other as Attorney. It is a good idea to also name an Alternate Enduring Power of Attorney in case both spouses are injured at the same time (e.g., in a car accident).

Be sure to name people who are trustworthy in your Enduring Powers of Attorney documents. This decision is very important, and it can be hard and expensive for your family to change later. For example, do not just make the financial Attorney your eldest child by default. Choose someone you know you can trust, because they will have control over your money. Avoid making your Attorney someone who may be tempted to misuse your funds. This could include people who have problems with gambling, high financial needs or who have committed fraud in the past.

Being someone's financial or personal care Attorney is a big job. Choose someone responsible, who will spend the time to manage your affairs well.

Making someone an Attorney does not give that person the ability to change your Will. When you die, the Enduring Power of Attorney ends and your Executor takes over all decisions that you laid out in your Will.

Tip: It is a good idea to ask the people you name in your Enduring Power of Attorney document. Give them a copy or tell them where to find the document should they need to use it.

Tip: It is very important to name an Alternate Attorney in case the person you originally named in your Enduring Power of Attorney document is no longer able to act or make decisions on your behalf.

Tips for Caregivers: When taking care of financial matters, keep a copy of your Enduring Power of Attorney with you. Having your document on hand is helpful because you will need to show proof of Enduring Power of Attorney before acting on someone else's behalf (e.g., paying bills, changing insurance policies, selling their house or car, changing their address with Canada Post, etc.). Banks and other institutions may insist on seeing the original document.

Tips for Caregivers: If you use email, scan a copy of your Enduring Power of Attorney so that you have this ready to send when you are asked for it.

WHAT IF THERE IS NO ONE WHO CAN ACT ON MY BEHALF AS ENDURING POWER OF ATTORNEY?

If you do not have anyone trustworthy available to act on your behalf, such as a family member or friend, you can appoint The Public Trustee of New Brunswick or a licensed trust company to act on your behalf. Ask your lawyer or accountant about this. Keep in mind that choosing this option can be expensive.

You can contact The Public Trustee of New Brunswick at **1 (888) 336-8383** for details and cost information. If you cannot afford to pay, they may be able to reduce the cost of the services.

Tip: You could also appoint the Public Trustee as an Alternate Enduring Power of Attorney, in the event your chosen person can no longer act on your behalf.

Health Care Directives

A Health Care Directive is a document in which you state your wishes for your future medical treatment and care. As long as you are able to understand your doctors and communicate with them, you will make your own decisions about your health care. However, if in the future you can't make decisions on your own (e.g., after you have a stroke or if you are in a coma), this document will help your health professionals and your loved ones understand the decisions you would have made for yourself.

By setting up a Health Care Directive, you can state your wishes for future health care. Some examples include:

- I do (or do not) want CPR
- I do (or do not) want to be put on a respirator or ventilator
- I do (or do not) want to go to the Intensive Care Unit (ICU)
- I want to die at home, in hospice, or in hospital.

Tip: Talk with your doctor about these different choices. These are big decisions to make.

You can set out your health care instructions in three ways:

1. You can hire a lawyer to prepare an Enduring Power of Attorney for personal care and include your health care instructions in it.

2. You can make an Enduring Power of Attorney for personal care yourself using this form from the Public Legal Education and Information Service of New Brunswick (PLEIS): https://www.legal-info-legale.nb.ca/en/uploads/file/pdfs/planning_ahead/F-1.%20Enduring%20Power%20of%20Attorney%20for%20Personal%20Care%20-%20Forms%20-%20English.pdf. You must sign and date this document in front of two independent adult witnesses. The witnesses cannot be the people you name in the document (e.g., as your personal care Attorney), their spouse, common-law partner or child.

• Before completing this document, read this guide on Enduring Powers of Attorney published by the Public Legal Education and Information Service of New Brunswick: https://www.legal-info-legale.nb.ca/en/powers_of_attorney.

• For more information call PLEIS at (506) 453-5369 or Google "PLEIS Enduring Power of Attorney."

3. You can make your own Health Care Directive by writing your health care instructions down and dating and signing the document. You can also use this form from the Public Legal Education and Information Service of New Brunswick (PLEIS) https://www.legal-info-legale.nb.ca/en/uploads/file/pdfs/planning_ahead/F-2.%20Health%20Care%20Directive%20-%20Forms%20-%20English.pdf.

• Before completing this document, read this guide on Health Care Directives published by the Public Legal Education and Information Service of New Brunswick: https://www.legal-info-legale.nb.ca/en/health-care-directives.

• For more information call PLEIS at (506) 453-5369 or Google "PLEIS Health Care Directive."

Since Health Care Directives do not need to be made by a lawyer, they are easy to change and update as your health changes over time.

If you make different documents (e.g., An Enduring Power of Attorney and a Health Care Directive) and there is a conflict in your instructions, the most recent document will be followed. Keep your Health Care Directive up to date. Sign it and date it when you make changes.

It is important to give a copy of your Health Care Directive to your doctor, your personal care Attorney, and any family members or friends involved in your care, so they know your wishes for treatment if you are hospitalized and unable to communicate. It is also a good idea to give a copy to the Health Records Department at the hospital you go to. Again, keep in mind that what is set out in your most recent document are the instructions that must legally be followed.

Tip: It is a good idea to keep a copy of your Health Care Directives on your refrigerator so that it is easy to find. Ambulance workers will often check your refrigerator to see if there are directives posted there.

Tip: You can register your Health Care Directive with Medic Alert and wear a bracelet stating this.

Tip: You can change your personal care Attorney. In the case of separation or divorce, your ex-spouse is automatically no longer your personal care Attorney.

Tip: These online resources can be helpful for thinking about your health care instructions: https://planwellguide.com and https://www.advancecareplanning.ca.

Health and Medical Care

Numbers to know

911: If you are in a medical emergency, call **911**.

811: If you are not in an emergency but want to talk with a nurse about your health, call Tele-Care at **811**. Tele-Care is a free and confidential helpline for getting health advice from a registered nurse. It is open 24 hours a day, 7 days a week.

211: If you want to find programs and services in your community, call **211**. This is a free and confidential helpline to help you find social, community, health, and government services near you. You can also find them online at https://nb.211.ca

411: If you want to find businesses or residential listings in your community, call **411**. You can also find them online at https://411.ca.

Stay Healthy: Prevent Falls Before They Happen!

DID YOU KNOW?

- Falls are the leading cause of injury among older adults
- 8 older adults are hospitalized in New Brunswick each day because of falling
- More than 85% of injury-related hospitalizations for older adults are the result of falls
- More than 95% of hip fractures are caused by falling

To learn more about keeping your independence and preventing falls, visit https://www.findingbalancenb.ca or Google "finding balance NB."

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Medical Services and Programs

Finding medical services can be hard. Below is a description of some programs and services that can help you with your health and medical care, both in and out of hospital:

Accessing Healthcare and Mental Health Supports in New Brunswick

Are you looking for a healthcare provider? Do you need help accessing other health care options such as pharmacies, walk-in clinics, or addictions and mental health support?

The Department of Health's Accessing Healthcare website can help you find the healthcare services you need. For more information, visit socialsupportsnb.ca/healthcare.

The New Brunswick Extra Mural Program

Who are they and what do they do?

The Extra Mural Program helps people care for their health at home, so that they can stay out of hospital or that their time in hospital is shorter. Some services that they provide include nursing care, physiotherapy, occupational therapy, social work, respiratory therapy, speech language pathology, and clinical nutrition.

Extra Mural is not homemaker care. That is, they do not provide cleaning, cooking, and day-to-day help in your home. If you need homemakers, see the chapter on "Home Support Services" for more information.

How do you access services through Extra Mural?

- If you have a family doctor or nurse practitioner, you can refer yourself
- Your family doctor can refer you
- You must qualify for Extra Mural services. To qualify:
    - You must have a family doctor or nurse practitioner
    - You must have a Medicare card
    - You must need medical help in your home

Who would qualify for Extra Mural?

Example: Betty is 65 years old and has been discharged from hospital after a bad fall and will need help from an Occupational Therapist at home.

Example: Sam is 70 years old, has cancer and is not able to drive. He needs weekly nursing care while he is in treatment.

Who wouldn't qualify for Extra Mural?

Example: Fred is 65 and uses a cane to help him move around. Fred is able to drive himself to his doctor appointments and is able to maintain living at home independently, with a little help from his daughter.

Example: Clara is 70 and drives herself into town once a week for appointments and groceries. Clara likes living independently, but wishes she had some help in her home with cleaning and making meals.

How does Extra Mural work?

- **Extra Mural in the community:**
  - Extra Mural has health care professionals that work with patients in their homes.
- **Extra Mural in the hospitals:**
  - Extra Mural Liaison Nurses work with the hospital health care team, patients, and their families, to plan a safe and supported discharge from hospital to home. Follow-up by other Extra Mural services may also be arranged (e.g., Occupational Therapy, Physiotherapy, Speech Language Pathology).
- **Extra Mural in Long-Term Care:**
  - For those who qualify, Extra Mural offers services within Long-Term Care Homes. (See chapter on "Long-Term Care Homes" for full description of the different types of Care Homes.) They offer all services in Special Care Homes. They offer some services in Nursing Homes (e.g., Occupational Therapy and Physiotherapy are common in Nursing Homes).

What if you need palliative care?

Extra Mural supports a palliative care approach to help people die comfortably at home with medical supports. Extra Mural also supports Medical Assistance in Dying (MAID) services at home. For more information on MAID see the chapter on "End of Life."

Tip: Extra Mural does not offer Home Support Services, such as help with cleaning, grooming, bathing, etc. To learn more about this, see the chapter on "Home Support Services."

Tip: Do not worry if you are discharged from Extra Mural once things are going well. While Extra Mural services are usually for a shorter period of time, you can always get the services again if you need them and still qualify.

For more information on the Extra Mural Program, call **1-888-862-2111**, visit https://extramuralnb.ca/, or Google "Extra Mural NB."

Health Services Department

If the Department of Social Development has determined that you have low income, you may qualify for programs through Health Services. They offer a variety of services such as:

- Hearing Aid Program
- Dental Program
- Medical Supplies Program
- And more

For a full list of programs that they offer, call **2-1-1**, visit socialsupportsnb.ca/health-services or Google "DSD health services."

Vision Loss Rehabilitation Program:

Do you struggle with vision loss that affects your daily life?

If yes, Vision Loss Rehabilitation New Brunswick can help you with training and support. This is a free service. You can be referred by a health professional, such as your doctor, a nurse practitioner or an optometrist. You can also refer yourself by calling the nearest program office:

- Saint John: **506-634-7277**
- Fredericton: **506-458-0060**
- Moncton: **506-857-4240**
- Bathurst: **506-546-9922**

For more information on the program, visit socialsupportsnb.ca/vision-loss, or Google "Vision loss rehabilitation NB."

Health and Medication Coverage Plans

Are you wondering what programs are available to help you with health and prescription drug coverage? Do you need financial help paying for health-related issues or prescriptions?

If yes, the following programs may be able to help:

NEW BRUNSWICK PRESCRIPTION DRUG PROGRAM

If you receive the Federal Guaranteed Income Supplement (GIS), you are covered by the New Brunswick Prescription Drug Plan (NBPDP).

If you do not receive the Federal Guaranteed Income Supplement (GIS), but your income is below a certain amount, you may qualify for the New Brunswick Prescription Drug Plan (NBPDP).

For more information on this program and to apply, call **1-800-332-3692**, visit: socialsupportsnb.ca/prescriptions, or Google "NB Prescription Drug Program."

NEW BRUNSWICK DRUG PLAN

If you do not qualify for the New Brunswick Prescription Drug Plan (listed above), you may enroll in the New Brunswick Drug Plan, which is offered to New Brunswickers who do not have health insurance. Eligibility for this program is based on income.

For more information on this program, call **1-855-540-7325**, visit: socialsupportsnb.ca/prescriptions, or Google "NB Drug Plan."

MEDAVIE BLUE CROSS SENIORS' PRESCRIPTION DRUG PROGRAM

If you are 65 years old and over and are not covered by another drug program, you may apply for the Medavie Blue Cross Seniors' Prescription Drug Program.

To enroll in this program or for more information:

- Call **1-800-332-3692** to receive the Medavie Blue Cross Seniors' Prescription Drug Program application form
- The application form can be found here https://docs.medaviebc.ca/FORM-979E-MBC-Seniors-Application-Form_Fillable.pdf

MEDAVIE BLUE CROSS SENIORS' HEALTH PROGRAM

This program offers seniors with additional health benefits, such as chiropractors, hearing aids, diabetic test strips, and dental benefits.

To enroll in this program or for more information:

- Call: **1-844-209-7599**
- The application form can be found here https://docs.medaviebc.ca/members-EN/FORM-070-E-Seniors-Health-Program-Application-Form.pdf

Medications – Helpful information to know

WILL MY MEDICATIONS BE COVERED IF I MOVE INTO A LONG-TERM CARE FACILITY?

If the Department of Social Development decides that you have low-income, your medications may be covered in Long-Term Care (e.g., a nursing home).

There are also options to have your medications covered under some private health insurance policies (like Medavie Blue Cross or Sun Life) or programs offered through the Government of New Brunswick (see above).

If you pay privately for long-term care, then you must have your own private coverage or go through the New Brunswick Drug Plan. For more information on the New Brunswick Drug Plan, call **1-855-540-7325**, visit socialsupportsnb.ca/prescriptions, or Google "NB Drug Plan."

DO YOU HAVE A HARD TIME REMEMBERING WHICH PILL YOU'VE ALREADY TAKEN EACH DAY?

Ask your pharmacist about how to help you keep track. An occupational therapist can also review how well you keep track of your medications and suggest different strategies to help. Some strategies include:

- **Bubble packs:** Your pharmacist can package your pills in a special foil package to help you keep track of what pills you have to take and when.
- **Daily pill sorting boxes:** These help you keep track of what days to take which medications.
- **Automatic pill dispensers:** These are devices you can buy and program.

- **Medication reminder services:** You can use smart watches or devices like Google Home or Alexa to remind you to take medications. Some companies like CareLink Advantage also offer reminders through their alert devices. Carelink Advantage: Call **1-866-876-7401**, visit https://carelinkadvantage.ca/, or Google "carelink advantage."

DID YOU KNOW?

Pharmacies offer many different services and products. Some of these include:

- **Medication disposal:** You can take your old medications to the pharmacy for safe disposal. This is a free service.
- **Alternate forms of medicine:** Pharmacists can help you find alternate forms of medications for some health issues, if you do not have a prescription.
- **Medication review:** Pharmacists are experts in medications and can help you make sure that the medications you are taking are right for you.

Tip: Did you know that older adults are hospitalized five times more often than younger adults because of harmful medication side effects? As we age, our bodies process medications less well. This means that medications you might have taken for years can become unnecessary or even harmful. Here are some questions to ask your doctor or pharmacist:

- Why am I taking this medication?
- What are the benefits or harms of this medication?
- Does this medication affect any other medications that I am taking?
- Can this medication affect my memory?
- Can this medication raise my chances of falling?

To learn more about medication see www.deprescribingnetwork.ca

Adult Protection

Are you having a hard time taking care of yourself? Is someone you know not getting the care they need to be safe?

This may include things like:

- Poor hygiene
- Poor nutrition
- Not getting medical care when needed
- Going without heat, water, or electricity in the home, and/or
- Living in an unsafe environment

If so, the Adult Protection Program can help. If you have concerns about:

• a senior aged 65 or older, or

• an adult who lives with a disability

Contact Social Development at **1-833-733-7835** and press option 1 to make an Adult Protection referral.

Services are available 24 hours a day, seven days a week.

Visit socialsupportsnb.ca/adult-protection for more information.

Walkers, wheelchairs, grab bars, raised toilet seats, etc.:

Tools to help you move around safely

Do you have a hard time getting around (e.g., moving around the house, getting up and down stairs)?

Do you have a physical disability?

If so, the **first step** is to talk to someone who can help!

The following can help you find equipment that is right for you:

Private Occupational Therapists and Physiotherapists

- You can hire an Occupational Therapist or a Physiotherapist. An Occupational Therapist can work with you to make your daily activities easier to do. A Physiotherapist can help you get back on your feet after an injury or move around more easily. If you have private insurance (e.g., Blue Cross, Sun Life, etc.), check to see if these services are included in your plan. You may need a note from your doctor or nurse practitioner that says these services are needed. This note is needed so you can claim these costs on your health insurance and/or taxes. Doctors and nurse practitioners will sometimes charge a fee to write that note.

Extra Mural Program (to see an Occupational Therapist or Physiotherapist)

- You do not need a referral from your doctor or nurse practitioner to go through the Extra Mural Program. You can contact the Extra Mural Program directly to be referred for Occupational Therapy and Physiotherapy.
- For more information:
    - Phone number: **1-888-862-2111**
    - Website: https://extramuralnb.ca/en/ (Or Google Extra Mural NB)

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Outpatient Services (to see an Occupational Therapist or Physiotherapist)

- Depending on where you live, you may be able to see an Occupational Therapist or Physiotherapist via your local hospital or community health centre free of charge. Call your nearest hospital or health care centre and ask for the Occupational Therapy/Physiotherapy department to find out what services are available to you. Depending on the facility, you may not need a referral from your doctor or another health care professional.

Ability New Brunswick

- They can connect you with specialists (e.g., Occupational Therapists or Physiotherapists), help you find financial help, and point you in the direction of many other helpful services and information.
- For more information:
    - Phone number: **1-866-462-9555**
    - Website: https://www.abilitynb.ca/ (Or Google "Ability NB")

Family Doctor/Nurse Practitioner

- You do not need to be referred by your family doctor or nurse practitioner to see an Occupational Therapist or Physiotherapist. However, they can help you find one of these specialists. They can also help you find other services and figure out what may be causing the issue with mobility.
- If you have private insurance (e.g., Blue Cross, Sun Life, etc.), you may need a note from your doctor or nurse practitioner. This note is needed so you can claim these costs on your health insurance and/or taxes. Doctors or nurse practitioners will sometimes charge a fee to write that note.

Are you concerned about your home safety?

Tip: To request a Seniors Health, Wellbeing and Home Safety Review from the Department of Social Development, register online at socialsupportsnb.ca/homefirst. You can also call **2-1-1**.

Tip: A Home Safety Checklist can help you identify hazards in your home and make suggestions. For more information see https://nbtrauma.ca/wp-content/uploads/2020/11/TraumaNB_HomeSafetyChecklist_EN.pdf or Google "staying independent checklist NB". You can also ask for a home safety assessment from an Occupational Therapist.

Tips on buying or renting equipment (e.g., walkers, canes, wheelchairs, lift chairs, etc.): There are many kinds of equipment that can help you. These include walkers, canes, wheelchairs, raised toilet seats, seats for the shower, chairs that raise you up to help you get out of the chair, and grab bars (e.g., by your bed, in the shower, next to the toilet), etc.

Financial Tip: Before you buy, ask your Occupational Therapist if you can use any equipment that you may already have (e.g., a walker that used to belong to a friend or spouse). Equipment needs to be right for your height, weight, and needs. It is important that you have the right equipment for you.

Financial Tip: Ask your doctor or nurse practitioner to write a prescription for equipment (like walkers, wheelchairs, or lift chairs) before you buy them, so they can be claimed on your taxes or private health insurance, if your insurance plan covers this.

Financial Tip: Keep your receipts to use for when you file your taxes. You can find out more information about how to claim these kinds of purchases on your taxes here: https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/rc4065/medical-expenses.html or Google "Medical Expenses CRA."

Financial Tip: If you do not have the money to pay for equipment (e.g., wheelchairs, hearing aids, glasses), assistance finding financial help may be available through one of following:

- Health Services Branch of the Department of Social Development **(1-833-733-7835)**
- The Extra Mural Program **(1-888-862-2111)**
- Ability New Brunswick **(1-866-462-9555)**

Financial Tip: If you need financial help to buy equipment, it's good to start early. This process means first getting a note from your doctor or nurse practitioner. Then, you need an assessment and a recommendation from an occupational therapist or a physiotherapist. After that, you get a trial period for using the equipment. Then you apply for the equipment. After that, you can order and then will receive the equipment. All of this can take anywhere from 2 months to a year or more.

Drug Stores

Did you know that equipment like walkers, canes, and wheelchairs can be rented or bought from some drug stores?

Financial Tip: Most drug stores have "seniors' day" discounts. Try to buy equipment on these days or ask if they will give you the senior's day discount anyway.

Financial Tip: Some stores will let you put the price of a rental toward the purchase. So, if you rent a walker and decide you want to keep it, they will sometimes discount what you already paid from the price of the purchase.

Here is a list of some of the programs and services that are available in New Brunswick. Occupational Therapists and Physiotherapists (via **Extra Mural**, **Outpatient Services**, or hired **Privately**) and **Ability NB** (listed above) can help you figure out what you qualify for, and which of these are right for you.

Working with these professionals can help a lot so calling them is a good first step!

Veteran's Disability Benefits

Do you have a physical disability and are a veteran, a serving, or former member of the Canada Armed Forces or the RCMP, or their spouse or dependent?

Disability benefits are available to eligible veterans, serving and former members of the Canada Armed Forces and the RCMP, as well as to their spouses and dependents.

For more information:

Phone: **1-866-522-2122** (toll-free, English)

1-866-522-2022 (toll-free, French)

Website: https://www.veterans.gc.ca/en/financial-programs-and-services/compensation-illness-or-injury/disability-benefits (Or Google "Veterans disability benefits Canada").

Easter Seals Equipment Rental Programs

Are you having a hard time finding or paying for equipment rentals? You may qualify for help through Easter Seals.

These programs provide long-term loans for people who 'fall through the cracks' and can't get the equipment and help they need.

Contact number: **1-888-280-8155**

Personal Services Program: https://www.easterseals.nb.ca/index.php/en/inner-page/personal-services-program-psp (Or Google "Easter seals personal services program")

Equipment Recycle Program: https://www.easterseals.nb.ca/index.php/en/inner-page/social-development-equipment-recycle-program (Or Google "Easter seals equipment recycle program")

First Nations and Inuit Health Branch

Are you from a First Nations or Inuit community and are having a hard time with mobility (e.g., getting around the house or climbing stairs)? The First Nations and Inuit Health Branch can help you get started.

Contact number: **1-800-567-9604**

Website: https://www.sac-isc.gc.ca/eng/1569861171996/1569861324236 (Or Google "CRA indigenous health")

Canadian Red Cross: Health Equipment Loan Programs

Are you having a hard time moving around (e.g., trouble walking, getting up and down stairs) and need a short-term loan of equipment (e.g., wheelchair, walker, cane, bath seat, bed handle, lifts, etc.)?

The Canadian Red Cross offers free short-term equipment loans to people in need. You will need to have a written referral from a doctor, nurse practitioner, physiotherapist, or occupational therapist to borrow equipment through their programs.

To apply, contact your nearest local Canadian Red Cross office:

- Bathurst: 506-548-2824
- Campbellton: 506-759-8521
- Edmundston: 506-736-0050
- Fredericton: 506-458-8445
- Grand Falls: 506-473-5897
- Moncton: 506-863-2650
- Richibucto: 506-523-4479
- Saint John: 506-674-6200
- Tracadie: 506-395-2010
- Woodstock: 506-328-8881

For more information on this program, visit:
socialsupportsnb.ca/redcross

(Or Google “Social Supports NB Red Cross equipment loan”).

Health Services Program (Government of New Brunswick)

Do you have low income and need help finding medical supplies and equipment (e.g., wheelchairs, compression socks, hearing aids, etc.)?

This program helps people with low income to get the medical supplies and equipment they need (e.g., wheelchair, hearing aids, compression garments, ostomy supplies, vision care).

Contact number: **1-833-733-7835**

Website: socialsupportsnb.ca/health-services

Homeowner Repair Program for Seniors

Do you have low income and need to make changes to your home so that you can get around more easily and safely (e.g., putting in ramps, grab bars, brighter lights, or railings in hallways)?

This program gives financial help to seniors with low income to make changes to their house or apartment to make it easier for them to move around.

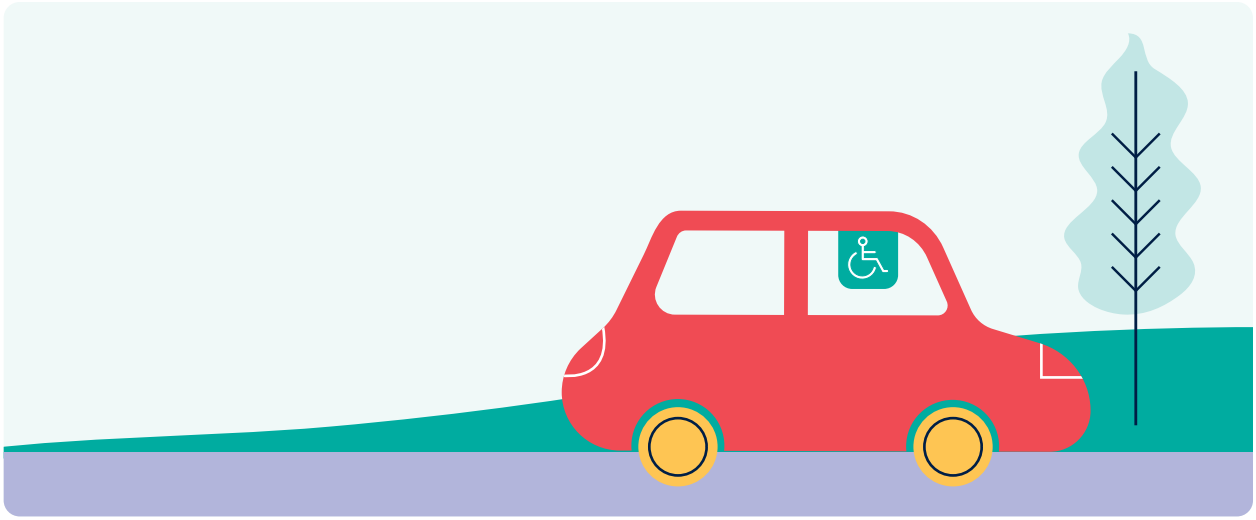
To qualify:

- You are 65 years of age or older
- You qualify as 'low income' by the Department of Social Development (**1-833-733-7835**)
- You have a hard time with daily living activities (moving around easily at home, getting dressed, getting up and down stairs, etc.)
- You own or rent a house or apartment

Contact number: **1-833-733-7835**

Website: https://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/Housing/HomeownerRepairProgramSeniors.pdf (Or Google "Homeowner Repair Program for Seniors GNB")

Tip: If you rent, you will need a written note from your landlord to approve the changes. Get this note before you start the application process.



Parking permits and placards for persons with disabilities

Do you have a physical disability and need a parking permit or placard (sign that hangs in your car window) for your vehicle?

You can get a temporary or permanent parking placard to hang in the window of your vehicle to be able to park in marked parking spots that are closer to buildings.

Contact number: **1-888-762-8600**

To apply: https://www.pxw1.snb.ca/snb7001/b/1000/CSS-FOL-78-9300B.pdf
(Or Google "GNB application for disabled parking permit")

Some of the application form needs to be filled out by your doctor, nurse practitioner, occupational therapist, or physiotherapist. Once the form is complete, send it by mail or bring it in to any Service New Brunswick centre to get your placard.

Tax rebate for specially equipped vehicles for persons with disabilities

Do you have a physical disability or have a hard time moving around and have bought a vehicle in New Brunswick?

If so, the provincial government will refund the 10 % provincial portion of the HST if:

- Your vehicle has the equipment installed to help a wheelchair or scooter to get in or out of your vehicle (e.g., hydraulic lifts);
- Your vehicle has special driving controls (e.g., hand controls, steering devices, etc.) that help with the operation of your vehicle (does not include spinner knots);
- Your vehicle is not operated by any person who earns any money by using your vehicle;
- You are not able to get any other GST/ HST credit or rebates related to the purchase of your vehicle.

Contact number: **1-800-669-7070**

To apply: https://www.pxw1.snb.ca/snb7001/b/1000/CSS-FOL-HST-R-02B.pdf
(Or Google “Tax rebate for specially equipped vehicles GNB application for refund”)

Vehicle Retrofit Program (Through Ability NB)

Does your vehicle need assistive technology (e.g., ramps) to make getting in and out or driving easier?

This program provides financial help up to 80% of the cost of installing accessibility features to your vehicle, to a maximum of $8000. You can renew this financial help every eight years.

Examples of changes to your vehicle that may be eligible:

- Wheelchair lifts and ramps
- Equipment for getting into a vehicle (such as a transfer seat)
- Roof, floor, and door alterations (only if needed to help with accessibility)
- Wheelchair and scooter lifts
- Driving equipment (requires evaluation, training, and retesting)
- Other features not listed above may also be considered

Contact number: **1-866-462-9555**

For more information, see socialsupportsnb.ca/vehicle-retrofit or Google "Application for Vehicle Retrofit Program Ability NB".

Vision Loss Rehabilitation Program

Is your daily life being affected by vision loss?

There are services offered through Vision Loss Rehabilitation New Brunswick to support you. These services can be accessed in two ways:

1. Referral from a health professional: A family doctor, a nurse practitioner, an ophthalmologist, optometrist, Extra Mural worker, or other health practitioners can send a referral in for you
2. Self-referral: If you have vision loss, you can contact one of the province's four Vision Loss Rehabilitation offices directly:
   - Bathurst: **506-546-9922**
   - Fredericton: **506-458-0060**
   - Moncton: **506-857-4240**
   - Saint John: **506-634-7277**

For more information on the Vision Loss Rehabilitation Program, you can also visit: socialsupportsnb.ca/vision-loss (Or Google "Social Supports NB Vision Loss Program").

Hearing Loss

Are you having trouble with your hearing?

If so, you can get your hearing tested by:

- Making an appointment with your family doctor or nurse practitioner. They can refer you to be tested by an audiologist, who specializes in hearing loss.
- You can also choose to find an audiologist yourself. Many audiologists have private offices which can be found by calling **4-1-1**.

Hearing aids are not covered by Medicare. Some private insurance companies (e.g., Blue Cross, Sun Life, etc.) may offer some coverage as part of your plan. If you have private insurance, check with your provider.

Some financial supports are available for people with low income. If you are a current client of the Department of Social Development (i.e., you have a Social Development health card that they provided you), you may be able to get some financial help for hearing aids. More information on this can be found by calling **1-833-733-7835** or online at socialsupportsnb.ca/health-services.

Living with Dementia

Have you noticed changes in your thinking, memory, or ability to do everyday activities? If so, talk with your family doctor or nurse practitioner and loved ones about your concerns.

Dementia is not a normal part of aging. Here are some of the differences:

NORMAL AGING	DEMENTIA
Getting lost in a new or unfamiliar place.	Getting lost in a familiar place, like your neighborhood or your home.
Missing a monthly payment, every once in a while.	Difficulty taking care of monthly bills. Not able to take care of banking or paying for every day shopping items.
Forgetting some events from a year ago.	Forgetting events from yesterday or the past week. Not able to remember upcoming appointments, even with frequent reminders.
Sometimes forgetting someone's name or what you were talking about.	Having a hard time following a conversation. Often repeating questions or stories. Trouble naming common items or close family members and friends.
Losing things from time to time.	Often misplacing things and not being able to find them, or later finding them in odd places.
Getting the day or date mixed up.	Losing track of time. Being unable to remember the date, season or year.
Being a bit slower to finish a normal task.	Taking a long time or not being able to complete a day-to-day task.

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There are other conditions that can cause symptoms similar to dementia. The following medical issues should be looked into before a diagnosis of dementia can be confirmed:

- Hearing loss
- Medication side effects
- Infection
- Depression or grief
- Delirium

It is important to understand why the changes in your thinking, memory and behaviour are happening. Early detection of dementia is important. Plan a visit to your doctor or nurse practitioner if you think you might be experiencing early signs of dementia.

If you do not have a family doctor or nurse practitioner, you can visit a general walk-in clinic in your area.

Tip: To rule out these other conditions, talk with your doctor or nurse practitioner, have your hearing tested and speak with your pharmacist about your medications.

Preparing to visit your doctor

When you make an appointment, tell the receptionist you have concerns about your thinking and memory. Ask what you can expect during the appointment, how long it will take, and if you can bring someone with you.

Be prepared for the visit! Use the checklist below to note the types of problems you have been having. If possible, note when you first noticed the problem:

PROBLEMS I AM EXPERIENCING	DATE THAT I (OR OTHERS) FIRST NOTICED THE PROBLEM
Attention: Do you often lose your train of thought or become easily distracted?	/ /
Coordination: Do you have trouble using familiar tools (e.g., having a hard time using a common tool such as a screwdriver)?	/ /
Mood: Do you feel low or have no interest in activities that used to be fun?	/ /
Daily activities: Do you have trouble doing daily activities (e.g., making a light snack)?	/ /

PROBLEMS I AM EXPERIENCING	DATE THAT I (OR OTHERS) FIRST NOTICED THE PROBLEM
Planning: Do you have trouble organizing your day or judging the safety of a situation (e.g., Can you explain what to do if there was a fire in your house)?	/ /
Getting lost: Do you often get lost (e.g., when walking or driving)?	/ /
Vision: Do you have trouble seeing or being able to recognize familiar faces?	/ /
Memory: Do your family members get annoyed because you ask the same questions over and over?	/ /
Language: Do you have trouble following instructions that have lots of steps (e.g., following directions like, "After you change your clothes, put your boots on and then meet me in the car.")?	/ /
Walking: Has there been a change in your ability to walk or have you been falling more often?	/ /
Personality and Behaviours: Are you... • Seeing or hearing things that aren't there? • Becoming suspicious of others? • Acting unusual in social situations?	/ /

Tip: Write down a list of questions you have for the doctor or nurse practitioner. Take your questions and the above checklist to your next appointment with them.

Tip: Make a list of all the specialists or other doctors who care for you and take all your medications to your appointments.

At the Doctor's appointment

Ask someone you trust to come with you to your appointment and to take notes. If possible, ask them to help you remember details or make a list about what you have been experiencing. It is important that you speak on your own behalf.

Once you are at the appointment with your family doctor or nurse practitioner, let them know if you have hearing loss, vision problems, recent illnesses, periods of grief or struggles with mental health, and if there is a family history of dementia or other diseases.

The appointment will likely involve:

a) History taking. The doctor will ask about your memory and how you have been making out at home (use the checklist on the previous page).

b) Physical and neurological exam. The doctor may listen to your heart and lungs. They may also test your reflexes or ask about changes in your strength.

c) Memory Screening. The doctor may conduct a paper and pen test to assess your memory.

d) In some cases, the doctor may also order blood tests and other tests, such as an MRI or CT scan, to help confirm the diagnosis or to rule out other diseases.

The appointment may end with the doctor giving you a diagnosis, or they may want to do more tests.

If you are diagnosed with dementia, here are some questions that can be helpful to ask your doctor or nurse practitioner:

- What type of dementia do I have?
- What stage of dementia am I in?
- What kinds of treatments can help (e.g., medications, occupational therapy)?

Tip: Write down the answers or have someone with you who can help you to remember.

After a dementia diagnosis

People can feel many different emotions after receiving a diagnosis of dementia. If you need to talk with someone about your feelings, call the Alzheimer Society of New Brunswick at **1-800-664-8411** or email **info@alzheimernb.ca** and ask about their free services. Even though they are called the "Alzheimer Society," they have information about all types of dementia.

Next steps:

TALK TO SOMEONE

When you are ready, talk to those you are close to about your diagnosis of dementia and the emotions you are experiencing.

LEARN ABOUT DEMENTIA

There are different kinds of dementia, including Alzheimer's disease, vascular dementia, fronto-temporal dementia, Lewy-Body dementia and mixed dementia. Learning about the type of dementia you have can help you understand your experience.

Tip for caregivers: It is difficult to watch a person with dementia's symptoms progress. Knowing about dementia and the various symptoms can help you prepare and build strategies.

The Government of New Brunswick's Dementia website has answers to many common questions about dementia.

Visit their website at: gnb.ca/dementia.

FIND INFORMATION AND SUPPORT

The Alzheimer Society of New Brunswick offers the First Link program, which focuses on helping you live well with dementia. Although they are called the "Alzheimer Society," they provide information and supports for all types of dementia.

Contact the Alzheimer Society for more information on these programs or to access free services. Call **1-800-664-8411** or email **info@alzheimernb.ca**.

PLAN FOR THE FUTURE

Dementia is a progressive degenerative disease, which means that the symptoms will get worse. Try to learn about the type of dementia you have, the symptoms you are likely to experience and build strategies to help you manage.

Each person's progression through dementia is unique. It is important to stay independent but equally important to accept others' help. Planning for the future is a way to feel in control. Think about what is important to you and make sure to write down your wishes and talk to family members, friends and your lawyer about your wishes. Here are some things to think about and plan for:

- Driving is a complex skill and eventually you will not be able to drive. See the chapter on "Driving Safety and Aging" for more information.
- You may eventually need help to remain in your home. See the chapter on "Home Support Services" for more information.
- You may need to consider moving into a Long-term Care facility. See the chapter on "Long-Term Care Homes" for more information.
- It is very important that you have a Will and Enduring Powers of Attorney signed before you lose the capacity to make these documents. See the chapter on "Legal Matters" for more information.

Tip: Make a list of family or friends you want to share your diagnosis with. Start with a small group and gradually, as you are comfortable, share your feelings about your diagnosis.

Tip: Tell people how to help you. For example, ask for appointment information to be written down. If an appointment will involve a lot of details, go with a person you trust who can help with complex decisions.

Tip: If you are employed, contact your employer's Human Resources department and ensure you know your rights at work.

Supports for Caregivers

Caregiving can be rewarding but it can also be difficult. It is important to recognize what you can do yourself and when you need help. Be realistic.

Take care of yourself

Maintain your own health and wellness so you can remain a caregiver for someone else.

Recognize burnout

- Are you feeling angry, withdrawn, anxious, or exhausted?
- Are you having trouble sleeping or concentrating?
- Have you gained or lost a lot of weight lately?

These can all be signs of stress. Take care of yourself by reaching out to friends and family to talk about your feelings and ask for help.

Build a Support network

- Make a list of people you can rely on for help and note what kinds of tasks they can do (e.g., preparing meals, driving, running errands, picking up groceries).
- Ask in your community about people who can help drive you or the person you are caring for to appointments.
- Have a list of friends who are available to chat on the phone. Keep their phone numbers close by.
- Talk with people who add humour to your day, or who can share a joke and help you remain positive.
- Ask friends or family members to make a meal for you or the person you care for.
- Look for services to help with the care work of cooking and cleaning (see the chapter on “Home Support Services.”).
- Talk to your employer about potential accommodations and supports. This could include things like working from home, extended lunches, flexible hours, etc.

Tip for caregivers: Follow up with your regular medical and dentist appointments. Don't let your appointments get lost in the business of caring for others.

Tip for caregivers: Tell people when you are feeling overwhelmed! Talk to friends and family. You can call **1-866-355-5550** to access free mental health support 24/7. Visit socialsupportsnb.ca/healthcare for more resources.

Tip for caregivers: The Alzheimer Society of NB offers free counselling services and support groups for caregivers, family, and friends of people living with dementia. Visit https://alzheimer.ca/nb/en or call **1-800-664-8411**.

Think About Using Home Respite or Relief Care

Respite or relief care is a service that gives short-term breaks to caregivers. This can be during the day or overnight.

You can apply for respite care through the Department of Social Development's Long Term Care Program. For more information, call **1-833-733-7835**, visit socialsupportsnb.ca/LTC or Google "Social Supports NB Long Term Care Program."

The following are common respite/relief care services (also see the chapter on "Home Support Services" for more information on each of these):

Medical Alert Systems: These tools can help ease the anxiety of caregivers who cannot be with the person they are caring for all the time. Medical Alert Systems allow individuals to call for help in an emergency. Some services also offer automatic fall detection, motion sensors, or medication reminders. For more information:

- **Carelink Advantage** – Visit https://carelinkadvantage.ca/ , Google "carelink advantage," or call **1-866-876-7401**.
- **Lifeline** – visit https://www.lifeline.ca/en/ , Google "Lifeline Medical Alert Canada," or call **1-866-729-0532**.
- **Caretrak** – Visit https://www.caretrak.ca/, Google "caretrak," or call **1-855-333-3381**.
- **Telus LivingWell Companion** – Visit https://www.telus.com/en/personal-health/livingwell-companion, Google "telus living well," or call **1-855-724-0031**.

Meals on Wheels: This service provides hot, nutritious, and affordable ready-made meals. To find out if there are services in your area and for more information, call **2-1-1**, visit https://socialsupportsnb.ca/en/program/meals-wheels , or Google "Meals on Wheels NB".

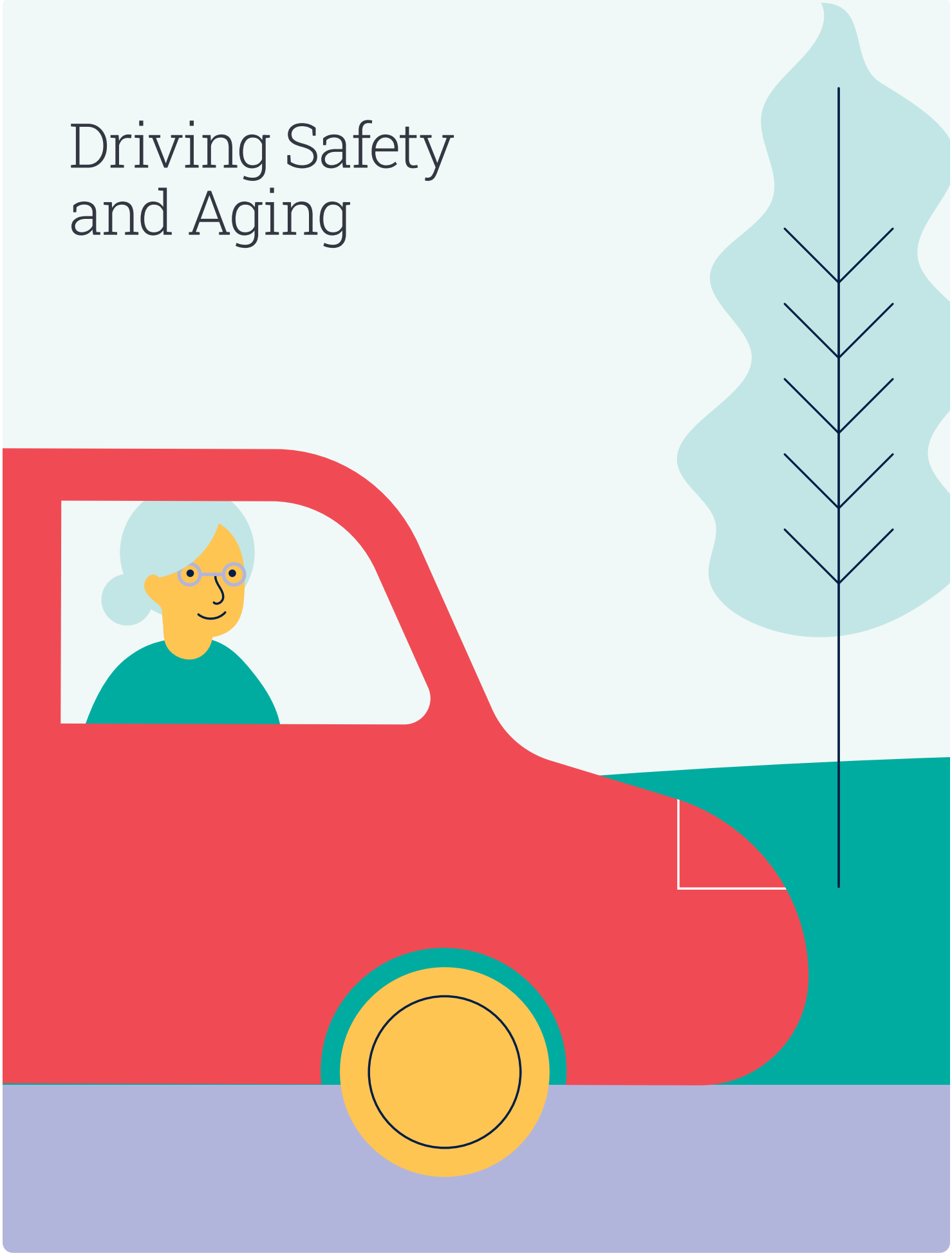
Adult Day Centers: Adult Day Centers offer a safe and supervised setting outside of the home. (See chapter on "Home Support Services" for more information.)

Home Support Services: Home support services may be able to help with a variety of daily activities like cooking, bathing, and cleaning. (See chapter on "Home Support Services" for more information).

Special Care or Nursing Home Respite: Some special care or nursing homes offer short-term respite care for caregivers. Cost and availability vary by location. Visit nb.211.ca online or call **2-1-1** for a list of special care or nursing homes in your area. For more information, see socialsupportsnb.ca/ltc.

Financial Tip: Do you need help paying for respite care services? Call the Department of Social Development at **1-833-733-7835** or try their online Financial Help Calculator to see if you qualify for financial help at Socialsupportsnb.ca/financialhelpcalculator.

Driving Safety and Aging



Healthy older adults are some of the safest drivers on the road. Many people can drive safely throughout their whole lives. But there are a number of health issues that can come with aging that impact driving safety (e.g., Dementia, Stroke, Parkinson's disease, vision problems).

Tip: As we age, we experience changes such as flexibility, range of motion, and even height. CarFit is a program that promotes safe driving by teaching you how to fit your car to you. To learn more about CarFit, visit https://caot.ca/site/prac-res/carfit?language=en_CA& or Google "CAOT carfit".

Driving and Dementia: People with dementia may still be safe to drive in the early stages of the disease. However, they will need to stop driving at some point. Knowing when it is no longer safe to drive and making a plan can make this change easier for you and the people who care for you. For more information go to www.drivinganddementia.ca.

When should I stop driving? What are the warning signs?

To check your driving safety, ask yourself and those close to you, the following questions:

- Have you had any car crashes or near misses in the past year?
- Have you been getting lost while driving?
- Have you been missing stop signs or ignoring other traffic signs?
- Do other drivers honk or pass you often?
- Is it hard for you to keep up with the flow of traffic?
- Have others made comments about your driving habits lately?
- Have there been changes in your driving? Do you need someone to go with you so you don't get lost?

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- Do you have a hard time working the brake and gas pedals?
- Are you driving less often because you are becoming more nervous?
- Is it more difficult to drive on roads with curves or to stay in the middle of your lane?
- Do you forget to use your blinker and check your mirrors when changing lanes?

If the answer was "yes" to any of the above, it is a good time to think about stopping driving.

What to do if I think I may no longer be safe to drive?:

- Talk to your family members or trusted friends. Have a one-on-one conversation about your concerns.
- Talk with your doctor about your concerns.
- Take a lesson or be retested. Local driving schools offer driving refresher courses for older adults. To find local driving schools in your area you can call 4-1-1, visit http://find-a-driving-school.ca/new_brunswick/, or Google "driving schools" in your area.

How can I prepare for the future?

Limiting Driving:

- Drive only routes you are used to.
- Try not to drive during rush hour. Try to drive only between the hours of 10:00 and 3:00.
- Try not to drive at night or when it is very sunny. These conditions can make it hard to see.
- Try not to drive at dawn and dusk. These are times when animals are most likely to be on the road.
- Try not to drive in bad weather.
- Try to avoid busy roads. Take a longer route if it means less traffic.
- Tell someone where you are going and when you should be back.
- Get rid of distractions: Turn off the radio. Don't eat or drink while driving. Don't drive when upset. Don't use your cell phone while driving. Try not to drive with pets in the car, or make sure they are in a carrier case.
- If you get lost, pull off the road into a safe space to figure out next steps.
- Plan your trip ahead of time. Map out your route and give yourself enough time

to avoid rushing. Group your outings (e.g. grocery and drug store), and plan appointments for the same day to reduce travel. Plan your route so you can make right turns into your destination and avoid crossing traffic by making left turns.
- Talk to your pharmacist about changes in your medications that may impact your driving.
- Get your vision and hearing checked.

Creating a Plan to stop driving:

If driving safety is becoming a problem, it is important to have a plan for when you will no longer be able to drive. Having information on transportation, delivery services, and other community resources can make it easier when you stop driving. Use the following suggestions to help you get started:

- Have open and honest conversations about driving with friends, family, and your doctor.
- Make a list of the people you can call on to get a drive to social and medical appointments.
- List the events that are priorities, and make sure regular, reliable transportation is available for those events.
- See if there are any public transit options in your area. If so, learn how to use them.
- See if any drug stores, supermarkets and stores offer delivery in your area.
- Find out if there is a “ride share” program in your community.
- If you go to church or other religious services, see if they offer transportation to services and events.
- Talk with other older drivers who have stopped driving and ask about how they found people to help with the driving. Ask them about how they adjusted to the emotional impact of not driving.
- Write an Advanced Directive for Stopping Driving. This involves writing a letter of agreement stating that when the time comes when it is no longer reasonable to drive, that you will stop driving. Sign and date the letter and give copies to your family.

Caregivers

IF YOU HAVE CONCERNS ABOUT AN OLDER PERSON'S DRIVING:

It is common for people to feel sad, depressed, isolated, angry, or frustrated at the idea of not being allowed to drive. This is often a very difficult change in people's lives. Think about how you would feel! When talking about your concerns, it is important to be patient, calm, and to let the person talk about their feelings and concerns.

Use this checklist of warning signs as a guide before starting a conversation about driving. If you feel safe enough, go for a drive with the older driver and make mental notes about the following issues. After the drive, write down the date and what you noticed. Look for patterns over time. Pay attention to when and how often you notice the following:

- Decrease in confidence or increased agitation while driving
- Difficulty turning to see when backing up
- Always has their foot on the brake
- Easily distracted while driving
- Other drivers often honking their horns
- Problems with signaling or trouble navigating turns
- Difficulty parking within a parking space
- Hitting curbs
- Noticing scrapes or dents on the car
- Failure to notice important traffic signs
- Driving at inappropriate speeds
- Needs to use a "co-pilot"
- Near misses or car accidents
- Hard time staying in the middle of the lane
- Getting traffic tickets or warnings when driving
- Getting lost in familiar places

IF YOU HAVE WATCHED THEIR DRIVING AND ARE CONCERNED, YOU CAN TAKE ONE OR MORE OF THE FOLLOWING STEPS:

See if they will agree to stop driving.

- Have a calm conversation and talk about your fear for their safety and the safety of others. This can be a difficult thing to do. Sometimes people won't understand that they are unsafe to drive and will be angry with you. In this case, you can also 'stay on their side' and ask their doctor, a driving school, or the Department of Public Safety to be the ones to step in.

Talk with the person's doctor or nurse practitioner about your concern.

- The doctor or nurse practitioner can tell the person to stop driving or can send the person for tests to see if they are fit to drive.

Ask the person to take a driver's test or a refresher course.

- To find local driving schools in your area you can call 4-1-1, visit http://find-a-driving-school.ca/new_brunswick/, or Google "driving schools" in your area.

If none of the above work and it is clear that the person is not safe to drive, you can report them to the Department of Public Safety in writing.

- The Department of Public Safety does not act on complaints made by phone and requires the written complaint to include:
  - Details of the concerns with specific events and dates
  - The name, date of birth and address of the unsafe driver
  - Name, address and phone number of the person making the complaint
  - The written complaint must be signed and dated
  - **Note that it is possible for the driver to find out from the Department of Public Safety who reported them.**

Caregivers

WHAT TO DO WHEN THE PERSON'S DRIVER'S LICENCE HAS BEEN TAKEN AWAY, BUT THEY WON'T STOP DRIVING

- Distract them when they want to drive.
- Suggest you will go for a drive later.
- Ask a friend to take the person for a drive.
- Explain why they do not need to go out in the car right now (e.g. "we can go visit them later, they are at work right now" or "let's plan to go to the store in a couple hours after I finish doing this").
- Remind the driver that they do not have a valid licence and that it is illegal to drive without one.
- Remind the person that if they are in an accident their insurance will not cover any costs.
- Ask the person's doctor to write a letter outlining why they can no longer drive.
- Remove the keys and the car from the person's view.

The Alzheimer Society of New Brunswick has useful resources to support caregivers of people with dementia. Call **1-800-664-8411** and ask what they can offer for help or check out their online resources:

- https://alzheimer.ca/en/help-support/im-living-dementia/managing-changes-your-abilities/driving-dementia (or Google "Alzheimer driving with dementia")
- https://alzheimer.ca/sites/default/files/documents/DrivingDementiaToolkit.pdf (or Google "The driving and dementia toolkit")

End of Life:

Things to think about, know, and do

It is not always comfortable or easy to do but planning for your death can bring peace of mind to you and those who care for you. There is no better time to start than right now!

Think and Talk

Think about what you want (and do not want) for medical treatments and care.

- For example, do you want medical treatments to keep you alive if your heart stops? These are big decisions. Your doctor can help you understand the different choices that you can make.

Think about how you want to be cared for at the end of your life.

- For example, do you want to be cared for at home, at hospice or at a hospital? Think about what you would want in different situations should your health needs change.

Talk with your family, friends, and your doctor about end-of-life.

- These conversations can be hard to have, but they will help others to know your wishes and make decisions during a hard time. Having these conversations can help those who will be grieving after you die.

Get Organized

Hire a lawyer to make your Will and Enduring Powers of Attorney

- Make sure you ask the people you name in your Will (as Executor) and in your Enduring Powers of Attorney documents. Keep them updated on all your important information, including where to find your legal documents.
- For more information, see the chapter on “Legal Matters.”

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Prepare your Health Care Directives

- Make sure that the people you name in your Enduring Power of Attorney document for Personal Care have agreed to this and know where to find a copy of your Health Care Directives.
- Keep your Health Care Directives in a place that is easy to find them, like on your fridge at home. Paramedics will sometimes check the fridge to see if they are on there.
- For more information, see the chapter on "Legal Matters."

Organize your bills, bank accounts, passwords, and other important documents in one place

- Make copies of any original documents. Keep the originals in a place that is safe from fire, water damage, loss, and theft.
- Make sure someone you trust knows where this information is.
- See the chapter on "My Record of Important Information" for an easy way to keep this organized.

Make a back up plan to pay all your bills

Option 1

- If you have a joint bank account with another person, like a spouse, they can continue to make your payments. There are risks in having joint accounts with another person, but it is common for spouses and common-law partners who share income and expenses. To learn the pros and cons of joint accounts,visit: https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/power-attorney-financial.html

Option 2

- If you are the only person named on your accounts as responsible for paying your bills, make an Enduring Power of Attorney for financial matters. You have to hire a New Brunswick lawyer to do this. Ask a person you trust if they are willing to act as your financial Attorney. Once the Enduring Power of Attorney documents are signed, take an original copy to your bank, and have it recorded on your file. Your financial Attorney will then be able to deal with your Bank to pay your bills for you. They have to keep records of every payment they make. They will also be able to make changes to any account (e.g., phone bill, power bill). See the chapter on "Legal Matters" for more information on this.

Note for Caregivers: Financial abuse is a very real problem and banks, and other companies take confidentiality and privacy very seriously. They will require that a financial Attorney is legally appointed and is not abusing the Enduring Power of Attorney. You will be required to show legal proof that you are allowed to take care of that person's financial matters.

Review the beneficiaries listed on all your policies and accounts and make sure they are up to date. Here are some examples:

- Registered Retirement Savings Plan (RRSP)
- Registered Retirement Income Fund (RRIF)
- Tax-Free Savings Account (TFSA)
- Pensions
- Life insurance policies

If you are thinking about Medical Assistance in Dying (MAID), some planning is needed:

TO SEE IF YOU ARE ELIGIBLE AND FOR MORE INFORMATION ABOUT MEDICAL ASSISTANCE IN DYING:

- Talk to your doctor
- View online, by clicking https://horizonnb.ca/patients-visitors/patient-information-resources/medical-assistance-in-dying-maid/ or Google "MAID Horizon."
- Call the Horizon Health Network: **1-844-225-0220**

Funeral Planning:

PRE-PLAN AND PAY FOR YOUR FUNERAL, WRITE YOUR OBITUARY, PLAN OUT DETAILS ON HOW YOU WOULD LIKE YOUR LIFE TO BE REMEMBERED.

- For example, do you want a green burial, a traditional funeral or cremation?
- What kind of service do you want to have, if any?
- If you want an obituary, is there anything specific that you want to be included?

Tip: Keep in mind that obituaries are optional. They can cost a lot to put in the newspaper. If you want an obituary, you can keep it short.

Tip: If you chose cremation, you do not have to buy an urn from a funeral home, which can be expensive. You can provide your own.

Tip: Funeral Homes can help you through this process. Many can also help you with the paperwork that will need to be done. They will charge a fee for this service.

Planning ahead makes sure that your wishes are known. It can also take a lot of pressure off of those who are grieving after you die.

PUT TOGETHER THE INFORMATION THAT FUNERAL HOMES WILL NEED. THEY DO NOT ALWAYS NEED ALL OF THE INFORMATION LISTED BELOW, BUT THEY CAN HELP YOU WITH THE PAPERWORK NEEDED AFTER DEATH (SUCH AS APPLYING FOR FUNERAL BENEFITS) SO HAVING THIS INFORMATION HANDY CAN BE HELPFUL:

- Social Insurance Numbers of the person who has passed away and their spouse (if applicable)
- A copy of the Will
- Marriage certificate (if applicable)
- Life insurance policies
- Details of private pension plans

Will you need financial help for funeral expenses? The following are benefits that you might qualify for. These could help pay for your funeral or other end-of-life expenses. Most funeral homes can help you with this paperwork.

CANADA PENSION DEATH BENEFIT

- If the person who has died was receiving a pension from the Canada Pension Plan (CPP), there may be a death benefit available.
- For more information and to see if you are eligible, contact Service Canada by phone at **1-800-277-9914**, visit https://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-death-benefit.html , or Google "Canada death benefit."

FUNERAL BENEFIT OF NB

- The Government of New Brunswick may be able to help to pay for funeral expenses, if you need financial help. This is depending on the income of the person who has died and the financial situation of their family members. It is usually only for clients of the Department of Social Development and/or people with very low income, such as people on social assistance.
- For more information or to apply, call the Department of Social Development at **1-833-733-7835**, visit socialsupportsnb.ca/funeral, or Google "Social Supports NB Funeral Benefit".

Tip: It is important to note that only certain funeral expenses are covered through the Funeral Benefit of NB program. Be sure you ask what is included, so you know what is covered and what is not.

SUPERANNUATION PROGRAM

- If you have worked for the Government of Canada, you may be eligible for help with funeral expenses through their Superannuation program.
- For more details, call **1-800-561-7930**

UNION BENEFITS

- Some unions will offer benefits to the survivors of union members. You can check with the specific union to see if they have any available benefits for funeral expenses.

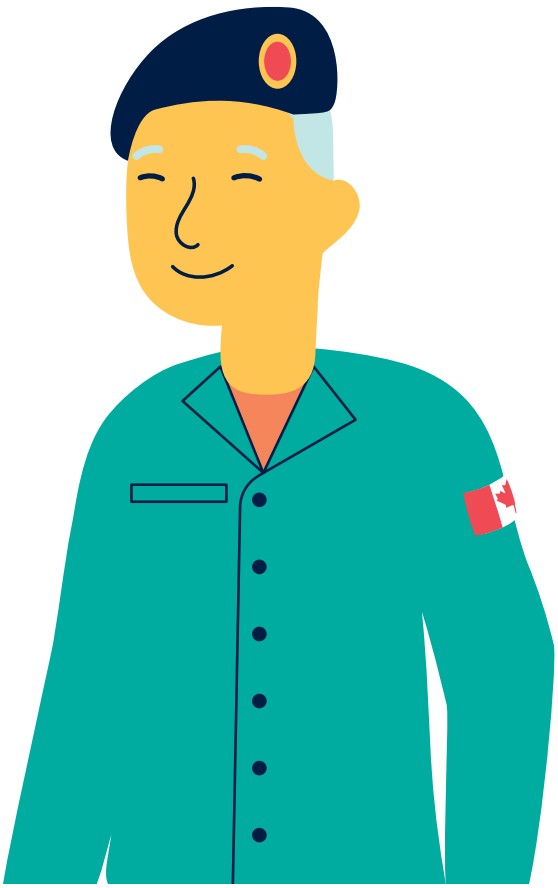
VETERAN'S LAST POST FUND

- Some members who served with the Canadian Armed Forces may be eligible for benefits through the Last Post Fund. Eligibility depends on when they served, and if they collected the Veteran's Disability Benefit.
- For more information call **1-800-465-7113**, visit https://www.lastpostfund.ca/, or Google "Last post fund Canada."

OTHER BENEFITS

- Other benefits do exist, so be sure to check with employers or private pensions to see if they are able to offer any financial help with funeral expenses.

Tip: Funeral Homes are usually able to provide you with the information and paperwork needed for some of the most common benefits listed above.



If you are at the end of life, there are different options for your care

Dying at Home

You have the option to live out the end of your life at home. It is important to know that a large team of people and many resources are often needed to provide this kind of full-time care (e.g., nurses, personal care workers, equipment). Talk with your doctor, family and friends to see if this option is possible for the people who will care for you. Ask your doctor about the New Brunswick Extra Mural Program, which offers supports for palliative care at home. For more information on the Extra Mural Program, call **1-888-862-2111**, visit https://extramuralnb.ca , or Google "Extra Mural NB."

Financial Tip: If you have private health insurance (e.g., Blue Cross, Sun Life), check to see if there are services covered that can help with your care (e.g., nurses, personal care workers, equipment).

Dying in Hospital

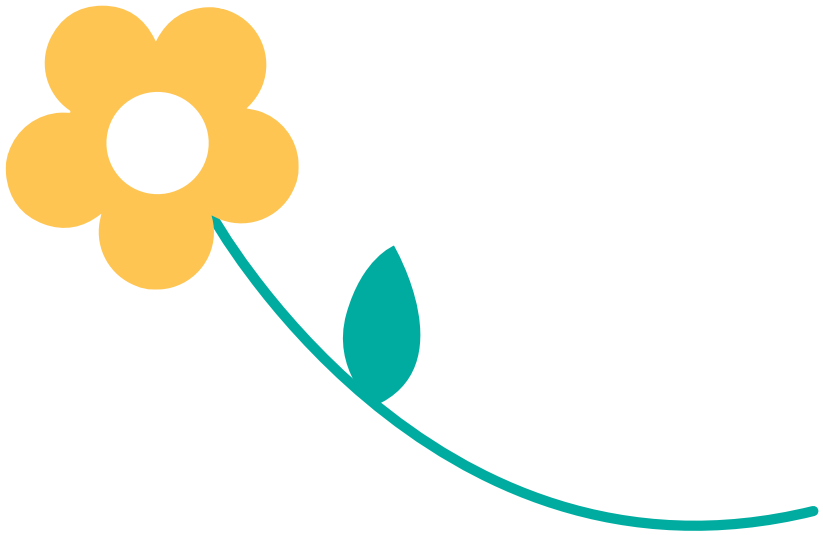
Palliative Care in hospital helps to prevent and relieve suffering. The goal is to make the quality of life better for both the patient and the family through support and treatment. This includes providing physical, social, emotional, practical, and spiritual support for the person living with a serious illness. It is important to note that not all hospitals in the province offer palliative care.

For more information about palliative care in New Brunswick or to find out which hospitals offer this service, talk with your doctor or call Horizon Health Network at **(506) 623-5500**, visit https://horizonnb.ca/services/health-and-aging-seniors-health/palliative-care/, or Google "Horizon palliative."

Dying at Hospice

Hospice care is a special kind of care that focuses on the quality of life for people who are dying and their caregivers. The goal of hospice is to provide pain control and help manage symptoms. They also provide spiritual and emotional support to help seriously ill people live in comfort and with dignity until they die. The main focus is keeping patients comfortable at the end of life. Depending on the services available in your area, hospice care can be provided in your home or in your community in a Residential Hospice.

For more information or to inquire about Hospice in your area, you can talk to your doctor, or contact the NB Hospice Palliative Care Association by phone: **(506) 857-5001.**



Healthy Seniors Pilot Project

Projet pilote sur les aînés en santé

RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

SOAR

Support Opportunities & Assistance for Research