Transitional Behavioural Support Unit (TBSU)

The Transitional Behavioural Support Unit (TBSU) provides support for individuals whose responsive behaviours have become unmanageable in their current setting. The average length of stay is three to four months at the TBSU. Once the client has reached their treatment goals, they are able to return to their home or to an appropriate alternative environment. Planning for the discharge location should begin early and should be discussed with the TBSU Social Worker and the Home and Community Care Support Services (HCCSS) Care Coordinator. Eligibility is determined by the Toronto Central HCCSS.

Background

Care Coordinators at HCCSS are to complete TBSU applications. This application is separate from long-term care (LTC); please refer to your Care Coordinator for more information. Similar to LTC homes, certain interventions cannot be provided in the TBSU, such as:

- Physical and chemical restraints
- 24/7 1:1 supervision/support

If your client requires such interventions, please refer to Centralized Access to Specialty Senior Beds (CASS) for more intensive behavioural stabilization services in a transitional setting. CASS applications are a separate referral form that is also processed by the HCCSS.

Structure and Alignment

Located in Baycrest's Apotex Centre, Jewish Home for the Aged, the Transitional Behavioural Support Unit (TBSU) is a 23-bed unit designed to provide time-limited, specialized support for seniors whose responsive behaviours have become unmanageable in their current setting, and for whom available resources have been unsuccessful in managing their challenging behaviours. TBSU applications are submitted after available psychogeriatric resources have already been already utilized, including: Behavioural Support Outreach Team (BSOT) (in LTC and/or Community), UHN BSS, LOFT BSTR, PRCs, GMHOT, CPOT or similar resources.

The TBSU has an enhanced care delivery model and physical environment, and is recognized as a specialized unit as stipulated within the Fixing Long-Term Care Act, 2021. The TBSU builds upon the knowledge and resources which currently exist in long-term care. The TBSU is staffed by an interdisciplinary team consisting of the following professions:

- Registered Nurses
- Physicians
- Personal Support Workers
- Social Worker
- Recreation Therapist
- Psychiatrist
- Physiotherapist
- Occupational Therapist
- Pharmacist
- Dietitian
- Unit Manager

Clients may transition from any sector (acute care, community or long-term care) into the TBSU. Upon admission to the TBSU, the client and family should start discharge planning immediately. To ensure a smooth transition for clients back to their original long-term care home (LTCH) or an LTCH of choice, there will be transitional support led by the unit social worker and supported by the interdisciplinary team and HCCSS.

In some cases, clients are able to return to living in the community. There are support services available in the community that should be identified with the TBSU Social Worker and HCCSS Care Coordinator prior to discharge, to ensure a smooth transition home. This may include, HCCSS home care services, Adult Day Programs, Behavioural Support Outreach Team (BSOT), or Community Pyschogeriatric Outreach Teams (CPOT). If returning to the community is your goal, please discuss it with the TBSU team upon admission to the unit.

Access and Referrals

Please ensure your clients meet the following eligibility criteria:

- Medically stable
- Primary diagnosis of progressive dementia with responsive behaviours that cannot be managed in the current environment
- Delirium has been ruled out
- Available community and/or hospital-based specialized psychogeriatric resources have been trialed and evaluated to be unsuccessful
- Behavioural pharmacological review and reconciliation of medications have been completed

For information about the Transitional Behavioural Support Unit (TBSU):

TBSU Social Worker

416-785-2500 ext. 2402

behaviouralsupport@baycrest.org

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