OUR PHILOSOPHY

The provision of support services is based on the following beliefs:

- Each individual is a unique adult and is deserving of respect and dignity.
- Support should be flexible, individualized and reflective of the participants' choices, abilities and existing support services.
- Choice often involves some elements of risk. Where possible, individuals will be permitted to experience the result of their choices to the extent that they are able.
- Independence is a dynamic process of accessing people and services as challenges and successes change.

We rigorously promote the rights of the individual and promote recognition of acquired brain injury and how it affects individuals and families through ongoing advocacy and public education.

VISION STATEMENT

To lead in the field of acquired brain injury rehabilitation, providing advocacy for successful re-entry into the community.

CONTACT INFORMATION

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ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION AGRÉMENT CANADA

ACCESSIBILE FORMATS & COMMUNICATION SUPPORTS

Special accessibility accommodations and materials in alternate formats can be arranged by contacting Brain Injury Community Re-entry (Niagara) Inc. at 905-687-6788 ext. 663 or www.bicr.org.

Disclaimer:
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The views expressed in this publication are the views of Brain Injury Community Re-Entry (Niagara) Inc. and do not necessarily reflect those of the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) or the government of Ontario.

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BRAIN INJURY COMMUNITY RE-ENTRY (NIAGARA) INC.

Long-Term Care Facility Transition

What kind of services are provided by a Long-Term Care Facility?

- Assumes responsibility for nursing care, health care, and personal care.
- All medical care provided by the facility's designated physician.
- Assistance with activities of daily living.
- Room and board (i.e., laundry and special diets are accommodated).
- Social and recreational programs.
- Social Work.
- Direct and open communication with families of individuals.

Who is eligible for long-term care?

- Be 18 years of age or older and posses a valid Ontario Health Card.
- Have health care needs that cannot be met with any combination of care-giving or community-based services in the home.

Admissions

- Application for admission into a provincially regulated Long-Term Care Home can only be made through the Community Care Access Centre.
- Niagara Branch (905) 684-9441.

Costs

- The Ministry of Health and Long-Term Care pays for the care you receive. However, the individual is responsible for covering the accommodation costs, which can be substantial.
- Long-Term Care Homes cannot refuse admission to eligible individuals based solely on their inability to pay for accom-modation. If the individual is unable to pay for the cost of the basic room, the government will provide subsidy to bring the cost to an affordable level.

End of Life or Palliative Care

Palliative care is a philosophy of care that focuses on two main things. It first seeks to support individuals coping with dying due to natural causes or a terminal illness, to experience the highest quality of life possible, for as long as possible. Next, it endeavors to make the dying experience as positive and pain free as possible by providing care and compassion for the person's body mind and soul. Palliative care also offers support to the dying person's family, friends and caregivers. Palliative care can be offered in a person's home, hospitals, hospices and long term-care homes. If you have any questions about palliative care please ask the Long Term Care coordinator at BICR, CCAC, or the facility where you or your loved one is living.

BICR's Role in the Transition

- Provide a designated Long-Term Care Case Facilitator to aide in the transition.
- Provide the Long-Term Care Facility, the individual, and their families with education about Acquired Brain Injury, general and person specific.
- Assist the individual, their family, and the Long-Term Care Facility with the initial transition into the Long-Term Care Facility.
- Assess the amount of support required by the individual from BICR. Assessment is based on consider–ation of age, medical status, and ability to actively participate in rehabilitation.
- BICR will develop a contract for services based on assessment.
- Services may include up to four hours per week of Case Facilitator and Rehabilitation Counselor shifts.
- BICR will gradually fade out services of an appropriately placed individual.