



Continuing Care Health Service Standards



May 2006



Alberta

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Alberta Continuing Care Health Service Standards

Introduction

In recent years, Alberta has seen a dramatic evolution in continuing care health and accommodation services. Changes in demographics have impacted continuing care health and accommodation services. As a result, this is an ideal time to review and update health care and accommodation services across the continuing care system.

In Alberta, there are currently about 330,000 seniors over the age of 65, with approximately 153,000 over the age of 75. The number of seniors over the age of 75 is expected to increase by approximately 67 per cent by 2025 to about 256,000. This age group is more likely to need health care services and to have a higher incidence and prevalence of chronic disabilities, Alzheimer's disease and other dementias.

There are about 20,600 people living in approximately 400 supportive living facilities (lodges, enhanced lodges, designated assisted living, group homes, adult family living, and family care homes). There are about 14,400 people living in approximately 200 long-term care facilities (auxiliary hospitals and nursing homes). Most seniors, however, live in their own homes and of these, a number receive home and community services.

The delivery of health care services has changed with regionalization. Regional health authorities (RHAs) continue to evolve while meeting their roles and responsibilities.

For seniors and younger persons with disabilities, there has been a shift away from institutional or facility-based care to community-based residential options such as supportive living. Many new models of service delivery and housing have been introduced resulting in a rapid growth of supportive living settings.

The unbundling of health care services and accommodation has had an impact on the operation of supportive living and long-term care facilities. Alberta Health and Wellness has retained responsibility for health care services while Alberta Seniors and Community Supports has assumed responsibility for overseeing the government's role in the provision of accommodation services (i.e. room, board and housekeeping).

Continuing Care System

Home Living	Supportive Living	Facility Living
Independent living in: <ul style="list-style-type: none"> • Houses • Apartments • Condominiums 	<ul style="list-style-type: none"> • Group Homes • Lodges • Enhanced Lodges • Assisted living • Apartments, condominiums with hospitality and/or health services 	Long-Term Care Facilities: <ul style="list-style-type: none"> • Nursing Homes • Auxiliary Hospitals
Community and home care assessed health services	Community and home care assessed health services	Nursing home and auxiliary hospital health care services

The **Continuing Care Health Service Standards** developed by Alberta Health and Wellness complement the **Accommodation Standards** developed by Alberta Seniors and Community Supports.

These standards were developed as a result of the public consultations undertaken by the *MLA Task Force on Continuing Care Health Service and Accommodation Standards* in 2005.

There will be an ongoing process to review and update the **Continuing Care Health Service Standards**.

In Alberta, health care and accommodation services in supportive living and long-term care facilities are subject to a wide variety of legislation (municipal, provincial and federal) that providers are required to comply with. The **Continuing Care Health Service Standards** are intended to build on existing legislation, and include a number of “best practice” standards not currently in legislation.

The **Continuing Care Health Service Standards** were issued pursuant to the authority of the Minister of Health and Wellness to issue directives and guidelines to Regional Health Authorities, pursuant to section 8 of the *Regional Health Authorities Act*. These standards replace the **Basic Service Standards for Long-Term Care Facilities**, released in April 1995.

Alberta Health and Wellness Continuing Care Health Service Standards

The **Continuing Care Health Service Standards** are divided into two parts:

- A. ***Putting Individuals First: Providing Quality Continuing Care Health Services***
- B. ***Quality Improvement and Quality Assurance Standards of Practice***

Regional health authorities (RHAs) receive global funding from the Government of Alberta to provide a variety of health services to the population in their regions, including continuing care health services. Each RHA identifies the appropriate mix and level of continuing care health services to provide, depending on each region's needs and priorities, and available resources.

It is important to recognize that these standards are not intended to limit RHA options for funding health services, but to ensure that when continuing care health services are provided through RHAs, clients receive quality continuing care health services that take into consideration personal choice and the importance of family and community.

Requirements and standards already contained in existing legislation are not repeated in the **Continuing Care Health Service Standards**, which are intended to build upon existing legislation.

The **Continuing Care Health Service Standards** have identified mandatory requirements (M) that must be complied with and performance expectations (P) that are best practice standards. It is expected that regional health authorities will make reasonable efforts and strive to meet the performance expectations.

Definitions

- **Assessed health service needs** are the unmet health service needs of clients, as assessed through the continuing care health service assessment and care plan processes as described within.
- **Client(s)** means individuals receiving continuing care health services in long-term care facilities or through community and home care programs, and where applicable, the clients' legal representatives.

- **Community and home care programs** means regional health authority programs which deliver continuing care health services in community or home settings (e.g. assisted living, supportive living, client's homes, community clinics, at school, work, congregate residential settings, etc.)
- **Continuing care health services** means health care services and personal care services provided by regional health authorities to clients with chronic care needs, where it is anticipated the client will require health services for a period *exceeding three months*, whether provided in long-term care facilities or through community and home care programs. These standards do not apply to individuals requiring short-term acute or sub-acute health care services.
- **Establish policies and/or processes** means including the necessary procedures to develop, implement, evaluate and update written policies/processes on a regular basis, taking into consideration best practices, and where applicable they are to be consistent with relevant legislation and professional standards of practice.
- **interRAI** means the RAI/MDS 2.0 and RAI/MDS-HC, or the most current version, which are comprehensive assessment and care-planning instruments used to assess residents in long-term care facilities and clients in community and home care programs. The *interRAI* instruments have a number of outputs including Resident/Client Assessment Protocols, Outcome Measure Scales, Quality Indicators and Resource Utilization Groupings (RUGS) that highlight areas that require further investigation, evaluate current clinical status and facilitate the allocation of resources.
- **Long-term care facilities** means “nursing homes” under the *Nursing Homes Act* and “auxiliary hospitals” under the *Hospitals Act*.
- **Personal care services** includes assistance with the activities of daily living (i.e. bathing, personal hygiene, grooming, dressing, toileting, incontinence management), assistance with therapeutic regimes (i.e. range of motion, medication assistance and reminders, simple wound care, respiratory equipment, ostomy care), simple bedside care (i.e. mouth care, turning, application of lotions), therapeutic interventions for behaviour management and maintenance of health records.
- **Regional Health Authorities** includes all regional health authorities and auxiliary hospital boards.
- **Staff** includes employees of the regional health authority, or an employee of a contracted long-term care facility or community and home care program operator, providing continuing care health services.
- **Unregulated health care provider** means health care providers not regulated under provincial legislation.

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Continuing Care Health Service Standards

A. Putting Individuals First: Providing Quality Continuing Care Health Services

Continuing Care Health Service Standards

The continuing care health service standards apply to all continuing care health services provided by regional health authorities in long-term care facilities, and through community and home care programs.

STANDARD 1.1

- 1.1 (a) Regional health authorities shall take all necessary steps to comply with the mandatory continuing care health service standards for the provision of continuing care health services in long-term care facilities and community and home care programs, where the services are provided directly by the regional health authority and where the regional health authority contracts with outside providers. (M)
- 1.1 (b) Regional health authorities shall make reasonable attempts to comply with the continuing care health service standards where there are performance expectations for the provision of continuing care health services in long-term care facilities and community and home care programs, where the services are provided directly by the regional health authority and where the regional health authority contracts with outside providers. (M)
- 1.1 (c) Where a regional health authority contracts with an outside provider, the regional health authority shall take all reasonable steps to ensure that the outside provider complies with the continuing care health service standards. (M)

Information on Continuing Care Health Services

Albertans have information on continuing care health services.

STANDARD 1.2

- 1.2 (a) Regional health authorities shall provide general information on available regional continuing care health services through a single access link, seven days a week with a toll-free phone line. Regional

co-ordinated access can be linked with other points of contact within the health system, for example Health Link. (M)

- 1.2 (b) Clients shall receive relevant and understandable information on the range of continuing care health services. (M)
- 1.2 (c) Regional health authorities shall ensure that clients seeking information on regional continuing care health services receive information within 72 hours. (M)
- 1.2 (d) Where a specific continuing care health service is not provided by the regional health authority, clients are informed of known available options, including information on how to access other services or settings. (P)

Waitlist Management

Clients have access to assessed continuing care health services based on urgency of need.

STANDARD 1.3

- 1.3 (a) Regional health authorities shall manage waitlists so that all eligible clients requiring continuing care health services have equal opportunity to access and receive regional continuing care health services based on levels and urgency of need as prime considerations. (M)

Client/Family Information and Feedback

Clients have information on services and are given opportunities for providing feedback.

STANDARD 1.4

- 1.4 (a) Regional health authorities shall have a clearly written document that outlines the continuing care health services provided or offered, any associated charges to individuals, and the responsibilities of the regional health authority, the facility or the program and the client. This document shall be provided to all clients prior to admission or commencement of services. (M)
- 1.4 (b) Regional health authorities provide information to clients on the importance of personal directives, guardianship, and trusteeship. (P)

- 1.4 (c) Where clients or families express an interest in forming a “resident family” council, regional health authorities shall ensure that each long-term care facility and community and home care program provides reasonable support and cooperation, including establishing and regularly reviewing Terms of Reference. (M)
- 1.4 (d) Regional health authorities shall have a systematic process for client and family feedback, including the use of surveys, and a clearly defined process for responding to quality concerns identified through client and family feedback. Surveys should be conducted at minimum every two years. (M)

Client Concerns

Clients have a process for raising concerns.

STANDARD 1.5

- 1.5 (a) Regional health authorities shall ensure that each long-term care facility and community and home care program has a concerns resolution process that reviews concerns and complaints of clients. The process shall be straight-forward, easy and non-threatening for clients and families to use. (M)
- 1.5 (b) Regional health authorities shall ensure that each long-term care facility and community and home care program takes all reasonable steps to address complaints in a timely manner and in accordance with its concerns resolution process. (M)
- 1.5 (c) Regional health authorities shall provide clients and families with general, applicable information on complaints and concerns resolution processes, including the Health Facilities Review Committee, *Protection for Persons in Care Act* and the Provincial Ombudsman. (M)

Promoting Wellness

Clients are supported, where appropriate, in maintaining and promoting a state of wellness and independence, including mental and physical health, and the prevention of disease and injury.

STANDARD 1.6

- 1.6 (a) Regional health authorities plan and provide continuing care health services in a manner that supports clients in maintaining and promoting a state of wellness and independence, including mental health and physical health, and the prevention of disease and injury.
(P)

Communicable Disease and Infection Prevention and Control

Clients are supported in maintaining and promoting a state of wellness, including infection and communicable disease prevention and control.

STANDARD 1.7

- 1.7 (a) Regional health authorities shall establish policies and procedures which incorporate current, relevant **communicable disease** prevention and control guidelines and policies pertaining to continuing care health service clients, staff and visitors, including, but not limited to:
- Health care provider and staff immunizations and screening;
 - Client/resident immunizations and screening;
 - Volunteer/visitor communicable disease prevention strategies;
 - Routine practice and additional precautions (e.g. handwashing, gloving, gowning and isolation techniques);
 - Communicable disease surveillance, outbreak detection and response, including reporting and control strategies; and
 - Mandatory and ongoing in-service training.
- (M)
- 1.7 (b) Regional health authorities shall establish policies and procedures which incorporate current and relevant **infection** prevention and control guidelines and policies pertaining to continuing care health service clients, staff and visitors, including, but not limited to:
- Infrastructure and environmental prevention and control of infectious diseases in long-term care facilities (e.g. waste management, laundry, housekeeping, air quality);
 - Infection surveillance, outbreak detection and response, including required reporting and control strategies;
 - Monitoring of antimicrobial use;
 - Cleaning, disinfection and sterilization of equipment and surfaces;
 - Routine practice and additional precautions (e.g. handwashing, gloving, gowning and isolation techniques);

- Monitoring of outside service providers, where services are provided in a long-term care facility where there is a risk of infectious diseases (e.g. massage, foot care, hair dressers);
- Where there are pets residing in a long-term care facility or visiting for pet therapy, pet health is monitored as it impacts resident health and safety, (e.g. immunizations, risk of infectious diseases and behaviour risks); and
- Mandatory and ongoing in-service training.
(M)

Standardized Assessment

Continuing care clients are assessed for health service needs using a standardized comprehensive assessment tool.

STANDARD 1.8

For the Purpose of Appropriate Planning

- 1.8 (a) Regional health authorities shall have processes in place to ensure that all potential continuing care clients are assessed for health service needs prior to commencing services, to determine level and urgency of need and appropriateness of services. (M)
- 1.8 (b) Where the regional health authority determines that:
- (i) The continuing care health services required to meet the client's assessed health service needs are not available locally; or
 - (ii) The available continuing care health services are not ideally suitable to meet the client's assessed health service needs; or
 - (iii) The client's preferred setting is either not available or is not ideally suitable to meet the client's assessed health service needs;

The regional health authority shall:

- Inform the client of why the assessed continuing care health services or preferred setting cannot be provided locally, or are not ideally suitable to meet the client's assessed health service needs;
- Provide the client with written notice outlining the associated risks with receiving the available continuing care health services or preferred setting; and

- Inform the client of available options, and provide assistance for referral to appropriate services. (M)
- 1.8 (c) Where the client still chooses the available services or preferred setting, and where the regional health authority (and where applicable, the facility operator) agrees to provide services:
- The regional health authority shall work with the client to mitigate and manage the risk; and
 - The client shall acknowledge the notice in writing. (M)

For the Purpose of Individual Care Planning

- 1.8 (d) Regional health authorities shall assess continuing care clients using a comprehensive assessment tool to identify individual health service needs. (M)
- 1.8 (e) All adult long-term care facility clients by September 30, 2007 shall be assessed using interRAI MDS 2.0, as may be amended from time to time. (M)
- 1.8 (f) All adult continuing care community and home care clients by September 30, 2007 shall be assessed using interRAI MDS HC, as may be amended from time to time. (M)
- 1.8 (g) Assessments and care planning shall be completed on admission to long-term care facilities and community and home care programs within the guideline time set by interRAI. (M)
- 1.8 (h) Where the initial interRAI assessment triggers further detailed assessment, or where additional specialized assessments are required, appropriate health care professionals shall be consulted in the development of the client care plan. (M)
- 1.8 (i) Resident or Client Assessment Protocols (RAPS/CAPS) that are generated from the interRAI assessments are to be considered when preparing the client care plan. (M)

Client/Family Involvement in Care Planning

Clients and/or their representatives are given an opportunity to participate in the care planning process.

STANDARD 1.9

- 1.9 (a) Regional health authorities shall establish policies and processes which are supportive and permit client involvement in care planning. (M)
- 1.9 (b) Regional health authorities shall establish policies and processes, which are supportive and permit, with the client's permission, involvement of others in care planning (e.g. identified family members, supportive living operators). (M)

Integrated Care Plan

Each client shall have one current, integrated care plan.

STANDARD 1.10

- 1.10 (a) Regional health authorities shall ensure that each client has one current, integrated care plan that complies with the following requirements. (M)
- 1.10 (b) The documented care plan shall include:
 - The result of the comprehensive health service assessment (including where relevant, results of diagnostic testing);
 - A description of the client's assessed health service needs;
 - A description of the goals and expected results within a specific time frame;
 - A detailed care plan outlining all assessed services required to assist clients in achieving identified goals and expected results;
 - A description of where and how, regional health authority health service interventions will be provided, including, but not limited to, assessed professional nursing, personal care, medication management and therapeutic services;
 - A description of any services that will not be provided or funded by the regional health authority;
 - A description of the roles and responsibilities of each health care provider team member, and where appropriate, other providers, such as supportive living operators, other organizations, clients, representatives and their families;
 - A description of how the continuing care health services will be monitored to determine whether the goals and expected results have been achieved;

- A planned process for evaluating the overall effectiveness of the interventions on an ongoing basis; and
 - Where the expected results have not been achieved, a description of how the care plan will, or has been revised.
- (M)

Evaluation and Revision of Care Plans

- 1.10 (c) Long-term care facility clients shall have their care plans reviewed and updated every three months, or more often as assessed health service needs change. (M)
- 1.10 (d) Community and home care clients shall have their care plans reviewed and updated annually, or more often as assessed health service needs change. (M)
- 1.10 (e) Each continuing care client, at minimum, shall have an annual continuing care health service team conference to review, evaluate and if necessary, update the care plan. (M)
- 1.10 (f) All care plan reviews shall include an evaluation of the overall effectiveness of the care plan, utilizing *interRAI* or other quality indicators. (M)
- 1.10 (g) Any new planned continuing care health service or change to the care plan shall be documented in the client's care plan, after consulting, where appropriate, with the client and relevant health care or service providers. (M)

Service Coordination

Regional health authorities are responsible for establishing processes to coordinate continuing care health services and assist providers, clients, families and other service providers to work together in facilitating links across the continuum of care.

STANDARD 1.11

- 1.11 (a) Regional health authorities shall establish health service coordination policies and processes that:
- Coordinate and integrate health care services; and
 - Ensures continuity of health services across the continuum of care (e.g. when a client is hospitalized or discharged from one continuing care program to another).

The process shall be transparent, seamless and communicated to the client.

(M)

- 1.11 (b) Regional health authorities shall establish policies and processes to ensure that when required, long-term care facility clients have access to emergency services, including on-call medical services, acute care and ambulance services. (M)
- 1.11 (c) Regional health authorities shall have an identifiable health care professional (care coordinator, also known as case manager) who shall be responsible for coordinating and integrating continuing care health services and ensuring continuity of health care services for each client. (M)
- 1.11 (d) The roles and responsibilities of the care coordinator includes, but are not limited to:

Client Communication

- Establishing rapport, developing trust and understanding the uniqueness of the client, supporting clients to assume responsibility for their own health, identifying factors that influence client health and reinforcing client strengths and abilities;
- Providing opportunities for clients or representatives, such as identified family members, to be involved in the assessment and care planning;
- Providing information to clients in a clear and easy-to-understand way on their assessment and care plan; and
- Appropriately supporting and assisting clients and family caregivers, where the care plan identifies that they are providing care.

Care Planning

- Ensuring that clients are assessed and care plans are prepared and updated;
- Coordinating interdisciplinary assessment and care planning, as required;
- Supporting collaborative relationships between the care coordinator and the family physician in a chronic disease management model supported by appropriate information sharing;
- Coordinating services by helping clients, their families and service providers to work together;
- Communicating with appropriate providers; and

- Documenting and communicating client wishes for end-of-life care and care in the event of serious illness or a life-threatening condition.
(P)

Client Health Information

Clients and continuing care service providers are supported in the sharing of relevant client health information for the purposes of care planning and the provision of continuing care health services.

STANDARD 1.12

- 1.12 (a) To the extent permitted by law, regional health authorities have policies and processes which permit the client and others, (such as supportive living operators and primary care physicians), in the appropriate sharing of client health information. (P)

Continuing Care Health Service Providers

Continuing care health services are delivered by educated and qualified health care providers working within their scope of practice or core competencies using evidence-based best practices to guide the delivery of services.

STANDARD 1.13

- 1.13 (a) Regional health authorities shall ensure that regulated health care providers work within their practice statement, competencies and conduct, as defined by the *Health Professions Act* or other relevant legislation, and governing professional organizations. (M)
- 1.13 (b) Regional health authorities shall establish policies and processes that define the appropriate competencies and scope of work for unregulated health care providers, and ensure they work within those policies. (M)
- 1.13 (c) In addition, regional health authorities shall ensure that unregulated health care providers are appropriately trained and work under the supervision of a regulated health care provider to provide safe care. (M)
- 1.13 (e) Regional health authorities shall ensure ongoing in-service training is provided for continuing care health service staff based on the changing needs of clients and current best practice. (M)

By **March 31, 2008**, regional health authorities shall ensure that all health care aides providing personal care services for continuing care clients shall meet the following requirements:

- Graduated from an education program using the Provincial Curriculum for Health Care Aides, or
- Can demonstrate competency as determined by the assessment tool contained in the Provincial Curriculum for Health Care Aides.

Nurse Practitioners

STANDARD 1.14

- 1.14 (a) Where applicable, regional health authorities shall establish policies and processes related to continuing care health services provided by nurse practitioners working in collaborative practices with family physicians. (M)

Physician Services

Clients have access to medically required physician services, including referral as required to specialist services.

STANDARD 1.15

Long-Term Care Clients (Nursing Home and Auxiliary Hospital)

- 1.15 (a) Long-term care facility operators shall ensure that all long-term care clients are under the care of a physician. (M)
- 1.15 (b) Physicians providing medical services in a long-term care facility collaborate with the medical director in the provision of quality medical services. (P)
- 1.15 (c) Long-term care facility operators shall have a physician as a medical director. The medical director is responsible for overseeing the quality of client medical care services and providing clinical leadership in medical research and education. (M)
- 1.15 (d) The medical director establishes policies and procedures governing the medical care of clients, including, but not limited to:
- Clinical assessment, initial and on-going as needed;
 - Medication review, every three months or more frequently based on the client's health needs;

- Reporting adverse drug reactions; and
 - An annual integrated care conference, at minimum, for each resident. (P)
- 1.15 (e) Responsibilities of a medical director, shall include but are not limited to:
- Reviewing medication utilization;
 - Investigating critical incidents;
 - Participating in the development of health service policies;
 - Programming and strategies;
 - Reviewing and monitoring of physician services;
 - Addressing concerns regarding medical practice; and
 - Communicating relevant regional medical policies to family physicians.
- (M)

Community and Home Care Clients

- 1.15 (f) Regional health authorities have protocols to ensure that community and home care clients who have unmet medical service needs have access to appropriate referral and medical care. This includes regional health authority clients receiving continuing care health services in their own homes, in supportive living, or in other community settings.
- (P)

Medication Management

Clients have access to clinical pharmacy and medication services based on assessed health service needs and current best practice.

STANDARD 1.16

Regional Systems

- 1.16 (a) Regional health authorities shall establish policies and processes to ensure safe medication management for continuing care clients. (M)
- 1.16 (b) Regional health authorities shall conduct an annual systematic review of policies, processes and procedures to ensure safe medication management for continuing care clients. The review shall include, but is not limited to:
- Prescribing - each medication order is supported with a clinical indicator.

- Assessment of the order - appropriateness of the medication, with defined goals and targets of therapy, is based on evidence and clinical indications.
 - Implementing the order - transcribing and distribution of medications is timely and appropriate.
 - Administering medications - roles and responsibilities for medication administration, medication assistance and medication reminders are clearly defined and followed. Medications are administered following industry and professional practices. Unregulated staff assisting with medication assistance or reminders shall be appropriately trained and supervised to ensure safe medication administration.
 - Monitoring - medication effectiveness is regularly monitored in compliance with professional standards, the interRAI assessment tools, and quality control measures.
 - Disposal - unused medications are disposed of appropriately and safely.
- (M)

- 1.16 (c) Regional health authorities shall ensure that each long-term care facility operator reviews medication utilization annually, or more often as may be required, to ensure appropriateness of medications. (M)
- 1.16 (d) Regional health authorities shall establish policies and processes to ensure that formularies are reviewed for evidence-based best practice and updated as necessary. (M)
- 1.16 (e) Regional health authorities shall establish policies and processes to ensure that where continuing care clients are transferred from one level of service to another, medication is reviewed and reconciled. (M)

Client Medications

- 1.16 (f) Where the regional health authority is responsible for medication management for clients, the regional health authority shall establish policies and processes which clearly define the roles and responsibilities for medication administration, medication assistance and medication reminders.

Policies and processes shall include, but are not limited to:

- Simple and easy to understand information for clients, or their representatives, about their medications, (including the expected outcomes, potential adverse effects and drug interactions, the risks

and consequences of non-compliance, and when medications may be discontinued to ensure the safe and proper use of medications).

- Health care providers administering medication adhere to current best practice and professional standards.
- The client chart documents indications for use, review of effectiveness, side effects and interactions of medications.
- Responsibility for monitoring the effectiveness and interactions of medications, including consultant/clinical pharmacy services and client responsibility.
- Processes to prevent, monitor, promptly respond to, and report any adverse events resulting from medication use.
- Medication review and assessment for desired outcomes, appropriateness, adverse effects and interactions before initial use and quarterly, or more often as may be required, to ensure optimal care. Medication reviews should be conducted by appropriate health professionals.
- Monthly physician review of any medications used for chemical restraints to ensure appropriateness (for example: antipsychotic, antianxiety, antidepressant, sedative and hypnotic medications).
- Where required, and based on the client's assessed health service needs, the care coordinator reviews and monitors medication prescriptions for clients with the appropriate professionals.
- Where appropriate, clients are supported in the self-administration and secure storage of their medications.

(M)

Therapeutic Nutrition and Hydration

Clients are assessed for nutrition and hydration needs.

STANDARD 1.17

- 1.17 (a) Regional health authorities shall assess continuing care clients for nutrition and hydration needs using interRAI or an equivalent assessment. (M)
- 1.17 (b) Where the assessment identifies a client with therapeutic nutrition or hydration needs, including but not limited to:
- Moderate to high nutrition or hydration risk;
 - Therapeutic diet;
 - Texture modified diet;

- Assistance with intake, including monitoring and adjusting assistance, as required; and
 - Significant food allergies;
- the client's needs shall be addressed in accordance with the care planning process. (M)

- 1.17 (c) Where texture modified diets are provided to clients, they shall be approved by a registered dietitian to ensure they are of high quality and nutrient dense. (M)

Therapeutic Services

Clients are assessed for therapeutic service needs.

STANDARD 1.18

- 1.18 (a) Where a client is assessed as requiring therapeutic services, (e.g occupational, rehabilitation, recreational therapy), the client's needs shall be addressed in accordance with the care planning process. (M)
- 1.18 (b) Based on assessed health service needs, regional health authorities have processes to coordinate access, including where appropriate, referral to therapeutic services (such as physiotherapy and occupational therapy) and other services, such as speech language pathology, audiology, respiratory therapy and mental health services. (P)

Oral Health, Dental, Podiatry, Hearing and Vision Services

Clients are assisted through referrals, as required, to access non-regional health services, such as oral health, dental, podiatry, hearing and vision services.

Note: This standard refers to services that are not considered part of the long-term care facility or regional health authority community and home care service programs. Clients or their representatives have primary responsibility for accessing these services, and are entirely responsible for any fees or associated risks.

STANDARD 1.19

- 1.19 (a) Regional health authorities have processes, including referral, which support clients in accessing other services, such as oral health, dental, podiatry, hearing and vision, based on assessed health service needs. (P)

Specialized Health Service Equipment and Medical-Surgical Supplies

Based on assessed health service needs, clients will be supported in accessing medically necessary health service equipment and medical-surgical supplies.

STANDARD 1.20

- 1.20 (a) Where equipment and/or medical-surgical supplies are required, but not provided or funded as part of the continuing care health services, clients are assisted, including referrals, to other programs (such as Alberta Aides to Daily Living) to access assessed equipment and/or medical-surgical supplies. (M)
- 1.20 (b) Regional health authorities shall establish policies and processes to ensure that health service equipment provided through the regional health authority is in safe working condition and in accordance with the manufacturers recommended use. (M)
- 1.20 (c) Regional health authorities shall establish policies and processes to ensure that all staff, clients, residents and family caregivers using health-related equipment, (for example a mechanical lift), provided through a long-term care facility or regional health authority community and home care program are instructed in safe use of the equipment. (M)

Operational Processes

Regional health authorities have operational policies and procedures for continuing care health services, including contracted continuing care health services.

STANDARD 1.21

- 1.21 (a) Regional health authorities shall establish operational policies and procedures for continuing care health services which reflect the changing characteristics of clients and current best practice, to guide

care planning and service provision as appropriate to the service stream. (M)

1.21 (b) Operational policies and procedures include, but are not limited to:

- Client Health Information Management
- Risk Management
- Client Safety
- Adverse Events/Client Abuse – prevention, management and reporting, including, but not limited to, reporting of suspected neglect or abuse in compliance with the *Protection For Persons in Care Act*, referral to the medical examiner in compliance with the *Fatality Inquiries Act*.
- Complications, Crisis or Emergencies - processes for dealing with complications, a crisis or an emergency, including basic life support.
- Aggressive/Violent Behaviour - prevention and management of aggressive or violent behaviour.
- Dementia - care of clients with dementia, cognitive impairment or mental health needs. This would include taking into consideration facility design, health care provider competencies and on-going education, and health care provider and family support on how to visit with residents with dementia.
- Personal Care of clients including oral care, continence management and safe bathing practices.
- Wound Management
- Restraints – decision-making and review of physical, chemical and environmental restraints to control or modify problem behavior.
- Pain Assessment and Management
- Palliative and End-of-Life Care - assisting clients to manage their pain and symptoms; assisting clients and their families prepare and plan for death; assisting clients and families to meet psychosocial, cultural and spiritual needs; assisting clients and families to link with support groups and hospice providers; and respecting client and family cultural beliefs in relation to pain management, the dying process and bereavement.
- Mental Capacity – assessment of decision-making capacity.
- Biomedical/Biohazardous Waste Management
- Emergency Preparedness including fire safety, prevention and pandemic planning. Disaster planning at the facility, municipal and regional level.

Any other policies, protocols or programs as may be determined from time to time by the operator or the regional health authority. (M)

B. Quality Improvement and Quality Assurance Standards of Practice

These standards relate to the organizational structures and processes that support health care providers in providing quality health services.

Quality Improvement

Regional health authorities have systems in place to regularly evaluate and improve continuing care health services.

STANDARD 1.22

- 1.22 (a) Regional health authorities shall establish a quality improvement program to regularly evaluate and improve continuing care health services, which may include, but is not limited to the following:
- Monitoring continuing care health service outcomes and comparing them with evidence-based best practice;
 - Reviewing critical incidents, near misses and other information to help prevent incidents from occurring in the future;
 - Monitoring overall quality of continuing care health services based on indicators such as resident, client, family and staff surveys;
 - Reviewing and comparing quality of services provided with quality indicators specified by Alberta Health and Wellness (e.g. interRAI indicators and/or other standardized quality measures);
 - Reviewing factors and trends identified in patient concerns resolution processes, critical incident reports and quality improvement recommendations;
 - Comparing facility and operator performance with other industry benchmarks and developing improvement plans for action;
 - Establishing staff training strategies to improve quality; and
 - Establishing a process to oversee plans of action.
- (M)

Note: Quality improvement programs should incorporate the Alberta Quality Matrix for Health developed by the Health Quality Council of Alberta. The matrix incorporates the six dimensions of quality (acceptability, accessibility, appropriateness, effectiveness, efficiency and safety) for the four areas of need (being healthy, getting better, living with illness or disability and end of life).

- 1.22 (b) Regional health authorities shall strive to achieve and maintain accreditation status, through the Canadian Council on Health Services Accreditation (CCHSA), or an approved accreditation process as may be determined by Alberta Health and Wellness, from time to time, for continuing care health services by September 1, 2010. (M)

- 1.22 (c) Regional health authorities shall prepare and submit an annual report on accreditation status and quality improvement activities for continuing care health services in a manner and form to be determined by Alberta Health and Wellness. (M)

Reporting

Regional health authorities collect and report information on continuing care health services to Alberta Health and Wellness.

STANDARD 1.23

- 1.23 (a) Regional health authorities shall collect and submit data in accordance with the *Alberta Continuing Care Information System Reporting Requirements*, as may be amended from time to time. (M)

Compliance

Regional health authorities demonstrate compliance with the continuing care health service standards and relevant legislation.

STANDARD: 1.24

- 1.24 (a) Regional health authorities shall establish policies and processes to ensure compliance with continuing care health service standards and legislation. (M)
- 1.24 (b) Regional health authorities shall provide an annual report, signed by the regional Chief Executive Officer, to the Minister of Alberta Health and Wellness, summarizing their compliance status with the continuing care health service standards and relevant legislation. (M)