MODEL STANDARDS FOR CONTINUING CARE AND EXTENDED CARE SERVICES

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Ministry of Health and
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ACKNOWLEDGEMENTS

Standards for Continuing Care and Extended Care Services is the result of the collaborative efforts of many people providing an invaluable range of experiences and perspectives. The process was strengthened by the knowledge, time and dedication to the project by the members of the six Standards Working Groups and the residential facilities, home support agencies and adult day centres that participated in the pilot testing of the standards. Their support, enthusiasm and assistance is gratefully acknowledged.

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INTRODUCTION

Standards for Continuing Care and Extended Care Services is the outcome of a two-year project to revise continuing care program standards and include in the residential component extended care services funded by the British Columbia Ministry of Health and governed and managed by health authorities.

With the overall goal of improving client outcomes, these standards are tools to assist health authorities, service organizations, and care providers in evaluating care, service delivery, and organizational systems. The standards in this document are those that consumers and the public can expect from a service. It is hoped these standards will become an integral part of organizations' and individual service providers' strategies for improving service quality.

The standards in this document are the result of an extensive developmental process which included six working groups. The Working Groups addressed Organizational Functions, Case Management, Integrated Home Health (Community Home Care nursing/Community Rehabilitation and Health Services for Community Living), Adult Day Centres, Home Support Services, and Residential Care Services. Over sixty participants from the British Columbia Association of Private Care, the British Columbia Health Association, and the Ministry of Health were engaged in this development process.

Pilot testing of the Organizational Functions, Adult Day Centres, Home Support Services and Residential Care Services standards took place in the fall of 1997. A five percent sample of Service Organizations (24 sites) were randomly selected from the five macro areas of the province. The participants were in agreement with the overall content of the draft document. They did however, provide many suggestions and comments to enhance the standards and criteria and much of this has been incorporated into the document.

There are two kinds of standards included in this document: organizational and program standards. Part I of this document is Organizational Functions Standards and sets out the expectations for the administration of an organization; these standards are general enough for use across all service settings regardless of size or services offered. Organizational standards address: leadership, utilization management and quality improvement, risk management, human resource management, information management, and financial management.

Part II of this document is focused on program standards that deal with client care and is intended for care providers to use to assess their own performance. Program standards include standards for the following five services: case management, integrated home health, adult day centres, home support services, and residential care. Each set of program standards has its own unique components based upon key functions in a particular setting.

The numbered sections in each of Part I and II identify the topics for the standard appearing within that section. Each topic consists of:

- a global outcome standard
- an accompanying rationale which provides the context for a fuller understanding of the standard's intent
- numbered process criteria and some specific indicators which describe staff performance expectations to facilitate the outcome standard[1]
- additional points to be considered when measuring the criteria
- a place to document the level of compliance with the standard (Level of Achievement)
- a place to document findings and make notes, observations and queries that might arise when reviewing a standard and its associated criteria (Comments)

The compliance scale selected for measuring the level of achievement of the standards and associated criteria was adapted from those used by the Joint Commission on Accreditation for Long Term Care and The Canadian Council on Health Services Accreditation and consists of the following four point scale:

Yes - used when the standard and associated criteria/indicators are consistently met

Partial - used when some of the standards and associated criteria/indicators are met

No - used when a standard and associated criteria/indicators are not met

N/A - used when a standard and associated criteria/indicators do not apply

Please see Appendix A for a glossary of terms used in this document.

The standards in this document and the process by which they were developed are based on the following set of guiding principles that resulted from a province-wide stakeholder consultation. This consultation included over 270 stakeholders representing clients, family and informal caregivers, and professional and paraprofessional staff from all service areas, and approximately forty advocacy groups.

[1] In Part II of this document, the integrated home health standards have two levels of criteria: the first level in bold is a more focused client outcome standard; the second level describes staff performance expectations.

GUIDING PRINCIPLES

INDIVIDUALITY

Each client is unique. Clients' personal preferences, lifestyle choices, and personal environments need to be recognized and respected. Learning the client's unique history, and accepting each client as an individual, facilitates the planning and effective delivery of care and services which are sensitive to their diversities.

CARING AND WELL BEING

Caring and empathy are central to the development of a relationship between client and provider. Demonstrating a genuine concern for the client and their welfare, and providing them with relevant and meaningful support and assistance, enhances the client's ability to achieve an optimum level of health and well being.

AUTONOMY AND DECISION MAKING

Client autonomy and self-determination are supported and respected. Clients enhance their ability to direct their own care by defining their unique needs, identifying their preferences and making independent choices about their lives.

CLIENT CENTRED

A client-centred organization understands and responds to the needs of its clients by measuring client satisfaction, identifying their priorities and applying what is learned to the design and delivery of care and services.

PROMOTION OF HEALTH

Clients can enhance their health potential and well being. Creating and sustaining an environment in which clients are supported to make healthy choices enables them to experience quality of life, as they define it, and realize their goals.

PARTNERSHIP

Organizations should build and maintain co-operative partnerships to respond to community needs and accomplish their overall goals. More effective and meaningful outcomes are achieved when members of the care team interact collaboratively with clients to plan, implement and evaluate care and service delivery.

QUALITY CARE AND SERVICES

Sound organizations strive to achieve the best possible outcomes for their clients while efficiently and effectively managing their resources. Achievement of desired health outcomes is enhanced in an environment in which care providers maintain current professional knowledge and apply best practices drawn from research and outcome evaluation to the delivery of care and services.

ORGANIZATIONAL FUNCTIONS

ORGANIZATIONAL FUNCTIONS

LEADERSHIP

STANDARD: 1. LEADERSHIP'S COMMITMENT TO EXCELLENCE AND CLIENT CENTRED CARE IS DEMONSTRATED. **RATIONALE: LEADERSHIP CREATES AN ENVIRONMENT WHICH SUPPORTS CLIENT CENTRED CARE AND PROMOTES ORGANIZATIONAL EXCELLENCE.**		
CRITERIA	**LEVEL OF ACHIEVEMENT**	**COMMENTS**
To demonstrate a commitment to excellence in care and service delivery the leadership[2]: 1.1 develops a vision and principles in consultation with clients, staff and stakeholders [3] which serves as the framework for all organizational activity. 1.2 adopts the principles of quality improvement and promotes an environment which respects clients and staff and values their involvement in finding solutions to improve care and service delivery. 1.3 establishes and maintains partnerships within the community by: - sharing information; - collaborating in the development and enhancement of programs and services; and, - identifying opportunities to utilize resources more effectively.		

[2] Leadership includes members of the governing body, the Chief Executive Officer and other senior managers and staff members in a leadership position within the organization.

[3] See glossary for definition of stakeholder.

ORGANIZATIONAL FUNCTIONS

LEADERSHIP

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
1.4 collaborates with stakeholders in a planning process which may include: - assessing internal and external influences; - considering alternatives and identifying priorities for action; - selecting preferred approaches; - establishing goals and objectives; and, - identifying time lines for implementation, the resources required and a mechanism for evaluating results. 1.5 evaluates programs and services and modifies them based on information received from stakeholders and quality improvement activities. 1.6 provides guidance and direction in the form of policies, procedures, standards or guidelines which: - address client care, support and administrative services; - are available to clients and staff of the organization; - reflect industry and professional practice standards and legislative requirements (e.g. WCB and Adult Guardianship); and, - are reviewed and authorized by the appropriate authority.		

ORGANIZATIONAL FUNCTIONS

UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT

STANDARD: 2. EFFECTIVE UTILIZATION OF RESOURCES AND COMMITMENT TO QUALITY IMPROVEMENT IS EVIDENT. **RATIONALE: SOUND [4] ORGANIZATIONS STRIVE TO ACHIEVE THE BEST POSSIBLE OUTCOMES FOR THEIR CLIENTS WHILE EFFICIENTLY AND EFFECTIVELY MANAGING THEIR RESOURCES.**		
CRITERIA	**LEVEL OF ACHIEVEMENT**	**COMMENTS**
To utilize resources efficiently and effectively and improve the quality of services, the organization: 2.1 adopts a systematic approach to measure, understand and reduce inappropriate utilization of resources. 2.2 reviews program and service utilization data. 2.3 measures and compares activities against similar organizations, current industry practice and benchmarks. 2.4 determines the appropriateness [5] of program and service activities and selects innovative solutions using available resources. 2.5 modifies standards and practices and reallocates resources to achieve desired outcomes.		

[4] See glossary for definition of sound.
[5] See glossary for definition of appropriateness.

ORGANIZATIONAL FUNCTIONS

UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
2.6 establishes a framework for quality improvement activities which includes: - communication of their commitment to CQI; - education and development of staff; - empowerment of staff; - implementation of work groups/teams to analyze information and seek improvement strategies; and, - outcome evaluation. 2.7 measures organizational performance and determines stakeholders needs and expectations to identify priorities for improvement. 2.8 initiates quality improvement activities by: - determining root causes of the problems; - identifying, selecting and implementing new processes; - documenting results; and, - tracking and providing feedback to staff and designated authorities. 2.9 monitors and evaluates the results of quality improvement initiatives. 2.10 demonstrates the outcome of quality improvement initiatives through: - implementation of new programs/services; - improvements in practices and processes; - stakeholder satisfaction; and, - increased efficiency/effectiveness.		

ORGANIZATIONAL FUNCTIONS

RISK MANAGEMENT

STANDARD: 3. RISKS TO STAKEHOLDERS AND THE ORGANIZATION ARE IDENTIFIED AND MANAGED. **RATIONALE: A SYSTEMATIC PROCESS FOR IDENTIFYING AND MANAGING RISKS IS ESSENTIAL TO AVOID LOSSES TO THE ORGANIZATION AND PROVIDE FOR THE SAFETY AND WELL BEING OF STAKEHOLDERS.** [6]		
CRITERIA	**LEVEL OF ACHIEVEMENT**	**COMMENTS**
To ensure risks are identified and minimized the organization: 3.1 identifies potential and actual risks through activities which include: - incident reporting (e.g. elopement, security, medication errors, falls and violence in the workplace); - formal complaints management processes; and, - surveys, reviews and reports from external bodies. 3.2 analyzes this information to determine the immediacy and severity of risks and potential loss to the organization. 3.3 reduces and minimizes potential and actual risks of injury or loss to clients, visitors, staff, reputation, property, net income, and liability of the organization through prevention activities and/or corrective action directed towards: **quality of care**; - abuse prevention; - infection control; - food safety;		

[6] For the purposes of this standard, stakeholders include governing bodies/owners, clients. staff, volunteers, visitors and contractors.

ORGANIZATIONAL FUNCTIONS

RISK MANAGEMENT

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
safety; - property and vehicle management systems; - preventative maintenance (e.g. safety devices, physical plant, vehicle, fixtures, equipment); **finance**; - acquisition and disposal systems; - contract review and indemnification of risks; and - claims and insurance; and, **human resources;** - occupational health and safety; - criminal record checks; - credentialling for staff, contractors, students and volunteers; - staff competency; - orientation and continuing education. 3.4 develops, tests and evaluates contingency plans for emergencies and unusual/unexpected events (e.g. fire, bomb threats, earthquake, snow storms, alternate water supplies and building evacuations). 3.5 reports risk matters to the appropriate authority (e.g. Insurer, governing body/owners and external bodies as required). 3.6 monitors and evaluates risk management activities on an ongoing basis to prevent, reduce and/or eliminate risks to the organization.		

ORGANIZATIONAL FUNCTIONS

HUMAN RESOURCE MANAGEMENT

STANDARD: 4. THE HUMAN RESOURCE MANAGEMENT PRACTICES OF THE ORGANIZATION ARE EFFECTIVE.

RATIONALE: SOUND HUMAN RESOURCE PRACTICES PROMOTE A SUPPORTIVE WORKING ENVIRONMENT FOR STAFF AND FACILITATE THE DELIVERY OF QUALITY CARE AND SERVICES.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To manage human resources effectively, the organization: 4.1 reviews human resource needs and requirements by considering: - utilization patterns; - demands for service; - availability of human resources; - requirements of funding bodies, collective agreements and, legislation. 4.2 adjusts staffing patterns to address: - clients' needs; - workload measurement requirements; - availability of resources; - disruption of service; and, - continuity of care. 4.3 recruits and selects skilled and appropriately trained staff by: - verifying credentials; - checking references; - screening criminal records; and, - assessing their suitability and competency to perform the job. 4.4 provides staff and volunteers with a clear statement of the scope, responsibilities and accountabilities of their roles.		

ORGANIZATIONAL FUNCTIONS

HUMAN RESOURCE MANAGEMENT

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
4.5 provides new staff and volunteers with a comprehensive orientation which outlines: - programs and services; - vision, values and principles; - goals and objectives; - standards of practice; - code of conduct; - relevant policies, procedures, guidelines and legislation; - safety measures; and, - community resources. 4.6 provides education to enhance the proficiency of staff and supports their continuous learning by: - involving them in determining their education needs; - obtaining feedback on the effectiveness of the training provided; and, - encouraging and supporting them to pursue other educational opportunities. 4.7 recognizes staff for their contribution to the organization. 4.8 provides staff with direction and support by: - sharing information; - fostering development of new skills; - encouraging individual initiative; and, - promoting staff empowerment and team work.		

ORGANIZATIONAL FUNCTIONS

HUMAN RESOURCE MANAGEMENT

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
4.9 promotes health and wellness of staff by: - providing Employee Assistance Programs or counselling assistance; and, - encouraging initiatives for wellness and prevention (e.g. Musculoskeletal Injury Prevention Programs). 4.10 establishes an organization-wide safety program to promote safe work practices through: - documentation and investigation of time loss inquiries; - implementation of recommended strategies; and, - coordination with external agencies (e.g. WCB) to facilitate claims management. 4.11 enhances work practices through a regular, documented, performance review process which: - is set out in policies, guidelines, and applicable collective agreements; - is based on agreed upon performance indicators related to the position; and, - should include a self appraisal component and the establishment of mutual goals. 4.12 monitors and evaluates human resource management practices and modifies them as required.		

ORGANIZATIONAL FUNCTIONS

INFORMATION MANAGEMENT

STANDARD: 5. TIMELY AND RELEVANT INFORMATION IS COLLECTED AND UTILIZED TO MAKE DECISIONS.

RATIONALE: EFFECTIVE MANAGEMENT AND UTILIZATION OF INFORMATION SUPPORTS DECISION MAKING AND ASSISTS THE ORGANIZATION TO DEMONSTRATE ACCOUNTABILITY.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To effectively manage information, the organization: 5.1 establishes information management practices that meet the needs of programs and services. 5.2 collects, analyzes and applies information to plan, develop and evaluate programs/services and support day to day activities (e.g. workload measurement). 5.3 establishes and maintains policies and guidelines to safeguard records and information that: - define confidentiality, disclosure and distribution; - describe storage, access and retrieval; - set requirements for collection, use and modification; and, - outline retention periods and methods of disposal. 5.4 monitors and evaluates information management practices and modifies them as required.		

ORGANIZATIONAL FUNCTIONS

FINANCIAL MANAGEMENT

STANDARD: 6. THE FINANCIAL RESOURCES OF THE ORGANIZATION ARE EFFECTIVELY MANAGED. **RATIONALE: EFFECTIVE STEWARDSHIP OF FINANCIAL RESOURCES DEMONSTRATES ACCOUNTABILITY AND SUPPORTS ORGANIZATIONAL VIABILITY.**		
CRITERIA	**LEVEL OF ACHIEVEMENT**	**COMMENTS**
To fulfil financial obligations, the organization: 6.1 follows generally accepted accounting principles. 6.2 plans collaboratively on an annual basis to develop a budget consistent with organizational goals, objectives and priorities. 6.3 implements and manages a system of internal control (e.g. designated signing authority, inventory and payment systems). 6.4 establishes policies and guidelines for handling client funds and, in facilities maintains individual client trust funds and accounts for these on a regular basis. 6.5 produces timely and accurate financial and statistical reports to meet internal and external requirements (e.g. yearly independent audits). 6.6 conducts financial risk management activities[7]		

[7] See Risk Management Standard page 5.

CASE MANAGEMENT

CASE MANAGEMENT

CLIENT CARE AND SERVICE COORDINATION

STANDARD: 1. CLIENT HEALTH STATUS IS ENHANCED THROUGH A CONTINUUM OF CARE AND SERVICES.

RATIONALE: PROVISION OF A CONTINUUM OF CARE AND SERVICES ASSISTS CLIENTS TO ATTAIN THE BEST POSSIBLE QUALITY OF LIFE, CONSISTENT WITH THEIR PREFERENCES AND ABILITIES.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
In keeping with the programs' values and applying a client centred approach to practice, the case manager: 1.1 establishes a rapport and encourages the development of a trusting relationship with clients by: - accepting their uniqueness; - listening attentively and being responsive to non-verbal cues; - interacting empathetically; and, - responding in a courteous, dependable and timely manner. 1.2 assists clients to understand the need for: - collecting personal and medical information; and, - protecting their information as it relates to the *Freedom of Information and Protection of Privacy Act*. 1.3 facilitates continuity of care and services by: - referring clients to program services, community resources and/or suggesting alternate services; - collaborating with clients/families and members of the health care team to provide support and share information (e.g. conferences); - coordinating and monitoring client care and services; and, - encouraging and supporting client interaction with service providers.		

CASE MANAGEMENT

CLIENT CARE AND SERVICE COORDINATION

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
1.4 supports clients to assume responsibility for their own health by: - encouraging their independence; - assisting them to identify the factors which influence their health; - reinforcing their strengths and abilities; and, - utilizing a health promotion approach to help them address lifestyle choices and decisions. 1.5 provides services in accordance with program standards and their professional practice standards and code of ethics. 1.6 ensures the effective utilization of program resources through management of facility waitlists and respite, adult day centre and home support services. 1.7 advocates, with the community and members of the health team, to enhance services for clients/families. 1.8 participates in research activities and program planning to identify, initiate and support improved approaches to practice and service delivery.		

CASE MANAGEMENT

INTAKE AND REFERRAL

STANDARD: 2. PROSPECTIVE CLIENTS ARE IDENTIFIED AND SCREENED THROUGH AN INTAKE PROCESS

RATIONALE: AN INTAKE PROCESS PROVIDES INFORMATION TO DETERMINE ELIGIBILITY AND FACILITATE ACCESS TO PROGRAM AND COMMUNITY RESOURCES.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
Through an established intake process, the case manager or designate: 2.1 provides clients with information on local program and community resources, on the assessment process and the need to access their personal information. 2.2 identifies the reason for referral, perceived urgency of need and potential risk factors. 2.3 addresses, where possible, client concerns and if the program can meet the identified client needs. 2.4 refers or directs clients to other resources where appropriate. 2.5 utilizes the information obtained to respond to the referral and to plan an assessment visit. 2.6 documents the intake information and the outcome of referral.		

CASE MANAGEMENT

ASSESSMENT

STANDARD: 3. CLIENTS' NEEDS AND HEALTH STATUS ARE ASSESSED.

RATIONALE: A COMPREHENSIVE, HOLISTIC ASSESSMENT ASSISTS CLIENTS TO IDENTIFY THEIR NEEDS AND EXPECTATIONS AND PROVIDES THE INFORMATION NECESSARY TO DEVELOP AN APPROPRIATE AND EFFECTIVE PLAN OF ACTION.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
Through an established process and in collaboration with the client/family and members of the health care team, the case manager: 3.1 completes an assessment to identify clients' needs and health status which includes their: - health perception, insight, attitudes and needs/goals; - ability to delegate responsibility; - cognitive function (e.g. level of coping, judgement, comprehension of consequences); - ability to communicate; - physical function, and its impact on their lifestyle (ADL); - ability to manage their household affairs (IADL); - significant relationships, care giver coping and community supports; - environmental safety and risk factors (e.g. home and neighbourhood); and, - behaviours and special care needs. 3.2 determines clients' health issues to be addressed in the care plan. 3.3 shares relevant information and makes referrals to facilitate access to needed services. 3.4 analyses and evaluates collateral information from the assessment and the health care team to develop the care plan.		

CASE MANAGEMENT

CARE PLAN

STANDARD: 4. CLIENTS' HEALTH ISSUES ARE ADDRESSED THROUGH AN INDIVIDUALIZED WRITTEN CARE PLAN **RATIONALE: A COMPREHENSIVE CARE PLAN ESTABLISHES A COORDINATED APPROACH TOWARD MEETING CLIENTS' NEEDS AND ENHANCING THEIR ABILITIES.**		
CRITERIA	**LEVEL OF ACHIEVEMENT**	**COMMENTS**
Through an established planning process based on the program values, the case manager: 4.1 develops and documents an individualized holistic care plan in collaboration with client/family which includes: - client needs based on identified health issues; - client goals and time specific outcomes; - range of services and role of contracted service providers; and, - role of client, family, community supports and services (e.g. volunteers, hospice). 4.2 shares information with the health care team and coordinates the services identified in the care plan. 4.3 conducts ongoing reviews and reassessments to identify clients' current health status. 4.4 modifies the care plan in response to clients' changing needs. 4.5 collaborates in case conferences with the health care team.		

CASE MANAGEMENT

DOCUMENTATION

STANDARD: 5. CLIENT CARE AND SERVICES ARE DOCUMENTED

RATIONALE: A COMPREHENSIVE, WELL-MANAGED SYSTEM FOR DOCUMENTATION OF CLIENT CARE AND SERVICES ENHANCES CARE PRACTICES AND STRENGTHENS COMMUNICATION AMONG MEMBERS OF THE HEALTH CARE TEAM.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To support the coordination of care and service delivery to clients and demonstrate accountability, the case manager: 5.1 establishes and maintains individual client records which: - include a comprehensive assessment of the client which rationalizes the plan for service delivery; - summarize discussions with clients, caregivers and service providers; - ensure utility of information recorded; and, - indicate client outcomes for care and services delivery. 5.2 ensures that the client's record is accessible to relevant members of the care team. 5.3 updates documentation on the client's record. 5.4 reviews documentation on the client's record to evaluate and improve the quality of care and services provided. 5.5 adheres to legal, professional and legislative requirements for records management. 5.6 monitors and modifies documentation practices to meet changes in legislative requirements and the needs of the organization.		

CASE MANAGEMENT

QUALITY IMPROVEMENT

STANDARD: 6. CLIENTS AND THEIR FAMILIES ARE ACTIVELY INVOLVED IN THE EVALUATION OF CARE AND SERVICES.

RATIONALE: ONGOING COMMUNICATION WITH CLIENTS AND SERVICE PROVIDERS PROVIDES OPPORTUNITIES TO ENHANCE THEIR SATISFACTION AND IMPROVE THE OUTCOME OF CARE.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To improve care and service delivery, the case manager: 6.1 ensures clients/families know whom to contact with their questions and concerns. 6.2 listens to clients/families and responds to their issues and concerns in a timely and considerate manner. 6.3 seeks input from clients/families regarding their experience with the care and services they receive through: - staff/client interactions; and, - ongoing dialogue with service providers. 6.4 identifies aspects of care and services that are important to clients/families, and considers these factors when implementing changes. 6.5 reviews the changes made in care and service delivery to determine if the best possible outcome has been achieved for clients/families. 6.6 maintains improvements in care and service delivery through ongoing monitoring and evaluation.		

INTEGRATED HOME HEALTH

INTEGRATED HOME HEALTH

SERVICE DELIVERY EXPERIENCE

STANDARD: 1. SERVICE DELIVERY MEETS THE EXPECTATIONS AND REQUIREMENTS OF THE CLIENT.

RATIONALE: OPTIMAL CLIENT OUTCOMES AND EFFICIENT RESOURCE UTILIZATION ARE ACHIEVED THROUGH A CLIENT DIRECTED, HEALTH PROMOTING APPROACH TO SERVICE DELIVERY. A CONSISTENT, HOLISTIC AND CLIENT DIRECTED APPROACH, PROVIDED BY THE MOST APPROPRIATE SERVICE, IS COST EFFECTIVE AS IT FACILITATES EQUITY, IS SENSITIVE TO INDIVIDUALITY AND PROMOTES POSITIVE HEALTH OUTCOMES.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
1.1 Client at first contact with the service receives timely support consistent with the nature and priority of their health issue. The staff: ♦ suggest alternative resources to those clients unsuitable for admission. ♦ adhere to local policy defining the acceptable time frame between the receipt of the referral and the initial client contact and/or admission. ♦ schedule initial visits according to priority need. **1.2 Clients whose requirements can most appropriately be met by the service are admitted. The staff:** ♦ ensure client meets eligibility as defined by MOH policy. ♦ determine client willingness to participate. ♦ determine that client can be safely and cost effectively managed on service: - client has acute, chronic and/or palliative conditions; - health requirements can be met by the health team; - services assist the client to remain at home for as long as possible; - resources are available; - environment is safe for staff. ♦ ensure client lives within service geographic boundaries. ♦ determine that client cannot reasonably access other more appropriate services.		

INTEGRATED HOME HEALTH

SERVICE DELIVERY EXPERIENCE

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
1.3 Client is an active participant and key partner throughout service delivery, to the greatest extent possible. The staff: ♦ provide information about services: - service philosophy and options; - role of key service providers; and, - how to address issues and concerns. ♦ determine that the client understands their rights related to freedom of information: - document evidence of discussion and client understanding of the purpose of collecting information, how it will be used, and the authority under which it is collected. ♦ obtain client informed consent on admission and on an ongoing basis for service delivery: - communicate required information in a manner that makes sense to the client; - ensure clients understand the options, consequences and potential risks prior to making decisions; and, - document evidence of informed consent. ♦ ensure client priorities, perspectives and individuality are central to service delivery: - ongoing interactions reflect the client's perceptions, opinions, expectations, preferences and beliefs. ♦ support client as a member of the health team: - establish a collaborative process in which information sharing about goals and possibilities is ongoing; - conduct care conferences in a manner that facilitates client comfort and participation; - have client identify family or other individuals in their environment to participate in service planning and activities as appropriate; and, - establish a milieu in which clients feel free to bring up issues without fear of reprisal.		

INTEGRATED HOME HEALTH

SERVICE DELIVERY EXPERIENCE

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
1.4 Client experiences a caring, therapeutic relationship with health team members throughout service delivery. The staff: ♦ spend adequate time to understand the client's health experiences, beliefs and values. ♦ actively listen and provide opportunity for clients to express opinions/concerns. ♦ check mutual perceptions through ongoing reflection with the client. ♦ are genuine, respectful, courteous and reliable. ♦ anticipate and effectively manage closure with the client. **1.5 Client receives support and education throughout service which allows opportunity for the development of knowledge, skills and confidence to perform activities and make choices that enhance their health and well being. The staff:** ♦ provide relevant and understandable information about health/wellness promotion and disease prevention. ♦ provide information that is relevant to the client's unique health issues, capability and readiness. ♦ assist the client to recognize their strengths and health promoting behaviours. ♦ support the client to adopt strategies that will minimize barriers to health and well being.		

INTEGRATED HOME HEALTH

SERVICE DELIVERY EXPERIENCE

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
1.6 Client's caregivers are supported, throughout service delivery, to manage the client health issues at home. The staff: ♦ acknowledge caregiver contributions towards managing care. ♦ consider caregiver abilities and unique needs in health plan. ♦ provide education to increase knowledge, skills and/or self-confidence. ♦ provide support to express feelings and experiences about impact of health issues. ♦ assist client and family or caregiver to recognize caregiver stress and their own response to stress. ♦ provide information about how to access services when required. ♦ provide opportunities for caregiver breaks/respite. **1.7 Client participates in an assessment that is based on their priorities and preferences. The staff:** ♦ explain the purpose of assessment to the client. ♦ complete an assessment for every client that considers all aspects of the client's health: - Support Network - Emotional Health - Personal Care - Home Management - Spiritual Health - Cognition/Perception - Mobility - Community, Social, Cultural - Nutrition - Finances - Physical Health - Physical Environment - Sexual Health - Communication - Health Perception/Health Management ♦ identify client values, health priorities and goals in their words.		

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
♦ select assessment methods with client involvement: - practitioner assessment and observation; - health records and test results; - other health team members reports and findings ♦ obtain information from client and others including: - family and caregiver experience; - experience with previous approaches to manage health issues; - abilities, strengths and preferences; - challenges and coping patterns; - motivation for change and readiness for learning; - knowledge and skill to manage health issues. ♦ provide opportunity for the client to review and discuss assessment findings and interpretations. ♦ document assessment findings and interpretations and share information with relevant members of the health team.		
1.8 Clients participate in the development of a health plan that directs service delivery. The staff: ♦ complete and document a health plan for all clients on the program longer than 48 hours. ♦ explain the purpose of the health plan to the client. ♦ ensure assessment findings and client preferences form the basis of the health plan. ♦ include plans for discharge in health plan. ♦ clarify client priority goals. ♦ identify mutually agreed upon goals that are: - understood and agreed upon by the client; - achievable and measurable.		

INTEGRATED HOME HEALTH

SERVICE DELIVERY EXPERIENCE

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
♦ collaborate with the client in determining a course of action and specific activities to achieve mutually agreed upon goals: - scheduling and activities reflect client preferences, whenever possible; - activities reflect evidenced based practice; - activities are consistent with accepted standards of practice and organizational policy; - ensure activities are consistent with ethical principles, rights and values; - identify individuals responsible to carry out activities; - define the predicted timeframe to achieve goals. **1.9 Client is involved in implementation and ongoing review of the effectiveness of the health plan. The staff:** ♦ implement activities as specified in the health plan. ♦ ensure ongoing review of progress toward achieving goals. ♦ obtain agreement from client that implementation activities are consistent with those defined on the health plan. ♦ revise health plan as required. ♦ document revisions and communicate to relevant members of the health team.		

INTEGRATED HOME HEALTH

SERVICE DELIVERY EXPERIENCE

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
1.10 Clients are discharged when the goals and the health plan have been achieved or can be independently achieved by the client, or when their requirements can no longer be met by the service. The staff: ♦ provide relevant information required by the client. ♦ Discharge client when any of the following are demonstrated: - client goals are achieved; - client and/or caregiver demonstrates the necessary knowledge and skill to manage health issues; - activities to manage health issues can be more effectively provided in an alternate setting; - client's home environment jeopardizes the safety of the staff; - client/family/caregiver chooses not to participate in mutually agreed upon activities; - client/family/caregiver no longer desires service. ♦ Seek client agreement with discharge plans. ♦ Implement activities consistent with the discharge plan. ♦ Document discharge and evidence of client participation. ♦ Communicate required information for continuity to relevant health team members.		

INTEGRATED HOME HEALTH

CONTINUITY AND COORDINATION

STANDARD: 2. CLIENTS ARE SATISFIED WITH THE COORDINATION AND CONTINUITY WITHIN AND BETWEEN SERVICES.

RATIONALE: CLIENTS PERCEIVE CONTINUITY AS A SIGNIFICANT ASPECT OF QUALITY CARE. SERVICES THAT ARE COORDINATED AND INTEGRATED, FACILITATE THE BEST USE OF RESOURCES, PROMOTE ACCESS TO THE MOST APPROPRIATE SERVICE AND MINIMIZE GAPS AND DUPLICATION.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
2.1 Client experiences continuity of care throughout service and transition between services. The staff: ♦ Provide service information to relevant individuals, groups or agencies: - description of services; - when and how to make a referral. ♦ Provide consistent and coordinated care: - inform client of the name of the health team member assigned as their primary contact; - involve client in all aspects of service; - inform client of relevant resources both within and outside the service; - identify care coordinator for clients with complex care needs; - conduct client/team conferences, as required; - ensure members of health team have a knowledge of community resources and the relative cost of services; - collaborate with other relevant members of the health team; - ensure that when more than one practitioner or service is involved, the activities to achieve goals are communicated and coordinated; - communicate health plan and results in a timely and effective manner to relevant individuals and agencies.		

INTEGRATED HOME HEALTH

CONTINUITY AND COORDINATION

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
♦ maintain communication and linkages within the organization and with outside groups and services to work together in meeting client requirements: - collaborate with client and hospital staff to facilitate continuity during hospital admission and/or discharge; - delegate care, as appropriate, to home support staff, according to established policy and guidelines; - maintain a comprehensive referral network within the organization and with other agencies. **2.2 Services are responsive to community health priorities. The staff:** ♦ ensure services are sensitive to community values and cultural groups. ♦ Involve appropriate individuals and agencies in community service planning, implementation and evaluation by: - providing opportunities for the community to identify their health priorities; - communicating these health priorities to appropriate individuals and agencies; - identifying community strengths, barriers, gaps and duplication; - coordinating with other agencies to promote integrated, co-ordinated services available to all. ♦ provide professional consultation to community groups, as appropriate. ♦ advocate on behalf of individuals, families or groups		

INTEGRATED HOME HEALTH

CONTINUITY AND COORDINATION

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
♦ participate with others in ongoing community health planning, as appropriate: - involve everyone most affected; - based on needs assessment data (e.g., sociodemographics, health status indicators, priorities as defined by community groups, available skills and resources); - identify strategies and activities, responsibility, expected outcomes, completion target dates; - communicate to individuals and agencies, as appropriate; - implement health plan activities; - monitor outcomes and effectiveness of actions and use as the basis for follow up plans.		

INTEGRATED HOME HEALTH

DOCUMENTATION

STANDRD: 3. HEALTH RECORDS ARE MAINTAINED FOR ALL CLIENTS

RATIONALE: A COMPREHENSIVE WELL-MANAGED SYSTEM FOR HEALTH RECORDS ENHANCES THE QUALITY AND COORDINATION OF CARE AND STRENGTHENS COMMUNICATION AMONG MEMBERS OF THE HEALTH TEAM.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
3.1 Client care and services are documented to meet professional, legal and communication requirements. The staff: ♦ ensure client is aware of information recorded about them and their right to review and correct any information: - evidence of compliance with Freedom of Information requirements. ♦ Ensure entries in health record meet professional and legal requirements: - entries are legible, permanent and concise; - approved abbreviations only; - corrections follow legal guidelines; - records are complete and retained as per policy and legal requirements. ♦ Document information required to facilitate communication, continuity and coordination: - evidence of client involvement at all stages of service delivery; - client goals, implementation activities, expected and actual outcomes of service data requirements as determined by MOH/organization.		

INTEGRATED HOME HEALTH

QUALITY IMPROVEMENT

STANDARD: 4. CLIENTS AND THEIR FAMILIES ARE ACTIVELY INVOLVED IN THE EVALUATION OF CARE AND SERVICES.

RATIONALE: ONGOING CLIENT FEEDBACK AND EVALUATION OF SERVICE PROVIDES OPPORTUNITIES TO ENHANCE CLIENT SATISFACTION AND IMPROVE CARE PRACTICES.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
4.1 Services are responsive to client feedback and continually strive to improve the quality and effectiveness of services. The staff: ♦ Identify and monitor indicators of success, including: - client satisfaction; - achievement of mutually negotiated goals in health plan (expected outcomes); - improvement in clients' ability to manage their own health issues. ♦ Seek input from clients regarding their experience with services: - facilitate input on service quality indicators such as, accessibility, continuity, satisfaction through means such as focus groups, surveys and interactions with clients; - listen to clients and respond to their issues and concerns in a timely and considerate manner; - analyze feedback and identify appropriate options; - implement options identified or communicate the need for change to the program manager. ♦ Analyze information and review current practices to maintain service strengths and identify gaps and variance: - between expected and actual outcomes; - between client expectations and service provided; - between activities defined on the health plan and actual activities. ♦ Maintain improvement activities through ongoing monitoring, evaluation and implementation of necessary change.		

ADULT DAY CENTRES

ADULT DAY CENTRES

ADMISSION AND ORIENTATION

STANDARD: 1. CLIENTS ARE WELCOMED AND SUPPORTED ON ADMISSION TO THE ADULT DAY CENTRE. **RATIONALE: PROVIDING INFORMATION AND SUPPORT TO CLIENTS ATTENDING THE CENTRE FACILITATES THEIR ADJUSTMENT, PROMOTES THE DEVELOPMENT OF RELATIONSHIPS AND ENCOURAGES THEIR PARTICIPATION.**		
CRITERIA	LEVEL OF ACHIEVEMENT	**COMMENTS**
During clients' admission and orientation, centre staff: 1.1 review relevant client information to determine if the service request can be met and confirm the acceptance of the referral. 1.2 contact clients within 14 days of referral. 1.3 Interview clients to identify their needs and preferences, and provide information about the centre (e.g. waitlist policy). 1.4 welcome new clients to the centre, familiarize them with their immediate surroundings and introduce them to staff & other clients. 1.5 Provide and document an orientation for clients and their caregivers which includes the following information: - a description of the services, programs and activities offered; - clients' involvement in the interdisciplinary care and services provided; - days and times of attendance and how to contact the centre if unable to attend; community transportation resources and contingency plans if transportation services are disrupted; - client charges (including transportation) and billing procedure - safety and emergency procedures; - client responsibilities e.g. medication, informing staff of changes in their health status; and, - avenues available for the client/caregivers to access information and address concerns. 1.6 document personal and medical information necessary for the immediate delivery of care/services.		

ADULT DAY CENTRES

CLIENT ASSESSMENT AND CARE PLANNING

STANDARD: 2. CLIENTS' INTERESTS, NEEDS AND ABILITIES ARE IDENTIFIED IN A WRITTEN INDIVIDUALIZED CARE PLAN.
RATIONALE: CLIENTS' SITUATIONS ARE UNIQUE. A COMPREHENSIVE PLAN PROMOTES A CONSISTENT APPROACH TO CARE/SERVICE DELIVERY.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
Through an established planning process, centre staff: 2.1 consider clients' cultural traditions, beliefs and practices and personal preferences. 2.2 encourage clients'/caregivers' ongoing collaboration. 2.3 assess clients' interests, needs and abilities utilizing available client assessment information from the client, caregiver, LTC1 and staff. 2.4 assess caregivers' needs and concerns (e.g. respite, education, support and ongoing communication) with the centre. 2.5 develop and document a holistic, individualized care plan, within six client attendance days, which may include: - clients' strengths, limitations and usual routines; - client and staff responsibilities in the delivery of care and services - (e.g. medications); - specific services and programs to address their physical, psychosocial and cultural needs; - advance directives; - clients' goals and time frames for review; - personal support system and involvement with other community services; - transportation requirements; and, - safety considerations.		

ADULT DAY CENTRES

CLIENT ASSESSMENT AND CARE PLANNING

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
2.6 communicate the care plan and changes in care/service delivery to the clients/caregivers. 2.7 review and modify the care plan at least annually or more frequently as required to meet clients' changing needs and preferences. 2.8 participate in interdisciplinary discussions or conferences to address complex or unusual client issues and needs.		

ADULT DAY CENTRES

CLIENT CARE AND SERVICES

STANDARD: 3. CLIENTS ARE SUPPORTED TO PROMOTE AND MAINTAIN THEIR HEALTH AND WELLNESS.

RATIONALE: PROVIDING PROGRAMS AND SERVICES SUPPORTS THEIR INDEPENDENCE AND ASSISTS THEM TO REMAIN IN THEIR HOME.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To provide care and services based on clients' individualized care plans, centre staff: 3.1 promote a team approach to coordinate care and services. 3.2 provide care and services in accordance with the centre's guidelines and their professional practice standards and code of ethics. 3.3 establish a rapport and develop a caring relationship with clients by: - accepting their uniqueness; - recognizing and responding to their verbal/non-verbal cues; - demonstrating a genuine concern; and, - being courteous and dependable. 3.4 advocate on behalf of the clients and caregivers. 3.5 provide a pleasant dining experience which offers opportunities for socialization and considers clients': - preferences (food likes/choices); - requirements for therapeutic/nutritional meals, hydration and snacks; and, - need for assistance with eating (e.g. positioning and utensils). 3.5 encourage and support their participation in a range of therapeutic and recreational programs and activities, which: - are determined by their culture, interests and choice; - acknowledge their limitations;		

ADULT DAY CENTRES

CLIENT CARE AND SERVICES

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
- contribute to feelings of competency and accomplishment; - improve or maintain strengths and abilities, (e.g. socialization skills); and, - are outlined in a monthly calendar and made available to clients and caregivers.		
3.7 encourage independence and offer clients assistance with personal care which may include: - grooming, hygiene and toileting; - skin care; - medications; and, - other presenting needs.		
3.8 monitor clients' health status and provide professional health care services as required.		
3.9 support and assist clients with walking and regular exercise.		
3.10 assist clients to communicate by: - ensuring communication aids are in good repair; - recognizing and responding to their verbal and non verbal cues; - using key phrases in their language; and, - accessing clients, staff and volunteers who speak the client's language.		
3.11 assess and respond to clients' behaviours by: - identifying causes and triggers for behaviour; - recognizing their level of cognition and non-verbal cues; - adopting consistent, calm and compassionate approaches; - encouraging purposeful activities consistent with their previous lifestyle; - providing where possible, a safe, low stimulus environment; and, providing emotional support, information and assistance to caregivers.		

ADULT DAY CENTRES

CLIENT CARE AND SERVICES

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
3.12 monitor the care and services provided and adapt client's care in response to their changing status. 3.13 facilitate continuity of care by: - providing emotional support and information to clients and caregivers; - collaborating with other care providers to provide support, share information and plan the client's care; - coordinating referrals to appropriate community services; and, - providing client's care plan and other pertinent information upon discharge.		

ADULT DAY CENTRES

CLIENT COMFORT AND SAFETY

STANDARD: 4. CLIENTS' NEEDS FOR A COMFORTABLE, SAFE AND SECURE ENVIRONMENT ARE ADDRESSED.

RATIONALE: PROVIDING A COMFORTABLE AND SAFE ENVIRONMENT CONTRIBUTES TO A POSITIVE EXPERIENCE FOR CLIENTS ATTENDING THE CENTRE.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To promote clients' comfort and well-being, centre staff: 4.1 provide a homelike environment by: - considering clients' needs and preferences (e.g. lighting, decor, temperature, furnishings and private/rest area); - supporting their interaction and socialization; and, - encouraging their independence. 4.2 address safety considerations such as: - design features (e.g. finishes, grab bars, handrails, and ramps and walkways that are wheelchair accessible); - maintenance of equipment and furnishings; - secured entrances and exits; - storage for personal belongings, equipment and supplies; and, - a first aid kit. 4.3 identify and respond to specific risk factors for clients (e.g. abuse and neglect, elopement, equipment needs and use of mobility aids). 4.4 follow safe work practices related to: - storage of food, supplies and equipment; - food handling and handwashing; - lifts and transfers; - blood and body fluids exposure management; and, - Workplace Hazardous Materials Information System (WHMIS). 4.5 participate in testing of contingency plans (e.g. fire, earthquakes and bomb threats);		

ADULT DAY CENTRES

CLIENT COMFORT AND SAFETY

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
4.6 ensure the following documented information accompanies clients on outings: - name of centre; - name and telephone number of contact person; - medical problems/allergies/medications; - physician's name and telephone number; - home address and telephone number; and, - recent photograph of the client. **Where the centre owns or operates a vehicle, the staff:** 4.7 follow guidelines to ensure that clients are safely transported. 4.8 insure, inspect, maintain, and operate the centre vehicle as required by the *Motor Vehicle Act*. 4.9 demonstrate their knowledge of safety while transferring, loading and unloading clients and handling emergencies during transport. 4.10 develop and test contingency plans for disruptions in transportation services. 4.11 ensure there is a method for communication in emergencies on client outings (e.g. cellular phone).		

ADULT DAY CENTRES

DOCUMENTATION

STANDARD: 5. THE CARE AND SERVICES PROVIDED TO CLIENTS ARE DOCUMENTED.

RATIONALE: A COMPREHENSIVE, WELL-MANAGED SYSTEM FOR DOCUMENTATION OF CLIENT CARE AND SERVICES ENHANCES CARE PRACTICES AND STRENGTHENS COMMUNICATION AMONG MEMBERS OF THE CARE TEAM.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To support care and service delivery and demonstrate accountability, the centre staff: 5.1 establish and maintain individual client records which: - provide an overall picture of the client and their plan of care; - describe the care provided; - summarize interdisciplinary conferences including decisions made and actions taken; and, - indicate care outcomes. 5.2 ensure that clients' records are accessible to relevant members of the care team. 5.3 review documentation on the clients' records to evaluate and improve the quality of care and services provided. 5.4 adhere to legal, professional and legislative requirements for records management (e.g. Freedom of Information and Protection of Privacy, consent and confidentiality). 5.5 monitor and modify documentation practices to meet changes in legislative requirements and the needs of the centre.		

ADULT DAY CENTRES

QUALITY IMPROVEMENT

STANDARD: 6. CLIENTS AND THEIR CAREGIVERS ARE ACTIVELY INVOLVED IN THE EVALUATION OF CENTRE CARE AND SERVICES.

RATIONALE: ONGOING COMMUNICATION WITH CLIENTS AND CAREGIVERS PROVIDES OPPORTUNITIES TO ENHANCE THEIR SATISFACTION AND IMPROVE THE OUTCOME OF CARE.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To improve care and service delivery, the centre staff: 6.1 ensure clients/caregivers know who to contact with their questions and concerns. 6.2 listen to clients/caregivers and respond to their issues and concerns in a timely and considerate manner. 6.3 seek input from clients/caregivers regarding their experience with the care and services they receive through: - staff/client interactions; - care team/interdisciplinary conferences; - surveys; and, - suggestion boxes. 6.4 identify aspects of care and services that are important to clients/ caregivers, and consider these factors when implementing changes. 6.5 review the changes made in care and service delivery to determine if the best possible outcome has been achieved for clients/caregivers. 6.6 maintain improvements in care and service delivery through ongoing monitoring and evaluation.		

HOME SUPPORT SERVICES

HOME SUPPORT SERVICES

ADMISSION AND ORIENTATION

STANDARD: 1. CLIENTS ARE INFORMED OF THE SERVICES THEY WILL RECEIVE.

RATIONALE: THE ESTABLISHMENT OF A POSITIVE SERVICE RELATIONSHIP IS MOST LIKELY TO OCCUR WHEN CLIENTS UNDERSTAND THE SCOPE OF SERVICE, THEIR RESPONSIBILITIES AND THE RESPONSIBILITIES OF THE AGENCY.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
During clients' admission and orientation, the staff: 1.1 review relevant client information to determine if the service request can be met and confirm the acceptance of the referral. 1.2 contact the client to confirm service arrangements. 1.3 provide and document an orientation for clients/caregivers which includes: - a description of services offered; - an overview of clients' and staff roles and responsibilities; - relevant agency policies (e.g. client funds, personal valuables and the requirement for the client to be present during service delivery); - the agency code of conduct for staff (e.g. accepting gifts, smoking); - the process for contacting the agency during regular office hours and after hours; - the verification of authorized services, the billing procedure and cancellation policy; and, - avenues available for the client/family to access information and address concerns. 1.4 identify and discuss potential safety risks in the home with clients and caregivers; and inform them of their responsibility to provide a safe environment.		

HOME SUPPORT SERVICES

CLIENT SERVICE PLAN

STANDARD: 2. CLIENTS' CARE AND SERVICE REQUIREMENTS ARE IDENTIFIED AND ADDRESSED IN A CURRENT, INDIVIDUALIZED, WRITTEN SERVICE PLAN

RATIONALE: CLIENTS' SITUATIONS ARE UNIQUE. A CLIENT SPECIFIC SERVICE PLAN, SHARED AMONG AGENCY STAFF, PROMOTES A CONSISTENT APPROACH TO CARE AND SERVICE DELIVERY.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
During the planning process, the staff: 2.1 review the clients' assessment information. 2.2 consider clients' cultural traditions, beliefs, practices and personal preferences. 2.3 develop and document a holistic individualized service plan in collaboration with clients and caregivers which includes: - clients' interests, needs and usual routines; - clients' strengths and abilities; - goals and time frames for review; - client, caregiver and team member's responsibilities in the delivery of care and service; - client specific instructions including: Personal Assistance Guidelines; and, - safety considerations. 2.4 ensure the service plan is documented and accessible to relevant staff and when in the home, the client's privacy is respected. 2.5 communicate the service plan and any changes in service delivery to the care team, clients and where appropriate, their caregivers.		

HOME SUPPORT SERVICES

CLIENT SERVICE PLAN

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
2.6 review and modify the service plan in response to the changing needs and preferences of the client. 2.7 initiate and participate in interdisciplinary discussions/conferences to address complex or unusual client issues and needs.		

HOME SUPPORT SERVICES

CARE AND SERVICES

STANDARD: 3. CLIENTS ARE SUPPORTED TO REMAIN IN THEIR HOME ENVIRONMENT AND TO ACHIEVE AN OPTIMAL LEVEL OF HEALTH AND WELL BEING.

RATIONALE: PROVIDING CLIENTS ASSISTANCE WITH THEIR ACTIVITIES OF DAILY LIVING AND MANAGEMENT OF THEIR HOME SUPPORTS THEIR AUTONOMY AND ASSISTS THEM TO MAINTAIN THEIR INDEPENDENCE.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To provide care and services, the staff:[8]		
3.1 promote a team approach to coordinate care and services.		
3.2 adhere to their agency's guidelines and their professional practice standards and code of ethics.		
3.3 establish a rapport and develop a caring relationship with clients by: - accepting their uniqueness; - recognizing and responding to their verbal/non-verbal cues; - demonstrating a genuine concern; and, - being courteous and dependable.		
3.4 advocate on behalf of the clients and caregivers.		
3.6 support clients' independence and offer them assistance with personal care, ADL and IADL's as outlined in their individualized service plan.		
3.7 review clients' status, recognize and respond to their care needs and report any significant changes to the case manager and/or other members of the care team (e.g. coping, nutrition, comfort, behaviour, mobility and safety).		

[8] In the case of Home Support Services, "staff includes the agency supervisor and the home support worker."

HOME SUPPORT SERVICES

CARE AND SERVICES

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
3.7 develop and follow safe work practices related to: - storage of food, supplies and equipment; - foodhandling and handwashing; - lifts and transfers; - universal precautions; and, - Workplace Hazardous Materials Information System (WHMIS). 3.8 identify and respond to specific risk factors for clients (e.g. abuse and neglect, equipment and use of mobility aids). 3.9 monitor and evaluate the service provided and adapt client's care in response to their changing status. 3.10 facilitate continuity of care by: - providing emotional support and information to clients and caregivers; - collaborating with other care providers to provide support, share information and plan the client's care; - coordinating referrals to appropriate community services; and - providing client's care plan and other pertinent information upon discharge; and, - maintaining where possible consistent staff assignments.		

HOME SUPPORT SERVICES

DOCUMENTATION

STANDARD: 4. THE CARE AND SERVICES PROVIDED TO CLIENTS ARE DOCUMENTED.

RATIONALE: A COMPREHENSIVE, WELL-MANAGED SYSTEM FOR DOCUMENTATION OF CLIENT CARE AND SERVICES ENHANCES CARE PRACTICES AND FACILITATES COMMUNICATION AMONG MEMBERS OF THE CARE TEAM.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To support care and service delivery and demonstrate accountability, the staff: 4.1 establish and maintain individual client records which: - provide an overall picture of the client and their plan of care; - describe the care provided; - summarize interdisciplinary conferences including decision made and actions taken; and, - indicate care outcomes. 4.2 ensure that the client's record is accessible to relevant members of the care team. 4.3 review documentation on the client's record to evaluate and improve the quality of care and services provided. 4.4 adhere to legal, professional and legislative requirements for records management (e.g. Freedom of Information and Protection of Privacy, consent and confidentiality). 4.5 monitor and modify documentation practices to meet changes in legislative requirements and the needs of the agency.		

HOME SUPPORT SERVICES

QUALITY IMPROVEMENT

STANDARD: 5. CLIENTS AND THEIR FAMILIES ARE ACTIVELY INVOLVED IN THE EVALUATION OF CARE AND SERVICES.

RATIONALE: ONGOING COMMUNICATION WITH CLIENTS AND CAREGIVERS PROVIDES OPPORTUNITIES TO ENHANCE THEIR SATISFACTION AND IMPROVE THE OUTCOME OF CARE.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To improve care and service delivery, the staff: 5.1 ensure clients/caregivers know who to contact with their questions and concerns. 5.2 listen to clients/caregivers and respond to their issues and concerns in a timely and considerate manner. 5.3 seek input from clients/caregivers regarding their experience with the care and services they receive through: - staff/client interactions; - care team/interdisciplinary conferences; - surveys; and, - suggestion boxes. 5.4 identify aspects of care and services that are important to clients/ caregivers, and consider these factors when implementing changes. 5.5 review the changes made in care and service delivery to determine if the best possible outcome has been achieved for clients/caregivers. 5.6 maintain improvements in care and service delivery through ongoing monitoring and evaluation.		

RESIDENTIAL SERVICES

RESIDENTIAL SERVICES

PRE - ADMISSION

STANDARD: 1. PROSPECTIVE RESIDENTS, FAMILIES AND CAREGIVERS ARE PROVIDED WITH SUFFICIENT INFORMATION TO MAKE A DECISION ABOUT THE SUITABILITY OF THE FACILITY.

RATIONALE: RESIDENTS, THEIR FAMILIES AND CAREGIVERS ARE ABLE TO MAKE INFORMED DECISIONS WHEN THEY UNDERSTAND THE CARE AND SERVICES THE FACILITY PROVIDES.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
Prior to admission, the facility staff:		
1.1 discuss and provide prospective residents/caregivers with written information which includes: - care and services; - the facility's philosophy of care; - organizational structure; - types and qualifications of staff; - admission procedure; - access to community resources (e.g. advocacy groups, counsellors and volunteer services); - physical environment and resident's personal space and furnishings; - programs, services, supports; and, - pertinent policies related to care planning, food services, medications, smoking, alcohol use, visiting, restraints, pets, per diem cost, personal charges (e.g. dental), and personal belongings.		
1.2 discuss with residents/caregivers program policies, the length of the waitlist, levels of care and the capacity of the facility to accommodate residents' long term needs.		
1.3 inform prospective residents/families of the facility's guidelines regarding communicable disease screening, medical history and advance directives.		
1.4 provide a tour of the facility.		

RESIDENTIAL SERVICES

ADMISSION AND ORIENTATION

STANDARD: 2. RESIDENTS ARE WELCOMED AND SUPPORTED DURING THEIR ADMISSION TO THE FACILITY.

RATIONALE: PROVIDING INFORMATION TO RESIDENTS AND CAREGIVERS ENHANCES THEIR UNDERSTANDING OF THE FACILITY SERVICES, REDUCES THEIR ANXIETY AND EASES THE RESIDENTS ADJUSTMENT TO THEIR NEW HOME.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
During residents' admission and orientation, the interdisciplinary team[9]: 2.1 welcomes residents/caregivers, familiarizes them with their surroundings, and introduces them to residents and staff. 2.2 provides and documents an individualized orientation for residents/ caregivers which includes: - an overview of residents' rights and responsibilities; - staff roles; - resident care and activities; - involvement of residents/caregivers in facility life; - avenues available for the residents/caregivers to access information and address concerns; - emergency/safety procedures; and, - a review of pre-admission information. 2.3 reviews and completes the facility agreement with residents and/or their representatives which may include: - values and philosophy of care; - levels of care; - relevant policies of the facility; - the layout of the facility and grounds; - social and recreational activity		

[9] See glossary for a definition of interdisciplinary team.

RESIDENTIAL SERVICES

ADMISSION AND ORIENTATION

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
- expectations, types and qualifications of staff, services available in the facility; - process for initial assessment and care plan development; - process for ongoing monitoring, revisions to care/service plans, and care conferences; and, - personal charges (e.g. billing procedures, per diem and laundry).		

RESIDENTIAL SERVICES

ASSESSMENT

STANDARD: 3. RESIDENTS' INDIVIDUAL HEALTH NEEDS AND PSYCHOSOCIAL STATUS ARE ASSESSED BY THE INTERDISCIPLINARY TEAM.

RATIONALE: A HOLISTIC ASSESSMENT IDENTIFIES RESIDENTS' ABILITIES AND NEEDS AND PROVIDES THE INFORMATION NECESSARY TO DEVELOP AN INDIVIDUALIZED CARE PLAN.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
During assessment, the interdisciplinary team: 3.1 reviews residents' pre-admission and admission documents; the physician's assessment and orders, and other pertinent health assessments. 3.2 collaborates with residents/caregivers and other members of the care team to identify residents' needs and abilities. 3.3 completes and documents an initial assessment[10] of residents within 24 hours of admission which identifies: - immediate care needs (e.g. diet and medication); - risk factors (e.g. allergies, dysphagia, falls, behaviour); - personal preferences; and, - contact person. 3.4 completes and documents a holistic assessment within 6-8 weeks of admission which identifies residents': - strengths, abilities and limitations; - health perception, needs and goals; - need for support, education and learning (e.g. adaptive devices, nutrition, hydration and medication);		

[10] Content of 3.3 is an appropriate level of assessment for residents admitted for respite.

RESIDENTIAL SERVICES

ASSESSMENT

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
- functional status including: . cognition, . communication, . ADL and mobility; and . behavioral and emotional needs. - social history and life skills; - personal support system; - therapeutic recreation and leisure interests; - spiritual and cultural beliefs; and, - preferences regarding advance directives and degrees of intervention. 3.5 analyzes all assessment information to develop the resident's plan of care. 3.6 identifies care needs that cannot be met in the facility and collaborates with community resources to find appropriate alternatives.		

RESIDENTIAL SERVICES

RESIDENT CARE PLAN

STANDARD: 4. RESIDENTS' NEEDS, ABILITIES AND HEALTH ISSUES ARE ADDRESSED IN A CURRENT, WRITTEN, INDIVIDUALIZED CARE PLAN.

RATIONALE: A COMPREHENSIVE CARE PLAN THAT RECOGNIZES THE UNIQUENESS OF RESIDENTS, PROMOTES A CONSISTENT APPROACH TO CARE DELIVERY.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
During the care planning process, the interdisciplinary team:		
4.1 encourage the participation of the resident and their caregiver.		
4.2 develops a holistic, individualized care plan which includes: - resident's interests, needs and usual routines; - resident's strengths, abilities, limitations and concerns; - care interventions; - resident and team members responsibilities in the delivery of care; - safety considerations; and, - time frames for review.		
4.3 conducts an initial care conference within 6-8 weeks of admission to review and discuss the assessment data and determine the care plan.		
4.4 communicates the care plan to members of the interdisciplinary team and residents/families as appropriate.		
4.5 conducts a case conference to review and modify the plan at least annually and when required, to address residents changing needs and preferences.		
4.6 seeks clinical expertise to address complex or unusual resident issues and needs (e.g. Geriatric Assessment Teams).		

RESIDENTIAL SERVICES

RESIDENT CARE AND SERVICES

STANDARD: 5. RESIDENTS ARE SUPPORTED TO MAINTAIN THEIR HEALTH AND WELL BEING.

RATIONALE: PROVIDING CARE AND SERVICES WHICH RESPOND TO RESIDENTS' NEEDS AND RESPECT THEIR LIFESTYLE CHOICES IS FUNDAMENTAL TO THEIR HEALTH AND SENSE OF WELL BEING.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To support and assist residents, the interdisciplinary team:		
5.1 creates a warm, secure, homelike setting for residents by: - demonstrating a genuine concern for their well being; - accepting their uniqueness - respecting their privacy and lifestyle choices; - including them in decisions regarding facility life; and, - welcoming their caregivers/family members to participate in facility activities.		
5.2 promotes a team approach to coordinate care and services.		
5.3 provides care and services in accordance with the facility's guidelines and their professional practice standards and code of ethics.		
5.4 advocates on behalf of residents and their families.		
5.5 recognizes and accommodates residents' preferred bedtimes, awakening times and other sleep/rest routines.		
5.6 encourages independence and offers residents assistance with their personal care which includes: - oral care; - grooming, appearance and preferred style of dress; - bathing, skin and nail care; - toileting; - peri-care; and, - continence management.		

RESIDENTIAL SERVICES

RESIDENT CARE AND SERVICES

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
5.7 provides nursing treatments such as: wound care, management of infections, ostomy care, tube feedings and oxygen therapy.		
5.8 supports and assists residents to maintain their mobility through walking programs and regular exercise(8)		
5.9 assists residents to communicate by: - ensuring communication aids are available and in good repair; - recognizing and responding to their verbal and non verbal cues; - using key phrases in their language; and, - accessing residents, staff and volunteers who speak the resident's language.		
5.10 provides a pleasant dining experience which offers opportunities for socialization and considers residents': - requirements for therapeutic/nutritional meals, hydration and snacks; - preferences (e.g. company for meals, serving time, location, food likes/choices), and, - need for assistance with eating (e.g. positioning and utensils).		
5.11 encourages and supports residents to participate in a range of therapeutic programs and recreational activities of their choice which: - are determined by their interests, needs and abilities; - acknowledge their limitations; - contribute to feelings of competency and accomplishment; - improve or maintain strengths and abilities (e.g. socialization skills), and, - are outlined in a monthly calendar and made available to residents and their families.		

RESIDENTIAL SERVICES

RESIDENT CARE AND SERVICES

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
5.12 recognizes and responds to residents' comfort and pain level.		
5.13 supports residents to maintain their spirituality by encouraging their involvement in religious services and customs known to be important to them.		
5.14 anticipates, recognizes, supports and responds to residents' with palliative care needs by: - monitoring and controlling symptoms; - adapting routines to accommodate residents/caregivers need for privacy and modified routines; - providing emotional support and information to residents/ caregivers; and, - collaborating with community resources to arrange counselling, hospice and chaplain services.		
5.15 assesses and responds to residents behaviour (e.g. agitation, depression, acute confusion, dementia and delusions) by: - identifying causes and triggers for behaviour; - recognizing their level of cognition and non-verbal cues; - adopting consistent, calm and compassionate approaches; - encouraging purposeful activities consistent with their previous lifestyle; - providing, where possible, a safe, low stimulus environment; and, - providing emotional support, information and assistance to families.		
5.16 respects residents' right to independence and to be at risk by: - identifying and discussing with families potential and actual risks to the resident; - exploring options for minimizing the risk; - supporting residents' optimum level of functioning; and, - adapting the environment to promote their safety and the safety of staff.		

RESIDENTIAL SERVICES

RESIDENT CARE AND SERVICES

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
5.17 **in the exceptional instance when restraint[11] is necessary** ensures that; - all reasonable alternatives have been explored with the resident, caregiver and care team; - the least restrictive type is used; - the designated family member is informed of the application of a restraint; - the residents' emotional and physical needs are met; - their comfort and safety are monitored; and, - the need for restraint use is reassessed. 5.18 monitors and evaluates the resident's health status and adapts their care and care plan accordingly. 5.19 facilitates continuity of care by: - providing information and emotional support to residents and their caregivers; - communicating with other care providers to provide support, share information and plan the resident's care; - coordinating referrals to appropriate community services; and, - providing residents' care plan and other pertinent information upon transfer and/or discharge.		

[11] See definition of restraint in the glossary.

RESIDENTIAL SERVICES

DOCUMENTATION

STANDARD: 6. THE CARE AND SERVICES PROVIDED TO RESIDENTS ARE DOCUMENTED.

RATIONALE: A COMPREHENSIVE, WELL-MANAGED SYSTEM FOR DOCUMENTATION OF RESIDENT CARE AND SERVICES ENHANCES CARE PRACTICES AND STRENGTHENS COMMUNICATION AMONG MEMBERS OF THE CARE TEAM.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To support care and service delivery and demonstrate accountability, the interdisciplinary team: 6.1 establishes and maintains individual resident records which: - provide an overall picture of the resident and their plan of care; - describe the care provided; - summarize interdisciplinary conferences including decisions made and actions taken; and, - indicate care outcomes. 6.2 ensures that the resident's record is accessible to relevant members of the care team. 6.3 reviews documentation on the resident's record to evaluate and improve the quality of care and services provided. 6.4 adheres to legal, professional and legislative requirements for records management (e.g. Freedom of Information and Protection of Privacy, consent and confidentiality). 6.5 monitors and modifies documentation practices to meet changes in legislative requirements and the needs of the facility.		

RESIDENTIAL SERVICES

QUALITY IMPROVEMENT

STANDARD: 7. RESIDENTS AND THEIR CAREGIVERS ARE ACTIVELY INVOLVED IN THE EVALUATION OF CARE AND SERVICES.

RATIONALE: ONGOING COMMUNICATION WITH RESIDENTS AND CAREGIVERS PROVIDES OPPORTUNITIES TO ENHANCE THEIR SATISFACTION AND IMPROVE THE OUTCOME OF CARE.

CRITERIA	LEVEL OF ACHIEVEMENT	COMMENTS
To improve care and service delivery, the interdisciplinary team: 7.1 ensures clients/caregivers know who to contact with their questions and concerns. 7.2 listens to clients/caregivers and responds to their issues and concerns in a timely and considerate manner. 7.3 seeks input from residents/caregivers regarding their experience with the care and services they receive through: - staff/client interactions; - care team/interdisciplinary conferences; - surveys; and, - suggestion boxes. 7.4 identifies aspects of care and services that are important to residents/ caregivers, and considers these factors when implementing changes. 7.5 reviews the changes made in care and service delivery to determine if the best possible outcome has been achieved for residents/ caregivers. 7.6 maintains improvements in care and service delivery through ongoing monitoring and evaluation.		

GLOSSARY OF TERMS

GLOSSARY

For the purpose of this document, the following interpretations have been used:

Abuse - any action/inaction which jeopardizes the health or well-being of a person and may include physical abuse, psychological or emotional abuse, financial abuse or exploitation, sexual abuse, medication abuse, violation of civil/human rights or neglect. (Inter Ministry Committee on Elder Abuse)

Access - refers to client ease of obtaining appropriate service.

Actions/Activities - specific activities carried out by the client or staff which contribute to meeting client health goals as defined in the health plan; includes health interventions and treatment.

Acute Service - services designed for clients with an acute condition who will likely return to pre-episodic level of functioning and self care. Ultimate objective of service is to eliminate symptoms and/or existing health issues for which the client was admitted. Service is time limited.

Advance Directive - a document allowing a person to give directions about future medical care or to designate another person(s) to make medical decisions if they should lose decision making capacity.

Advocacy - representation of individuals who are unable to act on their own behalf. This ensures the preservation of the individual's rights and access to the resources which will enable individuals to fulfil their responsibilities. (CCHSA, 1996)

Appropriateness - extent to which a particular procedure, treatment, test or service is effective, clearly indicated, adequate in quantity and provided in the setting best suited to the client's needs. (JCAH, 1996)

Assessment - process of collecting, validating, reflecting, understanding and interpreting necessary information obtained through participatory dialogue, active listening, critical questioning, observation, interview, record review and testing for the purposes of determining client abilities, challenges and possibilities to maintain or improve their health.

Best Practices - superior method or an innovative practice that contributes to improved performance and is developed through a formal process that incorporates best scientific evidence and expert opinion. (Adapted from JCAH, 1996)

Caregiver	- a family member, significant other or volunteer who contributes the benefits of medical, social, economic or environmental resources to a dependent or partially dependent individual. (Adapted from JCAH, 1995)
Care Conference	- health team discussion (may include client) focusing on an individual client/resident for the purpose of communication, coordination and evaluation of care.
Care Plan	- an individualized action plan that takes into account the client's unique needs, the goals of care, implement, direct and evaluate the client's care. (CCD Standards, 1989)
Care plan review	- a process for reviewing and making documented changes in client care or services in accordance with changes in their condition, psychosocial status, response to care, achievement of goals within specified time frames and changes in the environment. (Adapted form JCAH, 1995)
Case management	- the involvement of a health care provider to assist a client in assessing health and social service systems and to assure that all required services are obtained. (Mosby, 1995)
Case manager	- a care provider specialized in co-ordination of the overall needs of the client with the health care resources of the community.
Chronic Service	- services designed for clients with chronic disabilities/conditions. Ultimate objective is maintenance of current level of functioning or slowing/preventing deterioration. Service may or may not be continuous.
Client	- refers to individuals/groups/communities receiving the care or service and their representative (family, caregiver, delegate).
Client Centred	- identifying the client and simplifying, refocussing and redesigning the organization's processes so that resources are organized and allocated based on client needs. (CCHSA, 1995)
Client Directed	- an approach to service that embraces a philosophy of respect for, and partnership with people receiving service. It recognizes the autonomy of individuals, the need for client choice in making decisions about their requirements, client abilities, and the need to ensure that the service fits the context in which the client lives. (Law, Batiste and Mills)
Client Record	- the service provider's documentation related to pertinent aspects of the client's history including the services provided and the outcome of such interventions. (Standards Manual for Individuals Providing Brain Injury Services to Residents of British Columbia)
Client Satisfaction	- the degree to which service meets or exceeds client expectations.

Collaborative	- a joint communicating and decision making process with the expressed goal of working together with clients towards identified health outcomes, while respecting the uniqueness and diversity of each member of the team. (Draft Definition of MOH, RNABC and BCHA, 1996)
Community	- the individuals, families, groups, agencies or institutions within the locality served by the organization. (JCAH, 1995)
Continuity of Care	- a component of client care quality consisting of the degree to which the care/services needed is coordinated among practitioners and across organization and time. (JCAH, 1995)
Coordination	- process of coordinating services provided by an organization, including referral to appropriate community resources and liaison with other providers to meet the ongoing identified needs of clients, to ensure implementation of the plan of service and to avoid unnecessary duplication of services. (CCHSA, 1996)
Credentialling	- process which includes competencies, knowledge and skills to be certified; assessment of each individual to determine compliance with requirements; issuance of a document to attest to the individual's possession of the requisites. (CCHSA, 1995)
Criteria	- focused, measurable, specific expectations of performance with respect to achievement of a particular standard.
Data	- organized facts from which information can be generated. (CCHSA, 1996)
Degrees of intervention	- a continuum of care options appropriate in the management of long term care clients. It is comprised of care options ranging from supportive care (relief of pain) to admission to intensive care and cardio-pulmonary resuscitation. (Adapted from Mosby, 1995)
Delegation	- assigning of authority to care provider/home support worker to carry out a particular professional task in a situation where there is a professional who agrees to accept the delegation of responsibility and can ensure the care provider/worker has adequate knowledge and skills to perform the task safely.
Discharge	- to discontinue active treatment or intervention.
Effectiveness	- service that has the most positive health outcomes (quality care).
Efficiency	- service that is managed and delivered at the lowest cost consistent with quality care.
Eligibility	- the entitlement of an individual to access the programs/services funded directly or indirectly by the Ministry of Health.

Equity	-	services are equally available to all regardless of their age, gender, national and ethnic origin, geographic location, race, colour, language, creed, religion, sexual orientation, diagnosis, disability, availability of primary caregiver, ability to pay, criminal conviction, family status. (Canadian Palliative Care Association, 1995)
Ethics	-	standards of conduct that are morally and culturally correct. (CCHSA, 1997)
Evaluation	-	assessment of the degree of success in meeting the goals of the organization, organizational unit or client. (CCHSA, 1997)
Evidence based	-	practice of any professional group that is based on a theoretical body of knowledge, empirically evaluated and is known to be beneficial and effective for the client. (CCHSA, 1997)
Family	-	an individual's immediate relatives and/or significant others. (CARF, 1996)
Goal	-	a statement of what is to be accomplished. (CCD Standards, 1989)
Guidelines	-	statements which lead, guide, or direct activity and/or provide a suggested framework for action. (Wagner))
Health	-	extent to which an individual or group is able, on the one hand to develop aspirations and satisfy needs and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is seen as a positive concept emphasizing social and personal resources, as well as physical capacities. (CCHSA, 1996)
Health Issue	-	a concern that interferes with the health and wellbeing of individuals and groups.
Health Plan	-	see care plan.
Health Promotion	-	process that enables people to increase control over, and to improve their health (WHO, 1986)
Health Status	-	an indication of the health and wellbeing of an individual, group or population. (MOH, 1996)
Health Team	-	health professionals, care staff and client working collaboratively to achieve common client goals through an identified health plan.
Holistic	-	a system of comprehensive client care that considers the physical, emotional, social, economic and spiritual needs of the individual, their response to the illness and the effect it has on their ability to meet self-care needs.(Mosby, 1995)

Indicator	- a measurement tool, screen or flag which is used as a guide to monitor the quality or appropriateness of an important aspect of care or service. Indicators may be seen to support criteria by identifying individual cases of apparent substandard care or outcomes needing an in-depth review. (Adapted from Wagner and Wilson)
Industry Standard	- a practice, rule, principle or measure established as a model or example by authority, custom or general consent.
Informal Caregiver	- any unpaid person providing support and care to the client. May be a volunteer, family member or friend. (Canadian Palliative Care Association, 1995)
Information Management	- an organization-wide function that includes clinical, financial and administrative databases (CCHSA,1996)
Informed Consent	- consent given by a client who understands the information provided by the health professional about his/her condition and the proposed health care options, if any, and the specific consequences of accepting or declining the recommended treatment. Informed consent confirms the right of a capable adult to give or refuse consent to health care, and to name a substitute consent person(s) when an adult is not capable of providing "informed consent". (CCHSA, 1996)
Intake	- process where information is collected about a person who has been referred as a potential client and a decision is made whether to refer that person to an external agency or to accept that person as a client.
Interdisciplinary	- a variety of disciplines that participate in the assessment, planning, and/or implementation of a person's care. (e.g. Physicians, pharmacists, dietitians). (Adapted from CARF, 1993)
Leadership	- those individuals in an organization who set expectations, develop plans and implement processes to assess and improve the quality of the organization's governance, management and support functions. (e.g. governing body, CEO and senior managers and staff). (JCAH, 1995)
Mission	- a clear written statement of the purpose of the organization which focuses the direction and character of its programs and services toward the fulfilment of this purpose; encompasses a statement of philosophy. (CCD Standards, 1989)
Objectives	- specific, realistic, and measurable statements that support the attainment of longer term goals. (Standards Manual for Individuals Providing Brain Injury Services to Residents of British Columbia)
Palliative Service	- services designed for clients with an end stage illness or preparing for death. Ultimate objective of service is enhancement of client's condition, dignity, quality of life and to relieve, eliminate and/or control symptoms. Service may or may not be continuous.

Partnership - a collaborative relationship in which all parties share power.

Performance Indicators - valid and reliable quantitative process or outcome measures related to one or more dimensions of performance. (Hersey and Banchard)

Personal Information - recorded information about an identifiable individual. (FOIPP)

Policy - written statement that identifies and interprets the organization's position on a given subject. Policies prescribe limits, assign responsibility, set out expectations and serve as a basis for on site decision making. (MOH)

Procedure - written set of instructions conveying the approved and recommended steps for a particular act or sequence of acts.

Quality Assurance - a planned and systematic activity for monitoring and evaluating the quality of care and services, including a plan of action(s) and follow-up to ensure the action(s) is effective in continuously improving the quality of care and services. (CCHSA, 1992)

Quality of Life - the degree to which the client is satisfied that they have opportunities to achieve happiness and fulfilment. (Green and Kreuter)

Quality Improvement - the effort to improve the level of performance of a process. It involves measuring the level of current performance, finding ways to improve that performance, and implementing new and better methods.(Berwick)

Requirements - - physical, psychological, social or environmental factors that contribute to health and wellbeing. They may or may not be perceived or expressed by the person/group in need. They must be distinguished from demands which are expressed desires not necessarily needed. (Adapted from CCHSA, 1996)

Resident - a person living in a residential care facility. (CCD Standards, 1989)

Respite - the provision of services to a client in order to permit a period of relief or rest for the primary caregiver. (CCD Respite Committee)

Restraint - any chemical, electronic, mechanical, physical, or other means of controlling a resident's freedom of movement.

Risk Management - a system for the detection, evaluation, prevention and resolution of risks: involving losses by an organization from injury to people and damage to property. (Rozovsky and Rozovsky, 1983)

Safety - degree to which risk of an intervention and risk in the environment in which service is provided are reduced for the client and others, including the staff and volunteers. (CCHSA, 1996)

Service Delivery Plan	- an individualized plan developed for the coordination of client services considering factors such as client preference; level of care; appropriateness of available option; availability of family and community support systems. (CCD Standards, 1989)
Sound	- demonstrating good judgement, based on thorough knowledge and experience.
Stakeholder	- an individual or group having an interest in the organization
Standard	- an established, measurable, achievable and understandable statement of expectations which describes a (desirable) level of performance against which actual performance can be compared. (Adapted from Wagner)
	Structural Standard focus on the framework that provides support for the actual provision of care in an organization. They tend to measure the capacity to deliver the services rather than the quality of the actual services rendered. (Adapted from Wagner)
	Process Standard focus on the staff and the service delivery process. These standards are usually written in terms of actions and/or behaviours. (Adapted from Wagner)
	Outcome Standard the end result of goal directed action. (Adapted from Wagner)
Stewardship	- the responsibility of being entrusted as caretaker or custodian by effectively managing the affairs of an organization. (Adapted from Mosby, 1995)
Timely	- service that occurs at a point where it is most beneficial or necessary. (JCAH, 1995)
Utilization Management	- a systematic approach to measure, understand and reduce inappropriate utilization of resources with the t objective to contain costs and improve the quality of care. (Adapted from Harrigan, 1992)
Values	- a basic set of beliefs which communicate what is important to the organization, what it stands for and how it operates on a day to day basis in pursuit of it's vision. (Hersey and Banchard)
Vision	- provides a picture of the future you seek to create described in the present tense, which guides all organizational activities. (Kouzes and Posner)
Wellbeing	- a dimension of health beyond the absence of disease or infirmity, including social, emotional, and spiritual aspects of health. (Green and Kreuter)

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